New Mexico Medicaid Guide for School-Based Services

A Guide for Local Education Agencies, Regional Education Cooperatives, and Other State-Funded Education Agencies

HEALTH CARE AUTHORITY

Produced and Issued by:
New Mexico Health Care Authority
Medical Assistance Division
School Health Office

August 2005
Revised, August 2008
Revised, August 2009
Revised, September 2011
Revised, January 2014
Revised, August 2015
Revised, August 2016
Revised, August 2017
Revised, August 2020
Revised, August 2022
Revised, August 2023

Table of Contents

Appendices

Appendix A: Governmental Services Agreement

Appendix B: Provider Participation Agreements, Provider Type/Specialty List & NPI Taxonomy List

Appendix C: MSBS Program Regulations

Appendix D: Covered Services, Procedure Codes & Rates

Appendix E: Medicaid General Provider Policies

Appendix F: MSBS Quality Assurance Checklist

Appendix G: MSBS Provider Licensure & Supervision Requirements

Appendix H: MSBS Procedure for Notifying the Primary Care Provider & Completing the Good Faith Effort

Appendix I: Sampled Participant E-mail & RMTS Sample Participant Screens

Appendix J: Program Activity Time Study Codes

Appendix K: Time Study Cost Pool Job Descriptions

Appendix L: NM MAC Program Participant List Guide

Appendix M: Administrative Claim Form and Cover Letter

Appendix N: NM MAC Program Financial Reporting Guide

Appendix O: School Health Office & Managed Care Organization Contact Information

Appendix P: Acronym Dictionary

Appendix Q: Annual Report (Discontinued FY16)

Appendix R: Medicaid Site Visit Tool

Appendix S: How to Spend MSBS Funds

Appendix T: Direct Medical Services Cost Report Template

Appendix U: Direct Medical Services Cost Report Instructions

Appendix V: Behavioral Health Templates

Appendix W: Parental Consent Template

Section I – Program Introduction, Overview & History

I. Introduction

Healthy children and youth have a better chance of achieving academic, social, and personal success than children and youth who are singled out by a health concern or disability that impacts their ability to participate in school. Because of their position in the daily lives of children, youth, and their families, New Mexico schools are poised to offer unique advantages and opportunities that can help families access health information, medical and behavioral health services, and facts about Medicaid enrollment. Through the Medicaid School-Based Services (MSBS) program, New Mexico schools also offer key health and health-related services that are designed to integrate and maintain active learning for Medicaid-eligible children and youth with special education and/or health care needs.

The MSBS program, formerly known as Medicaid in the Schools (MITS), was added in 1994 as a Medicaid-covered benefit for children and youth from age three through age 20. For a school to receive reimbursement for services through the MSBS program, each Medicaid-eligible recipient must have an Individualized Education Plan (IEP), Individualized Family Service Plan (IFSP), a section 504 accommodation plan pursuant to 34 CFR 104.36 (504 plan), an Individualized Health Care Plan (IHCP) or other plan of care, that specifies the services required to treat (through correction, amelioration, or the prevention of deterioration) the eligible recipient's identified medical condition(s); or the services are otherwise deemed medically necessary as appropriate for each covered service.

The vision, core beliefs, and goals of the MSBS program are:

Vision

All children and youth in New Mexico schools will be healthy and successful.

Core Beliefs

- Children and youth must be healthy in order to be successful in school.
- Schools are a critical link to health care for children and youth.
- Comprehensive health focuses on the whole child and includes, but is not limited to, mental/behavioral, dental, physical, and vision health.
- When comprehensive health services are readily and locally available at school, they can increase access to needed care for students and their families and result in improved student success.
- Families are integral to the success of the MSBS program.
- Public and private partnerships, collaboration, and funding are necessary to make comprehensive health services available at, or through, schools.
- Active participation of state agencies (Health Care Authority, Department of Health, and Public Education Department), families, and the schools is essential for the MSBS program to function successfully.

Funds generated by the MSBS program are encouraged to be used to support school health and health-related services for all children and youth. **Program Goals**

1. To enroll students in the Medicaid Program.
2. To increase access to comprehensive health services for children and youth through the MSBS program.
3. To increase and maximize the financial resources available for school-based services.
4. To increase collaboration between schools, families, community providers, and state agencies, so that each partner has a defined role and demonstrates commitment and accountability to the MSBS program.
5. To develop and implement standards for providing or linking comprehensive health services through the schools.

6. To develop and implement a long-range plan to ensure the sustainability of a comprehensive MSBS program.

Multiple resources were used to develop New Mexico's MSBS program, including, but not limited to, 42 CFR Part 43, Centers for Medicare and Medicaid Services (CMS) Medicaid School-Based Administrative Claiming Guide of May 2003; the New Mexico State Plan; New Mexico Administrative Code (NMAC) 8.320.6 New Mexico Medicaid School-Based Services for MAP (Medicaid Assistance Program) Eligible Recipients Under 21 Years of Age; information from other states, including Iowa, Wisconsin, Florida, Michigan, Louisiana, Texas, Missouri, Washington, and Ohio; and the experiences of individuals who worked with the former MITS program in New Mexico. The *New Mexico Medicaid Guide for School-Based Services* (referred to hereafter as the Guide) was developed to provide MSBS program guidance.

II. Overview

Pursuant to the requirements of the Individuals with Disabilities Education Act (IDEA – P.L. 94-142) and Section 504 of the Rehabilitation Act of 1973, New Mexico schools deliver a broad range of educational, social, and medical services that are needed to ensure a free and appropriate public education to children and youth who have disabilities. In New Mexico, the MSBS program includes several direct medical services, including physical, occupational, audiological, and speech therapies; behavioral health services; social services; nutritional assessments and counseling; transportation; case management; and nursing services. IEP services are reimbursable by Medicaid if they are determined to be medically necessary in accordance with Medicaid policy and are part of the Medicaid-eligible recipient's IEP or IFSP for the treatment of an identified medical condition.

The implementation of Free Care Expansion, which allows for the reimbursement of services provided to Medicaid enrolled children for services provided through a section 504 accommodation plan (504 plan), an individualized health care plan (IHCP) or are otherwise medically necessary; seeking this additional reimbursement provides additional necessary services to our most vulnerable students within the school setting.

In addition to coverage of direct services, the MSBS program historically allowed participating Local Education Agencies (LEAs), Regional Education Cooperatives (RECs) and other State-Funded Education Agencies (SFEAs) to claim reimbursement for certain allowable administrative activities; however, the Health Care Authority Medical Assistance Division (HCA/MAD) discontinued the practice of administrative claiming on September 30, 2002. This generated momentum for a redesign of the MSBS program among both state agency and school district representatives, who determined that they would work together to resolve the key issues surrounding administrative claiming. These issues included the codes, cost allocation methodology, and time study model. An effective, accurate, and efficient administrative claiming program was reinstated as part of the MSBS program on November 1, 2004.

III. History

In 2006, the CMS Regional Office conducted a funding review of the MSBS program for the 2005 federal fiscal year (October 1, 2004 – September 30, 2005). The purpose of this review was to examine the MSBS funding flow, sources of the non-Federal share, and to verify if the mechanism for transferring the state share used to fund the MSBS program met federal requirements. In response to the findings of the CMS review, HCA/MAD implemented several changes to the MSBS program. These changes included:

- Changing the process for providing the required non-federal share of funding to ensure that state general funds are being provided by the participating LEAs, RECs, and SFEAs.
- Implementation of a monitoring, oversight, and technical assistance program to ensure that LEAs, RECs, and SFEAs participating in the MSBS program are in compliance with state and

federal requirements. This process included a four-year cycle of on-site reviews of direct service claims as well as desk audit reviews of administrative claims.

In 2011, CMS approved the implementation of a web-based administrative claiming program to improve the random moment sample process and provide a more compliant and efficient administrative claiming process. The random moment sampling and administrative claiming process were transitioned to the current web-based format in January 2011.

In 2016, CMS approved a cost reporting and settlement methodology for the direct medical services portion of the MSBS program. This CMS preferred process incorporates the results of the current random moment time study (RMTS) and provider reported allowable costs to determine if the "interim" payments made to the provider have covered the provider's costs for providing Medicaid–eligible direct medical services. The cost reporting and settlement methodology will reduce risk for the LEAs, RECs, and SFEAs as well as the state. It will also ensure that participating LEAs, RECs, and SFEAs receive an appropriate level of reimbursement based on their actual costs for providing direct medical services.

In 2022, CMS approved a State Plan Amendment (SPA) for the implementation of Free Care Expansion. The Free Care Expansion was possible due to a 2014 CMS policy shift (known as the "Free Care policy reversal"), which allowed states to seek reimbursement for all covered services provided to children enrolled in the Medicaid program.

IV. Schools as Medicaid Providers

Federal Medicaid law does not mandate that schools be reimbursed for health and health-related services that are provided to Medicaid-eligible children. However, passage of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) and the 2014 Free Care policy reversal clarified that federal Medicaid matching funds are available and may be used for health-related services that are covered under the Medicaid State Plan when those services are provided as part of an IEP, IFSP, 504 plan, IHCP, or are otherwise deemed medically necessary as appropriate for each covered service, as under the MSBS program in New Mexico. Federal Medicaid reimbursement for health and health-related services provided to students receiving special education, and for outreach and care coordination activities provided to all students, may be generated by LEAs, RECs, or SFEAs. These entities may draw down Medicaid reimbursement for the federal share of costs for health and health-related services that are provided to students who are Medicaid recipients.

