NM Medicaid School-Based Services

Administrative Claiming Implementation Plan

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HEALTH CARE AUTHORITY

NM Health Care Authority
Medical Assistance Division

NEW MEXICO MEDICAID SCHOOL-BASED SERVICES ADMINISTRATIVE CLAIMING IMPLEMENTATION PLAN

TABLE OF CONTENTS

I. INTRODUCTION 1

II. MEDICAID SCHOOL-BASED SERVICES PROGRAM ADMINISTRATION 1

III. INTERAGENCY AGREEMENTS 3

IV. MSBS PROVIDER PARTICIPATION REQUIREMENTS 3

V. RANDOM MOMENT TIME STUDY 4

VI. ADMINISTRATIVE CLAIMING COST ALLOCATION AND METHODOLOGY 13

VIII. TRAINING 16

IX. DOCUMENTATION 17

X. CLAIMS SUBMISSION 17

XI. STATE AND FEDERAL ACCESS TO RECORDS 18

XII. MONITORING AND OVERSIGHT 18

XIII. PROVIDER COMPLIANCE 19

XIV. CONCLUSION 20

Appendix A: HCA/PED Interagency Governmental Services Agreement FY 24-27

Appendix B: MSBS Governmental Services Agreement FY 25-28

Appendix C: MSBS for Recipients 0-21 Years of Age Program Activity Time Study Codes

Appendix D: New Mexico MAC Program Random Moment Time Study (RMTS) Guide

Appendix E: New Mexico MAC Program Random Moment Time Study (RMTS) Sampled Staff Training

Appendix F: New Mexico MAC Program Random Moment Time Study (RMTS) Coder Training

I. INTRODUCTION

Healthy children and youth have a better chance of achieving academic, social and personal success than children and youth who are singled-out because they have an unmet health need or disability that interferes with their capacity to learn. Because of their position in the daily lives of children, youth and their families, New Mexico schools are poised to offer unique advantages and opportunities that can help families access health information, facts about Medicaid enrollment and medical and behavioral health services. Under the auspices of the Medicaid School-Based Services (MSBS) program, New Mexico schools offer key health and health-related services that are designed to facilitate and maintain active learning for Medicaid-eligible children with special education and health care needs.

The New Mexico Health Care Authority (HCA) added the MSBS program, formerly known as Medicaid in the Schools (MITS), in 1995 as a Medicaid-covered benefit for children and youth under 21 of age. At the time, for a school to receive reimbursement for services through the MSBS program, each Medicaid-eligible recipient was required to have an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) that specifies the services required to treat (through correction, amelioration, or the prevention of deterioration) his or her identified medical condition(s).

Since its inception, the MSBS program has undergone a number of changes. In 2002, the program saw the addition of nursing services and the termination of administrative claiming. In 2003 the program again saw change, beginning with a renewed commitment to revisit and improve upon all aspects of MSBS and to bring back administrative claiming to participating school districts. In October 2004, the program was changed to include an MSBS revised time study, a reorganization of state staff, and new measures for ensuring program accuracy and success. In the 2010-2011 school year, New Mexico transitioned the program to a competitively procured statewide contractor for purposes of program administration in coordination and under the direction of HCA. Additional changes were presented in 2015 to accommodate the state moving to a cost-based reporting methodology for its direct service program which resulted in some minor changes to the time study process as outlined in this document. Effective state fiscal year 2023, HCA will be expanding the coverage of school-based services from Medicaid enrolled students with an IEP/IFSP to include all Medicaid enrolled students where medical necessity has been otherwise established. This change was made in accordance with CMS-issued State Medicaid Director Letter (SMDL) 14-006, the Free Care provision from CMS policy adding medically necessary services.

II. MEDICAID SCHOOL-BASED SERVICES PROGRAM ADMINISTRATION

At the beginning of 2003, an organizational unit was created within the New Mexico Human Services Department Medical Assistance Division (HSD/MAD) devoted exclusively to Medicaid school health issues and more specifically, to the administration and management of the MSBS program. Due to a state reorganization in 2024, the state agency was renamed the Health Care Authority (HCA). The MSBS Program consists of two components: Medicaid Direct Services and Medicaid Administrative Claiming. The New Mexico Guide for School Based Services states that a local education agency (LEA), regional education cooperative (REC), or other state-funded education agency (SFEA) must participate in direct services in order to participate in

Administrative Claiming. However, the LEA, REC or SFEA may choose to participate in direct services and not participate in administrative claiming.

