STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES, BUREAU FOR MEDICAL SERVICES (DHHR/BMS)

TIME STUDY IMPLEMENTATION GUIDE
&
SCHOOL BASED HEALTH SERVICES PROCESS GUIDE

FOR

DIRECT SERVICES AND MEDICAID ADMINISTRATIVE CLAIMING

Implementation Date – July 1, 2014
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[1] Revision of May 8, 2020 was made to include the State of Emergency Exception Section

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I. Medicaid Administrative Claiming & Cost Settlement Process Guide Overview

The West Virginia Department of Health and Human Resources, Bureau for Medical Services (DHHR/BMS) and individual Local Education Agencies (LEAs) share responsibility for promoting access to health care for students in the public school system. This may include coordinating students' health care needs with medical providers in an effort to prevent costly or long-term health care problems for at risk students. Many of these activities performed by LEA staff meet the criteria for Medicaid Administrative Claiming (MAC), which allows LEAs to recoup some costs associated with administrative activities that support Medicaid. Eligible activities are outlined in this guide, as well as a time study process that will be used to calculate both MAC claims and the Cost Settlement amount for the School Based Health Services (SBHS) Fee-For-Service (FFS) program.

Definition

The MAC program, administered by DHHR/BMS, allows LEAs to be reimbursed for some of their costs associated with school-based health and outreach activities which are not claimable under the Medicaid Fee-For-Service (FFS) program. The school-based health and outreach activities funded under MAC include: referrals of students/families for Medicaid eligibility determinations, providing healthcare information, coordination and monitoring of health services for students (when provided by non-Targeted Case Management cost pool staff), and interagency coordination of services.

Unlike the FFS program, individual claims for each administrative service rendered to or on behalf of a student are not required under the MAC program. However, it is necessary to determine the amount of time LEA staff members spend performing Medicaid-related administrative activities. Time spent by LEA staff on Medicaid administrative activities is captured through the use of Random Moment Time Studies (RMTS). Time study results are then used in a series of calculations to determine the percentage of LEA costs that can be claimed under MAC. MAC reimbursement to LEAs is made from Medicaid federal funds. LEAs are required to maintain documentation of the selected moments for audit purposes.

Medicaid Administrative Claiming Program and Direct School Based Services Guide

This Implementation Plan is designed to serve as the guide to LEAs who choose to participate in the FFS and MAC programs. It contains the policies and procedures that LEAs must follow to submit an administrative claim to Medicaid for reimbursement. It also addresses audit requirements. In the event that the Implementation Plan is revised, the effective date of the revision will be indicated at the bottom of each updated page.

II. Implementing Medicaid Administrative Claiming

Overview

LEAs participating in the West Virginia MAC program must meet a specific set of requirements. These requirements are as follows:

- Time studies completed at prescribed time intervals, quarterly;
- Statistically valid time study results;
- Cost determinations and allocations performed; and
- Quarterly Medicaid administrative claims prepared and submitted to DHHR/BMS

All participating LEAs will be included in the statewide sample for administrative claiming and/or direct FFS programs. Personnel and cost data will be compiled from each individual LEA. Medicaid eligibility data will also be applied to each individual LEA. Activity percentages derived from the statewide sample will be applied to each LEA to determine the reimbursement amount.

DHHR/BMS and the LEAs share a common interest in ensuring more effective and timely access to care and appropriate utilization of Medicaid-covered services. Promoting activities and behaviors that reduce the risk of poor health and poor health outcomes for the state's most vulnerable populations is a major consideration. The school setting provides opportunities for engaging children and their families to encourage and assist them in enrolling in Medicaid. This setting also affords an opportunity for the LEAs to deliver direct medical services to Medicaid eligible students. Each LEA can create a framework within its own unique environment that enables seamless health care delivery to children and eliminates many of the barriers to access.

Monitoring of administrative claiming records is required by DHHR/BMS and the Centers for Medicare and Medicaid Services (CMS). MAC payments are the federal share of funds paid for administrative services provided on behalf of Medicaid eligible school children and their families. LEA personnel deliver these services and the LEAs are responsible for upfront payment for services rendered. LEA payments to providers are inclusive of the state and federal shares. The MAC claim identifies the federal and state shares of the payment thus allowing the federal share funds to be returned to the schools through the claiming process.

The purpose of this guide is to outline a comprehensive approach and time study for use with both MAC and FFS cost claiming.

Interagency Participation Agreement

Each LEA participating in MAC must sign a LEA Assurances and Application for Certification. This agreement, identifies each party's responsibilities and must be signed before DHHR/BMS can request

federal reimbursement. After the DHHR/BMS signature is affixed, a signed copy will be returned to the LEA.

MAC Reimbursement

Federal Medicaid reimbursement under the MAC program will be made to LEAs implementing a program that meets the requirements in this guide.