HCA/MAD maintains a Governmental Services Agreement (GSA) with each LEA, REC, or SFEA that participates in the MSBS program. The GSA details specific contractual obligations for both HCA/MAD and the participating LEA, REC or SFEA. A template copy of the GSA and any amendments can be found in **Appendix A**.

V. Linkage between Schools and Health Care in their Communities

Another way in which MSBS-participating LEAs, RECs, and SFEAs, as Medicaid providers, are required to interact with their communities is through the development of relationships with the health care resources in their communities at large, such as primary care providers (PCPs) and care coordinators for students enrolled in *Turquoise Care*(New Mexico's Medicaid managed care program), and Indian Health Service (IHS) providers for Native American students who are enrolled in fee-for-service Medicaid. Because schools can play such a decisive role in the lives of children, youth, and their families, they are able to link children and youth to health care and other services that might not otherwise be accessible. The MSBS program recognizes that most New Mexico communities have existing networks for ensuring health care to children and youth that include physicians and dentists in

private practice, community health centers, and maternal and child health programs, as well as the schools.

Additionally, most of New Mexico's Medicaid-enrolled children and youth receive benefits through one of the *Turquoise Care* managed care organizations (MCOs) that have developed collaborative relationships with these community providers and programs. By working to develop relationships with the *Turquoise Care* MCOs and health resources in their communities, the schools can help facilitate the connection between students and the services they need while improving the overall system of care available to children and youth and reducing service duplication.

VI. Medicaid Services for Children and Youth with Special Health Care Needs

The *Turquoise Care* MCOs are contractually obligated to identify and provide services to individuals who fall into a category called Children with Special Health Care Needs (CSHCN), who may also be eligible to receive treatment under the MSBS program. This requirement reflects the strong commitment of HCA/MAD to increase access to care for children and youth in this particularly vulnerable population and the significant need for progress in reaching their families. HCA/MAD recognizes that the schools provide a critical access point for the *Turquoise Care* MCOs to achieve these goals, since many times the schools are the first point of contact for children, youth, and their families.

Historically, New Mexico schools have been successful at providing multiple health and health-related services to their students. Since the passage of IDEA, schools have been required to provide certain health and health-related services to students who have both disabilities and special education needs. HCA/MAD believes that schools are favorably poised to assist all children and youth, including those who are Medicaid-eligible, in accessing the care they need. Schools are not only involved in the early identification of health conditions, but also in the coordination of services with community resources and health care providers and in the provision of follow-up activities once a student has been referred for treatment.

VII. Medicaid Reimbursements to the School Districts

The cost of health-related services has traditionally been borne by LEAs, RECs, and SFEAs through a mix of federal, state, and local funding sources. Under IDEA, federal law entitles children and youth with disabilities to a free and appropriate public education. Further, the Free Care Policy reversal allows for Medicaid payment for covered services that are available without charge to the student population at large. Therefore, schools cannot charge students or their parents for any of the services that are provided under these mandates.

LEAs, RECs, and SFEAs may be reimbursed in the MSBS program for both direct services and administrative activities. The rates for direct and administrative claims are different, as are the billing and reimbursement processes.

Direct Services

Beginning July 1, 2015, direct medical services that are provided by qualified, professional personnel will be reimbursed according to the CMS approved cost settlement methodology. This will include "interim" reimbursements for direct medical services at the current NM Medicaid Fee for Service Current Procedural Terminology (CPT) Code Fee Schedule. A quarterly adjustment will be processed through the NM Medicaid fiscal Agent, Conduent, to deduct the non-federal (state) share so that the annual net payment to the LEAs, RECs, and SFEAs will only be the federal financial participation (FFP). The "interim" payments will then be compared to the LEA's, REC's, or SFEA's allowable costs, reported in the annual cost report, and a settlement value will be calculated. The quarterly adjustments will be done for the July – September, October – December, and January – March quarters. The adjustment for the April – June quarter will be deducted from the fiscal year settlement payment before it is

approved for payment to the LEA, REC, or SFEA. Participating LEAs, RECs, and SFEAs must certify that the remaining non-federal (state) share of their expenses comes from state general funds. The non-federal (state) share for NM is generally around 30% leaving a federal match of approximately 70%.

Administrative Services

Participating LEAs, RECs, and SFEAs are also reimbursed for administrative activities provided in support of the Medicaid program. These activities include but are not limited to: Medicaid outreach; facilitating Medicaid eligibility determinations; translations related to Medicaid services; program planning, policy development, and interagency coordination related to medical services; medical and Medicaid-related training; referral, coordination, and monitoring of Medicaid services; and scheduling referrals for medical services.

Administrative activities are reimbursed through a time study model agreed upon by HCA/MAD and CMS; this model allows for reimbursement of expenses at a rate of 50% federal funds. Participating LEAs, RECs, and SFEAs must certify that the remaining 50% of their expenses comes from state general funds.

VIII. Purpose of the Guide

This Guide is designed to provide MSBS program information to New Mexico's LEAs, RECs, SFEAs, state agencies, and other interested entities, including the correct and appropriate methods for providing and seeking reimbursement for Medicaid direct and administrative services provided to students with IEPs, IFSPs, 504 Plans, IHCPs, or services that are otherwise deemed medically necessary as appropriate for each covered service. Additional information about the Medicaid program and related eligibility and service policies is contained in the Medicaid State Plan and the Medicaid Policy Manual. It is the obligation of each MSBS-participating LEA, REC, and SFEA to ensure that they are compliant with current Medicaid policy pertaining to the services they render. This Guide does not supersede Medicaid policy and is not to be used in lieu of Medicaid policy. The information contained in this Guide will be updated as needed to reflect changes made to the MSBS program or Medicaid program

Other key issues addressed in this guide include:

- The steps required for schools and their ancillary personnel to become MSBS program providers
- The direct services and administrative activities for which Medicaid reimbursement may be claimed by LEAs, RECs, and SFEAs;
- The qualifications of the individuals providing Medicaid-reimbursable services in the schools;
- The procedures for claiming reimbursement for direct services and administrative activities; and
- The programmatic expectations of LEAs, RECs, and SFEAs that participate in the MSBS program

Section II - Steps to Becoming a MSBS Provider

There are four steps that a LEA, REC, or SFEA must take to become a MSBS program provider. These steps include 1) submission of a letter of intent, 2) entering into a Governmental Services Agreement (GSA with HCA/MAD, 3) obtaining a National Provider Identifier (NPI) number for providers, 4) completing a Provider Participation Agreement (PPA) application through the Medicaid fiscal agent, Conduent. Together, these actions ensure that an LEA, REC, or SFEA and its providers are prepared to provide and bill for services through the MSBS program, and that HCA/MAD and other state agencies are prepared to fulfill their obligations to school districts and to each other relating to the MSBS program.

I. Letter of Intent

The first step is to submit a letter of intent to participate in the MSBS program to HCA/MAD signed by the district superintendent, president of the school board, chairperson of the LEA, REC, or SFEA council, or other LEA, REC, or SFEA representative. The letter should indicate the district's interest in working collaboratively with health and human services providers in the local community to develop services that will support children and their families, and in using Medicaid as a resource for providing health and health-related services to children and youth through the MSBS program.

The letter of intent should be emailed to:

Msbs.schoolhealth@hca.nm.gov

Once HCA/MAD has reviewed the letter, an electronic link to this Guide, directions for completing the Medicaid provider participation agreement, and a checklist for additional steps will be sent to the LEA, REC, or SFEA. HCA/MAD staff will begin drafting a GSA (Governmental Services Agreement) between the agency and the LEA.REC, or SFEA.

II. Governmental Services Agreement (GSA)

For an LEA, REC, or SFEA to become approved as a MSBS program provider, it must enter into a GSA with HCA/MAD. This agreement details the respective responsibilities of HCA and the LEA, REC, or SFEA concerning program administration, billing, and payment. It also explains program parameters such as confidentiality requirements and the dispute resolution process. A template copy of the GSA and any amendments can be found in **Appendix A**.

Once all parties at the LEA, REC, or SFEA and HCA have signed and dated the GSA; HCA will provide a copy of the fully executed GSA for LEA, REC, or SFEA records.

III. National Provider Identifier

The National Provider Identifier (NPI) is a federally mandated identification number issued to health care providers. All HIPAA-covered individual and organizational health care providers must obtain an NPI to identify themselves on billing transactions. MSBS related service providers must have an NPI to apply for a Medicaid Provider Identification number.

Providers should apply for their own NPI, to learn more about the National Provider Identifier, go to https://nppes.cms.hhs.gov and can be found in **Appendix B.**

IV. Provider Participation Agreement

In addition to the signed GSA, an LEA, REC, or SFEA must submit a provider participation agreement (PPA) application to HCA/MAD through the fiscal agent, Conduent. A template copy of the group provider participation application (MAD 335) and process can be found in **Appendix B**.

The completed provider participation application, along with a copy of the signed GSA, should be submitted to Conduent for processing. Once approved, the LEA, REC, or SFEA will receive a packet of information from Conduent, including a group provider number and welcome letter indicating the official date of enrollment as a Medicaid provider. After the LEA, REC, or SFEA has received approval and a group provider number, applications for rendering providers may be processed.

As with all Medicaid-participating group providers, such as clinics and hospitals, each rendering provider (the provider who administering/preforming the service) must also be identified. To do this, an individual provider participation application (MAD 312) should be completed by each of the district's following rendering providers: nurses (RN and LPN),
occupational and physical therapists, speech-language pathologists and speech-language pathology clinical fellows, social workers (LCSW/LISW, LMSW, and LBSW), psychologists, other behavioral health providers (LMFT, LAMFT, LPCC, LMHC, CNS), nutritionists, dieticians, audiologists, and case managers.

