MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 08-36

Distribution: School Based Services

Issued: August 26, 2008

Subject: Technical Corrections, Clarifications and Moratorium Changes

Effective: July 1, 2008

Programs Affected: School Based Services (SBS) Fee-for-Service (FFS) Program

The purpose of this bulletin is to inform School Based Services providers of the following technical corrections, clarifications and changes.

- Addition of Certified Occupational Therapy Assistants (COTAs) and Physical Therapy Assistants (PTAs) for Assistive Technology Devices (ATD) services
- American Speech-Language-Hearing Association (ASHA) Certificate of Clinical Competence (CCC) Requirement
- Correction of Limited-Licensed Psychologist Credentials and Addition of Temporary Limited-Licensed Psychologist
- Cost Certification Form Clarification
- MAC Software Replacement
- Moratorium on Federal Regulations
- New Federal Guidance Regarding Personal Care Services Authorization
- New Procedure Codes/Deleted Procedure Codes
- Payment of Pended Case Management Claims
- Personal Care Services Billing Clarification
- Policy Clarification and Corrections
- Random Moment Time Study Chapter Correction

Addition of COTAs and PTAs for ATD Services

Section 2.2.C, Provider Qualifications description will be changed to reflect:
Assistive technology services may be reimbursed when provided by:

- A certified and registered occupational therapist (OTR) in the state of Michigan;
- A certified occupational therapy assistant (COTA) in the state of Michigan.

Section 2.3.B, Provider Qualifications description will be changed to reflect:
Assistive technology services may be reimbursed when provided by:

- A licensed physical therapist in the state of Michigan;
- A physical therapy assistant in the state of Michigan.

ASHA CCC Requirement

The Centers for Medicare and Medicaid Services (CMS) has clarified that a Speech Language Pathologists (SLP) must possess a current American Speech-Language-Hearing Association (ASHA) Certificate of Clinical Competence (CCC) in order to be eligible to bill Medicaid for services. However a non-ASHA CCC SLP can bill for therapies and evaluations if they are under the supervision of an ASHA CCC SLP.

Correction of Limited-Licensed Psychologist Credentials and Addition of Temporary Limited-Licensed Psychologist

Effective for dates of service on or after July 1, 2008, the School Based Services chapter, Section 2.5 Psychological, Counseling and Social Work Services, Provider Qualifications section will be corrected to reflect the appropriate credentials for a Limited-Licensed Psychologist. The bullet will be changed to read:

- A limited-licensed psychologist (Masters or Doctoral level) under the supervision of a licensed psychologist;

Effective for dates of service on or after July 1, 2008, the School Based Services chapter, Section 2.5 Psychological, Counseling and Social Work Services, Provider Qualifications section will add a Temporary Limited-Licensed Psychologist to the list of qualified providers. The bullet will read as follows:

- A temporary limited-licensed psychologist (Masters or Doctoral level) under the supervision of a licensed psychologist;

Cost Certification Form Clarification

Section 2 of the Cost Certification Form has been changed to clarify the Medicaid Provider Number box by including "NPI number" in parenthesis after the Medicaid Provider Number. Providers are to enter their National Provider Identifier (NPI) number in section 2.

Medicaid Administrative Claiming (MAC) Software Replacement

The MAC software is not able to manipulate data from more than one staff pool. The Michigan Department of Community Health (MDCH) will be utilizing claims development software from Public Consulting Group (PCG) to calculate the Random Moment Time Study results. Any reference to MAC in the School Based Services chapter and the Random Moment Time Study chapter will be changed to "claims development software".

Moratorium on Federal Regulations

On June 30, 2008, the President signed Public Act 110-252, the Supplemental Appropriations Act, 2008 placing a moratorium on six of the seven federal regulations affecting Medicaid and the School Based Services program. The moratorium delays the elimination of School Based Services Transportation and the Administrative Outreach Program (AOP) until April 1, 2009.

