Section 1

BENEFITS FOR SCHOOLS AND COMMUNITIES

For the schools:

- Reimbursement for services provided by school staff assisting the health components of public education and the community
- Strengthens local relationships among planning bodies, service providers, and public entities
- Diversifies funding base for needed health and social service programs

For Oregon's Children and Families:

- Supports activities necessary for the proper and efficient administration of the Medicaid State Plan that link children and families to Oregon's Medicaid healthcare system
- Assists in gaining access to and fully utilizing the benefits of the Oregon Health Plan
- Serves as an additional resource in the school settings for Oregon's vulnerable children and families to gain knowledge of Medicaid health care services
- Creates a unique opportunity to enroll eligible children in the Medicaid program, and to assist children who are already enrolled in Medicaid to access the benefits available to them.
- Continues to develop the seamless system of Medicaid services and supports available to Oregon's children and families

INTRODUCTION AND OVERVIEW

WHAT IS MEDICAID?

Under Title XIX of the Social Security Act, the federal government and states share the cost of funding the Medicaid program, which provides medical assistance to certain low-income individuals. Federal Financial Participation (FFP) is the federal government's share for states' Medicaid program expenditures. States may claim FFP for the costs of administrative activities, such as outreach, which support the Medicaid program. FFP made available for Medicaid Administrative Claiming (MAC) are only for those administrative activities that are found to be necessary by the Secretary of the U.S. Department of Health and Human Services for the proper and efficient administration of the state Medicaid Plan.

Summary:

- Title XIX is part of the Social Security Act related to Medicaid
- It is a Federal/State partnership to provide medical coverage for low-income children and families
- In Oregon, it is more commonly known as the Oregon Health Plan

WHAT IS MEDICAID ADMINISTRATIVE CLAIMING?

The overarching policy for Medicaid Administrative Claiming (MAC), as referred to in this document, is that it is a function "found necessary for the proper and efficient administration of the state Medicaid Plan." Schools are engaged in a variety of activities that would not traditionally be thought of as education. In carrying out the mission of meeting the educational needs of their students, schools find themselves delivering many different services to students that help ensure that students come to school healthy, ready to learn, and may benefit from instructional services. School Districts (SDs) and Education Service Districts (ESDs) can be reimbursed for the cost of performing certain Medicaid administrative activities.

Examples of these activities include:

- Discussing access to health care with a student/family
- Assisting in early identification of children who could benefit from health services provided by Medicaid
- Contacting pregnant and parenting teens about the availability of Medicaid prenatal, and well-baby care programs and services
- Providing referral assistance to families where Medicaid services can be provided
- Developing programs and policy to improve the delivery of health services in the school setting

Oregon's Health Authority (OHA), in concert with the federal government, has created a strategy by which school districts and ESD's can claim for costs, not otherwise reimbursed, for providing services that are directly related to the state Medicaid plan. A simple (web based) time study log instrument is used to measure activities, with minimal disruption to the daily routine to provide reimbursement for services rendered by the ESD or school district.

WHERE DOES THIS TAKE PLACE?

Administrative claiming activities may take place in the classroom, in the lunchroom, on the playground or field trips, during music, drama or athletic practice, in CARE team meetings or teacher guidance counseling sessions. Essentially, they may occur anywhere school-age children, their families and school personnel are together.

WHO CAN DO SCHOOL-BASED ADMINISTRATIVE CLAIMING?

Public ESD's and school districts will select school staff that routinely have contact with students and families. General categories include classroom teachers, school guidance counselors, administrators, non-clinical school psychologists, English Second Language (ESL) teachers, family advocates, classroom assistants, administrative support staff, and library assistants.

HOW ARE MEDICAID ADMINISTRATIVE CLAIMING (MAC) ACTIVITIES DIFFERENT FROM OTHER MEDICAID REIMBURSEMENT PROGRAMS?

Medicaid Administrative Claiming (MAC) activities are NOT direct medical services, whereas the **School Based Health Service (SBHS)** Fee-for-Service program is used to claim direct medical services rendered to individual children. School-based health services are billed to The Oregon Health Authority (OHA), Health Systems Division, (HSD) of Medical Assistance Programs (MAP) for the provision of Medicaid covered health services provided by or under the supervision of medically licensed staff to *Medicaid eligible students* pursuant to an Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP) under the Individuals with Disabilities Education Act (IDEA). School-based health services may include:

- Psychological services and evaluation
- Nursing services and evaluation
- Physical and occupational therapy and evaluation
- Speech therapy and evaluation
- Audiology evaluation and services

EI/ECSE Targeted Case Management (TCM) are child specific services that exclude direct services and is for the purpose of assisting Medicaid eligible individuals through coordination to gain access to needed medical, educational, health, social and other services. Key differences are:

1. Services are provided to the specific EI/ECSE target population;
2. The target population is individually identified as Medicaid eligible;
3. Referral coordination and monitoring activities for TCM may be for services provided by non-Medicaid providers and programs where as for MAC activities for referral coordination and monitoring are required to be for Medicaid covered services and the children and families referred may be eligible or potentially eligible for Medicaid and
4. The aforementioned conditions require additional documentation be obtained and consideration of student/family confidentiality laws.

STATE POLICIES AND GUIDELINES

OHA calls for certain policies and guidelines to be implemented statewide. These are primarily determined through any and all policy and guidance put forth by CMS. Policy and guidance will also be shaped by the conclusions found within federal or state audits.

The purpose of statewide policies and guidelines is to provide a consistent and reliable system for operations and the application of federal standards concerning MAC. These policies and guidelines:

- Ensure knowledgeable implementation;
- Limit exposure to unallowable claims;
- Provide smooth adjustments as conditions are modified;
- Reduce misunderstanding of program essentials, and;
- Provide routine implementation.

Many of the policies and guidelines are sections within the Intergovernmental Agreement between OHA and the ESD (*see Section 10 of the Manual)*.

STATEWIDE POLICIES:

ESD's shall:

1. Seek OHA assistance in the development and implementation of MAC.
2. Enter into an Intergovernmental Agreement (IGA) with OHA
3. Upon request, provide OHA with a list of local public school districts under sub contract with the ESD and the ESD's boiler plate sub-conttract language with requirements outlined in IGA with OHA and the ESD. (Review is not for legal sufficiency.)
4. Designate a MAC Coordinator serving as contact between OHA and local program operation.
5. Assign contact points for each district or building within the program for training and technical assistance.
6. Follow the protocols found in this OHA Medicaid Administrative Claiming Provider Manual.
7. Utilize the statewide Time Study Log (electronic web based version).
8. Utilize statewide methodology and activity codes.
9. Adopt randomization method provided by OHA.
10. Document training schedule and record participants.
11. Provide information to OHA or federal partners necessary for the smooth function of the program, including monitoring and auditing.

MAC "GETTING STARTED" CHECKLIST

This is a checklist of the activities an ESD and its school districts may want to follow in creating the MAC program. Many of the items can be accomplished simultaneously. OHA HSD Policy Unit is available to provide the necessary assistance to ensure implementation and program success. For more information, please contact Lasa Baxter at lasa.baxter@imesd.k12.or.us.

- ❑ Develop local interest and designate a MAC Coordinator
- ❑ Contact OHA, Health System Division, Medicaid Policy Unit with interest in participation
- ❑ Connect with an ESD who is operating MAC under an agreement with OHA for general information
- ❑ Conduct a meeting with administrators and OHA staff
  - o Develop an understanding of the process with decision makers
  - o Discuss issues of participation
  - o Include union representatives if necessary
  - o Establish a timeline for implementation
  - o Recommendation: Develop community-based advisory group to achieve a coordinated effort for use of funds for health and social services in the school and community setting
- ❑ Include personnel and business staff in a training with OHA to ensure they are informed and understand their role in the MAC claiming process
  - o Develop salary and benefit information of cost pool
  - o Determine methodology of participation (100% or Random selection)
  - o Implement Billing and IGC Invoice provided by OHA
  - o Develop Internal Controls for MAC process
- ❑ Enter into an Intergovernmental Agreement with OHA
- ❑ ESD enter into sub agreements with participating school districts for the work, which must be reviewed by OHA prior to implementation
- ❑ Develop a training process for MAC using OHA approved MAC training materials/model
  - o Recruit site trainers, technical assistance staff, and building coordinators (can be the same person per site)
  - o Develop training calendar including site level training
  - o Develop communication network for FAQ's
  - o Participate in a Training of Trainers with OHA
  - o Train all district staff prior to implementation of a survey period
- ❑ Develop Quality Assurance process following OHA guidance
- ❑ Implement a process for collecting and reviewing MAC claims data and supporting documentation

Section 2

CLAIMING PROCESS

The Medicaid Administrative Claiming (MAC) process permits the costs of allowable activities performed by school staff to be reimbursed under Medicaid. In order for this to be accomplished, the activities must be "***found necessary for the proper and efficient administration of the Medicaid State Plan*.**" Supported activities must be in the approved Medicaid State Plan for related administrative costs to be claimed. The codes used in Oregon reflect the Medicaid State Plan and are approved through the appropriate federal channels.

Medicaid does not pay for administrative expenditures (time of staff) related to, or in support of, services that are not included in the Medicaid State plan or services that are not reimbursed under Medicaid. Although these services may be in the best interest of the student/family, they are not in the Medicaid State Plan. Allowable expenditures (time of staff) are indicated in MAC Coding Guide in Section 7 of this Manual.

The claiming process employed by OHA and the district(s) has been approved by the federal government, the Center for Medicaid and Medicare Services. This operation process is straightforward and fulfills the federal guidelines in existence at this time.

FORMULA USED TO CALCULATE CLAIM					
Total Time Segments	**Billable Time Segments**				
	B1	**C1**	**D1**	**E1**	**Total**
0	0	0	0	0	0
% of Time Billable	0.00%	0.00%	0.00%	0.00%	0.00%
Student Population	**# of Medicaid Eligible**			**% Medicaid Eligible**	
0	0			0.00%	
Employees Sampled	0	**Employees in Cost Pool**		0	
Cost Determination for Outreach and Facilitation (B1)					
Allowable Salary/Benefit Cost				$0.00	
% of Billable Time				0.00%	
Outreach Subtotal				**$0.00**	
Cost Determination (C1, D1, E1)					
Allowable Salary/Benefit Cost				$0.00	
% Medicaid Eligible				0.00%	
% of Billable Time				0.00%	
Claimable Subtotal				**$0.00**	

Subtotal	**$0.00**
Indirect Rate (If Applicable)	0.00%
Rate Adjustment	$0.00
Program Cost Determination	
# of Employees x Program Cost	$0.00
Total	**$0.00**

Developing the Claim Methodology

The following outlines the process to establish a claim. All elements of the calculation are applied to the survey period in which the claim is established. OHA uses data from Oregon Department of Education (ODE) and OHA/HSDMAP to arrive at the Medicaid Eligible Rate (MER). The cost pool *(see Developing the Cost Pool Section 4)* information is provided by ESD/school districts for each survey period. The ESD shall calculate its claim based on the following process:

1. Provide cost pool ***(see Developing the Cost Pool Section 4)*** information on all staff determined eligible to complete the survey.
    a. Add actual salary, benefits, and allowable other personnel expenses (OPE) (no estimates) for the survey period represented by the time study.
    b. Exclude all federal funds applied to the salary, benefits and OPE of staff eligible to complete the survey.
        i. Exclude any staff positions (salary, benefits, and OPE) entirely supported by any federal fund allocation (i.e. IDEA, federal grants, etc.).
        ii. Exclude any ***portion*** of a staff position (salary, benefits, and OPE portions) funded by federal funds.
        iii. OHA staff will work with the ESD's/district(s) to further clarify unique or jointly funded positions.
        iv. See Developing the Cost Pool and Significant Issues (Section 4) for further guidance.