Rendering providers should submit their provider participation agreements with a copy of their certification(s) or license(s). Licenses for all providers should be kept on file.

The following provider types must submit copies of both their board **and** Public Education Department (PED) licenses:

- Occupational therapists (OTs)
- Physical therapists (PTs)
- Speech-language pathology clinical fellows (SLP-CFs)
- Speech-language pathologists (SLPs)
- Audiologists
- Licensed marriage & family therapists (LMFTs)
- Licensed master's level clinical/independent social workers (LCSWs/LISWs), licensed master's level social workers (LMSWs) and licensed bachelor's level social workers (LBSWs)
- Licensed registered nurses (RNs) and licensed practical nurses (LPNs)
- Licensed professional clinical counselors (LPCCs)
- Licensed mental health counselors (LMHCs)

The following provider types are required to submit **only** their board license:

- Licensed associate marriage & family therapists (LAMFTs)
- Psychologists Ph.D., Psy.D. or Ed.d
- Licensed psychiatric clinical nurse specialists (CNSs)
- Licensed nutritionists and registered dieticians

The following provider type is required to submit **only** their PED license:

- School psychologists (master's level)

Some providers do not require a rendering provider number. LEAs, RECs, or SFEAs may bill for services rendered by these providers using their supervising provider's number. These providers include:

- Occupational therapy assistants/interns
- Physical therapy assistants/interns
- Speech-language pathology apprentices/interns
- Delegated nursing service providers

Provider participation applications can be completed online through the Conduent Web Portal at: https://nmmedicaid.portal.conduent.com/webportal/enrollOnline.

Many rendering providers may already have a Medicaid number and NPI. In these cases, the rendering provider must be affiliated with the LEA, REC, or SFEA group provider number in order to bill for services under that LEA, REC, or SFEA. To become affiliated, the LEA, REC, or SFEA must submit a *New Mexico Provider Update (MAD 304)*, to the Medicaid fiscal agent, Conduent, utilizing the NM Medicaid Portal, requesting that the rendering provider be affiliated with the LEA, REC, or SFEA. Copies of the provider's certifications and licenses should be included with the submission.

The Medicaid number and NPI will be used by the LEA, REC, or SFEA to bill Medicaid for services provided only by that individual. The LEA, REC, or SFEA should bill Medicaid using its group provider number (NPI) with a reference to the rendering provider. As individual rendering providers change, each new rendering provider must submit an application and receive a rendering provider number (NPI). It is the responsibility of the LEA, REC, or SFEA to identify rendering providers who have left employment with the district and are no longer authorized to provide services. The *New Mexico Provider Update Form (MAD 304)* should also be completed to indicate a provider's disaffiliation with the LEA, REC, or SFEA and should be submitted to Conduent through the NM Medicaid Portal.

Once the LEA, REC, or SFEA becomes an MSBS program provider, it must notify Conduent of any changes in its provider status. These might include changes in contact information, the area in which services are being provided, or taxpayer identification numbers. The LEA's, REC's, or SFEA's group provider number should always be included in any written correspondence. Notice of changes should be submitted to Conduent through the NM Medicaid Portal.

Rendering providers must have a current New Mexico Regulation and Licensing Department (RLD), PED and/or other valid state license on file at Conduent to maintain an active Medicaid enrollment status. The new license must be submitted to Conduent within 90 days of the expiration date of the last license. The license should be submitted to Conduent through the NM Medicaid Portal. Failure to submit the license will result in termination of the provider's Medicaid number.

A re-verification document (TAD turn around document) for each enrolled provider must be completed and returned to Conduent every three years. Conduent will send the document to be completed and signed by the provider. The document will be sent to the most current mailing address affiliated with the provider; providers who are affiliated with more than one LEA, REC, or SFEA will only receive one re-verification document, which will only go to the 1st entity affiliated. Failure to submit the re-verification document will result in termination of the provider's Medicaid number.

V. Compliance with State and Federal Guidelines

HCA/MAD is firmly committed to administering a MSBS program that is effective in the lives of recipients, is user-friendly to participating schools and their providers, and is compliant with both state and federal law. Together with HCA/MAD and New Mexico's LEAs, RECs, and SFEAs, there are a number of entities that have key responsibilities to the MSBS program, and which play a critical role in effecting positive outcomes for school-age children and youth. The regulations for New Mexico's MSBS program (MAD 8.320.6) may be found in **Appendix C**.

CMS is charged with dispensing federal Medicaid funds to HCA/MAD for the provision of services to Medicaid-eligible populations and the administration of Medicaid programs at the state level. In turn, to ensure federal funding, HCA/MAD must abide by CMS guidelines and regulations concerning the flow of program dollars, reporting deadlines, quality, and service delivery.

VI. Identification of Medicaid-Eligible Children

Each MSBS-participating LEA, REC, or SFEA is expected to confirm the recipient's Medicaid eligibility prior to billing. Because a recipient's eligibility may not be continuous from month to month, it is critical that the LEA, REC, or SFEA, as a provider of services, document that the recipient was Medicaid-eligible during the time for which the claim was submitted.

Providers are encouraged to use the Conduent Web Portal to inquire about a recipient's eligibility. Log on to https://nmmedicaid.portal.conduent.com/static/index.htm for more information and to register as a Web Portal user.

Providers may also contact the Conduent Automated Voice Response System (AVRS) at 1-800-820-6901 24 hours a day/7days a week. To ensure confidentiality, the provider will need to provide AVRS with the LEA, REC, or SFEA group provider number and the recipient's name, date of birth, and social security or Medicaid identification number.

VII. Medicaid Application Process and Presumptive Eligibility

For a child less than 18 years old to receive Medicaid, a family member or legal guardian must apply for benefits on their behalf, unless the child is legally emancipated or has qualifying extenuating circumstances. Applications are processed at local offices of the HCA, Income Support Division (ISD). To find out the location of the nearest HCA/ISD office, the LEA, REC, or SFEA may contact HCA at 1-888-997-2583 or visit the HCA website at: https://www.hca.nm.gov/lookingforassistance/field_offices_1

Because the approval process is not immediate, LEAs, RECs, or SFEAs should have Presumptive Eligibility Determiners (PEDs) on-site. PEDs are certified by HCA to screen for Medicaid eligibility and submit ongoing applications on a client's behalf. PEDs submit the applications electronically through YESNM-PE, a secure on-line portal. Applications are then routed to local HCA ISD offices for processing. If an individual appears to eligible for Medicaid, they may also be granted short-term coverage, called Presumptive Eligibility (PE), while their on-going application is in process. PE coverage will remain in effect until the last day following the month the PE was granted OR until a final determination is made for an ongoing application. Individuals may be granted only one PE approval in a twelve-month period. School districts who wish to receive training for their employees to become PEDs should email HCA at HCA.PEDeterminers@hca.nm.gov

Section III – Random Moment Time Study

LEAs, RECs, and SFEAs participating in the MSBS program must require certain staff to participate in a quarterly time study that covers the period for which claimed direct medical service and administrative activities were performed. This time study, in turn, provides the basis for calculating amounts owed to the districts for these activities in the annual cost settlement report and quarterly administrative claims.

While many school district staff participate in direct medical services and administrative activities that are eligible for reimbursement by Medicaid, most do so only for a portion of their normal workday and at varying intervals. The time study allows MSBS program staff to determine this proportion. Components of the random moment time study (RMTS) include:

- Administering a random moment sampling (RMS) methodology,
- Participating in the time study; and
- Coding the time study.

I. Random Moment Sampling

The RMS time study model is used to measure the percentage of time that LEA, REC, and SFEA staff spends in performance of Medicaid-reimbursable direct medical services and administrative activities by sampling and assessing the activities of a randomly selected cross section of individuals. These individuals are queried at random over a billing quarter about their activities during a specified moment on a certain date. The sampling period is defined as the same three-month period comprising each quarter of the calendar:

- First Quarter: January 1-March 31
- Second Quarter: April 1-June 30
- Third Quarter: July 1-September 30
- Fourth Quarter: October 1-December 31

The summer period is distinguished from the regular school year and refers to the period between the end of one regular school year and the beginning of the next regular school year. In general, a time study is developed and conducted with respect to a particular period and must represent and incorporate the actual activities performed during that period.

The HCA/MAD School Health Office, along with Fairbanks, LLC, administers New Mexico's RMTS system. In summary, the RMTS system works as follows:

- Forty-five days prior to the beginning of each quarter, participating LEAs, RECs, or SFEAs submit a staff roster (Participant List) providing a comprehensive list of staff eligible to participate in the RMS time study. The list of names is subsequently grouped into job categories that describe their job function, and from that list all job categories are assigned into one of two "cost pools", as subsequently defined. Once the RMS period begins, the submitted roster of eligible staff cannot be updated or changed. The *NM MAC program Participant List Guide* may be found in **Appendix L**.

- The total pool of "moments" within the time study is represented by calculating the number of working days in the sample period, times the number of work hours of each day, times the number of minutes per hour, times the number of participants within the time study. The total pool of moments for the quarter is reduced by the exclusion of weekends, holidays, and hours during which employees are not scheduled to work.

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

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

- Each selected moment is defined as a specific one-minute unit of a specific day from the total pool of time study moments and is assigned to a specific time study participant. Each moment selected from the pool is included in the time study and coded according to the documentation submitted by the employee.