Fee-for-Service Program

Effective for dates of service on or after July 1, 2008, School Based Services providers will be able to bill for allowable specialized transportation services. The July interim payment was sent out prior to the passage of the moratorium and did not include the additional reimbursement for transportation services. Beginning with the August interim payment the monthly amounts have been adjusted to reflect the additional transportation revenue. The amount owed for the July 2008 additional transportation reimbursement will be included at the time of the final cost settlement.

The following specialized transportation chapter language will be inserted as Section **2.11** and Section **6.2** respectively:

2.11 Special Education Transportation

Definition	Special education specialized transportation services include transport to and from the beneficiary's pick-up and drop-off site where Medicaid services are provided. It includes no more than two one-way trips on a date of service.
	The need for special education transportation must be specified in the beneficiary's IEP/IFSP treatment plan. Medicaid may reimburse for special education transportation when a beneficiary receives a Medicaid-covered service on the same day. Medicaid does not reimburse for transportation provided in a regular or general education school bus. Also, there is no additional payment for an attendant.
Documentation	Federal requirements include documentation for transportation service claims that must be maintained for purposes of an audit trail, such as an ongoing trip log maintained by the provider of the special education transportation. Ridership must be documented for each one-way trip.
Procedure Codes	Use the following procedure codes when billing for Special Education Transportation. Bill the applicable code for each one-way trip. : ▪ **A0120** – Non-emergency transportation (one-way): minibus, mountain area transports, or other transportation systems. This procedure code may be billed when a special education vehicle with no special accommodation is required. The special education vehicle may not necessarily be adapted or specially equipped to serve disabled students. ▪ **A0130** – Non-emergency transportation (one-way): wheelchair van. This procedure code may be billed when a handicapped-equipped or -adapted vehicle is required. The motor vehicle is specialized (e.g., adapted bus, lift vehicle or van) for students who require accommodation for wheelchairs or other special equipment.

6.2 Method of Reimbursement for Specialized Transportation

6.2.A Reimbursement

Specialized Transportation costs reported on the SE-4094 are only the costs associated with the Special Education buses used for the specific purpose of transporting only Special Education children. This report does not include any federal dollars.

Medicaid-allowable Specialized Transportation costs include the following costs from the SE-4094:

- Salaries: Columns 4 & 6; lines 2, 4 & 7
- Benefits: Columns 4 & 6; line 8
- Purchased Services: Columns 4 & 6; lines 13-18 (vehicle related costs)
- Supplies: Columns 4 & 6; lines 20-22 (gasoline, oil/grease, tires etc.)
- Other Expense: Columns 4 & 6; line 26 (only the costs associated with adjustments to the allowable costs listed above)
- Bus Amortization: Columns 4 & 6; line 27

6.2.B Specialized Transportation Reconciliation and Settlement

On an annual basis, the cost per trip is calculated by dividing the total Medicaid reimbursable cost (Section B, steps 1 through 4) by the number of "allowable" one-way trips paid by the Medicaid Invoice Processing system per Intermediate School District (ISD). An "allowable" one-way trip is provided to a Medicaid-eligible beneficiary and fulfills all of the following requirements: documentation of ridership is on file, the need for the specialized transportation service is identified in the Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP), and a Medicaid-covered service is provided on the same date of service.

The Medicaid cost settlement amount is obtained by multiplying the total allowable one-way trips billed through the Medicaid Invoice Processing system times the total cost per trip. This total is compared to the interim payments and any over/under settlements are made. The cost settlement will be included with the FFS cost settlement payment/recovery.

Administrative Outreach Program
The attached School Based Services Administrative Outreach Program (AOP) chapter will be inserted into the Medicaid Provider Manual October 2008 quarterly update. Providers may continue to bill for AOP services until the moratorium expires on April 1, 2009.

Random Moment Time Study (RMTS)
AOP will also be added to the RMTS chapter. The time study is now comprised of four staff pools: AOP only, Direct Medical/AOP, Personal Care Services and Targeted Case Management.

