MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: School Based Services 03-04

Issued: October 15, 2003

Subject: School Based Services Settlement Agreement between the State of Michigan and CMS; New Medicaid SBS Outreach Program Policy and Special Monitoring Program

Effective: January 1, 2004

Programs Affected: Medicaid School Based Services Early Periodic Screening, Diagnosis and Treatment (EPSDT) Administrative Outreach Program [Medicaid]

PURPOSE OF POLICY

In May 2002, the United States Department of Health and Human Services (DHHS), acting through the Centers for Medicare and Medicaid Services (CMS), entered into a settlement agreement with the Michigan Department of Community Health (MDCH) in the matter of the State's Medicaid School Based Services Administrative Outreach Program disallowance and appeal. This bulletin reflects changes to the program policy as a result of that agreement.

BRIEF DESCRIPTION OF POLICY

Medicaid is implementing a new claims development methodology for the Administrative Outreach portion of the School Based Services (SBS) Program, effective January 1, 2004. The new method includes the following:

- A random moment time study using the Medicaid Administrative Claiming System (MACS) software
- New time study activities
- Two options for claims development
- Establishment of central administrative responsibilities
- A single method of determining the discounted Medicaid eligibility rate
- A special monitoring system
- A revised provider "Assurance of Understanding and Compliance" document.

The State will use the competitive bidding process to select a contractor for the implementation and operation of the random moment time study (RMTS), a contractor who will provide an optional service to complete the claims development process for ISDs and a contractor who will participate in the special monitoring system.

The bulletin officially promulgates the reimbursement provisions of the Settlement Agreement, specifically and by reference, and acknowledges that they are subject to later adjustment. There are prospective and retrospective reimbursement requirements, including a retrospective backcasting method to be determined by CMS and applied to adjust claims for quarters in calendar year 2000 and later that were accepted on an interim basis at either twenty percent (20%) or thirty percent (30%).

SETTLEMENT AGREEMENT

In 2000, the DHHS, acting through the CMS, imposed a federal reimbursement disallowance for the administrative outreach component of the SBS Program. In May 2002, the State of Michigan and DHHS/CMS negotiated a settlement agreement that requires significant revisions to the SBS Administrative Outreach Program. The Program has been revised in accordance with the terms set forth in the settlement (a complete copy of the settlement agreement may be viewed on the MDCH web site www.michigan.gov/mdch). The settlement clearly states the conditions, activities, requirements, and procedures that the MDCH is responsible for implementing, and this is the primary basis for the revisions to the SBS Administrative Outreach policy as stated in the bulletin. MDCH will adopt, at any time, new CMS regulations and national guidelines related to the claims development methodology for this program.

HIGHLIGHTS OF FINANCIAL TERMS OF THE SETTLEMENT AGREEMENT

CMS will accept for reimbursement, on an interim basis, thirty percent (30%) of the submitted claims for the SBS administrative outreach activities covering quarters beginning with the January-March 2000 quarter through 3-30-03 and at twenty percent (20%) from 4-01-03 through 12-31-03. Valid claims (as determined by the CMS) that are received for four quarters, beginning with the quarter of January-March 2004 (the implementation date of this new claims development methodology) are subject to later "backcasting" adjustments. CMS will backcast the results of those approved quarters to adjust claims for quarters in calendar year 2000 and later that were accepted on an interim basis at either 20% or 30% so that payments will appropriately reflect the results of the approved system.

Each Intermediate School District/Detroit Public Schools (ISD/DPS) that participated in the Outreach Program during the time period covered by the settlement is affected by this backcasting process. If the final allowed amounts are less than the interim reimbursement, the difference will be paid back to the CMS through the MDCH Claim Adjustment process. The backcasting methodology will be determined by the CMS and follow the interim payment and reserve account schedule illustrated below. It also shows the MDCH plan for holding some of the reimbursement in reserve if it is needed after the backcasting process is complete.

Claim Period	Interim % Amount Allowed/Accepted	Funds
CMS Billing Quarters July 1998-December 1999	50% of amount claimed by ISDs/DPS	State assumes loss of the remaining amounts of disallowed claims
CMS Billing Quarters January 2000-September 2001	30% of amount claimed by ISDs/DPS	State assumes loss of the remaining amounts of disallowed claims **prior to backcasting**
CMS Billing Quarter October 2001-December 2001 **(ISD/DPS billing quarter beginning July 1, 2001)**	30% of amount claimed	State places 100% of the ISD/DPS share of the interim allowed funds in a reserve account
January 2002 –March 2003 **(ISD/DPS billing quarter beginning October 1, 2001)**	30% of amount claimed	State places 1/3 of the ISD/DPS share of the interim allowed funds in a reserve account, and the ISDs/DPS will receive their portion of the remaining 2/3

Claim Period	Interim % Amount Allowed/Accepted	Funds
April 2003-September 2003	20% of amount claimed	State places 1/3 of the ISD/DPS share of the interim allowed funds in a reserve account, and the ISDs/DPS will receive their portion of the remaining 2/3
October 2003-December 2003	0% of amount claimed	Payment for this quarter will be included in the backcasting process for quarters beginning January 1, 2002 to the date of implementation of the new program.
Effective date when new methodology begins, applies to time studies conducted beginning with the January-March 2004 quarter.		The State will not hold back any funds beginning with the effective date of the new methodology

All retrospective and prospective provisions of the settlement agreement are accepted as Medicaid policy.

The ISD/DPS share of both administrative outreach and fee-for-service payments continues to be equal to 60 percent (60%) of the federal Medicaid funds received by the State resulting from the amount billed to Medicaid by the SBS Providers.

MANUAL MAINTENANCE

Retain this bulletin for future reference.

QUESTIONS

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231 or e-mail ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll free 1-800-292-2550.

APPROVAL

Paul Reinhart, Director
Medical Services Administration

MEDICAID SCHOOL BASED SERVICES
ADMINISTRATIVE CLAIMING PROGRAM

I. PROVIDER ENROLLMENT

A. Enrollment

In order to participate in the Medicaid School Based Services Administrative Outreach Program, currently enrolled providers of the services -- Michigan's 57 Intermediate School Districts (ISD) and Detroit Public Schools (DPS) -- need not re-enroll with the Medicaid Program. However, those 58 providers who wish to participate and also meet program criteria were required to sign a revised Assurance of Understanding and Compliance agreement with the MDCH in order to receive reimbursement for Outreach services provided. The new Assurance agreement, dated November 2002, (see attached) provides written confirmation that school districts understand and comply with all program policy for the SBS Administrative Outreach program.

B. Certification of Qualified Staff

Since commencement of the SBS program, the Michigan Department of Education (MDE) has been the agency providing the MDCH with documentation that enrolled ISDs/DPS meet the regulatory requirements set forth for all staff providing services in either the fee-for-service or Administrative Outreach components of the program.

Enrollment as a provider in the SBS Administrative Outreach Component remains predicated upon the certification to the MDE that the educational and experiential requirements and credentials of all staff (i.e., licensure, certification, registration, etc.) who may be performing activities that are claimable have been met and are current. The MDE will assist any school districts in this certification process and verify the status of their certification in writing, along with recommendations, with a copy sent to the MDCH.

II. CLAIMS DEVELOPMENT OVERVIEW

Using the State of Michigan's competitive bid process, the MDCH will select one Contractor to implement and administer the MACS random moment time study. The Contractor will also provide the IDSs and DPS the option of performing certain time study responsibilities and claims development activities on behalf of those ISDs/DPS that choose to participate in this portion of the State contract and pay for these services.

A. Two Options for Enrolled Providers for Developing Claims

Under the new claiming methodology, enrolled ISDs/DPS must choose one of the approaches below to generate their quarterly claim. All ISDs and DPS will be required to use the State's new Medicaid Administrative Claiming System (MACS) software to generate their quarterly claim and to utilize the services of the State's RMTS and Claims Development Contractor, who will conduct the statewide time studies each quarter. The 58 providers (57 ISDs and DPS) will select a level of service depending on their unique needs and their capacity to perform tasks related to this program.

1. IDSs/DPS choose to be independently responsible for their own claims development.

   ISDs/DPS may, alone or as a consortium of districts, use the information from the time studies provided by the RMTS and Claims Development Contractor and develop their claim independently or choose to hire consultants/billing agents to assist them. Either way, they must utilize the MACS software and complete the key functions required to develop and validate the claim. Each ISD/DPS or their billing agent must assign only one person as the designated coder for the program. These districts must also assume total responsibility for complying with all aspects of the program policy and cooperate fully with the CMS-mandated special monitoring and MDCH financial auditing systems.

   The cost for the Contractor will be charged back to providers who participate in this option based on the Contractor's projected cost per ISD (after Federal match).

   ISDs/DPS who choose this option and who request reimbursement in the form of federal matching funds/federal financial participation (FFP) for the costs of administering this portion of the program shall obtain a written statement from the CMS that attests their respective consultants/billing agents were selected utilizing the federal procurement process as per federal regulations; and that the entity is not reimbursed on a contingency-fee basis. A copy of this documentation must be submitted to the MDCH. A request to change this option may only be made once per year, and must be received by the MDCH by July 1st.

2. Districts choose the State Claims Development Contractor.

   The Contractor will develop an implementation plan on behalf of its ISDs and DPS to conduct the statewide time studies each quarter, utilize the MACS software, as well as complete all other key functions required for valid claim development. The Contractor must assign only one person as the designated coder for the program. The MDCH will oversee the Contractor and ISDs/DPS participating in this option to assure their compliance with all aspects of the program policy. The ISDs/DPS must cooperate with the CMS-mandated special monitoring and MDCH financial auditing systems.

   The cost for the Contractor will be charged back to providers who participate in this option based on the Contractor's projected cost per ISD (after Federal match).

   Prior to selection of the State Claims Development Contractor, if that vendor has current contracts with any of the ISDs/DPS or one or more consortia, the Contractor will release any and/or all the districts, if that is the desire of the districts, from their current contract without penalty. The ISD/DPS/consortium may transfer into the State's Claims Development contract at the price agreed upon in the State contract.

B. Overview of Claims Development Process

Based on Federal and State statutes and regulations, below is a partial list of specific functions and tasks that must be accomplished for reimbursement of Medicaid Administrative Outreach services. More details appear in subsequent sections. Claims will be developed by the State's Claims Development Contractor or independent ISDs/DPS utilizing the MACS software following these basic steps:

- The quarterly RMTS sampling results are produced by the State's RMTS and Claims Development Contractor, who converts them to percentages. The percentages are applied to program costs to determine reimbursement and entered onto the first sheet of the MACS Workbook
- The MACS cost/claim generation component automates nine Excel spreadsheets and links the spreadsheets where possible. The ISD costs are entered onto the appropriate worksheets and the software calculates and produces the claim

- The claim is submitted to MDCH with verification of claim validity from each ISD/DPS or the lead district for the consortium
- The ISD and/or Contractor must cooperate with any special monitoring activities conducted by the Special Monitoring Contractor, the MDCH or the CMS at any stage of the time study and claims development processes
- The ISD and/or Contractor must comply with all conditions set forth by the MDCH as SBS policy

C. Implementation Plan

Each ISD/DPS must submit an Implementation Plan that identifies the claims development option selected and reflects the details of their SBS Administrative Outreach Program operation for review and approval by the MDCH and by CMS. Any subsequent changes must also be reported and receive approval.

Claims may not be submitted to the MDCH for reimbursement until the MDCH has approved the Implementation Plan that will be utilized based on this published policy.

III. CMS-MANDATED SPECIAL MONITORING SYSTEM

As a condition of reinstating the SBS Administrative Outreach component of the Medicaid Program, the State of Michigan agreed in May 2002 to design and institute a system for monitoring time studies and the claims development process. The CMS and the MDCH agreed to "engage jointly in monitoring…implementation (of the new program) to assure proper use of the time study codes by school staff and proper application of the time study methodology." The State may use a contracted firm to assist in the monitoring. Any contracted firm used must be completely independent from the process of preparing and submitting claims and shall be reimbursed in a manner that is also independent of that process. The MDCH will use a combination of internal staff and contract with one vendor to accomplish the terms of this requirement.

After the federal financial participation amounts are deducted, the State will assume 40 percent (40%) of the remaining costs for the special monitoring contract and the ISDs/DPS will be responsible for 60 percent (60%) of those costs. This reflects the standard division of shared federal financial participation for the SBS Program.

Any Contractor selected by any ISD/DPS or consortium of ISDs to assist in the development of claims must cooperate and provide requested information to the MDCH staff, CMS monitors and the Special Monitoring Contractor. The MDCH and/or the MDE will coordinate any visits or onsite activities between the ISDs/DPS and the Special Monitoring Contractor to assure continuity in procedures and consistency in implementation.

Any of these parties may, at any time, observe the time studies, observe the training, review the time study materials, records and data, or interview time study participants before or after the time studies occur each quarter.