- Time study participants are notified via email to participate in the time study and of their sampled moment. Sampled participants will be notified of their sampled moment no earlier than three (3) business days prior to their sampled moment. At the prescribed moment, each sampled participant is asked to record and submit their activity for that particular moment. The sampled moment will remain open for three (3) business days after the specific moment has occurred. The participant will receive notification of their sampled moment both three (3) business days prior and within 24 hours prior to the moment arriving. After the third (3rd) business day, the participant's login will not work, and they will no longer be able to respond to the time study. The time study response window will exclude weekends, holidays and days identified as not working per the LEA/REC/SFEA calendar, such as but not limited to, spring break and winter break. However, in the event that a participant is not working during their sampled moment, and unable to complete the moment, the Program Contact can report that participant as either on "Paid Time Off" or "Not Working/Not Paid". The Program Contact can report participants as "Paid Time Off" or "Not Working/Not Paid" at any time prior to the last business day of the quarter.

- Fairbanks' central coders will review the documentation of participant activities performed during the selected moments and determine the appropriate activity code. In a situation when insufficient information is provided to determine the appropriate activity code, the central coder will contact the sampled participant and request submission of additional information about the moment. In addition, the program coordinator at the applicable LEA, REC, or SFEA is copied on that follow-up email so that they are aware that a request for additional information has been made. Once the information is received, the moment will be coded and included in the final time study percentage calculation. All moments will be coded separately by at least two coders as part of a quality assurance process. The moments and the assigned codes will be reviewed for consistency and adherence to the state-approved activity codes.

- Moments not returned by the school district will not be included in the database unless the return rate for valid moments is less than 85%. If the statewide return rate of valid moments is less than 85%, all non-returned moments will be included and coded as non-Medicaid. To assure that districts are properly returning sample moments, districts' return percentages for each quarter will be analyzed. If an individual district returns less than 85% of their sampled moments, HCA/MAD may enforce sanctions, which may include, but not be limited to: conducting more frequent monitoring reviews, eliminating the school district's claimed portion of federal funds, or, ultimately, termination of the school district's GSA.

- Fairbanks will perform validity checks to ensure that all districts complete at least 85% of valid random moment samples. HCA/MAD will also review 5% of valid coded responses and coding on a quarterly basis.

- Once all quarterly random moment data has been received and Time Study results have been calculated, statistical compliance reports will be generated to serve as documentation that the sample results have met the necessary statistical requirements.

II. Time Study Participants

When an LEA, REC, or SFEA constructs the list of staff that should be included in the time study, it must determine first whether the individuals in those positions perform direct medical services or administrative activities that support the MSBS program, and second whether they are less than 100% federally funded.

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

Cost Pool 1: Direct Service Staff
Staff in Cost Pool 1 are direct service staff that have direct responsibilities related to the MSBS program that include the regular performance of one or more Medicaid-allowable direct medical services or administrative activities.

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

For a complete list of positions that may be included in the time study, refer to **Appendix K**.

Employees and contracted staff who may participate in the time study generally include, but are not limited to:

- Providers of direct health services;
- School health aides;
- Program and staffing specialists; and
- Allowable staff whose salaries are paid from MSBS funds.

Certain individuals should **not** participate in the time study. In general, these include:

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

ALL direct service provider positions that will be claimed on the annual cost settlement report **MUST** be included in the Random Moment Time Study. If a position is not included in the time study during the cost reporting period, expenses for that position are not eligible for reimbursement through the cost report.

III. Coding the Time Study

There are 20 program activity codes that may be used to complete the time study. These are:

- CODE 1A Non-Medicaid Outreach
- CODE 1B Medicaid Outreach
- CODE 2A Facilitating Application for Non-Medicaid Programs
- CODE 2B Facilitating Application for Medicaid Programs
- CODE 3 School-Related and Education Activities
- CODE 4A Direct Medical Services, Not Covered as IDEA/IEP Service
- CODE 4B Direct Medical Services, Covered as IDEA/IEP Service
- CODE 4C Direct Medical Services, Covered as IHCP/BHCP/504/Other
- CODE 5A Transportation for Non-Medicaid Programs
- CODE 5B Transportation for Medicaid Programs
- CODE 6A Non-Medicaid Translation
- CODE 6B Translation Related to Medicaid Services
- CODE 7A Program Planning, Policy Development, and Interagency Coordination Related to Non-Medical Services
- CODE 7B Program Planning, Policy Development, and Interagency Coordination Related to Medicaid Services
- CODE 8A Non-Medical/Non-Medicaid Training
- CODE 8B Medical/Medicaid-Related Training
- CODE 9A Referral, Coordination, and Monitoring of Non-Medicaid Services
- CODE 9B Referral, Coordination, and Monitoring of Medical Services
- CODE 10 General Administration

CODE 11 Not Paid/Not Worked

In accordance with federal rules, the time study must incorporate a comprehensive list of the activities performed by staff whose costs are to be claimed under Medicaid. That is, the time study must reflect *all* of the time and activities, whether allowable or unallowable by Medicaid, performed by employees participating in the MSBS direct medical services or administrative claiming programs. Therefore, for each reimbursable direct medical services or administrative activity code, there is a corresponding non-reimbursable activity code.

A detailed description of the MSBS program activity codes can be found in **Appendix J**.

Section IV – Billing for Direct Services

I. Covered Direct Services

In accordance with MSBS program regulations at 8.320.6 (**Appendix C**), an LEA, REC, or SFEA that is approved as a Medicaid provider may be reimbursed for certain health services provided to Medicaid recipients. These services must meet several conditions to be eligible for payment through the MSBS program, including:

- The services provided must be medically necessary and must be necessary for the treatment of the recipient's specifically identified medical condition and meet the needs specified in the IEP, IFSP, 504 Plan, IHCP, or are otherwise deemed medically necessary as appropriate for each covered service.

- The services listed on the Individualized Treatment Plan (ITP) section of the IEP, IFSP, a 504 plan, IHCP, or other plan of care must be developed in conjunction with the appropriate qualified physical therapist, occupational therapist, speech therapists, audiologist, nurse, and/or behavioral health provider. Direct care services must be listed within IEP, IFSP, 504 plan, IHCP or otherwise medically necessary plan of care.

- The LEA, REC, or SFEA is responsible for providing equitable IEP or IFSP services to students that are parentally placed in a private school that is within the geographic boundaries of the LEA, REC, or SFEA.

- The LEA, REC, or SFEA must make a "good faith effort" to notify the eligible recipient's PCP of the services to be provided through the IEP or IFSP.

- The frequency and duration of services billed to Medicaid may not exceed what is specified in the IEP, IFSP, 504 Plan, IHCP or other plan of care. and

- **Parental consent must be obtained for services listed in the IEP or IFSP in order to bill for Medicaid**. Consent means that the parent has been fully informed of all information relevant to the activity for which consent is sought and agrees in writing. Code of Federal Regulations (CFR) 300.154 and NMAC 6.31.2.9 require parental consent. For more information about IDEA requirements, contact the Office of Special Education of the New Mexico Public Education Department (PED).

- There are certain conditions in which parental consent is not required for the provision of non-IEP/IFSP services. These conditions include:

    - In New Mexico, students under the age of fourteen may consent to initial assessment and/or early intervention services, limited to verbal therapy, not to exceed a two-week period. After the initial period, parental consent is required (see NMSA 32A-6A-14). In addition, students fourteen and older may consent to receive individual psychotherapy, group psychotherapy, guidance counseling, case management, family therapy, counseling, substance abuse treatment
      or other forms of verbal therapy without parental consent (see NMSA 32A-6A-15).

    - In New Mexico, cases in which a minor needs immediate hospitalization, medical attention or surgery and the parents of the minor cannot be located for the purpose of consenting, after reasonable efforts have been made, consent may be given by any person standing in loco parentis to the minor (see NMSA 24-10-2).

Reimbursement is made directly to the LEA, REC, or SFEA, even when therapy providers offer services under contract to the LEA, REC, or SFEA. **In order for LEA, REC, or SFEA, to seek reimbursements providers must be licensed and Medicaid enrolled.**

Under the MSBS program, direct services include:

- **Initial evaluations** that result in an IEP, IFSP, 504 Plan, IHCP, or other plan of care and subsequent **re-evaluations**.

- **Therapies**, including physical, occupational, audiological, and speech-language pathology therapies required for treatment of an identified medical condition. These services must be provided by appropriately licensed providers.

- **Behavioral health services**, including counseling, evaluation, and therapy required for treatment of an identified medical condition. These services include regularly scheduled and structured and/or unplanned (in certain circumstances) counseling or therapy sessions for recipients, either independently or in a group, with their parents or guardians, or with other family groups. Unplanned/unscheduled services provided in the absence of a plan of care (IEP, IFSP, 504 plan, IHCP or otherwise medically necessary plan of care) may be covered if medical necessity is justified through service documentation that is signed by a qualified provider.

  Behavioral health services may be provided by those Providers listed below. These Providers must adhere to all State and Federal regulations including the NM Regulation and Licensing Department Divisions. It is the District/REC/SFPS and the Individual Provider/s responsibility to adhere to each NM Regulation and Licensing Divisions/Boards rules and regulations regarding scope of practice and supervision by both the Supervisor and Supervisee. Refer to Appendices E and G.