2. Calculate time spent on Medicaid allowable activities by surveyed staff.
    a. Use the MESD web based Time Study instrument approved by OHA *(see Survey Process Section 5 for further discussion)*.
    b. Capture 100% of *paid staff time* of **all** activities performed (both Medicaid allowable and unallowable) on specified random survey days.
    c. Report **only paid** staff time between the hours of 7 a.m. and 8 p.m. of the Time Study instrument.

d. Calculate discounted and non-discounted codes *(see Section 2, page 16 for instructions).*

e. Coding of the Time Study instrument establishes the percent of time spent on Medicaid allowable and unallowable activities. The claim is calculated using the percent attributed to the Medicaid allowable activities.

f. New staff hired during the middle of a survey period may be trained to participate in the next survey period but must not participate in the midst of a survey period

3. Determine school-age population for the county in which the ESD provides services: (ODE annual audited data)
    a. OHA uses the most recent school year annual audited Average Daily Membership (ADM) student count as reported and verified by the Oregon Department of Education.
    b. This number will be used for each survey period during the applicable fiscal year.
    c. OHA HSD uses the final actual audited ADM from the most recent school year for the current school year being claimed.
    d. Data is applied by county of residence to more accurately match OHA Medicaid data for the same population.
4. Determine the school-age Medicaid eligible count for county: (OHA monthly data)

    a. OHA Division of Medical Assistance Programs provides monthly data of school age Medicaid eligible individuals for the survey period.
    b. OHA averages monthly counts to establish the Medicaid eligible count for each survey period.
    c. This number will be calculated against ODE data and applied during the survey period represented by the Time Study.

5. Using **3a** (above) as the denominator and **4a** (above) as the numerator, OHA will calculate the percent of school-age Medicaid eligible rate (MER) for the counties in which the ESD provides service.
    a. ***Example:***
    1950 school age ADMr for Jefferson County/8500 Medicaid eligible school age students for Jefferson County = 22.94**%**

6. To calculate claim: The ESD or school district will multiply the cost pool (see paragraph 1 above) x the result of the Time Study Instrument for non-discounted activities (code B1) + the cost pool (see paragraph 1 above) x the school age MER (see paragraph 5 above) x the result of the Time Study Instrument for discounted activities (codes C1, D1, and E1). The result will equal the total claim.

7. If applicable a state approved indirect cost rate as established by ODE may be applied to the total claim amount. (For instructions on how to apply for an ODE indirect rate access the following web address: http://www.ode.state.or.us/search/results/?id=195

8. Apply cost for administration of the web-based time study instrument each claiming period.

Payment of local Match funds and Medicaid Reimbursement for Federal Financial Participation (FFP) Cost Sharing

1. The ESD shall pay the 50% public fund local match portion of the total claim amount each survey period using allowable resources non-federal funds transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control to OHA prior to OHA pulling down the 50% federal share portion. The local and federal shares will be combined to create a payment of 100% of the total claim billed for payment. This shall occur at the time the ESD submits its invoice to OHA for each survey period, which may include allowable Medicaid administrative activities costs reported during each survey period, including an ODE state approved indirect rate and the cost for administration of the web-based time study.

2. A completed MAC Local Match Leveraging Form #1419 must accompany each payment for Medicaid Administrative Claiming (MAC) activities invoiced for each survey period to DHS/OHA Financial Services Receipting Unit in accordance with the process outlined on the form. Ensure the Intergovernmental Agreement (IGA) number and ESD provider name are included. Link to form is below:
   http://www.oregon.gov/oha/healthplan/Pages/forms.aspx

3. Receipt of form #1419 enables OHA to identify the public fund match payment was transmitted/deposited from the ESD, the amount of ESD match funds and the invoice to be processed and paid for amount claimed.
4. Pursuant to 42 CFR 433.51the ESD certifies by signature on the MAC intergovernmental agreement (IGA) that the non-federal public fund match it transfers to OHA are not federal funds, or are federal funds authorized by federal law to be used to match other federal funds and that all sources of funds are allowable under 42 CFR 433 Subpart B."
5. Upon receipt of the ESD's transfer of the non-federal public fund matching share and OHA's acceptance of the MAC invoice, OHA will claim FFP from CMS and reimburse the ESD for the total allowable costs of providing Medicaid administrative services as identified in the itemized invoice.

Separate 1.5% Intergovernmental Charge (IGC)

Separately, the ESD shall submit a statement (see Form Section for Sample Statement) to OHA for an intergovernmental charge of 1.5% (one and one half percent) of the total allowable cost of providing Medicaid administrative activities for each completed survey period. The statement must accompany the 1.5% payment to OHA for the IGC and include the following information:

- ESD and OHA Intergovernmental Agreement (IGA) number
- IGA Expiration date
- ESD agency name and contact information
- Survey period for the IGC payment
- Amount of IGC payment
- ESD's Check number and date for IGC payment

The IGC is a separate charge and shall not be included as part of the invoice submitted to DHS/OHA for Medicaid administrative activities performed for federal financial participation as part of cost sharing for these services; and

The ESD understands that no portion of any Medicaid payments for Administrative Claiming may be used to pay the 1.5% separate Intergovernmental Charge (IGC) and represents that ESD will use other public funds that are not associated with the Medicaid payments to pay the IGC.

MAIL the payment and statement for School-Based MAC IGC to:

OHA Receipting Unit
P.O. Box 14006
Salem, OR 97309-5030

DISCOUNTED AND NON-DISCOUNTED CALCULATION

NON-DISCOUNTED

Non-discounting applies to Code B1, which is eligible for 100% reimbursement. This is the "non-discounted" code. The formula used to calculate the non-discounted portion of the claim is:

Cost pool
X
Percent of time spent on B1
=
Total non-discounted claim

DISCOUNTED

Discounting is the process by which the cost pool and the percent of time spent on allowable activities is discounted by the school-age Medicaid eligible student percentage (MER) for that period. This process applies to codes C1, D1, and E1. The formula used to calculate the discounted portion of the claim is:

Cost Pool
X
Percent of time spent on C1, D1 and E1
X
Percent of school-age Medicaid eligible students
=
Total discounted claim

The discounted total is added to the non-discounted total to establish the claim. The current indirect rate of each school district or ESD (established by ODE) is then applied to determine the total claim for each school district or ESD. The ODE approved indirect rate can only be applied to the school district or ESD for which it was approved.

NOTE: Discounting is not related to the 50% match requirement that is applied to the total claim.

DETERMINING INDIRECT COSTS

Indirect costs can only be claimed if there is a **current year** indirect cost rate approved by the cognizant agency responsible for approving such rates. In Oregon the cognizant agency for Education Service Districts (ESDs) and school districts (SDs) is the Oregon Department of Education (ODE).

Where indirect costs are allowed, the ESD or school district must certify that costs claimed as direct costs (claimed through the survey process) do not duplicate costs claimed through application of the indirect cost rate. Employees listed as part of the calculations on the *Restricted Indirect Cost Allocation Plan* cannot be included in the cost or survey pool as this would constitute duplicate claiming.

For ESD's and school districts with an ODE approved and current indirect rate, the indirect rate (stated as a percentage) is to be applied to the sub-total amount claimed after direct cost calculations are complete. The indirect rate can only be applied to the specific claiming unit it is approved for. No indirect rate can be applied to the cumulative total of all sub-agreement entities under one Intergovernmental Agreement.

For ESD's and school districts without an ODE approved or current indirect rate, no indirect rate can be applied.

The ODE approved and **current year** indirect cost rate will be applied to each survey period of claiming within its applicable fiscal year.

For instructions on how to apply for an ODE indirect rate access the following website:

http://www.ode.state.or.us/search/results/?id=195

For more information, please contact Lasa Baxter: lasa.baxter@imesd.k12.or.us

Section 3

MEDICAID: MULTIPLE LEVERAGING PROGRAM PARTICIPATION GUIDANCE

Oregon is required to provide assurances to Centers for Medicare and Medicaid Services (CMS) of non-duplication of costs associated with Medicaid administrative leveraging and direct service leveraging programs. The administrative and direct service leveraging programs discussed in this policy are School-Based Health Services (SBHS) direct service (Fee-for-Service), Early Intervention/Early Childhood Special Education (EI/ECSE) Targeted Case Management (TCM) and Medicaid Administrative Claiming (MAC).
Medicaid rules also require states to ensure appropriate coordination of providers. As Oregon is experiencing a growth in interest and operation of administrative and direct service leveraging programs, Oregon Health Authority (State Medicaid Agency) finds it necessary to provide clarity, guidance and policy to meet its federal requirements.
This document represents clarification of existing Medicaid policy and explanation of the procedures to be used for participation in Medicaid leveraging programs.

Definitions of Leveraging Programs:

School-Based Health Services (SBHS): SBHS are special education, related services, or early intervention services and any services authorized under Oregon's Medicaid State Plan approved by Center for Medicare and Medicaid Services (CMS) that also are considered special education, related services, or early intervention services provided to a Medicaid eligible child eligible under the Individuals with Disabilities Education Act (IDEA). SBHS billed to Medicaid are limited to the amount frequency and duration specified on a Medicaid eligible child's current Individualized Education Program (IEP) or Individual Family Service Plan (IFSP), must meet criteria as necessary and appropriate, be recommended by a physician or other licensed practitioner within the scope of practice, and provided by medically qualified staff.