Federal Guidance on Personal Care Services Authorizations

In accordance with 42 CFR 440.167, CMS clarified that an authorization for Personal Care Services (PCS) may be done by a physician or "other licensed practitioner" operating within the scope of their practice. The State has determined that the other licensed practitioners could be a Registered Nurse (RN), Registered and Certified Occupational Therapist (OT), Licensed Physical Therapist (LPT), Master of Social Work (MSW), or ASHA CCC Speech Language Pathologist (SLP). It is expected that personal care services will be authorized by the appropriate practitioner. For example, personal care for behavioral problems is properly authorized by an MSW.

New Procedure Codes/Deleted Procedure Codes

Reinstated Code:
Effective for dates of service on or after April 1, 2008, the following code will be billable.

TARGETED CASE MANAGEMENT – Section 2.10:

- **T2023** – Targeted case management, per month

New Codes:
Effective for dates of service on or after July 1, 2008, the following new codes have been added to the allowable codes billable under the School Based Services program coverage.

OCCUPATIONAL THERAPY SERVICES– Section 2.3.A:

- **97116** – Gait training (includes stair climbing), each 15 minutes

OCCUPATIONAL THERAPY & PHYSICAL THERAPY SERVICES– Sections 2.2.A, 2.2.C, 2.3.A & 2.3.B:

- **97542** – Wheelchair management (e.g., assessment, fitting, training), each 15 minutes

OCCUPATIONAL THERAPY SERVICES (ORIENTATION AND MOBILITY SUBSECTION) – Section 2.2.B:

- **G9041** – Rehabilitation services for low vision by qualified occupational therapist, direct one-on-one contact, each 15 minutes

- **G9042** – Rehabilitation services for low vision by certified orientation and mobility specialist, direct one-on-one contact, each 15 minutes

SPEECH, LANGUAGE AND HEARING THERAPY– Section 2.4.B:

- **97755** – Assistive technology assessment (e.g. to restore, augment or compensate for existing functional tasks and/or maximize environmental accessibility), direct one-on-one contact by providers, with written report, each 15 minutes. (If assessments are done for equipment that is covered under the Durable Medical Equipment (DME) program, all policies and procedures applicable to that program must be adhered to by the school based provider.)

TRANSPORTATION SERVICES NEW CODES – Section 2.11:

- **A0120** – Non-emergency transportation (one-way): minibus, mountain area transports, or other transportation systems

- **A0130** – Non-emergency transportation (one-way): wheelchair van.

Deleted Codes:
Effective for dates of service on or after July 1, 2008, the following procedure codes have been deleted:

PHYSICAL THERAPY SERVICES – Section 2.3.A:

- **97762** – Checkout for orthotic/prosthetic use, established patient, each 15 minutes

TARGETED CASE MANAGEMENT DELETED CODE – Section 2.10:

- **T1017** – Targeted case management, each 15 minutes (this code has been replaced by procedure code G9012)

SPEECH, LANGUAGE AND HEARING THERAPY – Section 2.4.B:

- **97530** – Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes

  Note: In the Speech, Language and Hearing section the code 97530 was listed with the description for 97532 neither code is a billable under the Speech, Language and Hearing Therapy section 2.4.B; however 97530 is still a valid billable Physical Therapy service code.

Payment of Pended Case Management Claims

All claims pended since April 1, 2008, pursuant to approval of the moratorium are being forced for payment. New claims for dates of service prior to July 1, 2008, will continue to be paid based on the FY08 fee screens. Claims for dates of service on or after July 1, 2008, will be paid in accordance with the new cost-based reimbursement methodology.

Personal Care Services (PCS) Billing Clarification

PCS may be provided to a Medicaid beneficiary by multiple providers on any given date of service. However, since the service utilizes a per diem (daily) procedure code for billing, only one claim per recipient can be accepted by MDCH per recipient per date of service.

Policy Clarifications and Corrections

Age Limit
Effective July 1, 2008, School Based Services covers medically necessary services for eligible children under 21 years of age.