The Medicaid School Health Office currently includes five(5) staff allocated to the MSBS program including one (1) Staff Manager, two (2) Program Managers, and two (2) Financial Analysts. The job responsibilities of the individuals in these positions are described below.

Staff Manager
The Staff Manager has overall responsibility for all programs managed in the School Health Office, including the MSBS program. The program manager is also charged with managing the statewide RMS/Administrative Claiming/Cost Settlement contract and the Interagency Governmental Services Agreement (GSA)[1] with the New Mexico Public Education Department (PED). The Staff Manager is responsible for the design and evaluation of the MSBS program, including the RMTS and Cost Settlement activities. This includes collaboration with other department staff on the promulgation of program rules, amendments to the Medicaid State Plan and reporting of program wide data.

Program Managers
The MSBS Program Managers have overall responsibility for the implementation and management of the program. The Program Managers are also charged with resolving outstanding issues, clarifying policy, assuring quality and program compliance, overseeing the provision of direct services and administrative claims and coordinating with programs in and outside of Medicaid.

Financial Analysts
The Financial Analysts have overall responsibility for the Administrative Claiming and Cost Settlement portions of the program, including reviewing and approving quarterly administrative claims and cost settlements for payment, developing and implementing new Governmental Services Agreements (GSAs) associated with the program, overseeing the payment of direct services and administrative claims and assuring quality and program compliance and coordinating with programs in and outside of Medicaid.

Positions in Other Departments
In addition to the five (5) staff that are allocated to the HCA School Health Office for purposes of managing the MSBS program, there is also a key position located within the PED that is integral to the administration of the program, as described in the Interagency GSA in Appendix A of this proposal. This position collaborates with the HCA School Health Office staff by assisting in activities for the MSBS program, such as training, communication, monitoring, oversight and quality assurance and coordination of services and programs across state agencies.

[1] The State of New Mexico utilizes Governmental Services Agreements (GSAs) as the predominant form of contract between the State and other public entities when one public entity provides services for another public entity. The usage of the terminology of GSA is unique for the purpose of contract documents within the State of NM and this document.

III. INTERAGENCY AGREEMENTS

Each New Mexico local education agency (LEA), regional education cooperative (REC), or other state-funded education agency (SFEA) that participates in the MSBS program is required to enter into a GSA with HCA that describes the objectives and responsibilities respective to each party. HCA works closely with participating school districts, and other state agencies including PED, through an interagency GSA that addresses and provides clarity concerning all key issues including program coordination, billing requirements, staffing, care coordination and communication. The HCA/PED GSA is Appendix A and the MSBS GSA for LEAs/RECs/SFEAs is Appendix B.

IV. MSBS PROVIDER PARTICIPATION REQUIREMENTS

In New Mexico, there are currently 148 LEAs, RECs, or SFEAs, comprising 88 school districts, 8 Regional Education Cooperatives, 2 state schools and 50 charter schools, approved to participate in the MSBS program[2]. All school districts must meet Medicaid participating provider requirements as well as requirements specific to the MSBS program in order to provide direct services or perform administrative activities. The Centers for Medicare & Medicaid Services Guide to Medicaid Services and Administrative Claiming released in May 2023, provides the framework for the administrative claiming guidelines established by HCA. The guidelines are discussed in detail in the New Mexico Medicaid Guide for School-Based Services. The guide is distributed to each LEA, REC and SFEA that participates in the MSBS program. The guide is updated yearly and serves as a comprehensive tool in the day-to-day operation of the MSBS program. The most current version of the New Mexico Medicaid Guide for School-Based Services, including all appendices, is available on the HCA website at https://www.hca.nm.gov/providers/medicaid-school-based-services-program/.

A. Governmental Services Agreement with HCA

As described in Section III of this proposal, all New Mexico LEAs, RECs and SFEAs must enter into a GSA with HCA before they begin providing services or billing for administrative activities under the MSBS program. The GSA outlines the multiple obligations of HCA and the LEA, REC, or SFEA in providing and billing for services through the program. While the full GSA may be found at Appendix B, examples of the LEA, REC and SFEA responsibilities include the assignment of a specific local Medicaid coordinator to act as a liaison between the district and the state, billing requirements and related timelines, and the role of the school in coordinating recipient care.