  - A licensed clinical/independent social worker (LCSW/LISW);
  - A licensed marriage and family therapist (LMFT);
  - A licensed associate marriage and family therapist (LAMFT) supervised by a Ph.D., Psy.D., Ed.D., LISW/LCSW, LPCC or LMFT;
  - A licensed professional clinical counselor (LPCC);
  - A licensed psychiatric clinical nurse specialist (CNS);
  - A licensed psychiatrist, psychologist, or psychologist associate;
  - A licensed bachelor's level social worker (LBSW), licensed master's level social worker (LMSW), or licensed mental health counselor (LMHC) supervised by a licensed Ph.D., Psy.D., Ed.D., Ed.S., or LCSW/LISW, or other board approved provider (must be listed on the NM Social Work Board Approved Supervisor List – 06.21.2024 Board Approved Supervisor List or have written Social Work Board Approval)
  - (**Note:** Comprehensive Diagnostic Evaluations conducted by these providers are not covered under MSBS); or
  - A licensed school psychologist – Level 1 school psychologists must be supervised by a Ph.D., Psy.D. Ed.D or Ed.S. who is licensed by the NM Psychologist Examiner's Board or a PED Level 3 School Psychologist

- **Nutritional assessments and counseling** provided by a licensed nutritionist or dietician for a recipient who has been referred for a nutritional need. A nutritional assessment consists of an evaluation of the nutritional needs of an individual based on appropriate biochemical, anthropomorphic, physical, and dietary data, including a recommendation for appropriate nutritional intake.

- **Transportation services** for recipients who must travel from the school to receive a covered service from a Medicaid provider because the service is unavailable in the school setting.

Transportation services are reimbursable when provided on the date of a scheduled medical service. They are also reimbursable for transporting students with disabilities to and from the school on the date of a scheduled service if the recipient requires transportation in a modified vehicle that meets the recipient's needs.

- **Case management services** that are furnished in the school setting to recipients who are considered to be "medically at-risk", a term that refers to individuals who have a diagnosed physical or behavioral health condition with a high probability of impairing their cognitive, emotional, neurological, social, or physical development. Case management services must be coordinated with the recipient's MCO if the recipient is enrolled in the *Turquoise Care* program. Examples of case management activities that are covered under the MSBS program include:

  - Assessments of the recipient's medical, social, and functional abilities every six months, unless more frequent reassessment is indicated by the recipient's condition.
  - Developing and implementing a comprehensive plan of care that helps the recipient retain or achieve a maximum degree of independence.
  - Mobilizing "natural helping" networks, such as family members, church members, community organizations, support groups, friends, and the school; and
  - Coordinating and monitoring the delivery of services, evaluating the effectiveness and quality of services, and revising the plan of care as necessary.

  Recipients have the freedom to choose a case management service provider. Medicaid pays for only one case management provider to furnish services during a given time period. If a recipient has a case manager or chooses a case manager who is not employed by or under contract with the LEA, REC, or SFEA, the LEA, REC, or SFEA must coordinate with the case manager in the development of the ITP.

- **Nursing services** that are required to treat an identified medical condition that qualifies a recipient for an IEP, IFSP, 504 Plan, IHCP, or are otherwise deemed medically necessary as appropriate for each covered service. Nursing services require professional nursing expertise and must be provided by a licensed registered nurse (RN) or licensed practical nurse (LPN) in accordance with the New Mexico Nurse Practice Act. In addition, nursing services may be provided by a delegated nursing provider under the supervision of a RN, if the delegated nursing provider is 1) appropriately trained in the service they will deliver by the supervising RN, 2) the training occurred prior to the delegated nursing service, 3) training documentation is available that is signed and dated by the supervising RN. Emergency or unplanned/unscheduled nursing services may be covered in the absence of a plan of care (IEP, IFSP, 504 plan, IHCP or otherwise medically necessary plan of care) if medical necessity is justified through service documentation that is signed by a qualified provider.
    - **Individualized Health Care Plans (IHCP)** are required for medication administration/medical procedures ordered by the Primary Care Provider/Specialist.

- **Telemedicine (Teletherapy) services** provided in accordance with 8.210.2 NMAC. The modifier "GT" should be utilized when billing for services provided via telemedicine.

- **Co-Therapy** is an allowable therapy method for providing IEP, IFSP, 504 Plan or other medically necessary related services. Recommended best practice is that any potential therapy method(s) be listed in the Prior Written Notice (PWN) of the IEP or other documented plan of care. Therapy notes should indicate that co-therapy was utilized, and the notes should clearly demonstrate work toward the goals and objectives for each individual therapy type.

- **Private School Services:** Parentally placed students in private school are under the obligation of the local LEA. If the parent chooses to put their student in a private school, that does not release the district of their obligation to provide any special education services, and the private school is not obligated to do so. If the local LEA provides IEP services and is not reimbursed

by the private school for the services delivered, the LEA has the right to claim Medicaid for reimbursement as long as other program rules are met. There needs to be a mechanism in place within the LEA to identify the student with a unique ID number.

- **Make-Up Services:** According to *Letter to Balkman, 23 IDELR 646 (OSEP, April 1995)*, Part B of the Individuals with Disabilities Education Act requires that the school district ensure that students with disabilities in the district are given a free appropriate public education (FAPE). The development and implementation of the IEP is essential to fulfilling FAPE requirements; "34 CFR § 300.346 states that the IEP for each child must include, among other components, a statement of the specific special education and related services to be provided to the child, the projected dates for the initiation of services and the *anticipated* duration of the services."

  In order to be sure that the district has met its responsibility to make sure that FAPE is made available to students there are several situations when missed services must be made-up. Services should be made-up when they are missed due to:
  - The provider is absent (sick, out of town, etc.);
  - The provider is at an IEP or evaluating another child.
  - The provider is at a district required function (meetings, trainings, etc.);
  - The student is participating in a school-sponsored activity (fieldtrips, assemblies, testing, parties, etc.);
  - The student misses' therapy because of a change in the normal school day (half-days).

  Letter to Balkman further states that when services are missed because of a student's participation in school-sponsored activities or a provider is unavailable, the school district should make other arrangements to provide the services required in the IEP at the scheduled time or reschedule them.

  The Medicaid School-Based Services (MSBS) program allows for the district to bill for reimbursement for services provided in these situations as long as the date of the missed service is documented in the providers notes and the note of the make-up session should indicate the missed date and amount of time that the make-up service is for. Furthermore, a provider can only provide make-up time prior to the scheduled time if the session will be missed due to a reasonably foreseeable event (therapist knows ahead of time that they have a doctor's appt., teacher has notified therapist of fieldtrip, etc.)

  Providers are not required to provide make-up services and MSBS does not allow for reimbursement when the student is absent from school in the following situations:
  - Student is absent (sick, family initiated activities, etc.);
  - Student is suspended for <u>less than 10 days.</u>
  - School holidays.

  Providers should not make up time for these situations and <u>under no circumstances</u> should they use them as dates for providing make-up time!

- **Compensatory Services** may be deemed necessary when IEP/IFSP services nave not been provided to the student for a prolonged period of time. Reimbursement would be allowed for compensatory services provided for situations including but not limited to:

  1. The LEA, REC or SFEA is unaware that an IEP exists for a transfer student and it is determined that services are owed retroactive to the student's enrollment in the LEA, REC or SFEA.
  2. The LEA, REC or SFEA was unable to provide a therapist to administer IEP/IFSP services i.e. unable to hire therapist. Upon filling the vacant position, it is determined that services are owed retroactive to the beginning of the vacancy.
  3. A therapist is out of work for an extended period of time, i.e. Maternity leave. The LEA, REC or SFEA will communicate with the parent/guardian regarding the situation so

that a determination can be made about how compensatory services will be provided for the student. When the situation permits, it is expected that this communication will occur prior to the therapist's absence.

The decision to provide compensatory services and the frequency/duration should be decided jointly between the LEA, REC or SFEA and the parent/guardian. Compensatory services do not need to be provided as a 1:1 ratio and negotiations of service time may be reached. Services may be provided in conjunction with regular IEP service time, as long as the compensatory service time is clearly defined.

Providers should note the compensatory time in their notes and list the reason for compensatory time, i.e. "This 30 min session is for the compensatory time owed to student for last school year, of the 120 minutes owed. 90 minutes remain."

It is the expectation that the therapist keeps track of the compensatory time owed and delivered and that billing does not exceed the total time owed.

- **The procedure codes** for MSBS-covered direct services and their Medicaid reimbursement rates may be found in Appendix D.

  A provider must correctly report service units for each procedure code in accordance with *Medicaid General Provider Policies* 8.302.2. For procedure codes that indicate services are to be billed as 1 unit per 15 minutes or per hour of service, the provider must follow the chart below when the time spent is not exactly 15 minutes or one hour.

	# of 15-min units to be billed	# of 1-hour units to be billed
Less than 8 minutes	0	0
8 minutes to 22 minutes	1	.25
23 minutes to 37 minutes	2	.50
38 minutes to 52 minutes	3	.75
53 minutes to 67 minutes	4	1.0
68 minutes to 82 minutes	5	1.25
83 minutes to 97 minutes	6	1.50

The American Psychological Association's guidance for Individual Mental Health Codes in relation to time frames for each code is listed below:

These psychotherapy services are considered face-to-face services with the patient and/or family member, with the patient present for some or all the service. The specific amount of time associated with these three code titles may well differ from the actual time you provided psychotherapy. In general, you should select the code that most closely matches the actual time you spent. The CPT manual provides for flexibility by identifying time ranges in the descriptions of the three codes, as follows:

CPT Code	Total Duration of Psychotherapy Session
90832	16–37 minutes
90834	38–52 minutes
90837	53 or more minutes
90846, 90847	26 or more minutes

The psychotherapy codes should not be billed for any sessions lasting less than 16 minutes. The new codes are not intended to limit the length of time you schedule for psychotherapy. Psychologists who conduct sessions that require more than 60 minutes may continue to do so and will bill using the new 90837 code effective Jan. 1, 2014. Regardless of how long the session lasts, the psychologist's reimbursement will be based on the payment amount ultimately associated with 90837.