MDCH, CMS and the special monitoring contractor will have full access to all relevant MDCH records and records maintained by the participating ISDs/DPS and their claiming entities. They have the responsibility of monitoring each ISD to determine if they are meeting the program requirements. They will make site visits, observe training, review a sample of completed random moment data collection forms, and use other quality assurance techniques and sampling methods as appropriate.

IV. TIME STUDY METHODOLOGY

A. The Time Study Overview

The new time study design is simpler, requires less training for participants, and logs only what the participant is doing at one moment in time. All districts that participate in the SBS Administrative Outreach component must identify allowable Medicaid administrative costs within a given program by requiring that staff who spend a portion of their time performing outreach activities be available to participate in a quarterly time study.

There are two steps to completing a time study form. In the first step, the time study participants will hand-write answers to three questions (What are you doing? Who are you with? Why were you doing it?) that relate to their activities at their assigned moment that quarter. Time study participants will not code the activity they describe. There will be a central coding process for the time study forms.

For the second step, the time study forms are collected from the participants and one designated individual (from the ISD/DPS or the State's Contractor) who has received more training will assign the appropriate activity code for that moment based on the answers to the three time study questions. At this point, the time study form is completed and can be scanned into the MACS by the State Contractor.

B. The Time Study Participants

As a condition of renewed participation, the ISD/DPS providers must certify to the MDE that any staff providing services under the SBS program, or participating in a time study, meets the educational, experiential and regulatory requirements of the MDCH.

The following staff groups may be appropriate for inclusion in time studies if they are involved in SBS Administrative Outreach activities:

- Administrators
- Translators/Bilingual Personnel
- Early Identification/Intervention Personnel
- Interpreter
- Program Specialist
- Teacher Consultant
- Physician
- Physician Assistant
- Nurse Practitioner, Registered Nurse
- Psychologist
- Social Worker
- Physical Therapist
- Physical Therapy Assistant
- Occupational Therapist
- Occupational Therapy Assistant
- Speech - Language Therapist
- Audiologist
- Counselor
- Orientation and Mobility Specialist
- Case Manager
- Service Coordinator
- Special Education Teacher
- Support Personnel

In providing the staff pool eligible to participate in the time studies, school districts must certify the list of participants and activities to be claimed to ensure that all appropriate personnel are submitted. In short, the time study must include at least the following classes of individuals:

- Skilled professional medical personnel (SPMP) who directly perform approved Medicaid administrative outreach functions, whether they are directly employed by the ISD/DPS or are contracted personnel for which the ISD/DPS can document a *de facto* employer-employee relationship.
- All other personnel who perform approved Medicaid administrative outreach functions, whether they are directly employed by the ISD/DPS or are contracted personnel for which the district can document a *de facto* employer-employee relationship.
- Contracted SPMP for which a *de facto* employer-employee relationship cannot be documented. These individuals are considered "other personnel" and their activities are claimed at the 50% FFP rate.

C. Federal Financial Participation for Services/Activities performed by Skilled Professional Medical Personnel (SPMP)

Effective January 1, 2003, ISDs/DPS or their billing agent must bill SPMP administrative activities at the Federal Financial Participation (FFP) rate of 50% for allowable medically necessary administrative activities provided by SPMPs and their direct support staff if certain professional education, training, and supervision requirements are met. However, it is also necessary to continue to identify and report SPMP activities separately on the quarterly claim and not include the SPMP expenditures with the other 50% matchable expenditures. Because the results of the new program will be applied to prior billing quarters when SPMP activities could be recognized at the 75% rate, it is still necessary to identify and record the SPMP amounts on the quarterly claim for the backcasting process.

The coder for a time study form completed by an SPMP should check certain activity codes (codes 8 or 11) when the time study participant has states they are SPMP by answering questions 4-6 on the time study form.

- The activities relate directly to the administration of the medical assistance program (Medicaid) and are not direct medical services.
- An SPMP is defined as a person who has professional education and training in the field of medical care or appropriate medical practice. "Professional education and training" means the completion of a two-year or longer program leading to an academic degree or certificate in a medically-related profession of a medical license, certificate, or other document issued by a recognized national or State medical licensure or certifying organization, or a degree in a medical field issued by a college or certified by a professional medical organization. Experience in the administration, direction, or implementation of the Medicaid program is not considered the equivalent of professional training in a field of medical care.
- The SPMP performs duties and responsibilities that require professional medical knowledge and skills.
- There exists documentation of an employer-employee relationship between the ISD/DPS and the SPMP and direct supporting staff or a documented *de facto* employer-employee relationship for such contracted personnel. SPMP for whom a *de facto* employer-employee relationship cannot be documented also must participate in a time study, and must be included in the cost and time studies for "other personnel".
- The direct supporting staff of an SPMP are defined as those who are secretarial, stenographic, copying personnel, and file and record clerks who provide clerical and support services that are directly necessary for the completion of the professional medical responsibilities and functions of the SPMP. The support staff provides direct support exclusively to the SPMP. The SPMP must directly supervise the supporting staff and the performance of the supporting staff's work. Costs associated with direct support personnel should be included with the costs of the employee that directly supervises them and are

allocable and reimbursable at the same level as the employees they support. Direct support personnel are not included in the sample population since they do not directly perform Medicaid administrative activities.

For the situations in which contracted skilled medical personnel's *de facto* employer-employee relationship cannot be documented, these individuals are considered "other personnel" and their matchable activities are claimed at the 50% rate.

V. ACTIVITIES THAT CAN BE CLAIMED

This section lists 18 distinct activities that are likely to be performed by any of the time study participants during a typical workday. There will be centralized coding of the time study forms, either through a single designated ISD/representative or a single designated staff member of the contractor. Some of these activities may be claimed under Medicaid, and some may not. To assist the coder's understanding of which activity is most appropriate to check off during a time study, there are many examples listed under each definition, and other special notes to clarify the intent of the listing.

Summary of Time Study Activities

Activity	Reimburse	Discount	FFP Rate
1. MEDICAID OUTREACH AND PUBLIC AWARENESS	A	No	50%
2. NON-MEDICAID OUTREACH	U	No	
3. FACILITATING MEDICAID ELIGIBILITY DETERMINATION	A	No	50%
4. FACILITATING APPLICATION FOR NON-MEDICAID PROGRAMS	U	No	
5. PROGRAM PLANNING, POLICY DEVELOPMENT AND INTERAGENCY COORDINATION RELATED TO MEDICAL SERVICES	A	Yes	50%
6. PROGRAM PLANNING, POLICY DEVELOPMENT AND INTERAGENCY COORDINATION RELATED TO NON-MEDICAL SERVICES	U	No	
7. REFERRAL, COORDINATION, AND MONITORING OF MEDICAID SERVICES	A	Yes	50%
8. REFERRAL, COORDINATION, AND MONITORING OF MEDICAID SERVICES PERFORMED BY SPMPs	A	Yes	75%
9. REFERRAL, COORDINATION, AND MONITORING OF NON-MEDICAID SERVICES	U	No	
10. MEDICAID-SPECIFIC TRAINING ON OUTREACH, ELIGIBILITY AND SERVICES	A	Yes	50%
11. MEDICAID-SPECIFIC TRAINING ON OUTREACH, ELIGIBILITY AND SERVICES PERFORMED BY SPMPs	A	Yes	75%
12. NON-MEDICAID TRAINING	U	No	
13. DIRECT MEDICAL SERVICES	U	No	
14. TRANSPORTATION AND TRANSLATION SERVICES IN SUPPORT OF MEDICAID-COVERED SERVICES	A	Yes	50%
15. TRANSPORTATION AND TRANSLATION SERVICES IN SUPPORT OF NON-MEDICAID-COVERED SERVICES	U	No	
16. GENERAL ADMINISTRATION	R		
17. SCHOOL-RELATED AND EDUCATIONAL ACTIVITIES	U	No	
18. NOT SCHEDULED TO WORK AND NOT PAID	U	No	

"A" Allowable means the expense is covered by Medicaid.
"U" Unallowable means the expense is not covered by Medicaid.
"R" Reallocated means reimbursement across other activities.

Michigan's Administrative Outreach Component activity codes are designed to reflect the actual activities that may occur in a school on any given day, and the specificity of the unique health care programs within the State that are available to families. Some activities fully support the administration of the State Plan and/or the EPSDT program in the State, and others are more related to activities performed on behalf of Medicaid-eligible students. Because these medical- or health-related activities are provided for students who are both Medicaid and non-Medicaid eligible, it is necessary to develop and apply a formula that properly allocates which students are being supported. This is referred to as the discounted Medicaid Eligibility (MAE) rate. During claims development, the discounted MAE for each ISD/DPS will be applied to certain activities that support Medicaid-eligible students.

Apply a discount proportional to the Medicaid eligibility rate to activities that involve:

- Referral, coordination planning and monitoring health services designed to be delivered through the Medicaid Program that address the health needs of children.
- Program planning and policy development of Medicaid-covered services.
- Presenting or participating in training designed to educate the audience about the various Medicaid programs and the services covered by each, and how to more effectively refer students for services.
- Assisting or arranging for an individual to obtain transportation to Medicaid-covered services.
- Assisting, arranging or providing translation services related to Medicaid-covered services.

Using the above criteria, the following activities listed in the "Summary of Time Study Activities" will be discounted by the Medicaid eligibility rate released by the MDCH twice annually:

- Activity 5 - Program planning, policy development and interagency coordination
- Activities 7 & 8 - Referral, coordination and monitoring of Medicaid services
- Activities 10 & 11 - Medicaid-specific training on outreach and eligibility services
- Activity 14 – Transportation and translation service in support of Medicaid-covered services

No Medicaid discount applied to activities that:

- Inform children, parents and families, ISD/DPS staff and the community about the benefits, availability and how to access services and programs available through the Medicaid Program.
- Involve conducting outreach campaigns to reach and identify children in the school who are in need of health and preventive services covered by Medicaid.
- Facilitate potentially eligible students and their families who may or are completing the process of enrolling in the Medicaid program.

CODE 01-MEDICAID OUTREACH AND PUBLIC AWARENESS-A

This code is used when school staff are performing activities that inform eligible or potentially eligible individuals about Medicaid and how to access Medicaid programs. This code is also used for describing the services covered under Medicaid and how to obtain Medicaid preventive services. Activities related to Child Find will not be recorded here, but under Code 02.

It includes related paperwork, clerical activities, or staff travel required to perform these activities:

- Informing families and distributing literature about the services and availability of the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program and the many different Michigan Medicaid programs, such as Healthy Kids and Children's Special Health Care Services.
- Informing and encouraging families to access Medicaid managed care systems, i.e., Medicaid Health Plans.
- Informing families about the EPSDT and Medicaid health-related programs and the value of preventive health services and periodic exams.

- Assisting the Medicaid agency to fulfill outreach objectives of the Medicaid program by informing individuals, students, and their families about health resources available through the Federal Medicaid Program.
- Conducting Medicaid outreach campaigns and activities not related to Child Find, such as health fairs, that provide information about services provided by such entities as the Community Mental Health Service providers, Local Health Departments, etc.
- Conducting a family planning health education outreach program or campaign, if it is targeted specifically to Medicaid-covered family planning services.
- Contacting pregnant and parenting teenagers about the availability of Medicaid services, including referral to family planning and well baby care programs and services.
- Providing referral assistance to families with information about the Medicaid program.
- Providing information about Medicaid screenings that will help improve the identification of medical conditions that can be corrected or ameliorated through Medicaid services.
- Notifying families of EPSDT program initiatives, such as Medicaid screenings conducted at a school site. These screenings are distinct from other general health screenings that are covered in Code 02.
- Coordinating with the local media (newspaper, TV, radio, video) to inform the public about EPSDT screenings, health fairs and other health related services, programs and activities organized by the school.
- Coordinating or attending child health fairs that emphasize preventive health care and promote Medicaid services by presenting Medicaid material in areas with the likelihood of high Medicaid eligibility.
- Presenting and informing families about the availability of Medicaid providers of specific covered services and how to effectively utilize services and maintain participation in the Medicaid program.
- Providing parents, on report card pick-up day or at parent conferences, information about the Medicaid program and health care services available to eligible children, including EPSDT screening services and medically necessary treatment.

CODE 02-NON-MEDICAID OUTREACH-U

This code is used for performing activities that inform eligible or potentially eligible individuals about social, vocational and educational programs, including special education, that are not covered by Medicaid and how to access them. Activities include describing the eligible or potentially eligible individuals, the range of benefits covered under these non-Medicaid social, vocational, and educational programs, such as WIC, SSI, MI CHILD and LIF, Child Find, and how to obtain them.