B. State of Emergency Response

In the event there is a "state of emergency" or other disaster declared in the State of New Mexico that results in prolonged school closures that impact the schools' ability to participate in the RMTS as defined in the "Random Moment Time Study" section of this document, HCA will apply an "averaging" methodology to quarters occurring during the "state of emergency," including the quarter in which the state of emergency is declared and through the quarter in which the state of emergency period ends. The RMTS will use an average of the three

[2] Program participation for 2024-2025 school year. Current participation data is available from the HCA School Health Office.

previously completed quarters prior to school closures for claiming for any individual quarter impacted by the emergency. HCA will notify the Center for Medicaid & Chip Services (CMCS) within 15 days of determining that a quarter is statistically invalid, including the reason for the determination along with details and dates of the declaration of emergency. Upon HCA's determination that a quarter is statically invalid, the RMTS will not be conducted if the time study has not yet been initiated for the quarter or will be cancelled immediately upon determination within the quarter.

V. RANDOM MOMENT TIME STUDY

To participate in the statewide MSBS administrative claiming program, an LEA, REC or SFEA must require certain district staff to participate in a quarterly time study that covers the period for which claimed administrative activities were performed. This time study in turn, provides the basis for calculating amounts owed to the districts for these activities.

While many school district staff participate in administrative activities that are eligible for reimbursement by Medicaid, most do so only for a portion of their normal workday and at varying intervals. The time study allows MSBS program staff to document the portion of their day that is billable. Details on how to conduct the time study are discussed in the New Mexico Medicaid Guide for School-Based Services.

Components of the random moment time study include:

A. Random Moment Sampling Methodology

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

B. Time Study Participants

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

When a district constructs the list of staff that is included in the time study, it determines first whether the individuals in those positions perform administrative and/or direct service activities that support the MSBS program and then includes them in the appropriate category. Each category of staff will fall into one of two mutually exclusive cost pools. The purpose of two cost pools is to group staff into "like" categories. Cost Pool 1 is made up of direct service/therapy personnel and is the same listing of providers currently in the approved State plan for SBS. Cost Pool 2 is made up of staff involved in administrative activities rather than direct service activities. Staff that are 100% federally funded should be excluded from participation in the program, e.g. staff whose salary and benefits are paid entirely from IDEA or other federal funds.

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

The MSBS program includes a number of direct medical services, also known as Direct Services, that may include physical, occupational, audiological, and speech therapies; mental health services; social services; nutritional assessments and counseling; transportation; case management; and nursing services including delegated nursing. These services are reimbursable by Medicaid if they are listed in the Medicaid beneficiary's IEP, IFSP, section 504 Accommodation Plan, Individual Health Care Plan, Behavioral Health Care Plan, or are otherwise medically necessary as appropriate for each covered service and are provided by a qualified professional. Staff that fall under this description and are involved in these types of activities are included in Cost Pool 1.

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

1. Cost Pool 1

Staff that participate in administrative activities and are eligible to submit claims for the Direct Service (DS) Program are included in Cost Pool 1. The RMS Study will also be utilized to determine Direct Service cost reimbursement. In general, these employees include:

- Speech Language Pathologists
- Speech Language Pathology Clinical Fellows
- Speech Language Pathology Apprentices
- Audiologists
- Physical Therapists
- Physical Therapy Assistants
- Occupational Therapists
- Certified Occupational Therapy Assistants
- Licensed Independent Social Workers (LISW)
- Licensed Clinical Social Workers (LCSW)
- Licensed Marriage & Family Therapists (LMFT)
- Licensed Master's Level Social Workers LMSW)
- Licensed Bachelor's Level Social Workers (LBSW)
- Licensed Mental Health Counselors (LMHC)
- Licensed Psychiatric Clinical Nurse Specialists (CNS)

- Licensed Registered Nurses (RN)
- Licensed Practical Nurse (LPN)
- Certified Nurse Practitioner
- Licensed Professional Clinical Counselors (LPCC)
- Psychologists, Ph.D., Psy.D., Ed.D. or Ed.S.
- Psychologists, Masters Level Practitioner – Level 2 or 3
- Psychologists, Masters Level Practitioner – Level 1
- Psychiatrists
- Physicians
- Licensed Dieticians
- Licensed Nutritionists
- Case Managers–(Bachelor's Degree)
- Delegated Nursing Service Providers
- Associate Marriage Family Therapists
- Physician Assistant

2. Cost Pool 2

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

- Adaptive PE Teacher
- Assistive Technology Specialist
- Behavior Specialist
- Bilingual Specialist
- Child Find Specialist
- Child Specific Aide
- Community Health Advocate
- Educational Diagnostician
- Facilitator of IEP Services
- Guidance Counselor
- Interpreter/Translators
- Job Coach, Special Education
- Music Therapist
- Orientation & Mobility Specialist
- Recreation Therapist
- Health Aide/Clinic Attendant
- Nurse's Assistant
- Medicaid Presumptive Eligibility Determiner
- Parent Education Coordinator
- Program and staffing specialists
- Clerical Staff (Health Services/Special Education)