OHA HSD Policy personnel allocated to the function of administering Medicaid programs for services and activities, provided by public School Districts' and ESDs, work together to avoid duplication under Federal Financial Participation (FFP) as part of cost sharing leveraging Medicaid programs under multiple cost sharing programs described below:

EI/ECSE Targeted Case Management (TCM): The state plan recognizes the target group as children with disabilities (birth until eligible for kindergarten) eligible under the IDEA attending Oregon's programs for EI (birth to 3yrs.) or

ECSE (age 3 until eligible for kindergarten), and eligible for Medicaid under the state plan. EI/ECSE Targeted case management/service coordination are services furnished to assist children with disabilities eligible for EI/ECSE services in the target group, eligible under the State Plan, in gaining access to needed medical, social, educational, and other appropriate services in coordination with the child's Individualized Family Service Plan (IFSP) developed and implemented pursuant to IDEA.

- Case management does not include, activities that are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).
- Case management does not include, activities that constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible child has been referred.

Service coordination billed to Medicaid must be included in an eligible child's IFSP and are limited to activities that assist the eligible child in gaining access to needed medical social, educational, developmental and other appropriate services in coordination with the child's Individualized Family Service Plan (IFSP) developed and implemented pursuant to IDEA. EI/ECSE TCM services **exclude** SBHS specified on a child's IEP or IFSP that are provided by medically qualified/licensed staff because case management is built into the hourly cost rate established for each area of discipline to provide direct medical services such as OT, PT, Speech, Nurse services etc. under the SBHS program. This process is accomplished by billing DMAP for approved activities found within the federally approved State Plan Amendment.

The methods and standards for establishing payment rates/costs are set within guidelines found in Oregon's EI/ECSE TCM State Plan Amendment.

Medicaid Administrative Claiming (MAC): Time spent by school district staff on Medicaid administrative activities for the proper and efficient administration of the state's Medicaid plan captured through the use of a random time study. The eligible student population includes kindergarten through 21 (including but not limited to children in special education) who are Medicaid eligible or are potentially Medicaid eligible. These allowable activities may occur anywhere school-age children, their families and school personnel are together.
The program allows school districts to be reimbursed for some of their costs associated with school based administrative (non-direct services) health and outreach activities which are not claimable for leveraging Medicaid under the SBHS program "fee for service" or EI/ECSE TCM Program such as:

- the referral of students/families for Medicaid eligibility determinations;
- the provisions of health care provider information; and
- referral, coordination and monitoring of health services and interagency coordination.

School MAC Program Excludes: SBHS specified on a child's IEP or IFSP provided by medically licensed staff; and service coordination for EI/ECSE TCM specified on a child's IFSP.
This process is accomplished by DMAP reimbursement for administrative activities allowed by federal guidance and time accounting.

Participant: Individual who is performing the billable activity or participating in the time study for reimbursement.

Participating entity: Pursuant to 42 CFR 433.50 The public Education Service District (ESD) directly and through sub contracts with their public school districts is a public entity and unit of government that is authorized to participate in Federal Financial Participation (FFP) by providing the non-federal share of public funds for Medicaid reimbursement for covered Medicaid Administrative claiming activities has the legal ability to participate in Medicaid leveraging through contract, Intergovernmental Agreement, or by meeting qualifications found in the Medicaid State Plan.

Participation:
It is allowable for individual staff to participate in multiple leveraging programs. It is imperative that participants and the participating entity(s) know of the conditions, constraints, and liabilities when participating in multiple leveraging programs. OHA guidance regarding multiple participation are in keeping with the following three goals:

1. Fulfilling the responsibilities as the State Medicaid Agency;
2. Protecting entities and individuals from negative audit findings;
3. Ensuring a consistent statewide application of rule and protocol for leveraging.

OHA, through its authority as the State Medicaid Agency, develops, implements and approves participation in the leveraging programs operating in Oregon. Prior to participation in multiple leveraging programs, the participating entity(s) must meet the requirements of this rule and follow the guidance of the contractor or its agent.

General Guidance:

1. Participating entity(s) and individual(s) are responsible to ensure compliance with all applicable federal and state rules and guidelines including but not limited to: Office of Management and Budget (OMB) 2 CFR 200 Super Circular; work schedule; time accounting; training; differentiation of activity; and cost allocation.
2. The same cost may not be attributed to multiple programs. Duplicate costs are disallowed, whereas cost allocated between multiple leveraging programs is allowed under the provision of this rule.
3. Cost may only be allocated once to a specific leveraging program. This includes direct and indirect costs.

4. When participating in multiple leveraging programs with one being administrative claiming, costs are allocated by time study survey of a participant's **entire** workday, not just the portion of the workday assigned to administrative claiming. The time study clearly distinguishes direct services with administrative activities. The participant's **entire** actual non-federal salary, benefits and other payroll expenses (OPE) would be included in the administrative claiming cost pool.
5. Costs recovered through the leveraging programs may not exceed the actual costs associated with providing the approved services or activities. If participating in multiple leveraging programs, the cost either billed or reimbursed (or combination thereof) may not exceed the cost attributed to the individual providing the service or completing a time study.
6. The same activity or service provided by an individual for the same child/family may not be claimed twice even if accomplished through different leveraging methodologies.
7. Activities that are integral to or an extension of a direct service (i.e. follow up or monitoring activities associated with a SBHS or TCM service billed) may not be claimable under administrative claiming, if provided by the practitioner or individual billing who also is participating in administrative claiming.
8. In order for an employee to participate in two MAC programs the individual participant must be employed by the two separate agencies in which hold an IGA with OHA. Participation in both MAC programs is allowed under these circumstances.
9. Participation in two separate MAC programs by an individual employed by one agency is disallowed. For example, an ESD employee who works within a school district may only participate in the ESD's survey and not in the school district's survey in which they work.
10. Participation in two leveraging programs such as TCM and MAC, SBHS and MAC, or TCM and SBHS is allowed providing all provisions of guidance and rule are met.
11. If a portion of the time study employee's time is also billed as direct medical services (SBHS fee for service covered health services), then the administrative time study results should be validated by comparing the time coded to direct medical services to the actual amount of time billed directly. The results should be within a reasonable tolerance or else the time study may effectively result in duplicate payments being made.
12. Supervisors of multiple leveraging program participants must separate time and costs to the specific leveraging program by completing a time study for their **entire** workday. The supervisor's **entire** actual non-federal salary, benefits and OPE would be included in the administrative claiming cost pool.

13. All entities associated with leveraging need to be in clear and documented communication concerning the manner by which leveraging is accomplished. If there is participating staff(s) from a single entity engaged in leveraging through more than one entity, those entities must address in writing all matters of participation necessary to limit audit exposure or prevent fraudulent behavior.
14. State general fund and other allowable non-federal public fund resources shall be used to meet matching requirements of Medicaid programs. Participating entity(s) must retain documentation substantiating this.
15. Federal funds cannot be used to earn or match federal Medicaid funds.

Detailed Guidance:

1. Work Schedule

a. If the daily routine of the participant (i.e. nurse, licensed clinical counselor, supervisor, etc.) is mixed between leveraging programs, the MAC time study mechanism and document assigned to the participating entity must be used to allocate costs appropriately. The participant's entire actual non-federal salary, benefits and OPE will be included in the participating entity's MAC cost pool.

2. Time Accounting

a. **For MAC participation only:** 100% of a participant's paid MAC time must be accounted for in the time study (code survey).
    i. Paid time includes any paid leave such as sick, vacation, or paid personal business leave.
    ii. Unpaid leave or unpaid time not spent at work is not necessary to account for.

b. **For dual participation in separate leveraging programs:** 100% of a participant's paid time must be accounted for in the time study (code survey).
    i. The time survey will capture and clearly distinguish direct services and administrative activities.
    ii. Time spent in direct service (TCM or SBHS), including their associated services (extension of or integral to) must be accounted for by the "Direct Service" or other appropriate non-claimable MAC code to avoid duplicate payment.
    iii. The time survey, although completed on few specific days within a quarter, are statistically correlated to every workday representing time and cost allocation.

c. **TCM: EI/ECSE** Targeted Case Management services provided to an eligible child in the target group, by a dual claiming participant, that fall under a reimbursable MAC code, and are associated with

or an extension of a previous TCM bill, are **not claimable as MAC.** This applies whether or not the service constitutes another TCM bill or not.

Reminder: EI/ECSE TCM service coordination must be for a Medicaid eligible child and specified on the child's IFSP.

SBHS: Health services that are provided to an eligible child, by a dual claiming participant, that fall under a reimbursable MAC code, and are associated with or an extension of a previous SBHS bill, are **not claimable as MAC.** This applies whether or not the service constitutes another SBHS bill or not.

i. Reminder: Health Services must be for a Medicaid eligible child and required by the IEP or IFSP.

3. Cost Accounting

a. Salary, benefits and OPE for individuals participating in leveraging must be from state or other non-federal resources. (Salary, benefits and OPE for extra duty contracts and substitutes are not allowed in the cost pool.)
b. All costs must be actual costs expended or actual costs used in rate calculations.
c. For MAC, the cost must coincide with the time period of the time study (code survey).
d. At no time can the cost for reimbursement or billing (or combination thereof) exceed the actual cost of providing the services or activities.
e. When costs are allocated between leveraging programs, documentation must exist which shows how costs are allocated to each specific program.
f. The same costs may not be duplicated to support the same activity(s) or services.

Section 4

DEVELOPING THE COST POOL

Of critical importance is the development of an accurate **cost pool.** The cost pool is defined as the actual (not estimated) total salary and benefits (including OPE) invested in staff that is eligible to survey. Staff supported entirely by federal funds, are ***Not*** to be included in the cost pool or survey. Staff partially paid through federal funds may be included in the cost pool. However, the general fund portion of the cost of the employee may only be included. The employee must report their entire paid work time in the survey.

There are key rules to apply when developing your cost pool. There are also critical issues to address in constructing the cost pool. The following outlines each step to take including the associated rules and issues.

STEP ONE: IDENTIFY APPROPRIATE STAFF

A. Identify staff: Either certified or classified that routinely have contact with students and families.
B. Do not include staff such as maintenance, food services, bus drivers, and volunteers. These groups have limited contact with students to provide MAC services.
C. Do not include substitutes
D. Staff should be identified to the district or ESD they serve in. Roaming staff not employed by the ESD shall be assigned to the specific district they are employed by.
E. Staff hired during the midst of a survey period may not participate during that period, but must be trained first and then may participate in the following period.

STEP TWO: IDENTIFY ACTUAL SALARY AND BENEFITS INVESTED

A. From the staff list, report the actual salary, benefits and OPE (no estimates) invested in each individual for the survey period, removing fully federally funded positions and the federal portion of the split funded positions.
B. For the survey period, the ESD/school district would report the actual salary, benefits and OPE invested in each individual eligible to survey.

C. **Salary, benefits and OPE must be actuals.**
D. **Do not include salary and benefits for extra duty contracts.**
E. **Do not include costs for long or short term substitutes.**

***STEP THREE*: REMOVE FEDERAL FUNDS FROM COST POOL**

Federal funds the ESD/district expends (e.g. IDEA, Title I, federal grants, etc.) on salary and benefits may not be included in the cost pool. These funds must be removed from the cost pool to comply with federal regulations. Federal funds expended for services and supplies (S & S) costs, indirect or other non-personnel (non-salary and benefits) costs are not a part of the cost pool.