Description of Current Administrative Activities Paid by Medicaid

Several West Virginia state and local agencies are performing administrative services for the West Virginia Medicaid population and receiving Federal reimbursement for services which may be similar to those being considered for reimbursement in the school setting. Although local health departments, early intervention networks, etc. are performing outreach and referral for Medicaid eligibility activities, these activities are not addressing the needs pertinent to the Medicaid eligible school population for school-based services. The additional activities performed at the school site provide further assurance that all children are appropriately referred for Medicaid eligibility determinations and, if Medicaid eligible, are linked to medically necessary Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

Coordination of Activities

LEA staff must not knowingly perform activities that are already being offered or provided by DHHR/BMS, the West Virginia Department of Education (DOE), or other entities providing outreach, referral and assistance to Medicaid eligible and potentially eligible children and their families. The LEAs should constantly strive to become knowledgeable of Medicaid and health care resources in their communities and develop mechanisms to coordinate activities.

Examples of activities that should be coordinated include activities such as primary care case management or disease management. To avoid duplication of these functions, school personnel should, when needed, develop coordination mechanisms between the LEAs and the appropriate entities, and DHHR/BMS. Activities provided/conducted by another governmental component should also be coordinated. For example, it is not necessary for EPSDT educational materials, such as pamphlets and flyers that have already been developed by DHHR/BMS, to be redeveloped by schools. LEAs should coordinate and consult with DHHR/BMS to determine the appropriate activities related to EPSDT and to determine the availability of existing materials. Information on coordination activities and resources will be provided to the LEAs during training events.

III. LEA Staff Activities Included Under Medicaid Administrative Claiming

Overview

As stated previously in this guide, some of the activities routinely performed by LEAs are activities that could be eligible for Medicaid reimbursement under the MAC program. The purpose of this chapter is to define LEA activities for inclusion in MAC time studies and to specify which activities are Medicaid reimbursable. The following chapter defines the type of school staff members eligible to have their activities claimed by LEAs as MAC reimbursable activities. It is important to note that 100% of LEA staff time is considered during MAC time studies but that only certain staff activities, as defined in this chapter, are actually eligible for Medicaid reimbursement.

LEA Job Activities

The West Virginia DHHR/BMS has adopted the parallel coding structure recommended by CMS as stipulated in the revised May 2003 CMS Administrative Claiming Guide. This coding structure will be applied to all MAC claims filed commencing October 1, 2014. Each MAC activity is assigned a numeric or combination numeric/alpha code. These codes are used on time study forms for the purpose of determining the percentage of LEA staff time spent on each activity. Some activities, which are ineligible for MAC reimbursement, such as direct health care services billed under the SBHS FFS program, are included in the list because all job activities must be considered when time sampling is conducted. Thus they are designed to capture reimbursable and non-reimbursable MAC activities.

MAC Activities List

The major categories of MAC activities are:

CODE 1.a.	**Non-Medicaid Outreach**
CODE 1.b.	**Medicaid Outreach**
CODE 2.a.	**Facilitating Application for Non-Medicaid Programs**
CODE 2.b.	**Facilitating Medicaid Eligibility Determination**
CODE 3.	**School Related and Educational Activities**
CODE 4.a	**Direct Medical Services – Not Covered as IDEA/IEP Services**
CODE 4.b.	**Direct Medical Services – Covered as IDEA/IEP Services**
CODE 5.a.	**Transportation for Non-Medicaid Services**
CODE 5.b.	**Transportation-Related Activities in Support of Medicaid Covered Services**
CODE 6.a.	**Non-Medicaid Translation**
CODE 6.b.	**Translation Related to Medicaid Services**
CODE 7.a.	**Program Planning, Policy Development, and Interagency Coordination Related to Non-Medical Services**
CODE 7.b.	**Program Planning, Policy Development and Interagency Coordination Related to Medical/Medicaid Services**
CODE 8.a.	**Non-Medical/Medicaid Training**
CODE 8.b.	**Medical/Medicaid Related Training**
CODE 9.a.	**Referral, Coordination, and Monitoring of Non-Medicaid Services**

CODE 9.b. Referral, Coordination, and Monitoring of Medicaid Services
CODE 10. General Administration
CODE 11. Not Scheduled to Work

Definition of LEA Job Activities

Detailed definitions of each of the categories of job activities used in the MAC program are contained later in this document. This information should be made available to staff involved with the time study process. Medicaid does not pay for administrative expenditures related to, or in support of, services that are not included in West Virginia's State Medicaid plan or services which are not reimbursed under Medicaid. However, EPSDT services must be offered to a child whether or not West Virginia has included such services in its State Medicaid plan. Administrative expenditures related to, or in support of EPSDT are reimbursable under Medicaid.

MAC Interface with the School Based Health Services (SBHS) Fee-For-Service (FFS) Program

The Fee for Service (FFS) program provides reimbursement only for Medicaid eligible students with direct medical services referenced in their Individualized Education Programs (IEPs). MAC activities and reimbursement are not limited to IEP students or services. Student Medicaid eligibility status is not captured during the time study process. If an LEA is enrolled as an FFS provider and is billing Medicaid for covered services, the same services will not be reimbursed under the MAC program.