- Program administrators (Special Ed Directors/Coordinators, Health Service Directors/Coordinators)
- Special Education Teachers
- Vision Services Provider
- Other groups/individuals identified by the district and approved by HCA

3. Staff Not Included in the Time Study

Certain staff should not participate in the time study. In general, these include the following with the exception of those that may be eligible Delegated Nursing Service Providers that are not 100% federally funded:

- Principals
- Coaches
- Non-special education teachers
- Transportation staff
- Janitorial staff
- Cafeteria workers
- 100% Federal funded staff
- Any staff who do not typically or potentially perform allowable Medicaid administration functions

C. Process for Participating in the RMS Time Study

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

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

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

1. Identify Total Pool of Time Study Participants

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

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

The list of names is subsequently grouped into job categories (that describe their job function), and from that list all job categories are assigned into one of two "cost pools" as previously defined. Once the roster of eligible staff is submitted it cannot be updated or changed once the RMS period begins.

2. Identify Total Pool of Time Study Moments

The sampling period is defined as the three-month period comprising each quarter of the Federal Fiscal Year calendar. The following are the federal quarters followed for the Administrative Claiming program and a time study is performed for each of the quarters listed below:

- January 1-March 31
- April 1-June 30
- July 1-September 30
- October 1-December 31

The total pool of "moments" within the time study is represented by calculating the number of working days in the sample period, times the number of work hours of each day, times the number of minutes per hour, and times the number of participants within the time study. The total pool of moments for the quarter is reduced by the exclusion of weekends, holidays and hours during which employees are not scheduled to work. LEA calendars and individual participant schedules will be evaluated to ensure all potential days and staff time will be included for the quarterly time study. Once the sample has been generated, no further changes can be made.

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

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

Each time the selection of a moment and the selection of a name occurs, both the minute and the name are returned to the overall sample pool to be available for selection again. In other words, the random selection process is done with replacement so that each moment and each person are available to be selected each time a selection occurs. This step guarantees the randomness of the selection process.

Each selected moment is defined as a specific one-minute unit of a specific day from the total pool of time study moments and is assigned to a specific time study participant. Each moment selected from the pool is included in the time study and coded according to the documentation submitted by the employee. Any and all underlying data that would be needed to replicate any aspect of sampling or verify the overall statistical validity of the time study will be preserved (including seed number).

Sampling Requirements

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

As of May 2023 CMS policy permits a 5% precision level for random moment time study results that are used to claim MAC and Direct Service expenditures, as stated in the CMS May 2023 School-Based Guide to Medicaid Services and Administrative Claiming. However, in order to maintain consistent time study results, the New Mexico school-based program will utilize a 2% precision level for medical assistance (MAP) expenditures claimed under the cost based reporting methodology for its Direct Service Program. As a result, the following sampling methodology is defined for each Cost Pool.

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

Statistical calculations show that a minimum sample of 2401 completed moments each quarter, per cost pool, is adequate to obtain this precision when the total pool of moments is greater than 3,839,197. Additional moments are selected each quarter to account for any invalid moments or non-responsive moments. . Responses for moments that occurred when an employee is on unpaid time off or if they have left their position and have not been replaced are considered invalid responses. Invalid moments do not count against the 85% responses rate. Non-responses are moments that have not been completed by sampled participants.

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

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

where:

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

Correction for Finite Population

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

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

N=	Sample Size Required	Sample Size plus 15% Oversample
100,000	2345	2697
200,000	2373	2729
300,000	2382	2739
400,000	2387	2845
500,000	2390	2849
750,000	2393	2852
1,000,000	2395	2854
3,000,000	2399	2859
>3,839,197	2401	2860

Sampling Methodology - Cost Pool 2 (Administrative Services Providers Only)
CMS policy permits a 5% precision level for random moment time study results that are used to claim MAC expenditures, as stated in the CMS May 2023 School-Based Guide to Medicaid Services and Administrative Claiming. The RMTS sampling methodology for Cost Pool 2 must meet federal reporting and documentation requirements, and is designed to permit a level of precision of +/- 5% (five percent) with a 95% (ninety-five percent) confidence level for activities. Calculations show that a minimum sample of 385 completed moments each quarter is adequate to obtain this precision when the total pool of moments is greater than 222,639. Additional moments of at least 15% oversample should be selected each quarter to account for any lost moments (observations that cannot be used for analysis, i.e., incomplete moments or moments selected for staff no longer at the district, etc.).