NOTE: Documentation must be maintained detailing how the federal funds applicable to salary, benefits and OPE have been removed from the cost pool.

On an individual basis: Any federal funds that are applied to the salary, benefit and OPE package of an individual employee would be removed on a FTE person-by-person basis. Only general fund and other fund sources would remain in cost pool calculations.

- ✓ **If only a portion** of their time is counted as federal fund supported, the individual would remain in the survey pool and the non-federal portion of their salary and benefits would remain in the cost pool.
- ✓ **If all** of their time were federal fund supported, the individual must be entirely removed from both the cost and survey pool.

Other considerations

The ESD/district will want to set up a process to evaluate the cost pool on a systematic basis, assessing classifications and individuals as to their impact on the claim. Pruning the cost pool and the survey pool is an acceptable practice in order to present a more effective claim and reduce administrative burdens.

In summary

The development of an accurate cost pool is essential. Federal funds may not be used in the cost pool, so must be removed from the cost pool calculations. Documentation must be kept as to the process of removing the federal funds from the cost pool.

REPORTING UNIQUE POSITIONS RELATED TO SALARY AND BENEFITS

There are many questions related to unique positions and their inclusion in the cost pool, and paid and unpaid leave. The following examples and responses are not meant to be an exhaustive list, rather a representation of the potential issues an ESD/district will face when establishing and aligning the cost and survey pool.

Paid leave

- Paid leave is always a component for claiming.
- Individuals in the cost and survey pool who have taken **any** paid leave on a random day would have their survey (if included in survey sample group) completed reflecting all work hours as Code A, School Related Educational Activities.

Unpaid leave

- Staff on unpaid leave during an entire survey period may not be included in the cost pool, nor may they be included in the random survey selection process.
- Salary and benefits for individuals on unpaid leave during a portion of the survey period may be included. These staff must be included in the survey pool if they are included in the cost pool.
- Individuals who were on paid leave during a portion of the survey period may be included in the survey pool as well as their salary and benefits included in the cost pool. If included in the survey sample group and the survey falls outside the time of paid leave, the individual must complete a survey.

Part-time employees

- Part-time employees may be included in the cost pool under the same general guidance provided in the *Developing the Cost Pool* section 4.
- They will complete a paper or web based Time Study Log (if included in the survey sample group) for the entire amount of work time spent on the random day, even if it is a full day.
- There will be times (due to scheduling) when the part time employee will not be surveyed, similar to other employees in the cost pool.
- Part-time employees remain in the cost pool even if the random day is not a scheduled workday for them.
- The act of randomization over time will account for any single occurrence that appears to alter results.
- An analysis of the part-time status and claiming results should be made on an ongoing basis to present the most effective claim, limit exposure and reduce administrative burden.

Contract employees
All full or part-time contract employees **may** participate in the time study and **may** be included in cost pool as long as the contract payment is not based on a contingency fee arrangement, meaning the contract amount is not contingent or based upon the claim performance.

- ✖ Only the contracted amount of salary, benefits and OPE (if applicable) can be included in the cost pool.
- ✖ If a district contracts with another district, or with the ESD, for a full or part-time employee, the district or ESD with which the district contracts will be the unit which will claim both the costs and the survey time.
- ✖ If a district contracts with the private sector, or with a public unit outside of the district's ESD, the district can claim both the costs and the time of the person for the person under contract.
- ✖ Written agreements must be in place reflecting the relationships of all parties, which includes the relinquishment of rights to collect Medicaid Administrative Claiming for school-based purposes to the ESD/school district.
- ✖ An analysis of the contract status and claiming results should be made on an ongoing basis to present the most effective claim, limit exposure and reduce administrative burden.

School-Based Fee for Service employees
- ✖ School-based fee for service employees **may** participate in the time study and **may** be included in the cost pool (*see Section 4, Multiple Leveraging Policy)*.
- ✖ ESD/school district must provide thorough training establishing the differences and issues for the employee providing school-based health services (SBHS) fee for service, EI/ECSE Targeted Case Management and participating in MAC.

AT NO TIME CAN DUAL CLAIMING OCCUR (*see Section 3, Multiple Leveraging Policy)* including, but not limited to the following:

- ✓ Where fee-for-service, EI/ECSE TCM, and administrative claiming are used for the same service provided;
- ✓ Where two (or more) administrative claiming processes are ongoing through separate entities collaborating at the service level;
- ✓ Where TCM and administrative claiming are providing services to the same child/family;
- ✓ Where fee for service and TCM are providing services to the same child/family.

Example:

1. Medically qualified staff provides a direct service that is billed to Medicaid. A follow up meeting takes place on the MAC survey day. The medically qualified staff must code the follow up time as F, Direct Medical Services, because it is integral to the direct medical service.

TRAINING OF STAFF PARTICIPATING IN THE TIME STUDY

All staff in the sample universe must be adequately trained before the sampling for a survey period begins. Staff are required to receive training no less than once annually. Training may currently be acquired utilizing the web based training component provided by Multnomah ESD, through face to face training by a MAC Coordinator or OHA, or video teleconferencing provided by a MAC Coordinator or OHA, such as Skype or similar two way interactive communication. When training face-to-face or using two way interactive communications, the MAC Coordinator must sign the training log-in sheet, as must all individuals who were trained and provide record of it to the MESD in order to allow survey access and participation. OHA requires MAC Coordinators be trained no less than once annually either face-to-face or through a video-teleconference. Training must cover all aspects of the sampling process. Staff must be clear on how to complete the time study log, how to report activities under the appropriate time study code, the difference between health related and other activities, and where to obtain technical assistance if there are questions. Professional staff must understand the distinctions between the performance of administrative activities and direct medical services.

All training documentation, including the training sign-in sheets, training materials such as the approved activity codes, must be maintained and available for audit purposes. Staff may be trained before or after they are selected for inclusion in the time study. However, staff may not be chosen for the time study solely on the basis of having obtained prior training, as that may indicate bias in the sample methodology. (Ref: CMS Medicaid School-Based Administrative Claiming Guide May 2003, pg. 43 Section 5)

Section 5

SURVEY PROCESS – TIME STUDY PLAN

In order to calculate the time staff spends on allowable activities, a strategy called ***Random Moment Sampling*** (RMS) is employed. RMS takes a time frame (five days per survey period) chosen at random; staff is then "surveyed" through a standardized instrument, which is the (web based) Time Study Log. This ensures activities are not planned intentionally for financial gain (targeting) in advance to occur on the time study day, but occur as part of a natural course of action.

The ESD/district may choose to survey all eligible staff, or a representative portion thereof equaling a 95% confidence factor, +/- 5% error rate. If choosing the representative group, known as the sample group, the total effort of a sample group of staff can be determined with a high degree of confidence (95%) to represent having surveyed 100% of the staff 100% of the time. ***This does not mean that 95% of staff will be surveyed; it means that a representative portion of the staff that establishes the 95% confidence rate is surveyed.*** To determine the sample group size, calculations are accomplished using the web-based ***Sample Size Calculator,*** http://www.surveysystem.com/sscalc.htm (see example on the following pages).

Random Moment Sampling Process

1. On an annual basis, OHA will establish five random days per survey period through a random numbers assignment following the ODE state school calendar.
2. OHA will inform all participating ESD's with MAC agreements of the random survey dates prior to the start of the school year. For example, dates for the January – March survey period random days could be January 10th, January 30th, February 18th, February 19th, and March 22nd.
3. ESD's will assign a district or districts one of the five random survey dates without influence or input from the district each survey period representative of the typical school day, and assigned district(s) will be required to complete the time study on the designated random day. An individual may only participate on one survey one day per period. If an ESD has 5 or more participating Districts, all five random survey dates must be assigned and utilized to complete the survey. In the event the ESD has fewer than five Districts participating, the ESD must utilize no less survey dates than the total number of LEAs it has participating under MAC sub-agreements in addition to the ESD.
4. The ESD will inform the school district(s) of the week (not the specific date) of their assigned random date prior to the first day of the applicable

survey period. This will allow the ESD and school district(s) ample time for scheduling and providing training.

5. The ESD will inform the school district(s) of the specific random date no greater than 5 business days prior to the assigned date.

6. Either all or a random sample of staff (meeting the 95% confidence rate) will then complete the survey on the assigned random day.
7. Surveys will then be completed within 5 business days.
8. The survey periods are: September – December; January – March; and April – June. There are no random days or claiming for the months of July and August.
9. The ESD may request alternative random dates based on the specific guidance set forth later in Section 6.

Sample Universe

1. The sample universe is defined as all staff (certified and classified) employed by the district, state or county general funds, non-federal grant funds, or any other funds that are not federal in nature.
2. For the purposes of Medicaid Administrative Claiming, not all staff need be included in the sample universe. ESD's/districts can exclude certain classifications or individuals from the sample universe due to their positions, interactions with the student/family population, work schedule, or impact on the effectiveness of claiming ***(see Developing the Cost Pool Section 4).*** Based on historical claiming information, it is recommended to exclude maintenance, bus drivers, food service and volunteers.

Establishing the sample group

1. To establish the sample group, each ESD will employ a statistical method that meets or exceeds the 95% confidence rating (+ / – 5%) in order for each survey period claim to be valid.
2. Determining the sample group size is accomplished utilizing "The Survey System" by Creative Research Systems, found on the web at www.surveysystem.com, click on Researcher resources, and click Sample Size Calculator (see calculation example found on the next pages for further explanation).
3. OHA recommends oversampling by 10% to account for any unexpected circumstances.
4. CMS and the Federal Division of Cost Allocation approve this method of establishing a valid sample size.

Section 6

SURVEY PERIOD DESCRIPTION

Oregon's school based MAC program has three survey periods each school year. They are:

Fall: September – December
Winter: January – March
Spring: April – June

Each survey period will have random days chosen from all eligible school days of the period. Cost pools will also represent the survey period.

FALL: SEPTEMBER – DECEMBER

The potential random days can include the first day of school in September through the last day of school prior to the December break. Cost pool will be established beginning with September and ending in December.

WINTER: JANUARY – MARCH

The potential random days can include the first day of school in January through the last day of March. Cost pool will be established beginning with January and ending in March.

SPRING: APRIL – JUNE

The potential random days can include the first day of school in April through the last day of June. Cost pool will be established beginning with April and ending in June. This cost pool would also include the salary and related costs that reflect activities performed during the school year. These costs may include remainder of contract payments for salaries prorated over the year and paid and distributed in June, or paid in June and distributed during the summer break. The costs must be associated with the previous school year's contract, essentially closing out the districts/ESD's contractual obligation to the staff.