The program and time study have been designed to capture data for both the MAC and FFS programs. The activity codes utilized in the time study have been designed to ensure that there is no duplication of reimbursement between the two programs.

Allocable Share of Costs

Since many school-based medical activities are provided to both Medicaid and non-Medicaid eligible students, the time applicable to these activities must be allocated to both groups. Once time is allocated to the appropriate activity codes, costs are then associated with those codes and some of the costs must be discounted by the Medicaid percentage. Discounting involves the determination of a proportional share of Medicaid students to the total students and the total costs applicable to a specific activity in a particular school or LEA. Development of the proportional Medicaid share (also referred to as the Medicaid percentage) should relate to the Medicaid eligibility rate in the LEA submitting the claim. Claims will be developed on an LEA-wide basis based upon a statewide pool of staff that is sampled. Through the use of time studies which contain specific activity codes, the cost of school personnel is distributed to certain activities (time study codes) to determine the administrative cost allocable to the Medicaid program. The IEP Ratio will be utilized to allocate the proportional Medicaid share for the Cost Settlement of the FFS program annually. The Medicaid Eligibility Rate (MER) applies to the MAC program.

Unallowable Activities

This refers to an activity which is unallowable as administration under the Medicaid program, regardless of whether or not the population served includes Medicaid eligible individuals.

Application of Medicaid Share

Total Medicaid refers to an activity which is 100 percent allowable as administration under the Medicaid program.

Proportional Medicaid refers to an activity which is allowable as administration under the Medicaid program but for which the allocable share of costs must be determined by the application of the proportional Medicaid share (the Medicaid percentage). The Medicaid share is determined as the ratio of Medicaid eligible students to total students and is referred to as the Medicaid Eligibility Rate (MER). The IEP ratio is defined as the ratio of Medicaid Eligible Special Education Students with an FFS billable service on the IEP to total Special Education Students with an FFS billable service on the IEP.

Reallocated Activities refers to those general administrative activities performed by time study participants which must be reallocated across the other claimable and non-claimable activity codes on a pro rata basis. These reallocated activities are reported under Code 10, General Administration.

IV. Time Study Participants

Vision

The West Virginia Department of Health and Human Resources, Bureau for Medical Services (DHHR/BMS) and individual Local Education Agencies (LEAs) are committed to providing an efficient and effective School Based Health Services Program that complies with all applicable federal rules. To that end, BMS will implement a Random Moment Time Study (RMTS) methodology to support Medicaid reimbursement for Medicaid covered services delivered by schools and LEAs.

Introduction

The State of West Virginia established the School Based Health Services program to establish reimbursement for the provision of Medicaid-covered health services to Medicaid-eligible children in West Virginia public schools.

DHHR/BMS and LEAs are partnering to ensure that the reimbursement program operates according to the specifications and approval of the Centers for Medicare and Medicaid Services (CMS), U.S. DHHS. As part of that process, LEAs must participate in the Random Moment Time Study.

Required Personnel

Each LEA must designate an employee as the LEA RMTS coordinator or MAC program contact. This single individual is designated within the LEA to provide oversight for the implementation of the time study and to ensure that policy decisions are implemented appropriately. The LEA must also designate an Assistant LEA coordinator to provide back-up support for time study responsibilities.

Random Moment Time Study Methodology

West Virginia conducts a statewide time study on a quarterly basis for those LEAs that are participating in the MAC and FFS programs. The purposes of the time study are to identify the proportion of administrative time allowable and reimbursable under the MAC program and to identify the proportion of direct service time allowable and reimbursable under Medicaid to be used for FFS cost reporting. This time study will enable the State of West Virginia to conduct a cost settlement at the end of the state fiscal year for the FFS program.

In most LEAs, it is uncommon to find staff whose activities are limited to just one or two specific functions. Staff members normally perform a number of activities, some of which are related to the direct covered services and some of which are not. Sorting out the portion of worker activity that is related to these direct covered services and to all other functions requires an allocation methodology that is objective and empirical (i.e., based on documented data). Staff time has been accepted as the basis for allocating staff cost. The federal government has developed an established tradition of using time studies as an acceptable basis for cost allocation.

A time study reflects how workers' time is distributed across a range of activities. A time study is not designed to show how much of a certain activity a worker performs; rather, it reflects how time is allocated among different activities. As stated previously, the state will utilize a CMS approved Random Moment Time Study (RMTS) methodology and all LEAs who participate in both the MAC and FFS programs will be required to participate in the RMTS methodology.

The RMTS method polls participants on an individual basis at random time intervals over a given time period and totals the results to determine work effort for the entire population of eligible staff over that same time period. The RMTS method provides a statistically valid means of determining what portion of the selected group of participants' workload is spent performing activities that are reimbursable by Medicaid.