Response Rate Validity and Non-Response Methodology:

The **response rate** and **statistical validity** are related but distinct concepts within the Random Moment Time Study (RMTS) methodology, with specific guidance provided by CMS.

- Response Rate: The response rate measures the percentage of sampled moments completed and returned by participants.
    - CMS has indicated that moments categorized as "unpaid leave" are excluded from both the numerator (completed moments) and the denominator (total sampled moments) when calculating the 85% compliance rate.
    -

- Statistical Validity: Statistical validity ensures that a sufficient number of moments are completed and coded to produce reliable data within the required confidence level and margin of error.

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Step 1 – Response Rate: If the 85% response rate is not achieved, all non-responses are coded as non-allowable (non-Medicaid) time.

Step 2 – Statistical Validity: If, after coding all non-responses as non-allowable, statistical validity has not been met: Moments categorized as "unpaid leave" are progressively reclassified as non-allowable (non-Medicaid) time until the sample reaches the statistical validity threshold.

This dual-step approach is designed to ensure that no quarterly claim is ever disqualified from being reimbursed due to insufficient response rates or statistical validity issues. However, the measures in place act as safeguards for non-compliance, as coding non-responses and unpaid leave as non-allowable reduces the overall Medicaid claim. By prioritizing statistical validity while reducing allowable claims proportionally, the state maintains compliance with CMS requirements and ensures the integrity of the claiming process. This methodology allows the state to continue submitting claims under the RMTS methodology while adhering to federal standards and preserving data accuracy.



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

4. **Notify Participants about their Selected Moments**

Time study participants are notified via email to participate in the time study and of their sampled moment. Sampled participants will be notified of their sampled moment no earlier than two (2) business days prior to their sampled moment. At the prescribed moment, each sampled participant is asked to record and submit his/her activity for that particular moment, including confirming if it was a service that was part of a student's medical plan of care where medical necessity has been otherwise established. The sampled moment will remain open for two (2) business days after the specific moment has occurred. The participant will receive notification of their sampled moment no earlier than two (2) business days prior to the moment arriving. If the participant does not complete the moment on their sampled date, they will continue to receive daily reminders until their response is received or the 2nd business day has occurred. After the 2nd business day the participant's login will not work and they will no longer be able to respond to the time study. The time study response window will exclude weekends, holidays and days identified as not working per the school district/REC/SFEA calendar, such as but not limited to, spring break and winter break. However, in the event that a participant is not working during their sampled moment, and unable to complete the moment, the Program Contact can report that participant was either on "Paid Time Off" or "Not Working/Not Paid". The Program Contact can report participants as "Paid Time Off" or "Not Working/Not Paid" at any time during the quarter and no later than fourteen (14) calendar days after the last day of the quarter. For those participants who do not have online capability the RMTS Contact at the represented LEA, REC, SFEA will be able to print out the notification and distribute it to the participant. The participant can complete the sample by directly contacting the administrative claiming contractor's call center. The call center staff is trained to walk the participant through the appropriate questions, and then document the response in the system. The contractor's system then tracks and makes it visible to all system users that the response was taken over the phone. HCA will perform the following validity check:

1. Ensure that all districts complete at least 85% of valid Random Moment Samples;
2. Review 5% of valid coded responses and coding on a quarterly basis.

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.

5. Central Coding (Activity Coding)

Central Coders will be employed by HCA's contractor and will review the documentation of participant activities performed during the selected moments and determine the appropriate activity code. In a situation when insufficient information is provided to determine the appropriate activity code, the central coder will contact the participant or Program Coordinator at the individual LEA, REC or SFEA and request submission of additional information about the moment. Once the information is received the moment will be coded and included in the final time study percentage calculation. All moments will be coded separately by at least two coders as part of a quality assurance process. The moments and the assigned codes will be reviewed for consistency and adherence to the state approved activity codes. A final review is conducted by the Coding Supervisor in the event that the Central Coders do not agree on the assignment of the activity code for a particular moment. The Coding Supervisor conducts a

final review based on the time study participant's original submission and any follow ups received.

HCA will provide training to the coding staff on an as needed basis, but at a minimum annually to discuss issues surrounding the coding of moments. Training will include an overview of activity codes, samples of activities and appropriate processes for making coding determinations. On a quarterly basis, HCA will review a sample of the coding process and original participant documentation for Quality Assurance to show the data submitted in the time study questionnaires support the code selected and therefore show the codes are valid and accurate. In addition to the quarterly review, at its discretion, HCA can review the completed coding and original participant documentation at any time throughout the claim process or as needed for further review or audit purposes.