Procedures for Assigning Random Survey Dates

1) OHA will provide ESDs with random survey dates prior to start of the school year.

2) The ESD will assign the dates to school districts without influence or input from any school district.

3) The ESD will inform the school district(s) of the week (not the specific date) of their assigned random date prior to the first day of the applicable survey period. This will allow the ESD and school district(s) ample time for scheduling and providing training.

4) The ESD will inform the school district(s) of the specific random date no greater than 5 business days prior to the assigned date.

5) The school district(s) will accomplish the survey on the date assigned.

6) The ESD will ensure the fulfillment of the requirement to use five random days per quarter.

The ESD may submit cause for an alternative date to OHA following the Alternative Date Protocol for School Based MAC. OHA will, as appropriate, follow policy set forth for assigning an alternative random date (see below).

Procedures for Requesting an Alternative Date

Region X CMS approved for Oregon School-Based Administrative Claiming a procedure for selecting alternative quarterly random dates. OHA will administer this procedure. This procedure will allow for dates other than previously chosen random dates to be employed by the ESD/district, while fulfilling the requirements of employing five (5) random dates per quarter. ESDs/districts must have a substantiated reason for requesting an alternative date such as those that follow.

Reasons for requesting alternative random date:

1. ESDs/School districts in session less than a five day school week.
2. School day when random survey day was scheduled is cancelled due to weather, mechanical issues, crisis or other similar circumstances or types of closures.
3. Reduction of school days in a given year or quarter making a previously chosen date obsolete.

Procedures:

1. ESD/District will notify the ESD MAC Coordinator as to the need and reason for the alternative random date.
2. The ESD MAC Coordinator, by e-mail or in writing, will request an alternative date from OHA MAC staff, stating the reason for the request.
3. OHA will select the next random date as per the random number selection process and confirm by e-mail or in writing.
4. ESD MAC Coordinator will inform the ESD/district of the selected date and ensure compliance with the selection.
5. OHA will select no greater than three (3) alternative random dates per period for an ESD or district for the reasons indicated above.
6. Only reasons that meet the criteria stated under **Reasons for requesting alternative random date** will be approved
7. OHA and the ESD will ensure the fulfillment of the requirement to use five random days per quarter.

Section 7

SCHOOL-BASED MEDICAID/OHP ADMINISTRATIVE CLAIMING CODING

CODE A: School Related and Educational Activities, Discipline, Supervision, General Administration and Overhead, and Other services

Summary:

This code should be used for any school-related activities that are not health related, such as social services, educational services, and teaching services, employment and job training. These activities include the development, coordination, and monitoring of a student's IEP or other education plan. Use this code when providing for and administering any disciplinary action, including the general supervision of the student population, Use when performing activities that are not directly assignable to program activities, such as payroll or survey operations. Include related paperwork, clerical activities, or staff travel required to perform these activities.

Special Note:

Include in this code for all activities, including the health activities, related to development of the IEP. This code includes student and staff supervision activities.

Examples:

- Providing classroom instruction, lesson planning, testing, and correcting papers and monitoring student academic achievement.
- Performing activities that are specific to instructional, curriculum, and student-focused areas, such as reviewing academic records, enrolling new students, conferring with parents on academic matters.
- Developing all components of the IEP for a student, including the health related component.
- Coordinating, and monitoring the educational component (non-medical) annual reviews, and IEP meetings with parents/guardians.
- Providing individualized academic instruction to a special education student.
- Compiling attendance reports, report cards, text book reviews, reviewing technical literature and research articles.
- Participating in or presenting curriculum related training or instruction, attendance at curriculum, department meetings, or external meetings related to school educational issues or matters.
- Carrying out any office functions specific to instructional or academic areas, such as informing student/parents/guardians of immunization requirements for school attendance, copying, etc.

- Conferring with student/parents/guardians or other staff on academic matters, disciplinary issues or other school-related issues.
- Translation related to educational matters.
- Playground or lunchroom supervision, applying/supervising disciplinary activities.
- Providing general staff supervision of staff, including supervision student teachers or classroom volunteers, and evaluation of employee performance.
- Establishing goals and objectives of school-wide health-related programs for the general population as part of the school's annual or multi-year plan.
- Participating or facilitating school or unit staff meetings or training reviewing school/ district procedures and rules, or school board meetings.
- Performing administrative or clerical activities related to general building or district functions or operations, or other general administrative activities of a similar nature as listed above which cannot be specifically identified under any other activity code.
- Taking lunch, breaks, or any paid leave, or paid time not at work.

CODE B1: Medicaid/OHP Outreach and Facilitating Medicaid/OHP Eligibility

(Please Note: Direct medically licensed staff may only report claimable codes B1, C1.4 and E1, as well as, all non-claimable codes.)

Summary:

This code should be used when performing activities that inform eligible or potentially eligible individuals about Medicaid/OHP. This code should also be used when describing the range of services covered under Medicaid/OHP, how to access and obtain them, and the benefits of Medicaid/OHP preventative services. This code can be used when discussing Medicaid/OHP with students, parents, or their guardians. Use this code when assisting an individual in applying for and becoming eligible for Medicaid/OHP. This includes written or verbal information, related paperwork, clerical activities or staff travel required to perform these activities.

Examples:

- Informing Medicaid eligible and potential Medicaid eligible children and families about the benefits and availability of services provided by Medicaid (including preventive treatment, and screening) including services provided through the EPSDT program.
- Developing and/or compiling materials to inform individuals about the Medicaid program (including EPSDT) and how and where to obtain those benefits. Note: This activity should not be used when Medicaid-related materials are already available to the schools (such as through the

Medicaid agency). As appropriate, school developed outreach materials should have prior approval of the Medicaid agency.

- Distributing literature about the benefits, eligibility requirements, and availability of the Medicaid program, including EPSDT.
- Assisting the Medicaid agency to fulfill the outreach objectives of the Medicaid program by informing individuals, students and their families about health resources available through the Medicaid program.
- Providing information about Medicaid EPSDT screening (e.g., dental, vision) in schools that will help identify medical conditions that can be corrected or improved by services offered through the Medicaid program.
- Contacting pregnant and parenting teenagers about the availability of Medicaid prenatal, and well baby care programs and services.
- Providing information regarding Medicaid managed care programs and health plans to individuals and families and how to access that system.
- Encouraging families to access medical/dental/mental health services provided by the Medicaid program.
- Verifying an individual's current Medicaid eligibility status for purposes of the Medicaid eligibility process. (This may be accomplished by performing an eligibility check on-line, by reviewing the medical card, or contacting a local OHA agency to verify status of eligibility.)Explaining Medicaid eligibility rules and the Medicaid eligibility process to prospective applicants.
- Assisting individuals or families to complete a Medicaid eligibility application. Gathering information related to the application and eligibility determination for an individual, including resource information and third party liability (TPL) information, as a prelude to submitting a formal Medicaid application.
- Providing necessary forms and packaging all forms in preparation for the Medicaid eligibility determination.
- Referring an individual or family to the local Assistance Office to make application for Medicaid benefits.
- Assisting the individual or family in collecting/gathering required information and documents for the Medicaid application.
- Participating as a Medicaid eligibility outreach outstation, but does not include determining eligibility.

B1 Sub Coding

B1.1- Informing children and their families on how to effectively access, use, and maintain participation in Medicaid/OHP. (Includes describing the range of services, and distributing OHP literature)

B1.2- Assisting the student/family to access, apply for, and/or complete the Medicaid/OHP application. (Includes transportation and translation related to OHP application, and gathering appropriate information)

B1.3- Checking a student and/or family's OHP status.

B1.4- Contacting pregnant and parenting teenagers about the availability of Medicaid/OHP for prenatal and well baby care programs.

CODE B2: Non-Medicaid/OHP Outreach, Facilitating application for non-Medicaid/OHP programs

Summary:

This code should be used when performing activities that inform individuals about non-Medicaid/OHP social, vocational and educational programs (including special education) and how to access them, describing the range of benefits covered under these non-Medicaid/OHP social, vocational and educational programs and how to obtain them. Informing an individual or family about programs such as Temporary Assistance to Needy Families (TANF), food stamps, Women, Infants and Children (WIC), childcare, legal aid, and other social services or educational programs and referring them to appropriate agency to make application. This includes written material or verbal information. Include related paperwork, clerical activities or staff travel time required to perform these activities.

Special Note:

Child Find activities and any general student population health or wellness programs (anti-smoking, DARE, alcohol reduction, etc.) should be coded here. Use this code when providing services related to the determining, verifying initial and continuing eligibility for the Free and Reduced Lunch Program.

Examples:

- Informing families about general health education programs or campaigns and how to access them, conducting, scheduling or promoting these programs
- Scheduling and promoting activities which educate individuals about the benefits of healthy life-styles and practices
- Non-Medicaid/OHP outreach directed toward encouraging persons to access social, educational, legal, or other services not covered by Medicaid/OHP

- Child Find activities, e.g. assisting in the early identification of children with special medical/mental health needs which must be identified, located, and evaluated
- Explaining eligibility rules and the eligibility process to prospective applicants for non-OHP programs, providing the necessary forms and packaging all forms in preparation for the eligibility determination.
- Gathering information or documents related to or required for to the application and eligibility determination for an individual for non-OHP programs.
- Assisting the student/family to complete the non-OHP application(s). Assistance can include translation and comprehension activities related directly to application process.
- Informing students/parents/guardians about non-OHP programs, such as TANF, food stamps, WIC, childcare, legal aid and other non-OHP social or educational programs, and referring them to the appropriate agency to make application.
- Providing outreach, developing and verifying initial and continuing eligibility for the Free and Reduced Lunch Program.

CODE C1: Referral, Coordination, Monitoring and Training of Medicaid/OHP services

(Please Note: Direct medically licensed staff may only report claimable codes B1, C1.4 and E1, as well as, all non-claimable codes.)

Summary:
This code should be used when making referral for, coordinating or monitoring the delivery of medical (Medicaid/OHP covered) services. This code may also be used when coordinating or participating in training events and seminars for outreach staff regarding the benefits of the Medicaid/OHP program, how to assist families to access Medicaid/OHP services, and how to more effectively refer student for services. Include related paperwork, clerical activities, or staff travel necessary to perform these activities.

Special Note:
Use this code when referring to actual Medicaid/OHP covered services. *NOTE*: For the purpose of MAC claiming monitoring means follow up to ensure services associated with a child's identified health condition are accessed. ***This does not include minor acute health conditions such as scratches, bruises, headaches, colds, requiring Band-aids or non-prescriptive medications.***

Examples:

- Identifying and referring adolescents who may be in need of Medicaid family planning services.