Time Study Start and End Dates

Each calendar quarter, the dates that LEAs will be in session and for which their staff members are compensated will be determined. LEA staff members are paid to work during those dates that LEAs are in session: as an example, LEAs may end the school year sometime in May each year. All days including and through the end of the school year would be included in the potential days to be chosen for the time

study. Each quarter, LEA calendars will be reviewed to determine those dates that the schools pay for their staff to work, and those dates will be included in the sample. Since school calendars change on an annual basis, the school calendars will be evaluated on an annual basis and the sample dates will be determined and documented. Calendars will be collected from each participating school district each year and utilized to determine the sample period. The dates for the sample period will be documented in the RMTS system and the state's RMTS contractor will be responsible for maintaining all backup to support the sample period.

Sampling Requirements (RMTS)

In order to achieve statistical validity, maintain program efficiencies and reduce unnecessary LEA administrative burden a consistent sampling methodology for all activity codes and groups will be used. The RMTS sampling methodology is constructed to achieve a level of precision of +/-2% (two percent) with a 95% (ninety-five percent) confidence level for activities.

Statistical calculations show that a minimum sample of 2401 completed moments each quarter, per cost pool, is adequate to obtain this precision when the total pool of moments is greater than 3,839,197. Additional moments are selected each quarter to account for any invalid moments. Invalid moments are moments not returned or inaccurately coded.

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

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

WHERE:

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

CORRECTION FOR FINITE POPULATION

N = population

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

The State will sample additional moments as needed to meet compliance. All returned and coded moments will be used in the calculation of the time study percentages.

N=	Sample Size Required	Sample Size plus the Minimum 15% Oversample
100,000	2,345	2,697
200,000	2,373	2,729
300,000	2,382	2,740
400,000	2,387	2,746
500,000	2,390	2,749
750,000	2,394	2,754
1,000,000	2,396	2,756
3,000,000	2,400	2,760
>3,839,197	2,401	2,762

RMTS Process & Notification

The RMTS process is described here as four steps:

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

Identify Total Pool of Time Study Participants

At the beginning of each quarter, participating LEAs submit a staff roster (Participant List) providing a comprehensive list of staff eligible to participate in the statewide RMTS time study. This 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 the four mutually exclusive cost pools for the statewide time study. The staff roster is only updated on a quarterly basis.

Identify Total Pool of Time Study Moments

The total pool of "moments" within the time study is represented by calculating the number of working days in the sample period, times the number of work hours of each day, times the number of minutes per hour, and times the number of participants within the time study. The total pool of moments for the quarter is reduced by the exclusion of weekends, holidays and hours during which employees are not scheduled to work. Additional information regarding the total pool can be found on page 10 under "Time Study Start and End Dates."

Randomly Select Moments and Randomly Match Each Moment to a Participant

Once compiled, each cost pool is sampled to identify participants in the RMTS time study. The sample is selected from each cost pool, along with the total number of eligible time study moments for the quarter.

Using a statistically valid random sampling technique, the desired number of random moments is selected from the total pool of moments. Next, each randomly selected moment is matched up, using a statistically valid random sampling technique, with an individual from the total pool of participants.

Each time the selection of a minute 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 minute 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.

The sampling period is defined as the three-month period comprising each quarter of the Calendar Year calendar. The following are the quarters followed for the MAC program:

- Quarter 1 = October 1 – December 31 (WVSFY Quarter 2)
- Quarter 2 = January 1 – March 31 (WV SFY Quarter 3)
- Quarter 3 = April 1 – June 30 (WV SFY Quarter 4)
- Quarter 4 = July 1 – September 30 (WV SFY Quarter 1)

The sampling periods are designed to be in accordance with the May 2003 Medicaid School-Based Administrative Claiming Guide, on page 42, Example 4, specifically:

"If the school year ends in the middle of a calendar quarter (for example, sometime in June), the last time study for the school year should include all days through the end of the school year. Therefore, if the school year ends June 25th, then all days through and including June 25th must be included among the potential days to be chosen for the time study."

Each quarter, dates that LEAs will be in session and for which their staff members are compensated will be identified. LEA staff members are paid to work during those dates that LEAs are in session; as an example, LEAs may end the school year sometime in May each year. All days including and through the end of the school year would be included in the potential days to be chosen for the time study. It is important to understand that although LEAs may end the school year prior to the close of the quarter, staff members may receive pay for services provided during the school year through the end of the federal fiscal quarter. LEAs typically spread staff compensation over the entire calendar year versus compensating staff members only during the months when school is in session.

The majority of LEA staff work during a traditional school year. Since the time study results captured during a traditional time study are reflective of any other activities that would be performed during the

summer quarter, a summer quarter time study will not be conducted. West Virginia will use an average of the three (3) subsequent quarter's time study results to calculate a claim for the July-September period. The three subsequent quarters utilized for the average for the July – September quarter would be the subsequent October – December, January – March and April –June quarters. This is in accordance with the May 2003 Medicaid School-Based Administrative Claiming Guide, page 42. Specifically:

"…the results of the time studies performed during the regular school year would be applied to allocate the associated salary costs paid during the summer. In general, this is acceptable if administrative activities are not actually performed during the summer break, but salaries (reflecting activities performed during the regular school year) are prorated over the year and paid during the summer break."