VI. ADMINISTRATIVE CLAIMING COST ALLOCATION AND METHODOLOGY

The cost allocation methodology and financial data used for the MSBS administrative claiming program are consistent with the requirements of OMB Circular A-87 and generally accepted accounting standards.

Participating LEAs will submit quarterly claims to HCA. These claims will be based on the quarterly costs, the time study, the Medicaid eligibility rate, the indirect cost rate (IDCR), and the FFP.

A. Cost Pools

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

1. Cost Pool 1: Direct Service Staff

Staff in Cost Pool 1 are Direct Service staff that have direct responsibilities related to the MSBS program that include the regular performance of one or more Medicaid allowable administrative activities. A complete list of the individuals who are included in Cost Pool 1 may be found in Section V-B.

2. Cost Pool 2: Other Health and Health-Related Staff

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

B. Total Costs

Eligible costs include direct personnel costs and indirect costs. Ineligible costs include revenue offsets as described below. It should be noted that third-party contractors that are hired by school districts to assist with the administration of the MSBS program are disallowed from inclusion in the total cost calculation.

1. Direct Personnel Costs

Direct personnel costs include salaries, wages, fringe benefits, contracted personnel payments or purchased administrative services, travel, training, materials, and supplies. Restricted federal funding must be deducted from the actual expenses; only state and local funding is included in calculating the claim. Employees whose positions are 100 percent federally funded must be excluded from time studies and cannot participate in the MSBS program. Employees whose salaries are supported with partial federal funding are allowed to participate in the time study and MSBS program, but the federally funded portion of their salary should be excluded when calculating the claim.

2. Indirect Costs

The unrestricted indirect cost rate is used to allocate a school district's indirect costs to the MSBS program. Participating LEAs, RECs or SFEAs should use the unrestricted indirect cost rate that is calculated on an annual basis by the New Mexico Public Education Department or other state/federal oversight agency, or approved by HCA.

3. Offset of Federal Revenues

The cost pool to be allocated is prohibited from containing federal funds, such as those apportioned through the Individuals with Disabilities Education Act (IDEA), and from including any non-federal fund base that is already matched for federal funds through another claiming channel. Insurance and other fees collected from non-government sources must be offset against claims for Medicaid funds, as well as all applicable credits, such as receipts or reduction of expenditure type transactions that offset or reduce expense items, allocable to federal awards as direct or indirect costs.

Funding Sources

Claims for approved Title XIX administrative functions may not include expenditures of:

- Federal funds received by the school district directly.
- Federal funds that have been passed through a State or local agency (e.g., outreach funding, IDEA grants).
- Non-federal funds that have been committed as local match for other federal or State funds or programs.

4. Payments to Third Party Contractors

Expenditures that are paid to third-party contractors for the help and administration of the MSBS program are not allowable as costs for administrative claiming reimbursement.

D. Calculating the Administrative Claim

To calculate the claim per cost pool, an LEA, REC, or SFEA must:

1. Assemble **direct costs** from which exclusions have been subtracted, as defined in the sections above;
2. Calculate the **total claimable costs** by applying the time study results and Medicaid eligibility percentage, to **direct costs**;
3. Apply indirect cost rate to **total claimable costs** to generate **total indirect costs;**

4. Sum **total indirect costs** to **total claimable costs** to determine **claim subtotal;**
5. Apply the FFP of 50% or 75% (applied for translation) to **claim subtotal** for **total claim amount**;
6. Maintain a separate documentation file for each quarter billed as discussed in Section VIII.

Claim Calculation Example

Total Participant Direct Costs	multiplied by
Percent of time claimable to Medicaid administration	multiplied by
Medicaid percentage (the percentage of Medicaid eligible individuals in the service population)	plus
Claimable indirect costs	plus
Subtotal	multiplied by
Percent of FFP (50% for some costs and 75% for other costs)	equals

Because LEAs, RECs or SFEAs provide school-based medical activities both to Medicaid and non-Medicaid eligible students, the costs applicable to these activities must be allocated to both groups. To do this, the LEA, REC or SFEA, together with HCA and PED staff, must calculate the proportion of Medicaid students in their district against total student enrollment.