It includes related paperwork, clerical activities, or staff travel required to perform these activities:

- Informing families about wellness programs and how to access these programs.
- Scheduling and promoting activities that educate individuals about the benefits of healthy lifestyles and practices.
- Conducting general health education programs or campaigns addressed to the general population.
- Conducting outreach campaigns directed toward encouraging persons to access social, educational, legal or other services not covered by Medicaid.
- Assisting in early identification of children with special medical/mental health needs through various Child Find activities.
- Developing the school district's student/parent handbook.
- Coordinating with the local media (newspaper, TV, radio, video) to inform the public about upcoming events, such as health fairs, or screenings that focus on non-Medicaid social, vocational and educational programs, and activities, such as scholarships, remedial classes, Child Find, DARE, anti-smoking campaigns, etc.

- Providing parents, on report card pick-up day or at parent conferences, information about non-Medicaid programs, social, vocational and educational, and general health care services available in the community or the school for their children.

CODE 03-FACILITATING MEDICAID ELIGIBILITY DETERMINATION-A

This code is used for assisting an individual to become eligible for Medicaid. This activity does not include the actual determination of Medicaid eligibility.

It includes paperwork, clerical activities, or staff travel required to perform these activities:

- Verifying an individual's current Medicaid eligibility status.
- Facilitating eligibility determination for Medicaid by planning and implementing a Medicaid information program.
- Participating as a provider of Medicaid eligibility outreach information.
- Explaining Medicaid eligibility rules and the Medicaid eligibility process to prospective applicants.
- Referring an individual or family to the local Family Independence Agency (FIA) or other local office to make application for Medicaid benefits.
- Assisting individuals or families to complete the Michigan Medicaid eligibility application.
- Assisting the individual or family in collecting/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 families to appropriate sources to obtain Medicaid applications.

CODE 04-FACILITATING APPLICATION FOR NON-MEDICAID PROGRAMS-U

This code is used for informing an individual or family about programs, such as Child Find, Food Stamps, SSI, WIC, Daycare, Legal Aid, Free and Reduced Lunch, and other social or educational programs and referring them to the appropriate agency to make application.

It includes related paperwork, clerical activities, or staff travel required to perform these activities:

- Explaining the eligibility process for non-Medicaid programs.
- Assisting the individual or family to collect/gather information and documents for the non-Medicaid program applications.
- Assisting the individual or family in completing the non-Medicaid programs application(s).
- Developing and verifying initial and continuing eligibility for the Free and Reduced Lunch Program.
- Providing necessary forms and packaging all forms in preparation for the non-Medicaid eligibility determination.

CODE 05-PROGRAM PLANNING, POLICY DEVELOPMENT AND INTERAGENCY COORDINATION RELATED TO MEDICAL SERVICES-A

This code is used for performing activities associated with the collaborative development of programs with other agencies that assure the delivery of Medicaid-covered medical/mental health services to school-age children. It applies only to employees whose position descriptions include program planning, policy development and interagency coordination, and/or those staff specifically appointed to appropriate committees/programs performing required activities.

It includes related paperwork, clerical activities or staff travel required to perform these activities:

- Defining the scope of each agency's Medicaid service in relation to the other, and identifying gaps or duplication of medical/mental health programs.
- Analyzing Medicaid data related to a specific program, population, or geographic area and working with Medicaid resources, such as the Medicaid Health Plans, to locate and develop EPSDT health services referral relationships and expanding school medical/mental health programs to school populations of need.
- Creating a collaborative of health professionals to provide consultation and advice on the delivery of health care services to the school populations and developing methods to improve the referral and service delivery process by Medicaid health providers.
- Containing Medicaid costs for individuals with multiple challenging disabilities by reducing overlap and duplication of Medicaid services through collaborative efforts with Medicaid Health Plans, local Community Mental Health Service providers and Local Health Departments.
- Monitoring and evaluating policies and criteria for performance standards of medical/mental health delivery systems in schools and designing strategies for improvements.
- As a part of the school health policy quality assurance system, maintain and ensure the continuity of all Medicaid health-related services, including development and monitoring contracts with private providers, agencies and/or provider groups.
- Overseeing the organization and outcomes of the coordinated medical/mental health service provision with Medicaid Health Plans.
- Developing internal referral policies and procedures for use by staff so that appropriate coordination of health services occurs between the various Medicaid providers and entities, such as Community Mental Health Service providers, Local Health Departments, Medicaid Health Plans, and those in the educational setting.
- Designing and implementing strategies to: identify students who may be at high risk for poor outcomes because of poverty, dysfunctional families, and/or inappropriate referrals, and need medical/mental health interventions, identify pregnant students who may be at high risk of poor health outcomes because of drug usage, lack of appropriate prenatal care, and/or abuse or neglect, and assuring students with any significant health problems are diagnosed and treated early.
- Presenting specific provider information about Medicaid EPSDT screening in the schools that will help identify medical conditions that can be corrected or ameliorated by services covered through Medicaid.
- Developing procedures for tracking and resolving families' requests for assistance with Medicaid services and providers. This does not include the actual tracking of requests for Medicaid services.
- Developing new health programs with local community health providers for the Medicaid population, as determined by a needs assessment and geographic mapping.
- Working with requests and inquiries from local school board members, county commissioners, or State legislators to resolve unique or unusual requests or boundary issues regarding appropriate care for certain Medicaid-eligible groups or populations.
- Coordinating with interagency committees to identify, promote and develop medical services in the school system.

SPECIAL NOTE: These activities relate to the program and not for a specific child.

CODE 06-PROGRAM PLANNING, POLICY DEVELOPMENT and INTERAGENCY COORDINATION RELATED TO NON-MEDICAL SERVICES-U

This code is used when performing activities associated with the development of strategies to improve the coordination and delivery of community services to school age children, and when performing collaborative activities with other agencies. Non-medical services may include social, educational, and vocational services.

It includes related paperwork, clerical activities or staff travel necessary to perform these activities:

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

CODE 07-REFERRAL, COORDINATION, AND MONITORING OF MEDICAID SERVICES-A

This code is issued for developing appropriate referral sources for program-specific services for the school district, coordinating programs and services at the school or district level, and monitoring the delivery of Medicaid services within the school system.

It includes related paperwork, clerical activities or staff travel necessary to perform these activities:

- Identifying and referring adolescents who may be in need of Medicaid family planning services.
- Making referrals for and/or scheduling appropriate Medicaid-covered immunizations, vision, and hearing testing, but not to include the child health screenings (vision, hearing and scoliosis) and immunizations that are required for all students.
- Providing information about Medicaid EPSDT screening (e.g., dental, vision) in the schools that will help identify medical conditions that can be corrected or improved by services through Medicaid.
- Contacting Medicaid providers of pediatric services in lower income areas to determine the scope of EPSDT screening and treatment services available to meet the needs of the at-risk child.
- Reviewing clinical notes of staff by a designated clinician to identify medical referral and follow-up practices, and making recommendations to supervisors for improvements as needed.
- Conducting quality assurance reviews of specific health-related programs objectives.
- Providing both oral and written instructions about the referral policies and procedures between the various agencies to parents for appropriate coordination of health services in the educational setting and for follow-up at home.

SPECIAL NOTE: Activities that are part of a direct service are not claimable as an administrative service. This code is not used for case management for a student with an IEP/IFSP or for actual targeted case management activities to assist student's access to medical services, such as:

- Coordinating evaluations and/or assessments needed by the student
- Facilitating and participating in development of the IEP/IFSP
- Linking or coordinating care across agency lines
- Reassessing or following up on the required needs of the student
- Monitoring needed medical, social, educational, and other services that are a part of the student's care plan

- Assuring care records are maintained

For staff performing any of the above activities, Code 13 is used. Michigan covers targeted case management for individual students as a direct fee-for-service activity that can be billed as medical service to Medicaid.

CODE 08-REFERRAL, COORDINATION, AND MONITORING OF MEDICAID SERVICES PERFORMED BY SPMPs-A

This code is used for skilled professional medical personnel who are providing medically necessary administrative activities and for which skilled professional medical knowledge is required.

This code is used for developing appropriate referral sources for program-specific services for the school district, coordinating programs and services at the school or district level, and monitoring the delivery of Medicaid services within the school system.

It includes related paperwork or staff travel necessary to perform these activities:

- Coordinating with interagency committees to identify, promote and develop EPSDT services in the school system.
- Coordinating the delivery of community based medical/mental health services and plans.
- Coordinating medical/mental health services with managed care plans as appropriate.
- Developing professional relationships for the purposes of referral of Medicaid-eligible students for EPSDT medical and other health-related services.
- Providing clinical information at the program level -- not for individual cases -- to providers about Medicaid policy and regulations.
- Developing a referral system that includes procedures for recording and reporting the requests and subsequent referral of families to the appropriate Medicaid service providers.
- Developing strategies for containing medical costs and improving services to children as part of the goals of the EPSDT program.
- Working with agencies providing Medicaid services to improve the coordination and delivery of clinical health care services, to expand access to specific populations of Medicaid eligibles, and to improve collaboration around the early identification of medical problems. Activities include development, implementation, and the amending of Interagency Agreements related to Medicaid services.
- Developing strategies to improve how the needs of medically-fragile individuals receiving Medicaid services are addressed.
- Developing and communicating both oral and written clinical and health care instructions to parents and school staff for appropriate coordination of health needs in an educational setting and/or follow-up at home.

SPECIAL NOTE: Activities that are part of a direct service are not claimable as an administrative service. This code is not used for case management for a student with an IEP/IFSP or for actual targeted case management activities to assist student's access to medical services, such as:

- Coordinating evaluations and/or assessments needed by the student
- Facilitating and participating in development of the IEP/IFSP
- Linking or coordinating care across agency lines
- Reassessing or following up on the required needs of the student
- Monitoring needed medical, social, educational, and other services that are a part of the student's care plan
- Assuring care records are maintained

For staff performing any of the above activities, Code 15 is used. Michigan covers targeted case management for individual students as a direct fee-for-service activity that can be billed as medical service to Medicaid.

CODE 09-REFERRAL, COORDINATION, AND MONITORING OF NON-MEDICAID SERVICES-U

This code is used for making referrals for, coordinating, and/or monitoring the delivery of non-medical, such as educational, services.

It includes related paperwork, clerical activities or staff travel necessary to perform these activities:

- Making referrals for, and coordinating access to, social and educational services, such as childcare, employment, job training, and housing.
- Making referrals for, coordinating, and/or monitoring the delivery of immunizations and child health screenings (vision, hearing, scoliosis) that are required for all students.
- Making referrals for, coordinating, and monitoring the delivery of educational, scholastic, vocational, and other non-health-related examinations/assessments.
- Gathering any information that may be required in advance of these non-Medicaid-related referrals.
- Participating in a meeting/discussion to coordinate or review a student's need for instructional, scholastic, vocational, and non-health-related services not covered by Medicaid.
- Monitoring and evaluating the non-medical components of the individualized plan, such as parent-teacher conferences about a student's educational progress or compiling attendance reports.
- Linking or referring a family to a non-medical service delivery system.
- Evaluating curriculum and instructional services, policies and procedures.
- Developing procedures for tracking families' requests for assistance with non-medical services and the providers of those services, such as tutors or remedial education courses.
- Health networking beyond the scope of Medicaid that is necessary to coordinate or monitor health fairs or screenings that focus on non-Medicaid social, vocational or educational programs and activities, i.e., scholarships, remedial classes, Child Find, DARE, anti-smoking campaigns, etc.

CODE 10-MEDICAID-SPECIFIC TRAINING ON OUTREACH, ELIGIBILITY AND SERVICES-A

This code is used for coordinating, conducting, or participating in training events and seminars for outreach staff regarding the benefits of the Medicaid program, how to assist families to access Medicaid services, and how to more effectively refer students for services. Training for Child Find activities is NOT recorded here, but under Code 12.

It includes related paperwork, clerical activities or staff travel required to perform these activities:

- Participating in or coordinating training that improves the delivery of Medicaid services.
- Participating in or coordinating training which enhances early identification, intervention, screening and referral of students with special health needs to EPSDT services.
- Coordinating training to assist families to access Medicaid services.
- Participating in or presenting training that improves the quality of identification, referral, treatment and care of children, e.g., talking to new staff about the EPSDT referral process, available EPSDT and health-related services.
- Conducting Medicaid outreach training of non-medical professional staff for the purpose of targeting and identifying children with special or severe health or mental health needs for appropriate referral to EPSDT screening services.
- Disseminating information on training sessions and conducting all related administrative tasks.
- Conducting seminars and presentations to teachers, parents, and community members on: appropriately identifying students concerning indications of mental health behavioral conditions (i.e., bi-polar disorders, drug/substance abuse, autism, attention deficit, mood disorders,

pervasive disability disorder, suicidal tendencies, and clinical depression); identification of physical disabilities and other medical conditions that can be corrected or ameliorated by services covered through Medicaid; and providing information on where and how to seek assistance through the Medicaid system.

CODE 11-MEDICAID-SPECIFIC TRAINING ON OUTREACH, ELIGIBILITY AND SERVICES PERFORMED BY SPMPs-A

This code is used for skilled professional medical personnel who are providing medically necessary administrative activities and that require skilled professional medical knowledge.