- Making referrals for or coordinating medical or physical examinations and necessary medical/dental/mental health evaluations
- Making referrals for scheduling EPSDT screens, inter-periodic screens, and [appropriate] immunization**s, including when these services are available without charge to the community at large, or Free Care (refer to CMS SMD letter 14-006, dated November 14, 2014)**. [NOT to include the state-mandated health services. Immunizations are a Medicaid covered service when they are not FREE CARE. Individual referrals for obtaining immunizations made to a Medicaid provider that are not for the purpose obtaining them from a free shot clinic are be claimable.]

  [NOTE: (See Page 21 of the CMS May 2003 Guide specifically states
  "to the extent that a medical service is not reimbursable under the Medicaid program due to the free care policy… In such a case the administrative activities related to assisting the child to obtain such immunizations "in the school" would not be reimbursable as a Medicaid administrative cost" (when they are provided in the school setting for free)] **Administrative activities** [mandated] **required by public education** during specific dates of immunization exclusion periods ([i.e.] compiling exclusion reports, contacting parents, establishing a list of students who need immunizations), are not claimable under MAC Code C1 and must be coded C2.

- 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 any information that may be required in advance of 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 covered by Medicaid.
- Coordinating the delivery of community based medical/dental/mental health services for a child with special/severe health care needs.
- 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 to provide 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 (see special note under C1 Sub Coding C1.3 below)
- Coordinating medical/dental/mental health service provision with managed care plans as appropriate.

C1 Sub Coding

C1.1- Referring students for medical, mental health, dental health and substance abuse evaluations and services covered by Medicaid/OHP. (Includes gathering information in advance or referrals)

C1.2- Coordinating the delivery of medical health, mental health, dental health and substance abuse services covered by Medicaid/OHP. (Includes Youth Services Team and CARE team meetings)

C1.3- Monitoring the delivery of medical (Medicaid/OHP) covered services (Can include monitoring and evaluating the medical services components of the IEP).

C1.4 - Training: Coordinating, conducting or participating in training events or seminars for outreach staff regarding the benefits of medical/Medicaid related services.

- **Special Note Regarding Monitoring:**
- Activities that are integral to or an extension of a direct service are considered a direct medical service and must be coded F.
- Monitoring activities related to **minor acute health conditions such as** scratches, bruises, headaches, colds, requiring Band-aids or non-prescriptive medications must be coded F.
- The monitoring of health/medical services on a child's IEP are considered a direct service or an extension of a direct service if they are performed by a licensed medical professional or an individual who has been delegated and trained by a Registered Nurse to perform such activities, these activities must be coded F.
- Monitoring a child's health condition regardless of the severity or type of condition is NOT a claimable activity under code C1.3. For example:
    - School secretary monitoring a child in the health room for adverse reaction to a bee sting (not claimable)
    - Teacher monitoring a child after insulin injection for signs of low blood sugar (not claimable)
    - Education Assistant monitoring a child for signs of seizure (not claimable)

Summary:
This code should be used when making referrals for, coordinating and/or monitoring the delivery of non-Medicaid/OHP services, such as educational services. Include related paperwork, clerical activities, or staff travel required to perform these functions.

Special Note:
This code may also be used when coordinating or participating in non-Medicaid/OHP training events and seminars, such as educational or social services.

Examples:

- Participating in or coordinating training and delivery of IDEA Child Find activities, services for non-Medicaid/OHP programs, and state education agency mandated health screens (vision, hearing).
- Participating in a meeting/discussion to coordinate or review a student's need for scholastic, employment, vocational, housing, childcare, and non-health related services, and making referrals for, coordinating and monitoring access and the delivery of those services.
- Gathering any information that may be required in advance of these non-Medicaid/OHP services.

CODE D1: Medicaid/OHP Transportation and Translation

(Please Note: Direct medically licensed staff may only report claimable codes B1, C1.4 and E1, as well as, all non-claimable codes.)

Summary:
This code should be used when assisting an individual to obtain transportation to services covered by OHP, arranging for or providing translation services to facilitate access to OHP services. Include related paperwork, clerical activities or staff travel required to perform these activities.

Special Note:
Does **NOT** include the provision of the actual transportation service or the direct costs of the transportation (bus fare, taxi fare, etc, but rather the **administrative activities** (related paperwork, clerical activities, staff travel time, etc.) involved in providing the transportation.

Examples:

- Scheduling or arranging transportation to OHP covered services.
- Scheduling, arranging or providing translation services that assist an individual to access and understand necessary care and treatment.
-

D1 Sub Coding

D1.1 –Scheduling or arranging transportation to OHP covered services. (Not as part of the direct services billing for transportation)
D1.2 - Scheduling, arranging or providing translation for OHP covered services. (Translation for access to or understand necessary care and treatment)

CODE D2: Non-Medicaid/OHP Transportation and Translation

Summary:
This code should be used when assist an individual to obtain transportation to services not covered by Medicaid/OHP, or arranging for or providing translation services related to social, vocational, or educational programs. Include related paperwork, clerical activities or staff travel time required to perform these activities.

Special Note: Use this code when accompanying an individual to non-Medicaid/OHP services.

Examples:

- Scheduling, arranging or providing transportation to social, vocational, and/or educational programs and activities.
- Scheduling, arranging, or providing translation services that assist the individual to access and understand non-OHP services.

CODE E1: Program Planning, Policy Development, and Interagency Coordination Related to Medical Services

(Please Note: Direct medically licensed staff may only report claimable codes B1, C1.4 and E1, as well as, all non-claimable codes.)

Summary:
This code should be used when performing activities associated with the development of strategies to improve the coordination and delivery of Medicaid/OHP coverable medical/dental/mental health services to school age children. Include related paperwork, clerical activities or staff travel required to perform these activities.

- **Special Note:**
  The position descriptions of employees performing these activities **do not need to** include program planning, policy development, and inter-agency coordination. Also, E1 activities **do not include** establishing goals and objectives of school-wide health-related programs for the general population as part of the school's annual or multi-year plan.(see Code A activities).

Examples:

- Working or collaborating with other agencies to identify gaps, overlap or duplication of medical/dental/mental health services to school age children, improve the coordination and delivery of Medicaid/OHP services, define the scope of each agency's Medicaid/OHP services, expand access to specific populations of Medicaid/OHP eligibles.
- Developing strategies to assess or increase the capacity of school medical/dental/mental health programs, close service gaps, analyze data and evaluating the need for Medicaid/OHP services to specific populations or geographic regions.
- Developing advisory or work groups of health professionals to provide consultation, advice and monitoring of the delivery of health care services to the school populations.
- Interagency coordination to improve delivery of Medicaid/OHP Services.

E1 Sub Coding

E1.1 - Developing strategies and policies to assess or increase the capacity of Medicaid/OHP covered school medical/dental/mental health programs. (Includes workgroups)
E1.2 - Working with other agencies and/or providers to improve the coordination and collaboration and delivery of Medicaid/OHP covered medical, mental health and substance abuse services.
E1.3 - Monitoring Medicaid/OHP covered medical/mental health/dental health delivery system in schools.

CODE E2: Program Planning, Policy Development, and Interagency Coordination Related to Non - Medical Services

Summary:
This code should be used when performing activities associated with the development of strategies to improve the coordination and delivery of non-medical/non-dental/non-mental health services to school age children, and when performing collaborative activities with other agencies. Non-medical services may include social, educational, and vocational services. Include related paperwork, clerical activities or staff time required to perform these activities.

Examples:

- Working or collaborating with other agencies to identify gaps, overlap or duplication of non-medical/dental/mental health services (e.g. social,

educational, and vocational) to school age children and improve the coordination and delivery of these services.
- Developing strategies to assess or increase the capacity of non-medical/dental/mental health school programs.
- Interagency coordination to improve delivery of non-Medicaid/OHP Services.

CODE F: Direct Medical Services

Summary:
This code should be used when providing care, treatment, and/or counseling services to an individual in order to correct or ameliorate a specific condition. It also applies to case management services as a part of the direct medical service(s). Include related paperwork, clerical activities, or staff travel required to perform these activities.

Examples:

- Providing health/dental/mental health services contained in the IEP.
- Conducting health/dental/mental health assessments/evaluations and diagnostic testing as part of the IEP development and related reports.
- Providing speech, occupational, physical therapies, counseling services to treat health/mental health condition, or performing developmental assessments, state mandated child health screens (vision, hearing, dental, scoliosis, and EPSDT).
- Administering first aid, or prescribed injection or medication to student.
- Activities that are integral to or an extension of a direct service are considered a direct service.

Section 8

TIME STUDY LOG INSTRUCTIONS FOR MEDICAID ADMINISTRATIVE CLAIMING

Marking or coding of the Time Study Log in its electronic web-based version establishes the base for determining allowable and unallowable activities, and hence, the Medicaid claim. It is particularly important to be mindful of how the document is completed. Accuracy is imperative and helps the claiming process move forward free from delay while limiting exposure in an audit.

The Time Study Log identifies 10 activity code categories, which are divided into 15-minute increments throughout a workday. Each activity code category is specifically defined and includes examples of activities that meet the description of each code. Staff may code only ***one category*** per 15-minute increment representative of the predominant activity performed and are required to code increments that are representative of their paid duty time only.

Survey Instructions
(reference Multnomah ESD web-site)

Timely Survey Completion
Providers must complete web based time study reporting within five (5) business days of the survey date. The survey date is included as one of the five (5) business days.

Section 9

MAC COORDINATOR
ROLES AND RESPONSIBILITIES

OHA requires that each participating ESD designate a MAC Coordinator. This single individual will provide oversight for the implementation and operations of MAC and ensure policy decisions are implemented appropriately at the local level. OHA recommends that the ESD designate a backup and dedicate support staff to assist in accurate and timely claiming operations.

Responsibilities of the MAC Coordinator

Contracts

- Maintain MAC Intergovernmental Agreement with OHA.
- Maintain sub-agreements with local public school districts

Information Flow

- Receive all correspondence and requests for information regarding MAC from OHA, local partners and federal officials.
- Compile, produce and disseminate all claiming reports, including the MAC annual report.
- Ensure all sub-contractors receive timely information regarding survey process, training, cost pool development and claiming.
- Work as a liaison between OHA and local operations regarding frequently asked questions, inquiries of state or federal guidance and other pertinent communication.

Policy

- Ensure accurate interpretation of policy and provide clear instructions of CMS and OHA policy for EA's
- Ensure all local applications (i.e. time study process, cost pool development, claiming calculation and training) of MAC are appropriate and in compliance with federal and state guidelines.
- Develop and interpret quality assurance protocols for local MAC, including assisting in the defining of roles and responsibilities of local participants.
- Disseminate policy or program information to ESD and its sub-agreement representatives participating in MAC.

Audits

- Develop guidelines for establishing and maintaining supporting documentation and agency wide audit files that are consistent with procedures outlined by OHA.