Generally, the federal share of the claim is calculated using the following formula:

Percentage of Medicaid administrative time claimable
X
Medicaid percentage
X
Total costs (direct and indirect)
X
Percentage of FFP == Total Reimbursement

It should be noted that because MSBS providers make referrals exclusively to other Medicaid providers, the provider participation rate is not used to discount the administrative code for Medicaid Referral and Coordination. In addition, it is important to emphasize that the Medicaid program cannot pay for any administrative activity that is already paid or otherwise reimbursable under another federal mechanism.

Medicaid Eligibility Rate (MER)
For many of the MAC activities performed by school district personnel the costs associated with these activities are only reimbursable to the extent they are allocable to the Medicaid enrolled population. Therefore, these activities will be adjusted by the Medicaid Eligibility

Rate (MER). This adjustment factor or "discount" reflects the nature of the administrative activity and the targeted population to which the administrative effort is directed.

The MER is determined by computing the total number of Medicaid eligible school age children (the numerator) for each LEA/REC/SFEA by the total student count (the denominator). This fractional value is applied to the total cost applicable to the DISCOUNT activity codes to determine the costs applicable to Medicaid administrative activities. The specific MERs will be calculated on an annual basis using the following.

The MAC Medicaid eligibility rate calculation is:

$$\frac{\text{[Number of Medicaid Students]}}{\text{[Total Number of Students]}}$$

The following process is followed:

- LEA, REC or SFEA submit their 80-day count via secure file transfer process each year. The 80-day count is the total number of students enrolled on the 80th day of the school year for each LEA, REC and SFEA. The count is collected on the 80th day of school because the New Mexico Public School funding formula is based on an 80-day membership of students.
- The 80-day count is matched through the Medicaid data warehouse for the same time period as the 80th day to determine Medicaid eligible recipients.

The percentage (MER) of Medicaid eligible recipients will be used on the LEA's REC's or SFEA's Administrative Claim and Annual Direct Services Cost Report and Settlement as further described in State Plan 4.19 B.

MERs are updated annually and the calculations go into effect for that calendar year, beginning with the January – March quarter and remain in effect for one year until the recalculation occurs.

VIII. TRAINING

Training will be led by HCA or its contractor in collaboration with MSBS program staff at PED. Participating LEAs, RECs and SFEAs are required to participate in annual training and new staff/LEAs/RECs/SFEAs are also required to complete an additional training. Both trainings will occur as live sessions at the beginning of each school year.

Both the annual sessions will include training on all aspects of the MSBS program, including a review of MSBS participation requirements, covered services, documentation requirements, RMS processes and time study codes, details on how to construct the cost pools and instructions on billing and related timelines. The New Mexico Medicaid Guide for School-Based Services will be disseminated during the training and available on the HCA website. Pre- and post-tests will be conducted to gauge the knowledge and understanding of participants. If correct responses on the post-test fall below 75 percent, additional training will be scheduled and/or specific issues will be addressed through an alternative format, depending on participants' needs. Schools and state

agencies will be asked to provide input concerning program successes and challenges, needed clarifications and possible revisions.

In addition, formal training sessions will be augmented by other information; which may include interactive web-based sessions, a list of "frequently-asked questions" on the HCA web site, a periodic newsletter, technical assistance provided by telephone and quarterly face-to-face meetings with school district representatives. All MSBS program training materials developed at the local level must be approved by HCA.

IX. DOCUMENTATION

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

1. The accounting information upon which the cost share is based, plus the basis for any inclusion or exclusion where costs were added or subtracted from the accounting system's totals to compile the cost pool;
2. A list of all revenues that were offset, according to source, when calculating the claim;
3. Rationale and calculations used to determine the percentage of the population that represents Medicaid recipients;
4. Original time study documentation, including sample pool participants, by function, title, name, rendering provider number, location, telephone number and coding;
5. The completed quarterly claim; and
6. A copy of the warrant and remittance advice.

These documents, along with any other supporting information used to substantiate the claim, must be maintained for a minimum period of six years. MSBS coordinators at participating LEAs, RECs or SFEAs must ensure that files are current, complete, accessible and secure.

X. CLAIMS SUBMISSION

Participating LEAs, RECs or SFEAs are responsible for submitting administrative claims in accordance with these guidelines:

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

2. All administrative claims must be prepared and submitted following HCA requirements, in accordance with federal and state Medicaid regulations, policies and guidelines, the New Mexico Medicaid Guide for School-Based Services, and the CMS School-Based Guide to Medicaid Services and Administrative Claiming from May 2023, and any federal and state revisions thereto.