This code is used for coordinating, conducting, or participating in training events, and seminars for staff who do outreach services regarding the benefits of the Medicaid program, how to assist families to access Medicaid services, and how to more effectively refer students for services.

It includes related paperwork and staff travel required to perform these activities:

- Developing and preparing for others to utilize information about Medicaid-covered services, specific health standards and criteria associated with identification/detection of certain illnesses required by the Medicaid program.
- Developing, participating in, or presenting training that addresses the clinical importance of pediatric standards for preventive care offered under Medicaid programs.
- Developing modules and providing training in the school setting, using clinical education and experience, to other professionals and para-professionals that describe medical protocols utilized to refer students for Medicaid-covered services that may be identified during the evaluation, assessment, or EPSDT screen.
- Developing and maintaining a system that provi des information and training to parents so they may better understand the connection between health issues and Medicaid coverages that may be pertinent to their child, and the importance of seeking Medicaid services and/or treatment when needed.
- Developing modules for, or presenting, a training seminar at which information is presented to colleagues, parents and/or teachers on Medicaid coverages and therapies, such as substance abuse, speech/language, physical/occupational, orientation and mobility, or adaptive physical education for preschoolers and youth.
- Designing and providing training to assist non-medically-oriented staff to recognize symptoms exhibited by students that could result in referrals to Medicaid providers.

CODE 12-NON-MEDICAID TRAINING-U

This code is used for coordinating, conducting, or participating in training events and seminars for outreach staff regarding the benefits of the programs, other than the Medicaid program, such as educational programs; for example, how to assist families to access the services of the relevant programs, and how to more effectively refer students for those services.

It includes related paperwork, clerical activities or staff travel required to perform these activities:

- Participating in or coordinating training that improves the delivery of services for programs other than Medicaid.
- Participating in or coordinating training that enhances IDEA Child Find Programs.
- Participating in or coordinating training that improves relationships between and among local agencies.
- Participating in training to improve computer skills to collect data.
- Training regarding educational issues.
- Training regarding other non-medical social service issues.

- Participating in or coordinating training that improves the medical knowledge and skills of skilled professional medical personnel.
- Training on general health awareness and prevention programs, such as DARE, sex education, the Michigan Model, vocational or scholarship programs, MEAP tests, etc.

CODE 13-DIRECT MEDICAL SERVICES-U

This code is used for providing actual health care services, such as treatment, counseling or service coordination; consultations with parents and other providers about the student's health care needs; or other direct care services to an individual in order to correct or ameliorate a specific condition. Medical evaluations or assessments that are conducted to determine a child's health-related needs for purposes of the development of the IEP/IFSP are covered under this code, as payment for some or all of those costs may be available under Medicaid through the fee-for-service component.

It includes related paperwork, clerical activities or staff travel required to perform these activities:

- Providing health/mental health services contained in an IEP.
- Medical/health assessment and evaluation as part of the development of an IEP.
- Conducting medical/health assessments/evaluations and diagnostic testing, and preparing reports.
- Providing health care/personal aide services.
- Providing speech, occupational, physical and other therapies.
- Administering first aid, or prescribed injection or medication to a student.
- Providing direct clinical and/or treatment services.
- Performing developmental assessments.
- Providing counseling services to treat health, mental health, or substance abuse conditions.
- Performing routine or mandated child health screens including, but not limited to, vision, hearing, dental, scoliosis, and EPSDT screens.
- Administering immunizations.
- Targeted Case Management, if provided as a medical service under Medicaid.
- Transportation, if covered as a medical service under Medicaid.
- Providing or participating in face-to-face interventions with either an individual student or a group (2-8 students).
- Developing/modifying specialized therapeutic materials to be used by the individual student.
- Discussing health care needs and the importance of well-baby care with adolescents.

CODE 14-TRANSPORTATION AND TRANSLATION SERVICES IN SUPPORT OF MEDICAID-COVERED SERVICES-A

This code is used for assisting an individual to obtain transportation to Medicaid-covered services. This does not include the provision of the actual transportation service, but rather the administrative activities involved providing transportation. This activity also does not include activities that contribute to the actual billing of transportation as a medical service, nor does it include accompanying the Medicaid-eligible individual to Medicaid services as an administrative activity.

This code is used for school employees who provide translation services related to Medicaid-covered services as an activity. Translation may be allowable as an administrative activity if it is not included and paid for as part of a medical assistance service.

It includes related paperwork, clerical activities or staff travel required to perform these activities:

- Scheduling or arranging transportation to Medicaid-covered services.
- Assisting or arranging for transportation for the family in support of the referral and evaluation activities.

- Arranging for or providing translation services that assist the individual to access transportation and medical services.
- Arranging for or providing translation services that assist the individual to "communicate" with service providers about medical services being provided.
- Arranging for or providing translation services that assist the individual to understand necessary care or treatment.
- Assisting the student to define/explain their symptoms to the physician.
- Arranging for or providing signing services that assist family members to understand how to provide necessary medical support and care to the student.

CODE 15-TRANSPORTATION AND TRANSLATION FOR NON-MEDICAID SERVICES-U

This code is used for assisting an individual to obtain transportation to services not covered by Medicaid, or accompanying the individual to services not covered by Medicaid.

This code is used for school employees who provide translation services related to social, vocational, or educational programs and activities as an activity separate from the activities referenced in other codes.

It includes related paperwork, clerical activities or staff travel required to perform these activities:

- Scheduling or arranging transportation for social, vocational, and/or educational programs and activities.
- Scheduling or arranging transportation to and from school when no Medicaid service has been provided.
- Arranging for or providing translation services that assist the individual to access and understand non-medical services, programs, and activities.
- Arranging for or providing signing services that assist the individual's or family's access and understanding of non-medical programs and activities.

CODE 16-GENERAL ADMINISTRATION-R

This code is used for time study participants performing activities that are not directly assignable to program activities.

It includes related paperwork, clerical activities or staff travel required to perform these activities. Typical examples (not all inclusive) of general administrative activities may include:

- Establishing goals and objectives of health-related programs as part of the school's annual or multi-year plan.
- Reviewing school or district procedures and rules.
- Attending or facilitating school or unit staff meetings, training, or board meetings.
- Performing administrative or clerical activities related to general building or district functions or operations.
- Providing general supervision of staff, including supervision of student teachers or classroom volunteers, and evaluation of employee performance.
- Reviewing technical literature and research articles.
- Taking lunch, breaks, leave, or time not at work when staff are paid for these activities.
- Processing payroll/personnel-related documents.
- Maintaining inventories and ordering supplies.
- Developing budgets and maintaining records.
- Training (not related to curriculum or instruction), such as how to use the district's new computer system.

- Other general administrative activities of a similar nature, as listed above, which cannot be specifically identified under other activity codes.

CODE 17-SCHOOL-RELATED AND EDUCATIONAL ACTIVITIES-U

This code is used for any other 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 education plan.

It includes related paperwork, clerical activities or staff travel required to perform these activities. Examples of activities may include:

- Providing classroom instruction (including lesson planning).
- Testing, correcting papers.
- Compiling attendance reports.
- Performing activities that are specific to instructional, curriculum, student-focused areas.
- Reviewing the education records for students who are new to the school district.
- Providing general supervision of students (e.g., playground, lunchroom).
- Monitoring student academic achievement.
- Providing individualized instruction (e.g., math concepts) to a special education student.
- Conducting external relations related to school educational issues/matters.
- Compiling report cards.
- Applying discipline activities.
- Activities related to the immunization requirements for school attendance.
- Compiling, preparing, and reviewing reports on textbooks or attendance.
- Enrolling new students or obtaining registration information.
- Conferring with students or parents about discipline, academic matters, or other school-related issues.
- Evaluating curriculum and instructional services, policies, and procedures.
- Participating in or presenting training related to curriculum or instruction (e.g., language arts workshop, computer instruction).
- Translating an academic test for a student.

CODE 18-NOT SCHEDULED TO WORK AND NOT PAID-U

This code is used for time study participants who are not scheduled to work and not paid on the randomly selected moment pre-printed on the time study form.

Examples of this may include:

- Participant is a part-time employee who is not scheduled to work at the selected sample time.
- The selected sample time falls before or after the participant's scheduled workday.
- School is closed due to an unpaid holiday or an unpaid school district day off (i.e. winter break, spring break, or a built-in "bad weather day").

VI. CLAIM CALCULATIONS

A. Random Moment Time Study Methodology

Michigan's administrative outreach claim is based on quarterly time studies conducted to establish the proportion of designated staff wage and benefit costs devoted to support the Medicaid program and, therefore, eligible for federal matching funds. This time study approach is in contrast to claims for other Medicaid services that are reimbursed on a service-by-service basis and provided per individual Medicaid-eligible student. The proportion of appropriate wage, benefit and administrative costs qualifying for federal reimbursement will be established through a random moment time study,

multiplied by the proportion of students who are Medicaid-eligible. Thus, designated staff need not submit a claim form for each outreach service delivered, but must instead participate in a time study when required.

A random moment consists of one minute of work done by one employee-both chosen at random-from among all such minutes of work that have been scheduled for all designated staff statewide. Time studies are a form of statistical surveying and thus have intrinsic, controllable errors called statistical or sampling error, and may have other types of error. Non-statistical errors may be systematic (i.e., mistakenly failing to record coffee breaks) or random (i.e., an employee unintentionally answering the questions incorrectly due to hurried form completion).

The RMTS method measures the work effort of the entire group of approved staff involved in the ISD/DPS medical and health-related services programs by sampling and analyzing the work efforts of a randomly-selected cross-section of the group. RMTS methods employ a technique of polling employees at random moments over a given time period and tallying the results of the polling over that period. The method provides a statistically valid means of determining the work effort being accomplished in each program of services. The sampling period is defined as the same three-month period comprising each quarter of the Federal calendar except there is an abbreviated sample period used in the summer quarter.

B. Random Moment Sampling

MDCH will use the Medicaid Administrative Claiming System (MACS) software to implement its statewide claiming methodology. The MACS produces random moments concurrent with the entire reporting period, which are then paired with randomly selected members of the designated staff population. The sampling is constructed to provide each staff person in the pool with an equal opportunity or chance to be included in each sample moment. Sampling occurs with replacement so that after a staff person and a moment are selected, the staff person is returned to the potential sampling universe. Therefore, each staff person has the same chance as any other person to be selected for each moment, which ensures true independence of sample moments.

Once the random sample of staff moments has been generated, the sample is printed in the form of master and location control lists for sample administration purposes, and as time study forms for collecting the moment data. Each sampled moment is identified on its respective control list in chronological order by the name of the staff person to be sampled and the date and time at which the recording should take place.

The RMTS and Claims Development Contractor will conduct the statewide time study each quarter for all ISDs and DPS and produce a report detailing the results. This involves importing clinician information from the ISDs/DPS, to compile the statewide pool of all eligible time study participants. The Contractor then randomly selects 4,000 moments. The person's name that is associated with each moment is placed on a time study form. The Contractor distributes the control lists of their selected staff and the time study forms to the independent ISDs prior to the beginning of the reporting period. The RMTS and Claims Development Contractor will directly distribute and collect the time study forms for the ISDs who participate in the claims development portion of the State contract.

The independent ISDs and/or the claims development Contractor must monitor the status of each time study form so that appropriate follow-up calls can be made for delinquent moments or missing data uses in the master list. Each is responsible for ensuring that a copy of the form and instructions is distributed to staff just prior to assigned moment. The completed time study forms are returned to the independent ISD or the claims development Contractor, generally on a weekly basis, for data entry and tabulation.

The RMTS system utilized by MDCH meets federal reporting and documentation requirements, and is designed to permit a level of precision of +/- 2% (two percent) with a 95% (ninety-five percent) confidence level for activities matchable at 50%. Calculations verified by MDCH show that a sample

of 2,401 moments statewide each quarter is adequate to obtain this precision. Four thousand (4,000) quarterly moments will be selected each quarter statewide to account for any lost moments (observations that cannot be used for analysis, i.e., incomplete forms or forms with contradictory information).

At the end of the sampling quarter, after all data has been collected and tabulated, program precision tables will be produced by the MDCH or its Contractor that provide a means of verifying that the sample results have a sampling uncertainty of no more than 2%, with 95% confidence. For this analysis the 95% confidence interval for the estimated matchable time staff spends on activities eligible for the 50% matching rate will have an uncertainty of 1%.

C. Implementation Plan

All 57 Michigan ISDs and the DPS who choose to participate in this program may form one or more consortia through agreements amongst themselves or may agree to act alone for the purposes of submitting claims for reimbursement. ISDs/DPS may change consortium membership only at the beginning of the first quarter of each year, and only after giving notice by the preceding July 1. Each ISD must develop an implementation plan for all responsibilities of the New Outreach Program, including those performed by their selected claims development contractor.

Each ISD must submit an implementation plan that reflects the details of their SBS Administrative Outreach program for review and approval by the MDCH, CMS and/or the special monitoring contractor. Any subsequent changes must also receive approval.