- Establish and maintains all required audit files; conducts periodic file audits to ensure documentation is current and accurate.
- Conduct periodic claiming process audits for compliance with MAC policy and procedures.
- Assist state or federal auditors in the execution of their work.

Staff Training

- Provide face-to-face training annually or more frequently as necessary for constituents.
- Identify the primary training contact (or designee) for the ESD and school districts.
- Develop a train the trainer consortium to serve the training needs of the ESD and school districts (if applicable).
- Ensure training is provided in compliance with state and federal guidelines found in the OHA MAC Provider Manual.
- Maintain documentation necessary to substantiate training requirements have been met.
- MAC coordinators must ensure that MAC trainers submit to the MESD for entrance into the web-based MAC reporting system, annual training list(s) identifying staff members in their cost pool that meet the annual MAC training requirement. The MESD will post the information in the MESD MAC data system ensuring only trained staff have access to take the survey. Use of the web-based training tool will automatically be reported to the web-based MAC reporting system.

Claiming Process

- Manage all aspects of the ESD and school districts claiming process found in the OHA MAC Provider Manual.
- Compile and process the local claim certifying its appropriateness prior to submittal.
- Submit quarterly claim in accordance with the Intergovernmental Agreement and OHA claiming methodology.
- Manage corrections and resubmittal process as necessary.
- Ensure no duplicate billings occur within the local process.

General

- Attend OHA MAC Coordinators meetings
- Assist in the development and facilitation of the local advisory groups in the reinvestment of funds.
- Encourage collaboration and coordination for program efficiency and effectiveness.

Oregon Health Authority Health Services Division, Medicaid Policy RESPONSIBILITIES

Oregon Health Authority shall:

1. Manage the development and completion of the IGA's with each ESD.
    a) Assist ESD in the review of and provide comments on the IGA sub-contracts between ESDs and public school districts to carry out Work under this Agreement. OHA' review of sub-contracts is not for the purpose of providing legal advice to ESDs and public school districts.
2. Provide ESDs with annual percent of Medicaid eligible by county.
3. Determine survey period random days annually and provide to ESDs.
4. Provide training and technical assistance on all aspects of MAC, including but not limited to:
    a) Coding;
    b) Claim process;
    c) Monitoring and compliance;
    d) Survey process including 95% confidence rate +/-5 determination;
    e) Cost pool process and development;
    f) Local coordination of effort; and
    g) Frequently asked question tracking
5. Review each claim for completeness and accuracy
6. Ensure 95% confidence rate +/- 5 is established and met for each claim
7. Provide guidance on state policy and oversight
8. Create, maintain and provide MAC provider manual
9. Assist in the full development of MAC at the local level
10. Inform EAs of all federal guidance that impacts MAC
11. Maintain documentation of training provided to EAs
12. Assist in responding to federal compliance issues

ESD RESPONSIBILITIES

Educational Service Districts shall:

1. Maintain appropriate process documentation, following retention schedule, including but not limited to:
    a) Sample group determination, sample selection, 95% confidence rating and sample results
    b) MAC web-based data reported in each random time study survey
    c) Cost pool data, updated each survey period for each district and ESD
    d) Claim summary for each district
    e) Certification of each claim
    f) Description of local monitoring process including frequency of reviews, staff performing reviews, and all review protocols
    g) Monitoring of sub-agreements
    h) Maintain required information on individuals who work under IGA
2. Provide technical assistance and training to Districts/ESDs and constituents on MAC process and coding
3. Maintain applicable training documentation:
    a) Training schedule (ensuring individuals are trained prior to survey)
    b) Training logs including attendance for each training
    c) Train the trainers activities
    d) Track FAQs and provide to OHA for response
    e) Create local mechanism for FAQ receipt and distribution (email, phone, newsletter, etc.)
4. Submit each survey period invoice for reimbursement to OHA
5. Reimburse OHA the State match portion of Medicaid funds in accordance with the terms of the agreement between OHA and the ESD. Separately, ESD will also pay OHA an intergovernmental charge for the non-federal share portion of the costs for OHA personnel allocated to the function of administering school Medicaid Administrative Claiming (MAC). OHA personnel are also responsible for providing assistance to ESDs and their school districts participating in other programs to avoid duplication of Federal Financial Participation (FFP) funds for services billed to Medicaid.
6. NOTE: It is advisable, but not required, to develop a local advisory group responsible for:

a) Integrating MAC projects with existing planning and advisory groups

b) Creating a mechanism for reinvestment project determination

c) Coordinating reinvestment of funds with community planning process

7. Provide OHA with required electronic signed copies of annual project reports for projects funded through MAC

8. IDEA Funds

a) If a school district spends reimbursements from federal funds (e.g., Medicaid) for special education and related services those funds will not be considered "state or local" funds for purposes of the maintenance of effort provisions under the IDEA. (See Section 10 Title 34: Education § 300.154 Methods of ensuring services)

AUDIT INFORMATION AND RESPONSIBILITIES

OHA will train ESD's and school districts about the importance and seriousness of a federal or state audit. OHA will assist federal and state staff in coordinating the audit, including scheduling and information gathering (within its purview) found necessary for a smooth and thorough audit.

The MAC Coordinator is key in the efficient and timely performance of an audit. The MAC Coordinator shall keep up-to-date documentation, maintain clear communication with school districts, and closely follow the information found within the OHA MAC Provider Manual.

The local MAC Coordinator must:

- *Ensure the ESD and school districts cooperate completely with OHA and federal agencies.*
- *Provide OHA and federal staff with the requested documentation in a timely manner.*
- *Provide OHA and federal staff with a MAC overview with an emphasis on the training provided to time study participants, including local monitoring and the quality assurance protocols.*
- *Study final audit findings and provide a written plan of action (within 30 days) that includes:*
    - *Acceptance of findings;*
    - *Rebuttal of specific findings if further documentation can sustain;*
    - *Timeline for corrective measures;*
    - *Individual(s) or entities responsible for implementation of corrective measures;*

- *Submit evidence supporting the plan of action within three (3) months of receiving the final audit report, if required.*

A **File Review Checklist** *form is found in the Form section of the this Manual to assist the MAC Coordinator and school districts in tracking and maintaining an audit file for each survey period invoiced. The audit files should be retained by the ESD and each school district as appropriate. See the File Review Checklist in Section 10 of this Manual for further detail.*

Section 10

School-Based Medicaid Administrative Claiming

Annual Project Report Fiscal Year:

ESD/District Name:

State Fiscal Year To Date Earning (Less State Share and 1.5% IGC):

State Fiscal Year to Date Project Expenditure:

<table>
<tr><td colspan="2">Project Description:

Contact Person:

Project Address:

Phone: Email:</td></tr>
<tr><td>Objectives of the Project (coordinated with the Local Comprehensive Plan):</td><td>Actual Outcomes of Service:</td></tr>
<tr><td colspan="2">Short description of project activities:</td></tr>
<tr><td colspan="2">Application to health and social services in the school setting:</td></tr>
<tr><td colspan="2">Future plans for this project:</td></tr>
<tr><td colspan="2">Additional needs of this ESD/District:</td></tr>
<tr><td colspan="2">Was project reviewed by Advisory council ☐ yes ☐ No</td></tr>
<tr><td colspan="2">List of organizations on the advisory Council (if applicable):</td></tr>
</table>

Signature of MAC Coordinator/representative: _____

Title: _____ ***Date:*** _____

Note: Use one form for each project funded. Do not detail individual line item expenditures of the project.

ANNUAL PROJECT REPORT FORM INSTRUCTIONS

OHA requires an electronic signed copy of Annual Project Report form(s) be submitted for each project funded through MAC reimbursement. This report is not a detailed individual line item expenditure report, rather an overview of the project, which shall include a short description of the project activities, objectives and actual outcome(s) of service. Original signed and/or scanned copies of annual project reports are required to be kept by the ESD.
It is the responsibility of the ESD to assure a form is completed for each project funded through MAC reimbursement. All reports are due to OHA October 1st allowing 90 days following the closure of a state fiscal year (the state fiscal year is noted by the year in which June 30 falls). However, locally ESDs may require sub-contractors to submit the reports at an earlier date.

FILE REVIEW CHECKLIST

The MAC Coordinator will establish and maintain audit files on each submitted claim. The Coordinator will conduct periodic reviews to ensure that the files are current, complete, accessible and secure. The following documentation will be required for each survey period's audit file:

- ❑ Electronic original time study logs
- ❑ Documentation of the Medicaid eligible percentage as identified by OHA on the Quarterly Medicaid Eligibility Report (MER)
- ❑ Copies of all worksheets or spreadsheets used in developing the claim and any computations or allocations used in reimbursement calculations
- ❑ Cost pool development documentation
- ❑ List of all participants in the time study
- ❑ Proof of Oregon Department of Education approved indirect cost determination for the applicable time study period
- ❑ A copy of the survey period invoice using the OHA MAC Invoice
- ❑ Copies of all training materials used to train staff
- ❑ Original signed MAC time study training forms for training sessions provided in person for the survey period being claimed

SURVEY PERIOD OUTCOME FORM

The ESD Coordinator will use this form to document the completion of the survey period Study Tracking Forms from each district or building.

_____**ESD** _____**Survey period/Year**

District/School	**Date Rec'd**	**Approved**	**Disallowed**	**Notes**

I certify that the results of the Time Study Tracking Forms from each district or building have been reviewed and appear appropriate.

_____Signature _____Date

TIME STUDY TRACKING FORM

Identify if this is for a school district or an individual school. Fill in the appropriate information in each box. This record is to be kept for each survey period. Only the names of those individuals being survey for the survey period need to be recorded. The ESD MAC Coordinator is required to keep a copy of this on file.

_____**School District/School Date of Survey**_____
Contact_____

Name	**Position**	**Building**	**Rec'd**	**Absent**	**Notes**

I certify that the results of the Time Study Log Sheets have been reviewed and appear reasonable.

_____MAC Coordinator/Supervisor Signature

_____Date of review

MEDICAID ADMINISTRATIVE CLAIMING TIME STUDY TRAINING
_____SCHOOL/DISTRICT/ESD
Date _____ Place _____Time_____
Trainer_____ Trainer's signature_____

ID#	NAME	SCHOOL OR ESD	POSITION	NEW/UPDATE

ESD

Address
City State Zip
EA Phone (503 Fax (503)

SCHOOL MAC INVOICE

LEVERAGING

DATE:	August 3, 2016
INVOICE #	
Intergovernmental Agreement (IGA) No.	**000000-0**
IGA-1 Effective (Fall Qtr 2009)	**1/1/2015**
IGA Expiration Date	**12/31/2020**

For Billing Purposes This Invoice Is Emailed To:

medicaid.leveraging@state.or.us

(enter "MAC" in the subject line)

Faxed to: 503-378-2806 (Salem) or Mailed To:
DHS Receipting Unit
P.O. Box 14006
Salem, OR 97309-5030

DESCRIPTION	AMOUNT
Medicaid Admin Claim **Winter January, February and March 2016:**	$ 0
DHS Payment Amount to ESD	0

If you have any questions concerning this invoice, ESD contact Info

Thank You!