II. Non-Covered Services

The services that are provided in the school setting under the MSBS program are subject to certain limitations and restrictions, like those set for other Medicaid services. Specifically, these services include:

- Services that are classified as educational;
- Services to non-Medicaid eligible individuals;
- Services provided by practitioners outside their area of expertise;
- Assistive technology;
- Vocational training services that are related exclusively to specific employment opportunities, work skills, or work settings;
- Services that duplicate those furnished outside of the school setting, unless determined to be medically necessary and given prior authorization by HCA/MAD or its designee;
- Transportation services that a recipient would otherwise receive in the course of attending school;
- Transportation services for a recipient with special education needs under IDEA who rides the regular school bus to and from school with other non-disabled children; and
- Services provided by providers that are 100% federally funded. These services do not have any allowable funding to serve as the required non-federal (state) share of services that must be provided by the LEA, REC, or SFEA.

III. Individualized Treatment Plan

The ITP is the medical portion of an IEP, IFSP, 504 Plan, IHCP or other plan of care and should be designed to state the medical needs, objectives, duration, service, and provider type of any reimbursable medical treatment to be provided under the MSBS program. The ITP is developed pursuant to the recipient's health history, medical and educational evaluations, and recommendations of their PCP, if applicable. The ITP should be developed by the LEA, REC, or SFEA, together with recipients, the appropriate service providers and their families (as applicable). It is a plan of care that should be agreed upon by the recipient's parents or legal guardians, evaluating provider, IEP or IFSP committee, and teacher as applicable for the service plan. The recipient's PCP must be notified of the IEP related services to be provided by the LEA, REC, or SFEA. This notification should be sent annually after each IEP or after an addendum to the IEP that results in a change of services to be provided by the LEA, REC, or SFEA.

IV. Provider Licensure and Supervisory Requirements

To participate in the MSBS program and receive reimbursement, an LEA, REC, or SFEA must be enrolled as a participating Medicaid provider**. Individual service providers that are employed by or are under contract with the LEA, REC, or SFEA must be authorized to enter into separate Medicaid provider participation agreements by meeting licensing and other qualification criteria.** The steps that must be taken by the LEA, REC, or SFEA and by individual providers are specified in detail in Section II, Part V of this Guide.
Eligible direct service providers and their qualifications include:

- **Physical therapists** and **physical therapy assistants** who are licensed by the Physical Therapy Board under the RLD and who meet licensure requirements of the PED. Physical therapy assistants must work under the supervision of a licensed physical therapist.

- **Occupational therapists** and **occupational therapy assistants** who are licensed by the Occupational Therapy Board under the RLD and who meet licensure requirements of the PED. Occupational therapy assistants must work under the supervision of a licensed occupational therapist.

- **Speech-language pathologists, speech-language pathology clinical fellows, speech-language pathology apprentices, and audiologists** who are licensed by the Board of Speech-Language Pathology and Audiology under the RLD and who meet licensure requirements of PED as applicable. Speech-language pathology clinical fellows and apprentices must work under the supervision of a licensed speech pathologist.

- **Social work practitioners** who are:

  - Licensed by the Social Work Examiners Board as master's level independent social work practitioners; or
  - Licensed by the Social Work Examiners Board as a bachelor's or master's level social worker and supervised by a licensed Ph.D., Psy.D., Ed.D., ED.S., LCSW/LISW, or other board approved supervisor.
  - Social work practitioners must meet licensure requirements of PED.

- **Psychologists** who are:

  - Psychologists (Ph.D., Psy.D., or Ed.D.) licensed by the New Mexico Psychologist Examiners Board; or
  - Master's level practitioners licensed by the New Mexico Psychologist Examiners Board as psychologist associates and supervised by a psychiatrist or Ph.D., Psy.D., or Ed.D. who is licensed by the New Mexico Psychologist Examiners Board
  - School Psychologists who meet licensure requirements of PED. Level One School Psychologists must be supervised by a Ph.D., Psy.D., Ed. D, or Level Three School Psychologist. Level Two and Three School Psychologists do not require supervision.

- **Physicians** and **psychiatrists** who are licensed by the Board of Medical Examiners.

- **Case managers** who:

  - Have a bachelor's degree in social work, counseling, psychology, nursing, or a related health or social services field from an accredited institution, and who have one year of experience in serving medically at-risk children or youth.
  - Have a registered or practical nurse license; or
  - Have a bachelor's degree in another field but have two years of direct experience in serving medically at-risk children or adolescents.

- Case managers must be registered as case managers with Conduent.

- **Counselors** who are:

  - **Licensed professional clinical counselors** who are licensed by the New Mexico Counseling and Therapy Practice Board under RLD.
  - **Licensed mental health counselors** who are licensed by the New Mexico Counseling and Therapy Practice Board under RLD and are supervised by a Ph.D., Psy.D., or Ed.D.

- **Licensed marriage and family therapists and licensed associate marriage and family therapists** who are licensed by the New Mexico Counseling and Therapy Practice Board under RLD. Licensed associate marriage and family therapists must work under the supervision of a Ph.D., Psy.D., Ed.D., LISW/LCSW, LPCC or LMFT. See NMAC16.27.19.10

- **Licensed psychiatric clinical nurse specialists** who are licensed by the New Mexico Board of Nursing.

- **Licensed nutritionists or registered dieticians** who are licensed by the New Mexico Nutrition and Dietetics Practice Board.

- **Licensed registered nurses or licensed practical nurses** who are licensed by the New Mexico Board of Nursing and who meet licensure requirements of PED.
  - Delegated nursing providers are not required to hold a license but must be supervised by a RN that meet the requirements above.

A document outlining who may participate in the MSBS program as a direct service provider and their licensure and supervision requirements may be found in **Appendix G**.

Contact information for RLD may be found at www.rld.state.nm.us. The PED Licensure Unit may be reached at (505) 827-1436.

V. Services Provided by Student Therapists and Interns

Services provided by student therapists and interns may be billable under the MSBS Program if they are provided in accordance with state and national standards for their professional association, including the American Physical Therapy Association (APTA), the American Occupational Therapy Association (AOTA), the American Speech-Language Hearing Association (ASHA), National Association of Social Workers (NASW), the National Association of School Psychologists (NASP) and others.

The following criteria should be considered for services provided by student therapists and interns to be Medicaid-billable:

- Student therapists and interns must be associated with an approved educational program. Unlicensed staff that **are not** affiliated with an educational program **do not** qualify as students or interns.
- Services provided should be under the supervision of a licensed and Medicaid-enrolled supervising therapist. Supervision requirements may differ for each educational program, professional association and licensure board.
  - Best Practice when Student is documenting direct service is to have their supervisor present alongside the student while entry is being written in the Documentation/billing system. As the Student advances in clinical setting, documentation may be done by the student and be put on hold for the Supervisor to review before the note is eligible/released for billing.

- Therapy Note must contain the Name of the Extern/Practicum Student, Name of University and what year/semester in their Bachelors or Master's Program, State level of Supervision, Direct/Indirect and the Name/Credential of their licensed Supervisor.
- These notes need to be printed out and signed by both the Supervisor and the student (either handwritten or DocuSign/goggle sign) if using a Third-Party billing system with an electronic signature system.

VI. Documentation Requirements

To ensure compliance with state and federal regulations, the LEA, REC, or SFEA should maintain adequate records to document service delivery for **six years** from the date of service. At a minimum, records documenting the provision of one of the services covered by the MSBS program should include:

- The name of the LEA, REC, or SFEA;
- The recipient's name, date of birth, and Medicaid number/unique identifier;
- The date and location of the service (school or home);
- The procedure code for the service;
- A description of the service provided, including the treatment code (ICD-10) and level of service;
- Signatures, or electronic signatures, credentials and licensures of the rendering provider(s). When the rendering provider works under the supervision of another provider, the supervisor must also sign the document.; and
- For IEP services, the document showing involvement of the student's PCP or documentation of the LEA's, REC's, or SFEA's good faith attempt to obtain a response from the PCP in accordance with Section IV, Part VI of this Guide.

For occupational therapy, physical therapy, speech therapy and audiology services, there is the additional requirement from the Affordable Care Act (CFR Title 42 Part 455), that the Ordering, Referring and Rendering (ORP) provider is enrolled in the Medicaid program and their NPI number is submitted with the service claim. The licensed provider that developed the IEP, IFSP, or other plan of care will serve as the ordering/referring provider for the term of that IEP, IFSP, or other plan of care.

Documentation should support the medical necessity of the service in accordance with the Medicaid regulation for medically necessary services found in the *Medicaid General Provider Policy* at MAD 8.302.1.7, which may be found in **Appendix E**.

A quality assurance checklist was developed by the HCA/MAD School Health Office to assist schools in ensuring that they meet all the required documentation standards for the MSBS program. This tool may be found in **Appendix F**.

For non-employee/non-licensed providers such as students and interns, district providers may have the student/intern practice documentation under their guidance.

- The student/intern (whether providing the direct service or documenting) must ALWAYS be identified as such in the notes.
- The note must reflect the student/intern's name, level, and institution they are associated with.
- Documentation must also state whether the student/intern provided direct services under direct supervision or independently.
- Students/interns should not be given their own accounts for documentation in a third-party billing system. Documentation should occur in the account of the supervising therapist.

VII. Coordination with Primary Care Providers

In New Mexico, most of the children and youth who are enrolled in Medicaid receive physical health benefits through one of the *Turquoise Care* managed care organizations (MCOs) and have a

designated physician or nurse practitioner who is called their Primary Care Provider (PCP). The role of the PCP is to provide a "medical home" for the recipient, to maintain the recipient's medical records, and to make referrals or authorize treatment that may be required as the result of diagnostic or routine screening visits, such as the Tot to Teen Health Check.