State of Emergency Exception

In the event that there is a "state of emergency" or other disaster declared in the State of West Virginia that results in prolonged school closures that impact the statistical validity of the RMTS as defined the Sampling Requirements (RMTS) section of this methodology under sampling precision and confidence level, DHHR/BMS will apply the summer quarter claiming methodology to statistically invalid quarters occurring during the "state of emergency" including the quarter in which the state of emergency is declared and the quarter in which the state of emergency period ends. This means no RMTS will be run during the impacted quarter(s) and claiming will be based on the average of the quarters that were completed. West Virginia will notify CMS within 15 days of determining that a quarter is statistically invalid, including the reason for the determination, along with details and dates of the declaration of emergency.

Notify Participants about their Selected Moments

Email is the standard method by which time study participants are notified of their requirement to participate in the time study and of their sampled moment. Sampled participants will be notified of their sampled moment no more than twenty four (24) hours prior to the sampled moment. At the prescribed moment, each sampled participant is asked to record and submit his/her activity for that particular moment. Additionally, if the moment is not completed the participant receives a late notification email at the twenty-four (24) and seventy-two (72) hour marks (as necessary) after their selected moments. Throughout this entire process, the LEA coordinators have real-time access in the online system to view their sampled staff, the dates/times of their sampled staff's moments, and whether or not the moment has been completed. The time study questionnaire or survey forms are not kept open more than three (3) business days after the end of the time study period to ensure the accuracy of the time. As explained later in this document, if the return rate of valid moments is less than 85%, non-returned moments will be included and coded as non-allowable codes/non-Medicaid time until the 85% threshold is reached.

The RMTS administrator will run compliance reports on a weekly basis and send the results to the LEAs. The LEAs also have the ability to run compliance reports on a daily basis. A validity check of the time study results is completed each quarter prior to the calculation of the claim. The validity check ensures that the minimum number of responses is received each quarter to meet the required confidence level. The

number of completed and returned time study moments is analyzed to confirm that the confidence level requirements have been met. Once the validity of the sample has been confirmed, the time study results are calculated and prepared for the calculation of the quarterly claim.

West Virginia has chosen to utilize a centralized coding methodology to be implemented by the contractor assisting West Virginia with the MAC and FFS programs. Under that methodology, the sampled staff member is not required or expected to code his or her moment. The sampled staff member is asked to document their activity by providing specific examples. At the end of the documentation, the sampled staff member is asked to certify their documentation.

The contractor will code all moments submitted and will randomly select a 5% sample of the coded responses which will be submitted to the State each quarter for validation. Once the coding is complete, all coded moments will be extracted from the system. Each moment will be assigned a random number using the random function found in Microsoft Excel. The moments will be sorted for lowest to highest by the random moments assigned. The first 5% of the moments will be deemed sampled and sent to the State for their review. The validation will consist of reviewing of the participant responses and the corresponding code assigned by the contractor to determine if the code was accurate. WVDE has a representative who will separately review the randomly selected 5% subsample of responses and coding and identify any disagreements with the coding staff. After that discussion on coding, coding instructions would be modified to document those coding decisions so that they can be consistently applied in future quarters.

At the end of each quarter, once all random moment data has been received and time study results have been calculated, statistical compliance reports will be generated to serve as documentation that the sample results have met the necessary statistical requirements.

Time Study Participants

All LEAs that participate in the statewide time study will identify allowable Medicaid direct service and administrative costs within a given LEA by having staff members who spend their time performing those activities participate in a quarterly time study. These LEAs must certify that any staff providing services or participating in the time study meet the educational, experiential and regulatory requirements. Participating LEAs must update their staff lists each quarter prior to the generation of the time study sample for that period. Only staff that meets the licensure requirements to bill the Medicaid Fee-for-Service program can be included in the Direct Service, Targeted Case Management or Personal Care provider cost pools. The update to the staff list must be completed prior to the start of the quarter. LEAs cannot make additions to their staff pool list once the time study sample has been generated for that period.

The following categories of staff have been identified as appropriate participants for the West Virginia time studies. Additions to the list may be dependent upon job duties. The decision and approval to include additional provider types requires an amendment to the existing state plan, which would be submitted to CMS by BMS.

This does not include individuals such as parents or other volunteers who receive no compensation for their work; this would include in-kind "compensation". For purposes of this implementation plan, individuals receiving compensation from LEAs for their services are termed "LEA staff". Beginning with the October 2014 quarter, West Virginia will begin using the statewide time study and its four cost pool methodology. All staff will be reported into one of four cost pools: 1) Direct Service, 2) Targeted Case Management, 3) Personal Care, and 4) Administrative Services. The **four cost pools are mutually exclusive, i.e., no staff should be included in more than one cost pool.** The Direct Service cost pool is comprised of direct service staff, including those who conduct FFS activities, and the respective costs for these staff. These costs include staff time spent on billing activities related to direct services. The Targeted Case Management

cost pool is comprised of staff who provide Targeted Case Management services. The Personal Care cost pool is comprised of individuals who provide personal care services to students. The Administrative Services cost pool is comprised of administrative claiming staff and the respective costs for these staff. The following provides an overview of the eligible categories of staff in each cost pool. The individuals listed in the Direct Service, Targeted Case Management, and Personal Care Providers cost pools must meet the provider credential and license requirements necessary to provide FFS care as defined in Section 3.1A of the approved State Plan Amendment.