BELOW INFORMATION AND INSTRUCTIONS FOR DHS PROCESSING SCHOOL MAC LEVERAGED CLAIMS

*Education Service District (ESD) 50% State Match Fund Share amount **MUST** be paid by ESD and receipted by DHS **prior** to DHS pulling down federal fund portion of the total claimed amount pursuant to 42CFR433.51* ***ESD 50% State Match Fund Share amount this claim*** $ 0

DHS USE ONLY

Receipting code: Index PCA AGY
A/R Batch _____ Receipted in by:_____
A/R Batch Date_____/_____/_____

Approved for Payment

***Payment to ESD equals** 50% State share receipted by DHS from ESD combined with 50% federal share portion resulting in **100% payment to ESD** for total school MAC claimed amount*

Mgr DMAP Budget & Finance
Dated:_____

Vendor: ESD Name and IGA no.
Payment Code: Index PCA Object $ 0

OK to pay upon receipt of matching funds per Linda J. Williams, Contract Adminstrator DMAP_____ (503) 945-6730

Date:
Reviewed/Accepted By Lasa Baxter, IMESD by OHA DMAP Contract (541)975-5614

(YOUR NAME) ESD

1.5% IGA Payment

ADDRESS

PHONE CONTACT

DATE:	
ESD Claim for MAC quarter	
Amount Claimed	
Agreement (IGA) No.	
IGA Effective Date	**01/01,2015**
IGA Expiration Date	**12/31/2020**

For Billing Purposes This IGA payment is emailed to:
medicaid.leveraging@state.or.us
(enter "MAC" in the subject line)
Faxed to: 503-378-2806
(Salem) or Mailed To:
OHA Receipting Unit
P.O. Box 14006

Salem, OR 97309-5030

DESCRIPTION ESD INTERGOVERNMENTAL CHARGE PAYMENT TO OHA	1.5% AMOUNT TO OHA
ESD Separate 1.5% Intergovernmental Charge payment to OHA for total allowable cost of providing Medicaid Administrative Claiming Activities Claimed in arrears on a quarterly basis for : ***0***	$ -

OHA use only: 1.5% FPA : Index: PCA Object A/R Batch _____ Receipted in by:_____ A/R Batch Date_____/_____/_____	Deposit Date:

A/R Unit cc: Linda J Williams Contract Administrator DMAP; And copy to DMAP Manager Budget and Finance

e-CFR data is current as of August 4, 2016

Title 34 → Subtitle B → Chapter III → Part 300 → Subpart B → §300.154

Title 34: Education

PART 300—ASSISTANCE TO STATES FOR THE EDUCATION OF CHILDREN WITH DISABILITIES

Subpart B—State Eligibility

§300.154 Methods of ensuring services.

(a) Establishing responsibility for services. The Chief Executive Officer of a State or designee of that officer must ensure that an interagency agreement or other mechanism for interagency coordination is in effect between each noneducational public agency described in paragraph (b) of this section and the SEA, in order to ensure that all services described in paragraph (b)(1) of this section that are needed to ensure FAPE are provided, including the provision of these services during the pendency of any dispute under paragraph (a)(3) of this section. The agreement or mechanism must include the following:

(1) An identification of, or a method for defining, the financial responsibility of each agency for providing services described in paragraph (b)(1) of this section to ensure FAPE to children with disabilities. The financial responsibility of each noneducational public agency described in paragraph (b) of this section, including the State Medicaid agency and other public insurers of children with disabilities, must precede the financial responsibility of the LEA (or the State agency responsible for developing the child's IEP).

(2) The conditions, terms, and procedures under which an LEA must be reimbursed by other agencies.

(3) Procedures for resolving interagency disputes (including procedures under which LEAs may initiate proceedings) under the agreement or other mechanism to secure reimbursement from other agencies or otherwise implement the provisions of the agreement or mechanism.

(4) Policies and procedures for agencies to determine and identify the interagency coordination responsibilities of each agency to promote the coordination and timely and appropriate delivery of services described in paragraph (b)(1) of this section.

(b) Obligation of noneducational public agencies. (1)(i) If any public agency other than an educational agency is otherwise obligated under Federal or State law, or assigned responsibility under State policy or pursuant to paragraph (a) of this section, to provide or pay for any services that are also considered special education or related services (such as, but not limited to, services described in §300.5 relating to assistive technology devices, §300.6 relating to assistive technology services, §300.34 relating to related services, §300.41 relating to supplementary aids and services, and §300.42 relating to transition services) that are necessary for ensuring FAPE to children with disabilities within the State, the public agency must fulfill that obligation or responsibility, either directly or through contract or other arrangement pursuant to paragraph (a) of this section or an agreement pursuant to paragraph (c) of this section.

(ii) A noneducational public agency described in paragraph (b)(1)(i) of this section may not disqualify an eligible service for Medicaid reimbursement because that service is provided in a school context.

(2) If a public agency other than an educational agency fails to provide or pay for the special education and related services described in paragraph (b)(1) of this section, the LEA (or State agency responsible for developing the child's IEP) must provide or pay for these services to the child in a timely manner. The LEA or State agency is authorized to claim reimbursement for the services from the noneducational public agency that failed to provide or pay for these services and that agency must reimburse the LEA or State agency in accordance with the terms of the interagency agreement or other mechanism described in paragraph (a) of this section.

(c) Special rule. The requirements of paragraph (a) of this section may be met through—

(1) State statute or regulation;

(2) Signed agreements between respective agency officials that clearly identify the responsibilities of each agency relating to the provision of services; or

(3) Other appropriate written methods as determined by the Chief Executive Officer of the State or designee of that officer and approved by the Secretary.

(d) Children with disabilities who are covered by public benefits or insurance.

(1) A public agency may use the Medicaid or other public benefits or insurance programs in which a child participates to provide or pay for services required under this part, as permitted under the public benefits or insurance program, except as provided in paragraph (d)(2) of this section.

(2) With regard to services required to provide FAPE to an eligible child under this part, the public agency—

(i) May not require parents to sign up for or enroll in public benefits or insurance programs in order for their child to receive FAPE under Part B of the Act;

(ii) May not require parents to incur an out-of-pocket expense such as the payment of a deductible or co-pay amount incurred in filing a claim for services provided pursuant to this part, but pursuant to paragraph (g)(2) of this section, may pay the cost that the parents otherwise would be required to pay;

(iii) May not use a child's benefits under a public benefits or insurance program if that use would—

(A) Decrease available lifetime coverage or any other insured benefit;

(B) Result in the family paying for services that would otherwise be covered by the public benefits or insurance program and that are required for the child outside of the time the child is in school;

(C) Increase premiums or lead to the discontinuation of benefits or insurance; or

(D) Risk loss of eligibility for home and community-based waivers, based on aggregate health-related expenditures; and

(iv) Prior to accessing a child's or parent's public benefits or insurance for the first time, and after providing notification to the child's parents consistent with paragraph (d)(2)(v) of this section, must obtain written, parental consent that—

(A) Meets the requirements of §99.30 of this title and §300.622, which consent must specify the personally identifiable information that may be disclosed (e.g., records or information about the services that may be provided to a particular child), the purpose of the disclosure (e.g., billing for services under part 300), and the agency to which the disclosure may be made (e.g., the State's public benefits or insurance program (e.g., Medicaid)); and

(B) Specifies that the parent understands and agrees that the public agency may access the parent's or child's public benefits or insurance to pay for services under part 300.

(v) Prior to accessing a child's or parent's public benefits or insurance for the first time, and annually thereafter, must provide written notification, consistent with §300.503(c), to the child's parents, that includes—

(A) A statement of the parental consent provisions in paragraphs (d)(2)(iv)(A) and (B) of this section;

(B) A statement of the “no cost” provisions in paragraphs (d)(2)(i) through (iii) of this section;

(C) A statement that the parents have the right under 34 CFR part 99 and part 300 to withdraw their consent to disclosure of their child's personally identifiable information to the agency responsible for the administration of the State's public benefits or insurance program (e.g., Medicaid) at any time; and

(D) A statement that the withdrawal of consent or refusal to provide consent under 34 CFR part 99 and part 300 to disclose personally identifiable information to the agency responsible for the administration of the State's public benefits or insurance program (e.g., Medicaid) does not relieve the public agency of its responsibility to ensure that all required services are provided at no cost to the parents.

(e) Children with disabilities who are covered by private insurance. (1) With regard to services required to provide FAPE to an eligible child under this part, a public agency may access the parents' private insurance proceeds only if the parents provide consent consistent with §300.9.

(2) Each time the public agency proposes to access the parents' private insurance proceeds, the agency must—

(i) Obtain parental consent in accordance with paragraph (e)(1) of this section; and

(ii) Inform the parents that their refusal to permit the public agency to access their private insurance does not relieve the public agency of its responsibility to ensure that all required services are provided at no cost to the parents.

(f) Use of Part B funds. (1) If a public agency is unable to obtain parental consent to use the parents' private insurance, or public benefits or insurance when the parents would incur a cost for a specified service required under this part, to ensure FAPE the public agency may use its Part B funds to pay for the service.

(2) To avoid financial cost to parents who otherwise would consent to use private insurance, or public benefits or insurance if the parents would incur a cost, the public agency may use its Part B funds to pay the cost that the parents otherwise would have to pay to use the parents' benefits or insurance (e.g., the deductible or co-pay amounts).

(g) Proceeds from public benefits or insurance or private insurance. (1) Proceeds from public benefits or insurance or private insurance will not be treated as program income for purposes of 2 CFR 200.307

(2) If a public agency spends reimbursements from Federal funds (e.g., Medicaid) for services under this part, those funds will not be considered “State or local” funds for purposes of the maintenance of effort provisions in §§300.163 and 300.203.

(h) Construction. Nothing in this part should be construed to alter the requirements imposed on a State Medicaid agency, or any other agency administering a public benefits or insurance program by Federal statute, regulations or policy under title XIX, or title XXI of the Social Security Act, 42 U.S.C. 1396 through 1396v and 42 U.S.C. 1397aa through 1397jj, or any other public benefits or insurance program.

(Approved by the Office of Management and Budget under control number 1820-0030)

(Authority: 20 U.S.C. 1412(a)(12) and (e))

[71 FR 46753, Aug. 14, 2006, as amended at 78 FR 10537, Feb. 14, 2013; 79 FR 76096, Dec. 19, 2014]

OHA Medicaid Administrative Claiming
Finance and Policy Analysis
500 Summer Street NE
Salem, OR 97301