For students with an IEP, PCP participation is critical to the overall success of the MSBS program. In some school districts, particularly those in larger urban areas or in areas with busy PCP practices, ensuring PCP involvement has posed a challenge. A school district may make a "good faith" effort to notify the PCP and obtain their signature by following and documenting certain steps. These steps are outlined in the *MSBS Procedure for Notifying the Primary Care Provider of MSBS Services and Completing the Good Faith Effort*, which can be found in **Appendix H**.

VIII. Claiming Medicaid Reimbursement for Direct Services

For an LEA, REC, or SFEA to receive reimbursement for the direct services provided through an IEP, IFSP, 504 Plan, IHCP, or other medically necessary services, described in Section IV, Part I of this Guide, it must meet several criteria. In summary, the LEA, REC, or SFEA must:

- Be an approved and enrolled Medicaid provider (refer to Section II of this Guide);
- When necessary, supervision must be provided by an appropriately licensed and Medicaid Enrolled Provider (refer to Section V of this Guide);
- File claims for reimbursement to the Medicaid fiscal agent, Conduent, within 120 days of the date that the service was provided; and
- Submit electronic claims for reimbursement on the 837P Health Care Encounter form.

Paper billing is only allowed in certain circumstances such as re-bills and adjustments, and prior approval may need to be obtained from Conduent. Direct service paper billing forms (CMS-1500) may be purchased at any office or forms supply location. Web-based electronic billing is available at no cost to providers through the New Mexico Medicaid program. Training and technical assistance in how to bill for direct services is available to all MSBS-participating LEAs, RECs, or SFEAs from Conduent. Conduent provider services staff may be reached at 1-800-299-7304.

An LEA, REC, or SFEA should bill for the direct services that are provided by staff who meet the professional requirements listed in Section IV, Part IV of this Guide. For example, an LEA, REC, or SFEA would be responsible for submitting speech therapy claims provided by speech therapists in accordance with the child's IEP, IFSP, 504 Plan, IHCP, or are otherwise deemed medically necessary as appropriate for each covered service, when that child is Medicaid-eligible.

To receive reimbursement for services, an LEA, REC, or SFEA should have well-developed Medicaid claim procedures in place. The documentation requirements discussed in Section IV, Part VI of this Guide are designed to prepare districts for a potential on-site audit by HCA/MAD, CMS, or the U.S. Department of Health and Human Services Office of Inspector General, and to ensure that billing is done only for enrolled staff. In contrast to many other Medicaid programs, services provided under the MSBS program do not require prior approval once the service is specified in the recipient's IEP, IFSP, 504 Plan, IHCP, or if otherwise deemed medically necessary as appropriate for each covered service. IEP services need to be coordinated with the recipient's PCP as specified in section.

Payments received for claims submitted by the LEA, REC, or SFEA will be considered "interim" payments for the purpose of the cost report settlement process. A quarterly adjustment will be processed through the Medicaid Management Information System (MMIS) to adjust for any non-federal (state) share of the approved reimbursements that was paid to the LEA, REC, or SFEA in the previous quarter so that the net payment to the LEA, REC, or SFEA is only the FFP. Overpayments will be deducted from future direct service payments to the LEA, REC, or SFEA.

IX. Remittance Advice and Re-Submission of Claims

To ensure payment on a claim, all the required fields on the CMS 1500 form (02/2012 version), if billing on paper, or the 837P Health Care Encounter form, if billing electronically, must be complete and accurate. If the form is incomplete or incorrectly completed, the claim may be denied for payment. If an LEA, REC, or SFEA receives a remittance advice showing that the claim was denied, the same claim may be corrected and resubmitted to Conduent.

Resubmission of denied claims must be submitted within **90 days** of the denial date on the remittance advice. A copy of the remittance advice page showing the denial must be attached to the claim as proof of timely filing. If filing electronically, corrected claims may be resubmitted electronically within the original **120-day time period** without proof of timely filing. Requests for adjustments on paid claims must be submitted to Conduent using the Adjustment or Void Request forms. Specific instructions can be obtained from the fiscal agent by contacting Conduent provider services at 1-800-299-7304.

Once a claim has been approved and processed for payment, a remittance advice that shows the status of all claims that the LEA, REC, or SFEA has submitted to Conduent will be available online at https://nmmedicaid.portal.conduent.com/. Remittance advices are critical for tracking correctable errors for resubmitted denied claims. A remittance advice newsletter containing important billing information is available online every Monday. LEAs, RECs, and SFEAs should review the remittance advice newsletter regularly to keep up-to-date on any changes regarding MSBS direct service billing processes. Questions about remittance advices may be directed to Conduent provider services.

X. Direct Medical Services Cost Report and Settlement

Beginning with cost reporting period starting July 1, 2015, HCA/MAD will begin settling Medicaid reimbursement for direct medical services at cost for all LEAs, RECs, and SFEAs. This methodology will include the results of the quarterly RMTS, an annual cost report, and reconciled settlement.

For Medicaid services provided by LEAs, RECs, or SFEAs during the state fiscal year, each LEA, REC, or SFEA provider must complete an annual cost report. The cost report is due on or before April 1 following the reporting period. The cost report template can be found in **Appendix T;** detailed instructions for completing the cost report and settlement can be found in **Appendix U**.

The primary purposes of the cost report are to:

1. Document the provider's total CMS-approved, Medicaid-allowable costs of delivering Medicaid coverable services using a CMS-approved cost allocation methodology.
2. Reconcile any interim payments to its total CMS-approved, Medicaid-allowable costs using a CMS approved cost allocation methodology.

The annual Cost Report includes a certification of funds statement to be completed, certifying the provider's actual, incurred costs/expenditures. All filed annual Cost Reports are subject to desk review by HCA/MAD or its designee.

On an annual basis, each provider will certify through its cost report, its total, actual, incurred Medicaid allowable costs/expenditures, including the federal share and the nonfederal share. Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

The cost reconciliation process must be completed by HCA/MAD within 24 months of the end of the reporting period covered by the Cost Report. The total CMS-approved, Medicaid-allowable scope of costs based on CMS-approved cost allocation methodology procedures are compared to any LEA provider's Medicaid interim payments delivered during the reporting period as documented in the MMIS, resulting in a cost reconciliation.

If a provider's interim payments exceed the actual, certified costs for Medicaid services provided in schools to Medicaid clients, the provider will remit the federal share of the overpayment at the time the cost report is submitted. HCA/MAD will submit the federal share of the overpayment to CMS within 60 days of identification.

If the actual, certified costs of an LEA, REC, or SFEA provider exceed the interim payments, HCA/MAD will pay the federal share of the difference to the provider in accordance with the final actual certification agreement and submit claims to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

Section V – Billing for Administrative Services

In addition to reimbursing LEAs, RECs, and SFEAs for direct health services that are part of a child's IEP, IFSP, 504 Plan, IHCP, or are otherwise deemed medically necessary as appropriate for each covered service, the MSBS program also reimburses them for the costs of certain administrative activities that directly support efforts to provide health-related services to Medicaid-eligible children and youth with special education and health care needs. These administrative activities include, but are not limited to, providing information about Medicaid programs and how to access them; facilitating the eligibility determination process; assisting recipients in obtaining transportation and translation services when necessary to receive health care services; making referrals for Medicaid-reimbursable services; and coordinating and monitoring medical services that are covered by Medicaid. These and other activities that may be reimbursed under the MSBS program are described in detail in this section of the Guide. An LEA, REC, and SFEA must participate in direct service billing in order to be eligible to participate in administrative claiming.

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

- Participating LEAs, RECs, and SFEAs will submit quarterly claims to HCA. These claims will be based on the quarterly costs, time study results, the Medicaid eligibility rate, the provider participation rate, and the FFP.

I. Medicaid Eligibility Rate

The Administrative Claim is based on the LEA's, REC's, or SFEA's Medicaid Eligibility Rate (MER), which is figured as follows:

- The LEA, REC, or SFEA submits their 80-day count to the Public Education Department (PED) annually. The 80-day count plus any confidential student information **must** be submitted through the MOVE IT DMZ portal, which is the HCA/PED secure file sharing system.
- The PED matches the 80-day count through the Medicaid data warehouse.
- The percentage of Medicaid eligible recipients will be used on the LEA's, REC's, or SFEA's claim.

II. Random Moment Time Study Results

The results of the RMTS are combined with the LEA's, REC's, or SFEA's allocation of costs and MER, determine the amount that the LEA, REC, or SFEA is eligible to receive for administrative activities during the sampled quarter.
Each of the allowable time study codes (5B, 6B, 7B, 8B, and 9B) may be reimbursed under the MSBS administrative claiming program at the 50 percent FFP rate. Unallowable activities are disallowed as administration under the Medicaid program, regardless of whether the population served includes Medicaid-eligible individuals.

There are two codes (1B and 2B) that are 100 percent allowable as administration under the Medicaid program. Reimbursement for the remaining allowable codes is determined based on the MER. For these codes, the Medicaid share is determined as the ratio of Medicaid-eligible students to total students.

General administrative activities performed by time study participants must be reallocated across the other activity codes on a pro rata basis. These reallocated activities are reported under the General Administration code (GA).