Assistive Technology Devise Service Definition
The header for the description of Assistive Technology Device Services in the sections 2.2.C., 2.3.B. & 2.4.B has been changed to reflect: "Assistive Technology Device Services". The header line in the Definition box has been changed to read: "Assistive Technology Device Services General Description".

Medicaid Eligibility Rate (MER) Clarification
Section 9.2, paragraph 1, Sentence 2 of the School Based Services chapter has been changed to read: "The support service codes will be gleaned from Field 43 and 57 of the December 1 Student Count Report. The support service codes have been reviewed and only those that relate to the covered school based health services are to be utilized. For Field 43 the following codes are utilized: 290, 310, 320, 360, 370, 400, 450, 460 and 470. For Field 57 the following codes are to be utilized: 801, 804, 805, 807, 808, 809, 812, 814, 816 and 818."

Pediatric Sub-Specialist
In Section 1.7.A. of the School Based Services chapter, all reference to pediatric sub-specialist has been removed. This is not a requirement for Medical Assistance (MA) and Children's Special Health Care Services (CSHCS) dually eligible individuals.

Scope and Coverage Codes
The following sentence will replace the current first sentence in the School Based Services chapter, Section 1.1: "The Medicaid School Based Services program covers services provided to children who are determined either dually eligible for Children's Special Health Care Services (CSHCS) and Medicaid (Title V/XIX) or those eligible for only Medicaid (Title XIX). The scope and coverage codes for these categories are 1F, 2F or 4F."

Code Clarification

- **97150 –** The description of this code has been corrected to remove the reference to 15 minutes in Section 2.3.A.

- **T2023 –** This monthly targeted case management code has been reinstated after clarification information was received from CMS regarding the language of the moratorium.

Random Moment Time Study Chapter Correction

Section 9.1.A of the School Based Services Random Moment Time Study chapter has been changed to add the following language after the cost report audit bullets:

"Verification of recipient eligibility, documentation of services in the IEP/IFSP and provider credentials." MDCH wants to reiterate that the procedure specific claims cannot be compared to the random moments sampled.

Manual Maintenance

Retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider manual.

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 email ProviderSupport@michigan.gov. When you submit an email, 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.

Approved

Paul Reinhart, Director
Medical Services Administration

SCHOOL BASED SERVICES ADMINISTRATIVE OUTREACH PROGRAM

CLAIMS DEVELOPMENT

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SECTION 1 - CLAIMS DEVELOPMENT OVERVIEW

Using the State of Michigan's competitive bid process, MDCH will select one Contractor to implement and administer the random moment time study. The Contractor will also provide the ISDs/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.

1.1 CLAIMS DEVELOPMENT ENROLLED PROVIDERS

All ISDs/DPS will be required to utilize the services of the State's RMTS and Claims Development Contractor, who will conduct the statewide time studies and develop and submit claims on their behalf each quarter.

The State Claims Development Contractor will develop an implementation plan on behalf of its ISDs/DPS to conduct the statewide time studies each quarter, utilizing the claims development 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 also cooperate with the 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/DPS (after federal match).

1.2 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 Program services. Additional details appear in subsequent sections of this chapter.

Claims will be developed by the State's Claims Development Contractor utilizing the claims development 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 claims workbook.
- The cost/claim generation component automates nine Excel spreadsheets and links the spreadsheets where possible. The ISD/DPS 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.
- The ISD/DPS and/or Contractor must comply with all conditions set forth by MDCH as SBS policy.

1.3 Implementation Plan

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

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

SECTION 2 - CLAIM CALCULATIONS

2.1 IMPLEMENTATION PLAN

Each ISD/DPS must submit an implementation plan that reflects the details of their SBS Administrative Outreach Program for review and approval by MDCH and CMS. 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 any review requested by the Department of Health and Human Services (DHHS), maintaining all necessary records for a minimum of six (6) years after submission of each quarterly claim.

2.2 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. The 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 CLAIMS DEVELOPMENT 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.