Each implementation plan must include explicit quality control review mechanisms to ensure full staff training and compliance, accuracy and completeness of the sample frame (designated employees), adherence to the MDCH-published methodology, editing of all moments for completeness and consistency, and accurate financial and staffing reports. Claiming entities must also fully cooperate with the MDCH independent Special Monitoring Contractor and any review requested by DHHS, maintaining all necessary records for a minimum of six (6) years after submission of each quarterly claim.

D. Statewide Quality Assurance/Performance Standards

Each of the State-selected Contractors will submit to the MDCH a written plan that includes their Quality Assurance Plan and how they will meet the performance standards required by the MDCH. The purposes of the performance standards are:

- To establish an explicit process for the ongoing monitoring of the SBS policy and their contract responsibilities;
- To assure they are monitoring ISDs' and DPS' performance districts perform in a wide variety of important quality outcomes; and
- That there is access to, and accuracy of the data that is delivered and reported.

E. Sanctions

It is the intent of the State to pursue, when necessary, remedial action or implement a Corrective Plan if the State-selected contractors, the ISD/DPS or their vendors are not in compliance with the new SBS Administrative Outreach published policy. If this is not successful, a contract payment freeze will be implemented and sanctions put in place until the matter is resolved. Those independent ISDs/DPS not participating in the State's claims development contract will be held accountable for their vendor's actions. The following are examples of causes for implementation of sanctions for all districts, but this list is not all-inclusive:

- Repeated errors in completing the RMTS forms or filing of the claims.
- Providing insufficient data or incomplete reports to the Contractors.
- Failure to use the MACS software.
- Failure to cooperate with, or submit requested information, reports, or data to the Special Monitoring Contractor, CMS, MDCH, MDE, and other staff involved during site visits, reviews or audits.

F. Confidentiality

Aggregate time study data may occasionally be useful for other administrative tasks, i.e., planning, and may be used in that way. However, any individually identifiable information must be protected as required by all applicable state and federal statutes and regulations to ensure confidentiality and protection of privacy.

G. Training

Non-statistical errors in time studies usually result from failure to observe the rules of the study, and it is the responsibility of the ISD/DPS to ensure the full cooperation of all participating staff. The most important techniques for minimizing these errors are adequate training of selected staff and follow-up support for those staff.

The approved training methods, materials, information, and instructions will be tailored to each group involved in the time studies each quarter. For example, all time study participants must clearly understand how to complete the time study form. The designated coders must be able to accurately code the activity, and know how to obtain assistance if they have questions. The randomly selected time study participants who are SPMPs must be clear on how to determine if and when their professional knowledge is required to perform a function or activity, and understand the distinctions between the performance of administrative activities and performance of direct medical services.

Because there have been many changes to the Administrative Outreach component of the SBS program, all those involved will need to participate in the training that is designed for them.

The RMTS Contractor will be responsible for developing training programs and materials and providing follow-up assistance as needed. For training, there are some services the Contractor will provide statewide, and other services that will be provided to the independent ISDs.

The RMTS contractor will be responsible for promoting consistency and accuracy of interpretations by the coders and will be encouraged to develop training methods that assure these outcomes. This aspect of the time study is critical for the integrity of the program and will be closely monitored by MDCH and CMS.

1. <u>Statewide</u>

   - All ISDs will have a Local ISD Coordinator/representative who receives training that ensures a thorough understanding of their coordinator responsibilities, the approved time study activities and the coding system used for data collection. Local ISD Coordinators who ISDS/DPS have opted to participate using the services of the State RMTS and Claims Development contractor will require less intensive training because their responsibilities will not be as significant. This is because many tasks, including coding the time study forms, will be completed by the State's contractor. These individuals must understand their role as liaison between the Medicaid Program, the RMTS Contractor and other staff, in addition to the basic purpose of the program, while assisting the RMTS and Claims Development Contractor to "navigate" the District as necessary.

2. Independent ISDs

- Because these ISDs/DPS have opted to be responsible for many tasks, training for these ISDs/DPS will be different. Independent ISDs/representatives will complete the staff pool list in MACS Employee File Writer format, send it to the State contractor, and update it each quarter for the time study participant pool database. They will receive training and technical support on how to accurately complete and forward the file and update it each quarter.
- One designated ISD/representative will also code the time study forms and will receive training and technical support to ensure thorough understanding of the new activity codes and how to code staff activities correctly. The training program will ensure a thorough understanding of all responsibilities, including interpretation of the time study answers and their relationship to the activities used for data collection. Training will include a review of the sampling system, the purpose of the sampling system, a review of the time study form and instructions, procedures for problem solving and resolution, the 18 Activity Codes and definitions, standardized time study forms and detailed instructions regarding completion of the form, and examples of possible responses for each activity code.
- The RMTS Contractor will be responsible for promoting consistency, accuracy and minimal variations of interpretations by the coders and will be encouraged to develop training methods that assure these outcomes. This aspect of the time study is critical for the integrity of the program and will be closely monitored by MDCH and CMS.
- The final steps of creating a claim for submission to Medicaid involve specific financial information unique to each ISD and its LEAs. The combined financial data is entered into the Excel spreadsheets of the MACS system. The independent ISDs will complete their own claim, either independently or through a contract with their own representative billing company. The independent ISDs/DPS will receive a written version of the MACS instructions from the RMTS and Claims Development Contractor, receive training and ongoing technical support from the State Contractor to enable them to complete the MACS Excel financial Workbook for the claims development process.

3. Time Study Participants

For time study participants, it is essential that these individuals understand the purpose of the time studies, that time is of the essence related to completion of the form and that their role is crucial. The RMTS Contractor will develop and provide detailed written information and instructions for completing the time study forms as a coversheet attached to each time study form. The coversheet will provide a “tutorial” with the aforementioned basics of the program as well as information about the Medicaid Administrative Outreach program.

H. Summary of Time Study Steps

1. For All ISDs Statewide

The RMTS Contractor will:

- Import eligible school district staff information
- Randomly select staff/moments to be sampled
- Generate printed RMTS forms for each moment
- Generate and distribute a master list of selected moments to the independent Local ISD Coordinators as a local control list
- Generate mailing labels addressed to randomly selected staff
- Scan completed and coded time study forms
- Transfer raw data from scanned forms to MACS
- Calculate activity percentages for each of the 18 activity codes
- Produce a quarterly report summarizing the results of the time study and forward it to the independent ISDs/representative within one month of the end of each quarter.

- The Contractor will produce periodic and special reports that provide data and information sorted by LEA, ISD, and billing consortium that are provided to the CMS, MDCH, MDE, ISDs and their auditors and the Special Monitoring contractor.

2. Claims Development Contract ISDs

For ISDs who elect to use all the services available from the State RMTS and Claims Development Contractor (Tier II), they will receive all services listed above, as well as the following from the RMTS and Claims Development contractor:

- Create and verify the eligible staff pool for time studies from information provided by the ISDs and update it each quarter
- Distribute time study forms and collect completed time study forms
- Designate and use one coder to code the forms of participating ISDs/DPS.
- Initiate and complete the ISD claim workbooks with the RMTS results. The Contractor will obtain the financial data from each LEA, verify accuracy and compile data to complete the workbook sheets.
- ISDs may belong to a consortium group consisting of more than one ISD that submits one combined claim. If an ISD is a member of a billing consortium, the Contractor will combine the participating ISD workbooks and consolidate them into one consortium claim that is submitted to MDCH.

In providing the lists of staff eligible to participate in the time studies, school districts need to review the list of participants and activities to be claimed to ensure that all appropriate personnel are submitted. In short, the time study must include at least the following classes of individuals:

- Skilled professional medical personnel (SPMP) who directly perform approved Medicaid administrative outreach functions, whether they are directly employed by the ISD/DPS or are contracted personnel for whom the ISD/DPS can document a *de facto* employer-employee relationship.

- All other personnel who perform approved Medicaid administrative outreach functions, whether they are directly employed by the ISD/DPS or are contracted personnel for whom the district can document a *de facto* employer-employee relationship.

- Contracted SPMP for which a *de facto* employer-employee relationship cannot be documented. These individuals are considered ”other personnel” and their activities are claimed at the 50% FFP rate.

Successful participation in the time study is a requirement of program participation. Because statistical sampling is used and sample sizes are minimized to allow for the least intrusion in regular work activities, the importance of recording all moments for all selected employees is critical to the accuracy and validity of the final results, and will be emphasized in all communications and trainings.

I. Summer Quarter Formula and Random Moment Time Study

The summer quarter months are July, August and September. There is a break period between the end of one regular school year and the beginning of the next regular school year during which only a few employees are working. The majority of school employees work during the school year and do not work for part of the summer quarter (9-month staff). However, there are some 9-month staff that opt to receive their pay over a 12-month period. Therefore, different factors must be applied to the summer formula in order to accurately reflect the activities that are performed by the staff.

The summer quarter will be divided into two parts producing two partial claims. The sum of both claims will be submitted to Medicaid for reimbursement for the quarter. The first part of the quarter

will extend from July 1 to the date the 9-month staff returns to work. The second part of the quarter will be from the date the 9-month staff returns to work through September 30.

The RMTS will still be performed in the summer quarter, but will take place only after the employees start back to work and will only be applied to the costs for the second part of the summer quarter. To accurately reflect the work efforts being performed when all staff have returned to work, the RMTS will be performed during a shorter time period. This will require the RMTS to be modified to determine the number of random moments to be used to produce a statistically valid sample that maintains a 95% confidence level with a precision level of +/- 2%.

1. Part I-Summer Break

- Salary and related costs for 9-month staff that were earned during the school year, but are paid during the summer break, will be collected in a separate cost pool. Salaries paid during this period for 12-month employees are not included in the cost pool.
- The cost pool containing the salaries and related costs of 9-month staff who are paid over 12 months will be claimed based on the average time study results from the previous three quarters.

2. Part II-Remainder of the Summer Quarter -- date 9-month staff return to work through September 30th

- Salary and related costs of all employees eligible for the time study are included in the cost pool, along with other allowable costs.
- A random moment time study is performed and applied to determine the percent of time claimable for Administrative Outreach during Part II of the summer quarter.

J. Factors for Claims Development

The MDCH will submit quarterly claims on behalf of all participating school districts, to the CMS. Each claim will be based on the following factors: the cost pool, percentage of time claimable to Medicaid Outreach Administration, the Federal Financial Participation (FFP) rate, and the discounted Medicaid eligibility percentage rate for that district. The factors for the summer quarter are described above.

1. The Cost Pool

This consists of the actual costs incurred for the quarter being claimed, such as salaries, overhead, etc. Each participating ISD/DPS must certify that the claim they submit to the MDCH contains sufficient non-Federal (State, county, or local) funds to match requirements and that the claim only includes actual costs.

2. The Federal Financial Participation Rate

There are two different rates of reimbursement allowed by the federal regulations for Medicaid administrative activities: 50% or 75%, based on staff responsibilities, education, and training. For those staff who meet the requirements (see IV C) that would qualify them as Skilled Professional Medical Personnel (SPMP) and are performing activities that require this expertise. Effective January 1, 2003, the activities performed by SPMPs are reimbursed at a 50% Federal rate. Because the results of the new program will be applied to prior billing quarters when SPMP activities could be recognized at the 75% rate, it is still necessary to identify and record the SPMP amounts on the quarterly claim for the backcasting process. Other activities performed by non-SPMPs and activities performed by SPMPs that do not require special medical knowledge are also reimbursed at a 50% Federal rate.

3. The Discounted Medicaid Eligibility Percentage

This is determined by the percentage of the student population in each ISD/DPS who are actually Medicaid beneficiaries. The discounted Medicaid eligibility rates will be determined twice each year and applied to certain activities in the claim calculation formula. To calculate the discounted Medicaid eligibility rates, the claiming entity will obtain the September and February fourth Wednesday pupil count report list from the Center for Educational Performance and Information (CEPI). The pupil count list will include the student name and date of birth. The MDCH will provide a method for using the list to verify the number of Medicaid-eligible students. This number will be used in a calculation with the total pupil count to determine the discounted percentage of Medicaid-eligible students in the ISD/DPS. The September pupil count list will be used to determine discounted Medicaid eligibility rates for time studies conducted in the Fall and Winter quarters, and the February pupil count will be used for time studies conducted in the Spring and Summer quarters.

Based on the above factors, the claim that is sent to Medicaid is calculated as follows:

Fall, Winter and Spring Quarter Formulas for Calculating Administrative Outreach Claims

Cost pools (salaries, overhead, etc.)	**X**	% time claimable to Medicaid Outreach Administration from time studies	**X**	Discounted by the Medicaid eligibility percentage	**X**	% Federal Financial Participation (FFP) rate	**=**	The amount of the claim submitted for Medicaid reimbursement

Summer Quarter Formulas

The summer quarter will be divided into two parts. The sum of both parts will be submitted to Medicaid for reimbursement. There will be two workbooks created for the summer quarter, one for each part.