III. Completing the Claim Form

The claim form, which can be found in **Appendix M**, includes several components. These include:

- General data regarding the LEA's, REC's, or SFEA's direct quarterly costs.
- Data regarding the LEA's, REC's, or SFEA's capital allocation, including buildings and equipment.
- The time study percentages, which are assigned by the Medicaid School Health Office based on the RMS time study results for the quarter.
- The LEA's, REC's, or SFEA's percentage of Medicaid-eligible recipients.
- Data regarding the LEA's, REC's, or SFEA's quarterly salary and benefit costs.
- The administrative claim invoice, which considers the factors listed above; and
- The quarterly certification of state expenditures, which is signed by the LEA, REC, or SFEA.

Detailed instructions regarding completion of the claim form can be found in **Appendix N**.

The claim form is due to the HCA/MAD School Health Office no later than **45 days after the end of the billing quarter**. Time frames may be reduced further due to state fiscal year-end closing dates. Each LEA, REC, or SFEA should identify the person who will be responsible for completing the claim form and provide their contact information to the HCA/MAD School Health Office.

As per Section IV.B.1.b. of the GSA, **any requests for extensions must be received, in writing, prior to 4:00 PM on the day BEFORE the designated due date** as published in the NM MAC Program Calendar. HCA reserves the right to reject any invoices that are received after the stated deadline.

IV. Offset of Revenues

Certain revenues must offset allocated costs to reduce the total amount of costs in which the federal government will participate. To the extent that the funding sources have paid or would pay for the costs at issue, federal Medicaid funding is not available, and the costs must be removed from total costs. The following include some of the revenue offset categories that must be applied in developing the LEA's, REC's, or SFEA's net costs:

- All federal funds;
- All state expenditures that have been previously matched by the federal government;
- Insurance and other fees collected from non-governmental sources;
- All applicable credits (those receipts or reduction-of-expenditure type transactions that offset or reduce expense items allocable to federal awards as direct or indirect costs); and
- Expenditures which have already been paid by any of the revenue sources above. A government program may not be reimbursed in excess of its actual costs.

V. Documentation of Administrative Activities

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

- The accounting information upon which the claim form is based, including the basis for any inclusion or exclusion of costs;
- A list of all revenues that were offset when calculating the claim;
- The enrollment lists used to determine the Medicaid eligibility rate;
- Time study documentation, including the sample pool participants by function, title, name, identification number, location, telephone number, and code assigned to their activity;
- The completed quarterly claim;
- A copy of the warrant;
- Job descriptions and licensure(s) of employees included in the sample pool;
- Proof of employee attendance for individuals included in the sample pool; and
- Any other supporting information used to substantiate the claim.

LEAs, RECs, or SFEAs must ensure that these files are current, complete, accessible, and secure. Administrative claim files must be maintained for a minimum of **six years**.

A quality assurance checklist was developed by the Medicaid School Health Office to assist schools in ensuring that they meet all of the required documentation standards for the MSBS program. The *MSBS Quality Assurance Checklist* is in **Appendix F**.

VI. Administrative Claims Submission

MSBS-participating LEAs, RECs, and SFEAs are responsible for submitting administrative claims in accordance with these guidelines:

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

- All administrative claims must be prepared and submitted on forms developed and approved by HCA/MAD, in accordance with federal and state Medicaid regulations, policies and guidelines, the CMS *Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming, 2023*,, this Guide, and any federal or state revisions hereto.

- Claims must be accurate and complete when submitted for payment, pursuant to the Medicaid Provider Participation Agreement and as required of all Medicaid providers, prior to submission of the claim to HCA/MAD, and according to this Guide.

- The LEA, REC, or SFEA should upload the required documentation to the *Audit Center* area of the Fairbanks website prior to submission of the quarterly administrative claim. The claim will not be considered complete or approved for payment until this step has been verified as complete by the School Health Office,

Section VI – Provider Compliance & Program Review

I. Monitoring, Oversight, and Technical Assistance

To ensure LEAs, RECs, or SFEAs participating in MSBS understand the program and have the requisite guidelines and procedures in place for administering the program, the HCA/MAD School Health Office includes several key methods of monitoring and overseeing the MSBS program, and for providing technical assistance to LEAs, RECs, or SFEAs. These include:

- State-level desk audits conducted on the quarterly administrative claims. These are a review of the LEA's, REC's, or SFEA's submitted time study questionnaires, calculation and supporting documentation, and a determination of the appropriateness of the claim.

- Periodic on-site visits to assess implementation of the RMS time study methodology and the results reported on the administrative claim and to provide technical assistance as needed.

- Identification of trends based on day-to-day telephone calls and email inquiries from participating LEAs, RECs, or SFEAs. Follow-up trainings will be tailored to correspond with these trends, and technical assistance will be provided as needed. HCA/MAD School Health Office staff will also use trends apparent from official grievances and appeals to coordinate trainings and direct the focus of on-site visits.

- Assessment of provider experience and program understanding through pre-tests and post-tests collected at training sessions.

- Maintenance of open lines of communication by HCA/MAD School Health Office staff, together with their counterparts at the Department of Health (DOH) and PED, and a willingness to resolve problems, address issues and concerns, and provide technical assistance as indicated.

II. Direct Services Provider Compliance

The documentation requirements (Section IV, Part IV) and the other program requirements listed throughout Section IV are designed to ensure that participating LEAs, RECs, and SFEAs comply with all MSBS program guidelines, policies, and regulations for direct health services.

For dates of service July 1, 2015 and later, the LEA, REC, or SFEA will be required to submit all supporting documentation for the annual Cost Report to the HCA/MAD School Health Office for a state-level desk audit to determine the appropriateness of the claim. Additional reviews of direct services claims may be conducted if the cost report and settlement process indicates that an LEA, REC, or SFEA has been inappropriately billing direct service claims and receiving excessive interim payments.

Beginning with dates of service July 1, 2022, and later, additional desk audits will also be done for a sample of RMTS moments coded as "4B – Direct Medical Services, Covered as IDEA/IEP Services" and "4C- Direct Medical Services, Covered as IHCP/BHCP/504/Other". These audits will be conducted to ensure that direct service moments from the RMTS can be appropriately supported through appropriate documentation. These audits will be conducted on an ongoing basis throughout each fiscal year.

Each site review or desk audit will be concluded with a findings letter, listing all areas of noncompliance, sent to the LEA. REC, or SFEA. The LEA, REC, or SFEA will be required to submit a Corrective Action Plan (CAP) to HCA/MAD within 30 working days of the date of receipt of the site review letter to remedy the immediate noncompliance issue(s).

The LEA, REC, or SFEA may be referred to the Health Care Authority, Office of Inspector General, Program Integrity Unit for a prospective and/or retrospective audit. The following may occur after an audit by the Medicaid Program Integrity Unit:

- If indicated, funds owed may be recouped from the LEA, REC, or SFEA;
- In all cases, the LEA, REC, or SFEA has the option to appeal through HCA/MAD's administrative hearing process pursuant to the Medicaid provider hearing regulations; and
- If indicated, the LEA, REC, or SFEA may be terminated from participation in the MSBS program, as set forth in *Medicaid General Provider Policies*, 8.302.1 (**Appendix E**).

III. Administrative Claim Provider Compliance

The measures for monitoring and oversight listed in Section VI, Part I are designed to ensure that participating LEAs, RECs, and SFEAs comply with program guidelines, policies and regulations, in accordance with the CMS *Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming, 2023*, this Guide, and other program requirements. However, in the event that a participating LEA, REC, or SFEA is found to be out of compliance through a desk audit or other means of oversight, the following principles shall apply:

- The claim for the quarter may be recalculated by HCA/MAD, based on the audit, and approved for payment;
- The claim for the quarter may be denied;
- The LEA, REC, or SFEA will be required to submit a Corrective Action Plan to HCA/MAD within 30 working days of receipt of letter from HCA/MAD to remedy the immediate noncompliance issue;
- The LEA, REC, or SFEA may be directed to submit a Directed Plan of Correction to HCA/MAD within 30 working days to remedy multiple or systemic noncompliance issues;
- Funds owed may be recouped from the LEA, REC, or SFEA;
- The LEA, REC, or SFEA has the option to appeal through HCA/MAD's administrative hearing process pursuant to the Medicaid provider hearing regulations.
- The LEA, REC, or SFEA may be terminated from participation in the MSBS program, as set forth in *Medicaid General Provider Policies*, 8.302.1 (**Appendix E**).

IV. Records Retention

According to the Governmental Services Agreement, Section II. B.29 "Retain complete documentation to support all claims submitted for direct services and allowable administrative costs for at least six (6) years from the date of creation or until ongoing audit issues are resolved, whichever is later, in accordance with the requirements of the Medicaid Provider Participation Agreement." This includes but is not limited to:

- Provider enrollment and licensure documents for both district employees and contractors
- IEPs, IFSPs,
- Service documentation including supervisor approval when necessary
- Student attendance
- Student lists that have been utilized to calculate Medicaid Eligibility Rates
- All financial documentation related to Administrative and Cost Settlement claims

V. Conclusion

New Mexico's MSBS program is reflective of extensive collaboration between HCA/MAD, PED, DOH and many of New Mexico's LEAs, RECs, and SFEAs. This collaborative approach has proven essential, not only as a means of strengthening both interagency and state/school district relationships, but also for informing and guiding decision making about the MSBS program's optimal organizational

structure, needed policy revisions, areas in need of clarity, and overall operation on both state and school district levels. This Guide outlines an improved structure for the MSBS program that will help to ensure its success in New Mexico.

Questions about this Guide, requests for technical assistance, or additional information about the MSBS program may be obtained by contacting the HCA/MAD School Health Office. Contact information for HCA/MAD School Health Office staff can be found in **Appendix O**.