2.3 FACTORS FOR CLAIMS DEVELOPMENT

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 Program 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.

2.3.A. 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 MDCH contains sufficient non-Federal (State, county, or local) funds to match requirements and that the claim only includes actual costs.

2.3.B. Federal Financial Participation Rate

Federal regulations allow for a reimbursement rate of 50% for Medicaid administrative activities.

2.3.C. Discounted Medicaid Eligibility Percentage

The discounted Medicaid eligibility percentage 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

- 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 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

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

The claims development software 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.

2.4 Financial Data

The financial data reported (salaries, benefits, supplies, etc.) must be based on actual detailed expenditure reports obtained directly from the participating ISDs'/DPS' financial accounting system. The financial accounting system data is 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.

2.5 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) who also provide direct care services must also be obtained from each participating ISD/DPS financial accounting system.

2.6 RMTS Documentation and Recordkeeping / Audit File Requirements

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 the State's RMTS and Claims Development Contractor.
- A completed quarterly claim, produced by the claims development software 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, and the CMS and maintain all necessary records for a minimum of six (6) years after submission of each quarterly claim.

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

2.7 Audit Activities to be Performed by MDCH Office of Audit Staff

MDCH audit review of selected ISD/DPS cost reports for the Administrative Outreach Program may include the following activities:

- Verification that the salaries listed for employees/positions included in the Random Moment Time Study (RMTS) staff pool match the payroll records for the same period as the time study.
- A review of the salaries of employees who changed positions during the time study period.
- If a replacement was hired/transferred, the auditor will verify that only the salary earned while working in a position on the AOP staff pool list was reported, and that salaries for both the original and replacement employees were not duplicated on the report for the same time period.
- Verification that any other salaries and costs for supplies, etc., are of direct benefit to the employees on the staff pool list, and therefore, allocable to the AOP in the same percentage as the AOP-eligible employees.
- Confirmation that none of the direct costs reported were also claimed as an indirect cost, that the proper indirect cost rate was used, and the rate was applied only to costs in the base. The employees in non-standard job categories are the most likely to be considered indirect type employees; therefore, documentation will be reviewed for these individuals.
- Verification that no federal funds were claimed on AOP cost reports and that AOP costs were not accepted for cost sharing.
- A standard review of other areas, such as confirmation that reported costs were actually paid, support documentation was maintained as required, and costs were properly charged to the correct accounts should also be expected.

- Any other area deemed necessary.

The ISD/DPS should be prepared to direct the auditor to any document used to support and identify the reported AOP costs.

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

2.9 Student-Specific Administrative Functions Expenditures

There are some Administrative Outreach functions that are identifiable to individual students after Medicaid eligibility has been determined. These functions 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.

2.10 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 in the Federal Office of Management and Budget (OMB) Circular A-87, must be followed. Examples 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 on 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.

2.11 Indirect Costs

Allocable indirect costs are the product of the school district aggregate, calculated, approved Medicaid administrative outreach claim amount, multiplied by the ISD/LEA unrestricted indirect cost rate, as approved annually by the Michigan State Board of Education (MSBE). The ISD/LEA 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.

2.12 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, reviewed by, and determined to be acceptable and accurate by MDCH and CMS.

2.13 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.

2.14 Fiscal Provisions

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

2.15 Submission of Claims

All claims must be developed and submitted using the reporting format (structured spreadsheet template) and approved certification forms.

The claim package consists of completed Excel workbooks for each individual ISD/DPS and are combined and consolidated into one claim that is submitted to MDCH.

All claims are to be submitted in accordance with the reporting requirements established by the MDCH. It is imperative that districts work closely with the 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.

2.16 Periodicity of Reporting

Districts must submit claims for expenditures related to approved Medicaid administrative outreach activities to the MDCH on a quarterly basis. The claim is due to 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	September 30	January 31	March 31
Fall	October 1	December 31	April 30	June 30
Winter	January 1	March 31	July 31	September 30
Spring	April 1	June 30	October 31	December 31