3. Claims must be accurate and complete when submitted for payment, pursuant to the Provider Participation Agreement and as required of all Medicaid providers, prior to submission of the claim to HCA, and according to the most current New Mexico Medicaid Guide for School-Based Services.

XI. STATE AND FEDERAL ACCESS TO RECORDS

All participating LEAs, RECs or SFEAs must cooperate with state and federal entities in oversight of the MSBS program. This includes responding in a timely manner to state and federal requests for documentation and other records associated with the MSBS program.

XII. MONITORING AND OVERSIGHT

To ensure that participating LEAs, RECs or SFEAs understand the program and have in place the requisite guidelines and procedures for program administration, HCA staff will institute five key methods of monitoring and oversight, to include:

1. State level desk audits will be conducted of the quarterly administrative claims that are submitted. These audits will be conducted on a 4-year cycle with two (2) claims per district reviewed every four (4) years. This will be comprised of a review of the district's calculation and supporting documentation, and a determination of the appropriateness of the claim and whether the formula was applied correctly.

2. State level desk audits were conducted on 100% of the cost settlement reports for the July 1, 2015 – June 30, 2016 reporting period. This included review of licensure for staff in Cost Pool 1, verification of payroll costs or contractor payments for reported staff, verification of reported costs for Direct Medical Supplies, Materials and Other Costs, verification of reported transportation costs and verification of reported numbers utilized to calculate Cost Allocation Statistics.

3. Trends will be identified by HCA staff based on day-to-day telephone calls and e-mail inquiries from participating districts. Follow-up trainings will be tailored to correspond with these trends, and technical assistance will be provided as needed. HCA staff will also use trends apparent from official grievances and appeals to coordinate trainings and direct the focus of on-site visits.

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

5. HCA staff, together with their counterparts at PED, will maintain open lines of communication and a willingness to resolve problems, address issues and concerns and provide technical assistance, as indicated.

In addition, HCA staff will provide monitoring and oversight to the statewide contractor to include:

1. HCA will review and approve all training material and program documentation completed by the contractor.

2. HCA will review and approve all categories of staff used in the program, prior to implementation by the contractor.

3. HCA will review and approve the time study methodology prior to implementation by the contractor. This review will include approval of time study questions, time study response format, and related process requirements.

4. HCA will provide training to the contractor's central coding staff annually, and on an as needed basis. Training will discuss issues regarding the coding of moments. Training will include an overview of activity codes, samples of activities, appropriate processes for making coding determinations, program updates, process modifications, and compliance issues.

5. HCA will review a sample of coded moments each quarter to ensure that coding is consistent and accurate across the sample. HCA will provide feedback to the contractor if any modifications are necessary as a result of this review.

6. HCA will review and approve the financial reporting process and template prior to the implementation by the contractor.

7. HCA will review and approve the appropriate claim template with the contractor prior to implementation. HCA will review claims prior to payment, to include the appropriate inclusion of unrestricted indirect cost rates, Medicaid eligibility rates and expenditures.

XIII. PROVIDER COMPLIANCE

The measures for monitoring and oversight listed in Section XII are designed to ensure that participating LEAs, RECs or SFEAs comply with program guidelines, policies and regulations and in accordance with both the CMS School-Based Guide to Medicaid Services and Administrative Claiming, May 2023 and the New Mexico Medicaid Guide for School-Based Services. However, in the instance when a participating LEA, REC, or SFEA is found through a desk or onsite audit or other means of oversight to be out of compliance, the following principles and guidelines shall apply:

1. The claim for the quarter may be recalculated by HCA or its contractor, based on the audit, and approved for payment;

2. The claim for the quarter may be denied;

3. The LEA, REC or SFEA may be required to submit a Corrective Action Plan to HCA within 30 working days to remedy the noncompliance issue;

4. If indicated, funds owed may be recouped from the LEA, REC or SFEA;

5. In all cases, the LEA, REC or SFEA has the option to appeal through the HCA administrative hearing process pursuant to the Medicaid provider hearing regulations.

6. If indicated, the LEA, REC or SFEA may be terminated from participation in the MSBS program as set forth in Medicaid General Provider Policies, 8.302.1 NMAC.

XIV. CONCLUSION

This plan is reflective of extensive collaboration between HCA, PED, DOH and many of New Mexico's LEAs, RECs and SFEAs, and is the product of numerous discussions that have taken place since 2003. This collaborative approach has proven essential; not only as a means of strengthening both interagency and state/school district relationships, but also for informing and guiding decision-making about the MSBS program's optimal organizational structure, needed policy revisions, areas in need of clarity and overall operation on both state and school district levels.