Part I - Summer Quarter from July 1 to the date the 9-month staff return to work

Cost pool (only the 9-month salaries and related costs that are paid during this time period)	**X**	Average % of time claimable to Medicaid Outreach Administration from the previous three quarters	**X**	Discounted by the Medicaid eligibility percentage	**X**	Percent of FFP rate	**=**	The amount of the partial claim for Part I of the Summer quarter

1. Salary and related costs for 9-month staff that were earned during the school year, but are paid during the summer break, will be collected in a separate cost pool. Salaries paid during this period for 12-month employees are not included in the cost pool.
2. The cost pool containing the salaries and related costs of 9-month staff who are paid over 12 months will be claimed based on the average time study results and Medicaid Eligibility (MAE) rate from the previous three quarters.

Part II - Remainder of the Summer Quarter – Begins on the date 9-month staff return to work through September 30

Cost pools (include all allowable salaries, overhead, etc.)	**X**	% of time claimable to Medicaid Outreach from the summer quarter time study	**X**	Discounted by the Medicaid eligibility percentage	**X**	Percent of FFP rate	**=**	The amount of the claim for Part II of Summer Quarter

1. Salary and related costs of all employees eligible for the time study are included in the cost pool, along with other allowable overhead.
2. An RMTS is performed and applied to determine the percent of time claimable for Outreach during Part II of the summer quarter.

NOTE: MACS will add the Summer Quarter Part I and Part II claim amounts together to reach the dollar amount of the total Summer Quarter claim submitted to MDCH for reimbursement.

K. Financial Data

The financial data (salaries, benefits, supplies, etc.) used to calculate the Administrative Outreach claim are to be based on actual detailed expenditure reports obtained directly from the participating ISDs'/DPS' financial accounting system. The financial accounting system data is to be applied using generally accepted governmental accounting standards and principles or applicable administrative rules. The expenditures accumulated for calculating the Administrative Outreach claim are to include only actual expenditures incurred during the claiming period, except for the summer quarter.

L. Funding Sources

Claims for approved Medicaid SBS administrative outreach functions may not include expenditures of:

- Federal funds received by the district directly
- Federal funds that have been passed through a State or local agency
- Non-Federal funds that have been committed as local match for other Federal or State funds or programs

It should be noted that funds received by an ISD/DPS for school based direct health services under the fee-for-service component are not Federal funds. They are reimbursement for prior expenditures and become, upon receipt, local funds.

M. Allocation of Salaries and Benefits of Personnel Providing Direct Care Services

Actual expenditures for salaries and benefits of all personnel included in an Administrative Outreach claim are to be obtained from each participating ISD/DPS financial accounting system. Expenditures related to the performance of approved Medicaid administrative outreach functions by contracted service providers (e.g., occupational therapists, physical therapists) also provide direct care services must also be obtained from each participating ISD/DPS financial accounting system.

N. Documentation and Recordkeeping/Audit File Requirements

Beginning January 1, 2003, ISDs/DPS or their billing agent must begin billing SPMP administrative activities at the 50% matching rate. However, to deal with the unique circumstances of recording SPMP activities that could be reimbursed at the enhanced 75% rate, it is also necessary to continue to identify and report SPMP activities separately on the quarterly claim and not include the SPMP expenditures with the other 50% matchable expenditures. Because the results of the new program will be applied to prior billing quarters when SPMP activities could be recognized at the 75% rate, it is still necessary to identify and record the SPMP amounts on the quarterly claim for the backcasting process.

ISDs/DPS must maintain documentation necessary for MDCH to determine that such claimed administrative outreach activities required the medical expertise of SPMP. These documents should include: (a) the type and purpose of the activity that was completed, (b) the provider of the activity,

(c) the date of the activity, (d) the amount of time the activity took, and (e) the medical need of clients that the activity met.

School districts also must maintain and update, as necessary, their staff pool lists and submit any changes to their claims development contractor. Such records should contain at least:

- Quarterly lists of individuals in each eligible classification for time study participants and SPMPs labeled separately.
- Documentation that each SPMP possesses the required education, training, and current credentials.
- Documentation of the supervisory relationship of all claimed direct supporting staff associated with each specific SPMP, such that the support staff provide **direct** support **exclusively** to the sampled participants, and
- Documentation of the district's determination of the *de facto* employer-employee relationship for each of the contracted (SPMP or direct support) staff claimed as such.

RMTS Documentation

Each participating school district will maintain a separate audit file for each quarter billed. The following minimum documentation will be required:

- Financial data used to establish cost pools and factors;
- A copy of the quarterly sample results, produced by either the State's RMTS and Claims Development Contractor or ISD/DPS/their vendor.
- A completed quarterly claim, produced by MACS and signed by the Chief Financial Officer of the ISD/DPS.
- A copy of the warrant, remittance advice or Electronic Funds Transfer (EFT) documentation, verifying that payment from MDCH was received.

Districts must cooperate fully with any review requested by the MDCH, the CMS, and special monitoring staff and maintain all necessary records for a minimum of six (6) years after submission of each quarterly claim.

SPECIAL NOTE: Any changes in Federal regulations related to claims for administrative expenditures are incorporated by reference into this document.

O. Non-Student Specific/Pre-Medicaid Eligibility Determination

There are some Administrative Outreach activities and expenditures that are approved by Medicaid that have not been addressed thus far. They are:

- Provided to the entire "at-risk" population,
- Not identifiable to individual students, and
- Provided before Medicaid eligibility is determined.

These are to be allocated to the approved Medicaid administrative outreach claim based on the results of the time study conducted during the claiming period.

P. Student-Specific Administrative Functions Expenditures

There are some administrative outreach functions that are identifiable to individual students after Medicaid eligibility has been determined. These are to be allocated in the administrative claim based on both the time study results conducted during the claiming period and the applicable discounted Medicaid eligibility rate.

Q. Non-Salary Expenditures

Expenditures for materials and supplies related to the approved Medicaid administrative outreach activities may be included in the claim if they can be attributed directly to individuals who are claimed. The principles for claiming expenditures and cost allocation, including correct depreciation of assets as published by the Federal Office of Management and Budget (OMB) in its Circular A-87, must be followed. Examples of these include: conference fees, registration fees, mileage, pagers, printing fees (i.e., for business cards), furniture, equipment, copy machine expenses, etc. Such expenditures are to be based upon actual detailed departmental expenditure reports obtained directly from the participating ISD/DPS financial accounting system. These expenditures may not include items identified as indirect costs, such as central business office operations, general building maintenance and repair costs, or any other costs classified as an indirect cost.

R. Indirect Costs

Allocable indirect costs are the product of the school district aggregate, calculated, approved Medicaid administrative outreach claim amount, multiplied by the ISD/DPS unrestricted indirect cost rate, as approved annually by the Michigan State Board of Education (MSBE). The ISD/DPS unrestricted indirect cost rate is calculated using the Federal Office of Management and Budget Circular A-87 "Indirect Cost Allocation Principles". The methodology used to determine the indirect cost rate specific to each district has been approved by the Federal cognizant agency. The indirect cost rates are updated annually by the Michigan Department of Education using the approved methodology, which is currently capped at 15%.

S. Activity Code Discount Processes

Michigan's Administrative Outreach Component activity codes are designed to reflect the Medicaid State Plan, the actual activities that may occur in a school on any given day, and the specificity of the unique health care programs within the State that are available to families. Some activities fully support the administration of the State Plan and/or the EPSDT program in the State, and others are more related to activities performed on behalf of Medicaid-eligible students. Because these medical- or health-related activities are provided for students who are both Medicaid- and non-Medicaid-eligible, it is necessary to develop and apply a formula that properly allocates which students are being supported. This is referred to as the discounted Medicaid eligibility rate. During the claims development, providers will apply the Medicaid eligibility rate to certain activities that support Medicaid-eligible students.

In general, activities will be reimbursed using the following criteria:

No Medicaid discount applied to activities that:

- Inform children, parents and families, ISD/DPS staff and the community about the benefits, availability and how to access services and programs available through the Medicaid Program.
- Involve conducting outreach campaigns to reach and identify children in the school who are in need of health and preventive services covered by Medicaid.
- Facilitate potentially eligible students and their families who may or are in the process of enrolling in the Medicaid program.

Apply a discount using the Medicaid eligibility rate to activities that involve:

- Referral, coordination planning and monitoring health services designed to be delivered through the Medicaid Program that address the health needs of children.
- Program planning and policy development of Medicaid-covered services.

- Presenting or participating in training designed to educate the audience about the various Medicaid programs and the services covered by each, and how to more effectively refer students for services.
- Assisting or arranging for an individual to obtain transportation to Medicaid-covered services.
- Assisting, arranging or providing translation services related to Medicaid-covered services.

Using the above criteria, the following activities will be discounted by the Medicaid eligibility rate released by the MDCH twice annually (also see table on Page 5, "Summary of Time Study Activities"):

- Activity 5 - Program planning, policy development and interagency coordination
- Activities 7 & 8 - Referral, coordination and monitoring of Medicaid services
- Activities 10 & 11 - Medicaid-specific training on outreach and eligibility services
- Activity 14 -Transportation and translation services in support of Medicaid-covered services

T. Claim Certification

The accuracy of the submitted claims must be certified by the chief financial officer, the superintendent of the district, or the consortium's lead ISD/DPS designee. Such certification is to be documented on an MDCH-approved certification form, and conform to the certification requirements of 42 CFR 433.51. Detailed claim analyses and supporting documentation will be maintained by the ISD/DPS for audit or future reference purposes according to the terms identified in the interagency agreement between the district and the MDCH.

Reimbursement will be paid after the claim has been submitted to the MDCH and reviewed by the MDCH Special Monitoring Contractor, MDCH, and the CMS optional review, and after all have determined that the claim is acceptable and accurate.

U. Annual Reconciliation

At the end of the district's fiscal year, and after its annual financial audit is completed, a reconciliation of the filed administrative outreach claims, with the financial accounting records and supporting documentation, must be performed. Adjustments to future administrative claims must be made based on the results of the reconciliation analyses to consider any year-end adjustments to accounting entries of any items which might have impacted the claim amounts.

V. Fiscal Provisions

School districts must use an appropriate Revenue Code to identify the Medicaid SBS Administrative Outreach Program funds within their accounting records.

W. SAS 70 Audit Requirement

The State's RMTS and Claims Development Contractor, and any billing agent hired by a Tier I ISD and/or the Detroit Public Schools for claims development is required to have a Type II Statements on Auditing Standards (SAS) 70 audit to provide the necessary assurances that the claiming process (i.e. methodology, time studies, cost allocations, etc.) has been properly applied.

A SAS 70 audit is an independent audit performed for the purpose of evaluating and issuing an opinion on a service organization's operational processes and controls. The auditor of the service organization is required to issue a report on controls placed in operation and tests of operating effectiveness, which is commonly referred to as a "Type II report", in accordance with the American Institute of Certified Public Accountants (AICPA) Statements on Auditing Standards (SAS) No. 70- "Reports on the Processing of Transactions by Service Organizations," as amended by SAS No. 88- "Service Organizations and Reporting Consistency."

The State's RMTS and Claims Development Contractor must undergo a SAS 70 audit annually. Billing agents hired by a Tier I ISD and/or the Detroit Public Schools must undergo a SAS 70 audit, at a minimum once every two years. If significant system changes, or changes in methodology have occurred, a SAS 70 audit must be completed in the year of the change. Once the SAS 70 audit has been performed under the new program, the school district's auditor should extend their audit procedures to a review of the billing company's process in the years that a SAS 70 audit is not completed, if the program is selected for testing as a major program under the requirements of OMB Circular A-133.

The initial SAS No. 70 audit under the new program must cover a six-month period (January 1, 2004 through June 30, 2004). After the initial audit, the subsequent audits must cover at a minimum the most recent six months. The SAS 70 audit must be submitted within 90 days after the end of the examination period.

Five (5) copies of the audit should be forwarded to:

Michigan Department of Community Health
Medical Services Administration
Program Policy Division
Attn: SBS Administrative Outreach Program Contract Manager
P.O. Box 30479
Lansing, MI 48909-7979

X. Submission of Claims

The ISDs/DPS, either individually or as a consortium, will submit claims using the MACS reporting format (structured spreadsheet template) and approved certification forms.

The claim package for the consortium will consist of completed MACS Excel workbooks for each individual ISD/DPS in the consortium. The completed workbooks for each ISDs/DPS participating in the consortium will be combined and consolidated into one claim that is submitted to MDCH.

All claims will be submitted in accordance with the reporting requirements established by the MDCH. It is imperative that districts work closely with their claims development Contractor to provide pertinent financial, enrollment and personnel data and meet their deadlines and any other technical specifications. Claims not submitted on time must be submitted the following quarter as an adjustment to the prior missed quarter and will be processed for that following quarter. Claims not conforming to reporting requirements will not be accepted or processed.