Cost Pool 1 (Direct Service Providers)

These providers may perform FFS and administrative claiming activities. Only those provider types included in the approved state plan will be included in the cost pool and time study.

- Licensed Audiologist
- Audiologist Assistant
- Licensed Registered Nurse (RN)
- Licensed Occupational Therapist
- Licensed Occupational Therapy Assistant
- Licensed Physical Therapist
- Licensed Physical Therapy Assistant
- Certified Speech Language Pathologist
- Certified Speech Language Pathologist Assistant
- Licensed and State Certified Psychologist
- Licensed School Psychologist
- Licensed Psychologist Independent Practitioner

Cost Pool 2 (Targeted Case Management Providers)

These providers may perform FFS and administrative claiming activities.

- Special Education Teacher
- Targeted Case Management Specialist
- Special Needs Care Coordinator

Cost Pool 3 (Personal Care Providers)

These providers may perform FFS and administrative claiming activities.

- Personal Care Aide
- Class Room Aide
- Interpreter

Cost Pool 4 (Administrative Service Providers)

These providers may perform administrative claiming activities only.

- School Administrators – Principals and Assistant Principals.
- State Certified Counselor
- Non-certified Psychologist/Psychologist Interns
- Non-certified Social Worker
- Psychologist Intern
- Special Education Administrator
- School Bilingual Assistant
- Speech Language Pathologist (Non-Masters Level and Non-Licensed)
- Program Specialist
- Other groups/individuals that may be identified by the LEA

The Targeted Case Management provider is required to meet state or national licensure, registration, or certification requirements of the profession in which they practice and must act within the profession's scope of practice. Additionally, only those Targeted Case Management providers who bill Targeted Case Management throughout the school year will be included on the cost reporting forms to ensure the appropriate cost allocation for reimbursement purposes. No providers included in the Direct Service, Administrative Services or Personal Care cost pools are included in the Targeted Case Management Cost Pool. There will be no duplication of staff in the four cost pools.

A practitioner that meets the qualifications established by the State's licensure act for educators may also provide Targeted Case Management services.

Staff members with job titles in cost pools 1, 2, 3 or 4 are not automatically included in the time study. An LEA must determine whether they meet all requirements above and if they are less than 100% federally funded. Individuals that are 100% federally funded will be excluded from the time study. Staff members that are partially federally funded may be included in the time study; however, any costs that are included in the cost pool must be net of all federal sources. All criteria must be met in order to be included in the time study.

Only providers of services included in the approved State plan can be included in the cost pool for the time study. Support staff, such as administrative assistants or secretaries that have a direct reporting relationship to someone listed on the staff pool list (which can be demonstrated through an organization chart or job description) can also have their costs included in the calculation of the claim but will not participate in the time study.

Part of the BMS review process is to ensure that all of the staff that will be submitted are included in the sample. The LEAs will send in a roster of participants. All of those staff members are loaded into the appropriate cost pool. The entire list of staff from all participating LEAs in a particular cost pool is included in the sample. At the end of the quarter, a financial schedule is sent to the LEAs to report allowable costs for staff. The list sent to the LEAs will only include the staff/positions reported at the beginning of the process. LEAs are instructed that they can only claim staff for participants that were sent in the roster process and thus included in the sample. The list of submitted staff will be compared against the list used in the sample. This list should be a match since all staff members submitted by the LEAs are included in the sample.

V. Training Types & Overview

LEA Coordinator Training (RMTS)

BMS will review and approve all RMTS training material used by the BMS contractor. Once the training material has been approved by BMS, the LEA contractor will provide initial training for the LEA coordinators, which will include an overview of the RMTS software system and information on how to access and input information into the RMTS system. It is essential for the LEA coordinators to understand the purpose of the time studies, the appropriate completion of the RMTS, the timeframes and deadlines for participation, and that their role is crucial to the success of the program. Participants are to be provided detailed information and instructions for completing and submitting the time study documentation of the sampled moment. All training materials will be accessible to LEA coordinators. In addition, annual training will be provided to the LEA coordinators to cover topics such as MAC program updates, process modifications and compliance issues.