Y. Periodicity of Reporting

The Districts will submit claims for expenditures related to approved Medicaid administrative outreach activities to the MDCH on a quarterly basis. The claim is due to the MDCH on or before 120 calendar days after the end of the reporting quarter.

Timeframes to Submit Administrative Outreach Claims to MDCH

	REPORTING PERIOD		CLAIM DUE TO MDCH	CLAIM SUBMITTED TO CMS BY MDCH
	BEGIN DATE	ENDING DATE		
Summer	July 1	Sept 30	Jan 31	March 31
Fall	October 1	December 31	April 30	June 30
Winter	January 1	March 31	July 31	Sep 30
Spring	April 1	June 30	Oct 31	Dec 31

School Based Services 03-04
Attachment III

COVINGTON & BURLING
1201 PENNSYLVANIA AVENUE, N. W.
P.O. BOX 7566
WASHINGTON, D.C. 20044-7566
(202) 662-6000

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May 30, 2002

Ms. Carol Isaacs
Deputy Director
Health Legislation and
Policy Development
Department of Community Health
Lewis Cass Building
320 South Walnut
Lansing, Michigan 48913

Dear Carol:

Enclosed is a signed copy of the settlement agreement in the school-based administrative cost matter, plus a copy of my letter to the Board requesting dismissal of our appeals.

Sincerely,

Charles A. Miller

Enclosures

cc: Paul Reinhart
Erica Marsden

bcc: Denise Holmes

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May 30, 2002

BY FACSIMILE AMD FIRST-CLASS MAIL

June K. Julien, Esq.
Staff Attorney
Departmental Appeals Board
Room 637-D, HHH Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Michigan Department of Community Health,
Docket Nos. A-01-01, A-02-01

Dear Ms. Julien:

This is to advise the Board that the appellant in the above-captioned case and the Centers for Medicare and Medicaid Services have now entered into an agreement of settlement that resolves the disallowances at issue in these cases. Accordingly, the appellant requests that its appeals in these cases be dismissed.

Respectfully,

Charles A. Miller
Attorney for Appellant

cc: Ted K. Yasuda, Esq.

DEPARTMENTAL APPEALS BOARD
UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

In the matter of	)	
	)	
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH	)	
	)	
Appellant,	)	Docket Nos. A-01-1
	)	A-02-1
vs.	)	
	)	
CENTERS FOR MEDICARE & MEDICAID SERVICES,	)	
	)	
Respondent.	)	
	)	
Appeal of disallowances relating to school-based administrative costs	)	

SETTLEMENT AGREEMENT

Appellant Michigan Department of Community Health ("State") and the United States Department of Health and Human Services, acting through the Centers for Medicare & Medicaid Services ("CMS"), hereby agree to the following terms in settlement of the administrative disallowance actions that are the subject of the appeals in the above-captioned proceedings:

Limitations on Settlement

1. The parties to this Settlement Agreement (hereinafter "Agreement") are the State and CMS, and the parties understand and agree that this Agreement is for the sole benefit of the parties and does not address or settle claims affecting any other person or entity.

2. The parties agree that this Agreement is limited to CMS's right to administratively disallow claims under Section 1116(d) of the Social Security Act, 42 U.S.C. § 1316(d), as further specified in this Agreement.

3. Notwithstanding any other term of this Agreement, it is understood and agreed that specifically reserved and excluded from the scope and terms of this Agreement as to any entity or person (including the parties hereto) are any and all of the following:

a. Any claims based on potential criminal liability, including liability to make restitution based on commission of a crime;

b. Any potential claims based on fraudulent conduct, including, but not limited to

any potential claims under the False Claims Act, 31 U.S.C. §§ 3729-3733, or the Program Fraud Civil Remedies Act, 31 U.S.C. §§ 3801-3812, or common law theories based on fraud.

c. Any potential claims based on any criminal conviction, including administrative sanctions authorized under 42 U.S.C. § 1320a-7.

Prospective Provisions

4. Immediately upon execution of this Agreement and dismissal of the appeals in DAB Dockets A-01-1 and A-02-1 on the basis of this Agreement, the State will submit to CMS proposed revisions to its time study codes and its methodology for conducting time studies. CMS will review the submission on an expedited basis and will provide any needed comments or technical assistance. The State agrees to fully cooperate with CMS and to develop a fully approvable time study code and methodology as soon as possible, but in no event later than 6 months after execution of this Agreement. If CMS cannot approve the State's revised time study codes and methodology within 6 months after execution of this Agreement, the parties agree that the Agreement will be rescinded in its entirety and that the parties shall be returned to the status quo which existed prior to the Agreement, including, but not limited to, reinstatement of all disallowances, and reinstatement of any appeals by mutual agreement.

5. Immediately following CMS approval of the time study code and methodology, the State will commence its public participation process required for adoption of the revised codes and methodology and will commence training school staff on them.

6. The approved system will be implemented on an expedited basis and as soon as possible, with a target implementation date of January 1, 2003 or earlier, but in no event later than April 1, 2003. Once implemented, claims for school-based administrative activities will be submitted on CMS-64 forms based on the results of the approved system.

7. Only upon CMS approval of the revised time study codes and methodology which must occur, if at all, within 6 months after execution of this Agreement (see ¶ 4) , CMS will accept for reimbursement on an interim basis thirty percent (30%) of the claims for school-based administrative activities submitted on CMS-64 forms covering quarters beginning with the January-March 2000 quarter and until the approval and implementation of the revised codes and methodology. CMS's reimbursement on an interim basis of thirty percent (30%) will be subject to later adjustment as set forth in ¶ 11 below. The period for which reimbursement on an interim basis of thirty percent (30%) will be granted shall not extend later than 6 months after execution of this Agreement, plus the additional period allowed for implementation under ¶ 6.

For the quarters beginning January - March 2000 through and including July - September, 2001, and pending implementation of the revised time study codes and methodology, the State agrees to a reduction to the CMS-64 of $226,663,724 and CMS agrees to issue a grant award in the amount of $97,141,596 in accordance with the above stipulations, subject to later adjustment as set forth in ¶ 11 below.

8. During the first two quarters of use of the approved revised codes and methodology CMS and the State will engage jointly in monitoring its implementation to assure proper use of the time study codes by school staff and proper application of the time study methodology. Either party may use contracted firms to assist in this monitoring, except that the State agrees not to use any contracted firm or entity heretofore used in connection with the preparation or submission of claims for school-based services, and further, that any contracted firm used by the State shall be completely independent from the process of preparing and submitting claims and shall be reimbursed in a manner that is also completely independent of that process. The monitoring referred to in this paragraph may include, but is not limited to, normal audit activities, observation of training, review of training materials, interviews of time-study participants, and verification and review of the claims submitted and the reimbursement amounts generated by the new methodology. CMS may at its option continue such monitoring activities after the first two quarters. The State agrees to share all information obtained through its monitoring process with CMS.

9. CMS will be free at any time and for any quarter to review the State's claims under the approved system in the same manner as it would be entitled to review any other State claim for matching Medicaid funds. In the event CMS is unable to verify for any two quarters during which the approved system was in operation that the approved system was being implemented properly and was producing valid results, CMS reserves the right to resume deferrals and/or denial of claims and the right to reopen and deny reimbursement in whole or in part for any period during which the thirty percent (30%) interim rate was used.

10. The State acknowledges that CMS may at any time adopt regulations or national guidelines relating to the use of time study codes or methodologies for conducting time studies or other elements of claims for school-based administrative activities, and that to the extent that such regulations or national guidelines are inconsistent with this Agreement, the State agrees that any such validly-adopted regulations or national guidelines will supersede the Agreement on a prospective basis. CMS agrees that the Agreement will be modified on a prospective basis to allow the State the benefit of different time study codes or methodologies permitted to other states under regulations or national guidelines, subject to the same conditions applicable to these other states under the regulations or national guidelines.

11. After the approved revised codes and methodology have been in use and have produced valid results for four quarters as determined by CMS, CMS will backcast those results to adjust claims for quarters in calendar year 2000 and later that were accepted on an interim basis at thirty percent (30%) pursuant to ¶ 7 above in order to appropriately reflect the results of the use of the approved system after four quarters of valid use. The feasibility and method of backcasting shall be determined by CMS and shall not be subject to challenge or appeal. In the event the net final amounts due the State under the backcasting process exceed the amounts received as interim payments, CMS will include the difference as part of the State's next grant award. In the event the net final amounts due the State under the backcasting process are less than the amounts received as interim payments, the difference will be deducted from the State's next grant award, subject to the right of the State to make repayment in installments under 42 C.F.R. § 430.48.

In the event that CMS determines that four valid quarters have not been generated by the revised codes and methodology so that no valid backcasting is possible, the parties agree that any potential claim for an upward adjustment of the thirty percent (30%) interim rate shall be deemed waived and that the reduction to the CMS-64 of $226,663,724 established under ¶ 7 shall remain binding on the State. In addition, CMS under these circumstances reserves (i) the right to resume deferrals and to disallow claims in whole or in part for any quarter during which the revised codes and methodology were employed and (ii) the right to reopen and deny reimbursement in whole or in part for any period during which the thirty percent (30%) interim rate was used.

Retrospective Provisions

12. CMS will not administratively disallow claims for school-based administrative claims (as reflected on the attached schedule) submitted on expenditure reports for the October-December 1996 through the April-June 1998 quarters. CMS will allow 50 percent (50%) of all claims for school-based administrative claims (as reflected on the attached schedule) submitted on expenditure reports for the July-September 1998 through the October-December 1999 quarters, and shall disallow the remaining 50 percent (50%) of the claims submitted for these quarters, which the State agrees not to contest. CMS agrees that it will waive any potential claim for interest that could stem from this action.

13. The State will adjust the CMS-64 for Quarters July-September 1998 through the October-December 1999 quarters to conform with ¶ 12. CMS will withdraw the two disallowances which form the subject matter of the appeals docketed under DAB A-01-1 and A-02-1, and the State will move to dismiss those appeals. CMS agrees that it will waive any potential claim for interest stemming from the disallowance originally imposed for the July-September 1998 quarter.

14. The parties agree that the effect of ¶¶ 12 and 13 is to require a reduction of $97,450,947 to the CMS-64 for the period covering the October-December 1996 quarter through the October-December 1999 quarter, and the State agrees not to contest this reduction. CMS will only issue a negative grant award in the amount of $49,760,091 in the settlement of the retrospective period since the balance of $47,690,856 has already been deferred.

15. The State agrees that it will not submit any additional claims for school-based administrative costs for any period during federal fiscal year 2001 or any earlier year. The CMS agrees that it will not seek to administratively disallow any claim for school-based administrative costs for any period during federal fiscal year 2001 or any earlier year except as provided in this agreement.

[REMAINDER OF PAGE INTENTIONALLY BLANK - SIGNATURE PAGE FOLLOWS]

Agreed to for the Department of
Health and Human Services

Dated: May 24, 2002

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and Human Services

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Charles A. Miller
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A	B	C	D	E	F	G
Quarter	TOTAL CLAIMS HISTORY FFP for QTRS 12/96 - 09/00	*Status of Funds*		Final Settlement		
		CMS Has Funds Deferred	*State Has Funds Paid*	Percent Allowed	Amount Allowed	Amount Disallowed
Oct-Dec 96	$9,942,138	$0	$9,942,138	100%	$9,942,138	$0
Jan-Mar 97	$28,566,492	$0	$28,566,492	100%	$28,566,492	$0
Apr-Jun 97	$59,438,607	$0	$59,438,607	100%	$59,438,607	$0
Jul-Sep 97	$63,648,635	$0	$63,648,635	100%	$63,648,635	$0
Oct-Dec 97	$0	$0	$0			
Jan-Mar 98	$27,015,621	$0	$27,015,621	100%	$27,015,621	$0
Apr-Jun 98	$30,399,459	$0	$30,399,459	100%	$30,399,459	$0
Jul-Sep 98	$55,915,833	$0	$55,915,833	50%	$27,957,917	$27,957,917
Oct-Dec 98	$10,393,305	$0	$10,393,305	50%	$5,196,653	$5,196,653
Jan-Mar 99	$36,693,506	$0	$36,693,506	50%	$18,346,753	$18,346,753
Apr-Jun 99	$44,208,394	$0	$44,208,394	50%	$22,104,197	$22,104,197
Jul-Sep 99	$33,409,568	$33,409,568	$0	50%	$16,704,784	$16,704,784
Oct-Dec 99	$14,281,288	$14,281,288	$0	50%	$7,140,644	$7,140,644
Subtotal	**$413,912,846**	**$47,690,856**	**$366,221,990**		**$316,461,899**	**$97,450,947**
Jan-Mar 00	$59,538,862	$59,538,862	$0	30%	$17,861,659	$41,677,203
Apr-Jun 00	$57,787,719	$57,787,719	$0	30%	$17,336,316	$40,451,403
Jul-Sep 00	$57,787,719	$57,787,719	$0	30%	$17,336,316	$40,451,403
Oct-Dec 00	$44,567,306	$44,567,306	$0	30%	$13,370,192	$31,197,114
Jan-Mar 01	$44,567,306	$44,567,306	$0	30%	$13,370,192	$31,197,114
Apr-Jun 01	$29,778,204	$29,778,204	$0	30%	$8,933,461	$20,844,743
Jul-Sep 01	$29,778,204	$29,778,204	$0	30%	$8,933,461	$20,844,743
Subtotal	**$323,805,320**	**$323,805,320**	**$0**		**$97,141,596**	**$226,663,724**
GrandTotal	**$737,718,166**	**$371,496,176**	**$366,221,990**		**$413,603,495**	**$324,114,671**
Percent Of Total Claims	100.00%	50.36%	49.64%		56.07%	43.93%

NOTE: These amounts do not include 1ST QTR FY 2002 Estimated Claim.

FY02 SBS EPSDT PENDING CLAIMS

		ISD BILLING QUARTER							
ISD	FFP	JULY-SEPT 2001	OCT-DEC 2001	JAN-MAR 2002	APR-JUN 2002	TOTAL GROSS	TOTAL FFP	ISD Reserve	ISD Payment Net of Reserve
Berrien	50%	$8,799,515.00	$10,925,339.00			$19,724,854.00	$9,862,427.00	$1,116,438.92	$658,797.94
	75%	$1,321,056.00	$1,617,887.00			$2,938,943.00	$2,204,207.25	$250,419.43	$146,337.88
	90%	$16,145.00	$25,337.00			$41,482.00	$37,333.80	$3,970.01	$2,750.08
COOR	50%	$4,654,185.00	$6,136,994.00			$10,791,179.00	$5,395,589.50	$601,145.37	$370,060.74
	75%	$700,695.00	$856,344.00			$1,557,039.00	$1,167,779.25	$132,743.95	$77,456.31
	90%	$15,850.00	$23,750.00			$39,600.00	$35,640.00	$3,837.38	$2,577.83
Genesee	50%	$2,325,541.00	$3,503,728.00			$5,829,269.00	$2,914,634.50	$313,359.41	$211,274.80
	75%	$233,678.00	$462,160.00			$695,838.00	$521,878.50	$52,135.76	$41,802.37
	90%	$6,159.00	$11,486.00			$17,645.00	$15,880.50	$1,611.80	$1,246.69
Ingham	50%	$1,460,173.00	$2,017,755.00			$3,477,928.00	$1,738,964.00	$191,342.89	$121,670.63
	75%	$292,356.00	$602,818.00			$895,174.00	$671,380.50	$66,323.60	$54,524.89
	90%	$2,970.00	$4,566.00			$7,536.00	$6,782.40	$725.24	$495.59
Kent	50%	$2,720,466.00	$3,976,497.00			$6,696,963.00	$3,348,481.50	$362,943.90	$239,782.77
	75%	$410,972.00	$865,995.00			$1,276,967.00	$957,725.25	$94,061.30	$78,329.25
	90%	$8,344.00	$11,049.00			$19,393.00	$17,453.70	$1,942.41	$1,199.26
Macomb	50%	$4,248,485.00	$5,380,324.00			$9,628,809.00	$4,814,404.50	$542,159.27	$324,433.54
	75%	$677,512.00	$993,280.00			$1,670,792.00	$1,253,094.00	$135,714.74	$89,842.18
	90%	$8,386.00	$7,764.00			$16,150.00	$14,535.00	$1,773.60	$842.70
Oakland	50%	$7,021,121.00	$10,511,652.00			$17,532,773.00	$8,766,386.50	$944,096.95	$633,852.82
	75%	$1,244,764.00	$2,034,459.00			$3,279,223.00	$2,459,417.25	$258,678.29	$184,016.82
	90%	$6,449.00	$9,555.00			$16,004.00	$14,403.60	$1,555.55	$1,037.10
Wayne	50%	$4,934,829.00	$5,698,721.00			$10,633,550.00	$5,316,775.00	$613,386.62	$343,632.88
	75%	$1,083,066.00	$1,696,102.00			$2,779,168.00	$2,084,376.00	$221,775.25	$153,412.43
	90%	$10,173.00	$7,651.00			$17,824.00	$16,041.60	$2,057.05	$830.44
Tuscola	50%					$0.00	$0.00	$0.00	$0.00
	75%					$0.00	$0.00	$0.00	$0.00
	90%					$0.00	$0.00	$0.00	$0.00
Montcalm	50%	$857,331.00	$1,017,635.00			$1,874,966.00	$937,483.00	$107,383.55	$61,363.39
	75%	$49,894.00	$79,165.00			$129,059.00	$96,794.25	$10,262.49	$7,160.47
	90%	$0.00	$0.00			$0.00	$0.00	$0.00	$0.00
Detroit	50%	$2,419,499.00	$7,017,117.00			$9,436,616.00	$4,718,308.00	$426,163.28	$423,132.16
	75%	$415,585.00	$2,181,301.00			$2,596,886.00	$1,947,664.50	$153,280.93	$197,298.68
	90%	$0.00	$0.00			$0.00	$0.00	$0.00	$0.00
QUARTER TOTAL									
Gross	50%	###########	$56,185,762.00	$0.00	$0.00	$95,626,907.00	$47,813,453.50	$6,611,288.95	$4,429,162.41
Gross	75%	$6,429,578.00	$11,389,511.00	$0.00	$0.00	$17,819,089.00	$13,364,316.75		
Gross	90%	$74,476.00	$101,158.00	$0.00	$0.00	$175,634.00	$158,070.60		
Gross Total		###########	$67,676,431.00	$0.00	$0.00	$113,621,630.00	$61,335,840.85		
						TOTAL			
Total FFP		###########	$36,726,056.45	$0.00	$0.00	$61,335,840.85			
Allow. FFP @ 30%		$7,382,935.32	$11,017,816.94	$0.00	$0.00	$18,400,752.26			
State 40% - Reserve		$2,953,174.13	$4,407,126.77	$0.00	$0.00	$7,360,300.90			
ISD 60%		$4,429,761.19	$6,610,690.16	$0.00	$0.00	$11,040,451.35			
ISD 1/3 Reserve		$4,429,761.19	$2,181,527.75	$0.00	$0.00	$6,611,288.95			
ISD 2/3 Pmt.		$0.00	$4,429,162.41	$0.00	$0.00	$4,429,162.41			
Total Reserve		$7,382,935.32	$6,588,654.53	$0.00	$0.00	$13,971,589.85			

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Estimate of Adequacy of the SBS Reserve Pool
Assumes that the CMS claim for FY'02 is 30% of $150M federal and FY'03 is 30% of $75M federal.

CMS-64 Qtr		Total Claims History FFP	State Reserve	ISD Reserve	Total Reserve
Sept '00		$175,114,300	$0	$0	$0
Sept. '01		$148,691,020	$0	$0	$0
Sept. '02 (est)		$150,000,000	$18,000,000	$13,432,500	$31,432,500
Sept. '03 (est)		$75,000,000	$9,000,000	$4,455,000	$13,455,000
Total		$548,805,320	$27,000,000	$17,887,500	$44,887,500
% Allowed	30.00%	$164,641,596			
CMS Pmt to DCH		$164,641,596			
Payment to CMS from Reserve		$0	$0	$0	$0
Reserve Balance					$44,887,500
Reserve Balance Distribution			$27,000,000	$17,887,500	
% Allowed	27.25%	$149,566,596			
CMS Pmt to DCH		$164,641,596			
Payment to CMS from Reserve		$15,075,000			($15,075,000)
Reserve Balance					$29,812,500
Reserve Balance Distribution (40%/60%)			$11,925,000	$17,887,500	
% Allowed	25.00%	$137,201,330			
CMS Pmt to DCH		$164,641,596			
Payment to CMS from Reserve		$27,440,266			($27,440,266)
Reserve Balance					$17,447,234
Reserve Balance Distribution (40%/60%)			$6,978,894	$10,468,340	
% Allowed	21.82%	$119,754,096			
CMS Pmt to DCH		$164,641,596			
Payment to CMS from Reserve		$44,887,500			($44,887,500)
Reserve Balance					$0
Reserve Balance Distribution (40%/60%)			$0	$0	
% Allowed	20.00%	$109,761,064			
CMS Pmt to DCH		$164,641,596			
Payment to CMS from Reserve		$54,880,532			($44,887,500)
Reserve Shortfall					($9,993,032)
Reserve Shortfall Distribution (40%/60%)			($3,997,213)	($5,995,819)	
% Allowed	15.00%	$82,320,798			
CMS Pmt to DCH		$164,641,596			
Payment to CMS from Reserve		$82,320,798	$27,000,000	$17,887,500	($44,887,500)
Reserve Shortfall					($37,433,298)
Reserve Shortfall Distribution (40%/60%)			($14,973,319)	($22,459,979)	

Sept. '02 est assumes ISD billing qtrs. 7/01 - 6/02
Sept. '03 est. assumes ISD billing qtrs. 7/02 - 12/02

ASSURANCE OF UNDERSTANDING AND COMPLIANCE

The _____ Intermediate School District (ISD) / Detroit Public Schools has signed a Medicaid Provider Agreement to fully participate as an enrolled Medicaid provider in the Michigan Department of Community Health (MDCH) Early Periodic Screening, Diagnosis and Treatment (EPSDT), Medicaid Administrative Outreach School Based Services Program.

This Assurance of Understanding and Compliance statement is required for participation as part of the provider agreement and becomes effective immediately with the execution of the district's authorized signature. Copies will also be provided to the Michigan Department of Education (MDE). This agreement will be terminated if the Intermediate School District/Detroit Public Schools is disenrolled as a Medicaid provider.

_____	_____
Signature	**Please Print Name**
_____	_____
Title	**Date**
_____	_____
Intermediate School District	**Medicaid ID #**

The School District understands and agrees to the following:

1) The above-named School District is the enrolled Medicaid provider.

2) The local Interagency Agreement between the above-named District and the MDCH that was put in place at the time of enrollment with the Fee-for Service component of the School Based Services program continues, as applicable, for implementation of Administrative Claiming for Outreach Services.

3) The Interagency Agreement currently in place between the District and any constituent local districts, indicating the leadership role of the District, remains intact unless all parties agree to modify the agreement.

4) The District provides the non-federal share of costs associated with services for federal Medicaid reimbursement.

5) In accordance with the conditions set forth in the Medicaid Provider Agreement, the District agrees to fully comply with all local, state and federal laws, regulations, guidelines, and requirements governing Medicaid providers, including the Medicaid program policy published by the MDCH regarding Medicaid School Based Services and the EPSDT Administrative Outreach Program.

6) The District agrees to comply with the confidentiality of patient medical records as cited in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The District will maintain the confidentiality of client/student records and eligibility information received from Medicaid and will use the information only in the administration, technical assistance, and coordination of school based services direct health care and Outreach Services.

7) The District will extend full cooperation with any program monitoring and oversight activities, including onsite visits by MDCH, its contractors or subcontractors, or the CMS and its representatives or agents, related to the claims development methodology. Activities include, but are not limited to, the time study training, time study materials or time study participants as they occur during every quarter. Coordination of monitoring and oversight activities and onsite visits will be completed with the MDE.

8) Districts will take responsibility for meeting certain technical specifications and requirements set forth by the MDCH, directly or through any of its contractors or subcontractors that are selected to administer, implement or oversee the Administrative Outreach component of the School Based Services program, including: participating in time studies, cooperating with special monitoring activities, adopting new claiming methodology, payment and use of the selected software, and participating in time study and software training.

9) The District will assure that any staff selected to participate in quarterly activities related to the times studies, including training, review of materials, or interviews before or after the time studies are conducted, meet the requirements for education, experience and credentials as stated in the published MDCH policy. This information must be updated quarterly, including the individual's discipline, applicable license, registration, and certification with all renewal dates. Documentation must verify that criteria are met.

10) The District agrees to pay for, through their claiming entity, the software required by the MDCH and agrees to meet technical specifications of that program for its installation, training, maintenance, and upgrades. The District will also fully utilize the program and complete the tasks required to complete valid claims each quarter, including interaction with any contractor or subcontractors of MDCH related to the software, methodologies, reports, claim calculations or submission of claims based on time studies conducted for this component of the SBS program.

11) The District accepts responsibility for any disallowances and will incur the penalties if any are imposed.

12) The District's external auditors will perform a single audit, as required.

13) The District's claim, through its Claiming Entity or as a single District, will be validated each quarter by a responsible party, such as the chief financial officer or superintendent, prior to submission to the MDCH.

14) The District agrees to pay back the MDCH the difference between the amount paid and any amount owed as adjusted in accordance with the CMS backcasting results.

15) The District agrees to one of the following approaches to generate their quarterly claims:
- District may, alone or as a consortium of districts, develop the claim independently.
- Choose to hire a consultant/billing agent to assist in claims development.
- Participate in the Claims Development Contract issued by the MDCH through the State's competitive bid process.