Central Coding Staff Training (Activity Coding)

Central Coders are employed by the contractor and will review the documentation of participant activities performed during the selected moments and determine the appropriate activity code. In a situation when insufficient information is provided to determine the appropriate activity code, the central coder may contact the individual LEA and request submission of additional information about the moment. Once the information is received the moment will be coded and included in the final time study percentage calculation. All moments will be coded separately by at least two coders as part of a quality assurance process. In the event there is a disagreement in coding, a quality assurance coder will review the information and determine the appropriate activity code. The protocol is part of the validation performed by the contractor. Once the final moment is selected and coded in the system, that moment, along with all other coded moments will be part of the pool from which the random sample of 5% of moments is chosen for the State to review. The contractor will provide additional training to the coders as needed to resolve any coding issues. The moments and the assigned codes will be reviewed for consistency and adherence to the state approved activity codes.

Sampled Staff Training

The primary purpose of staff training was to educate the sampled staff member on the activity codes so he or she could accurately determine the appropriate activity code for the activity they were performing at the sampled moment. Since West Virginia has implemented a centralized coding methodology, the training around the activity codes is no longer required since the sampled staff member will not have to code their moment. RMTS participants will not have access to the activity codes related to their moment.

All new employees who will be included in a quarter of the RMTS for the first time must take a training on the RMTS prior to participating. Participants should continue to review this training on an annual basis. The RMTS documentation system includes training information on the program and the staff member's

role in the program as well as how to complete the moment. The sampled staff member must visit these screens prior to being able to document their moment. For these reasons, training of sampled staff members on the activity codes will no longer be a required element for completion of their moment. The system will have training information that walks the sampled staff member through an overview of the program, their role, provide examples of responses and the required response elements. All sampled staff will be required to review the training information in the system prior to the completion of the sampled moment. If a participant is sampled for another moment later in the quarter, or in a future quarter, the participant must complete the training in the system before they can complete their moment. The training will be prompted when they log into the RMTS system. Annual refresher training will be made available to coordinators and any RMTS participants.

Documentation (RMTS)

All documentation of sampled moments must be sufficient to provide answers to the time study questions needed for accurate coding:

- Who was with you? (The sampled staff member must create a narrative to answer this question.)
- What were you doing? (The sampled staff member must create a narrative to answer this question.)
- Why were you performing this activity? (The sampled staff member must create a narrative to answer this question.)
- Is this activity regarding a Special Education student? (Radio buttons with the option of "Yes" and "No")
- Is the service you provided part of the child's IEP? (Radio buttons with the options of "Yes" and "No" and NA)

In addition, sampled staff will certify the accuracy of their response prior to submission—sampled staff members are assigned a unique user name and password that is only sent to them. They must use this unique user name and password to login and document their moment. After answering the documentation questions, they are shown their responses and asked to certify that the information they are submitting is accurate. Their moment is not complete unless they certify the accuracy of the information. Since the sample staff member only has access to their individual information, this conforms to electronic signature policy and allows them to verify that their information is accurate.

Each time study participant must certify the accuracy of his/her response prior to submission.

Additional documentation maintained by the contractor includes:

- Sampling and selection methods used,
- Identification of the moment being sampled, and
- Timeliness of the submitted time study moment documentation.

Time Study Return Compliance

DHHR/BMS will require an 85% response rate. Moments not returned or not accurately completed and subsequently resubmitted by the LEA will not be included in the database unless the return rate for valid moments is less than 85%. If the return rate of valid moments is less than 85% then non-returned moments will be included and coded as a non-allowable/non-Medicaid time until the 85% threshold is reached. The time study questionnaire or survey forms will be kept open no longer than three (3) business days after the end of the time study period to ensure the accuracy of the time. To ensure that enough moments are received to have a statistically valid sample, West Virginia will over sample at a minimum of fifteen percent (15 %) more moments than needed for a valid sample size. To ensure that LEAs are properly returning sample moments, the LEA's return percentage for each quarter will be analyzed.

In order to ensure time study compliance, DHHR/BMS has developed the following protocol for handling non-responses.

- If the statewide compliance rate for a quarter does not reach at least 85%, BMS will send out a non-compliance warning letter to each LEA that did not achieve an 85% compliance rate and had greater than ten (10) moments for the quarter.

- LEAs that are issued a warning letter would need to submit a corrective action plan to DHHR/BMS within 30 days of receiving the warning letter. This corrective action plan would detail the LEA's intended methodology for increasing its response rate. If the LEA has a non-response rate greater than 15% for two consecutive time study periods, the state would implement consequential action such as fiscal penalties to incentivize the district to either increase their response rate or stop participating in the MAC/SBHS benefit.

- For LEAs that are issued a warning letter, BMS will monitor the next consecutive quarter to ensure compliance is achieved. If this level of compliance is not achieved, DHHR/BMS will implement the following sanctions:

    - LEAs who have had one or more cost pools with two consecutive quarters of non-compliance will have these non-compliant cost pools removed from the RMTS starting with the next quarter and continuing for the remaining quarters of the fiscal year (July to June).
    - LEAs will be unable to claim direct service costs on the Annual Cost Report for staff listed on the staff pool list of the non-compliant cost pool during the quarters in which the cost pool was removed from the RMTS.

- LEAs will not be able to claim for MAC for any non-compliant cost pools during the quarters in which these cost pools were removed from the RMTS.
- LEAs will not be able to claim for MAC for any non-compliant cost pools during the first quarter (July- Sept) of the fiscal year.

- Any LEA subjected to such penalties will be afforded due process for Medicaid providers as covered under West Virginia state statutes.

- DHHR/BMS will gather as much information as possible from the SBHS Program RMTS Coordinators or participants to explain the reasons the non-returned moments were unanswered. The state will then analyze this data to ensure that the non-returns are reflective of the time study results. This data will not be included in the claiming process but will be used only to ensure that districts are not purposely withholding non-Medicaid related moments.

Time Study Activities/Codes

The time study codes are assigned indicators that determine their allowability, federal financial participation (FFP) rate, and Medicaid share. A code may have one or more indicators associated with it. These indicators should not be provided to time study participants.

The time study code indicators are:

Application of FFP rate	50 percent	Refers to an activity that is allowable as administration under the Medicaid program and claimable at the 50 percent non-enhanced FFP rate.
	75 percent	Refers to an activity that is allowable as administration under the Medicaid program and claimable at the 75 percent enhanced FFP rate.
Allowability & Application of Medicaid Share	U	Unallowable – refers to an activity that is unallowable as administration under the Medicaid program. This is regardless of whether or not the population served includes Medicaid eligible individuals.
	TM	Total Medicaid – refers to an activity that is 100 percent allowable as administration under the Medicaid program.

	PM	Proportional Medicaid – refers to an activity, which is allowable as Medicaid administration under the Medicaid program, but for which the allocable share of costs must be determined by the application of the proportional Medicaid share (using the Medicaid eligibility rate or the IEP ratio). For the MAC Program, the Medicaid share is determined as the ratio of Medicaid eligible students to total students. For the FFS Cost Settlement process, the Medicaid share is defined as the ratio of Medicaid Eligible Special Education Students with a SEMI billable service on the IEP to the total Special Education Students with a SEMI billable service on the IEP. The Proportional Medicaid share will be determined for each LEA.
	R	Reallocated – refers to those general administrative activities which must be reallocated across the other activity codes on a pro rata basis. These reallocated activities are reported under Code 10, General Administration.

VI. Time Study Activities

After RMTS participants log their moment, it is the Central Coder's responsibility to categorize the response. The coding structure below will determine whether the activities logged are claimable, non-claimable or an allocated expense.

All time study results will be aggregated statewide and applied equally to all providers participating in the SBHS Program.

The table below summarizes the codes, the activities associated with that code and the claimable status of the code.

THE FOLLOWING TIME STUDY CODES ARE TO BE USED FOR THE RANDOM MOMENT TIME STUDY:

Code	Activity	MAC Indicator(s)
1.a	Non-Medicaid Outreach	U
1.b	Medicaid Outreach	TM/50%

2.a	Facilitating Non-Medicaid Eligibility	U
2.b	Facilitating Medicaid Eligibility Determination	TM/50%
3	School Related & Educational Activities	U
4.a	Direct Medical Services – Not Covered as IDEA/IEP Service	U
4.b	Direct Medical Services – Covered as IDEA/IEP Service	IEP Ratio
5.a	Transportation Non-Medicaid	U
5.b	Medicaid Transportation	PM/50%
6.a	Non-Medicaid Translation	U
6.b	Medicaid Translation	PM/75%
7.a	Program Planning, Development and Interagency Coordination Non-Medical	U
7.b	Program Planning, Development and Interagency Coordination Medical	PM/50%
8.a	Non-Medical/Non-Medicaid related Training	U
8.b	Medical/Medicaid related Training	PM/50%
9.a	Referral, Coordination, and Monitoring Non-Medicaid Services	U
9.b	Referral, Coordination, and Monitoring of Medicaid Services	PM/50%
10	General Administration	R
11	Not Paid/Not Worked	U

These activity codes represent administrative and direct service activity categories that are used to code all categories of claims. For all activity codes and examples, if an activity is provided as part of, or an extension of, a direct medical service, it may not be claimed as Medicaid Administration

Note: Code 4b above pertains to the FFS program and utilizes the IEP ratio. This information will be used for the FFS Cost Settlement process per SPA 12-006.

When staff members perform duties related to the administration of West Virginia's Medicaid program, federal funds may be drawn as reimbursement for the federal share of the costs of providing these administrative services. To identify the cost of providing these services, a time study must be conducted among relevant staff. The time study identifies the time and subsequent costs spent on Medicaid administrative activities that are allowable and reimbursable under the Medicaid program. Only staff included in the sample will be eligible to have costs reported during the financial collection process.

Code 1.a. - Non-Medicaid Outreach –U

This code should be used by the central coder if the time study participant indicates he/she was performing activities that inform individuals about non-Medicaid social, vocational and educational programs (including special education) and how to access them; and that describe the range of benefits covered under these non-Medicaid social, vocational and educational programs and how to obtain them. Both written and oral methods may be used. Include related paperwork, clerical activities or staff travel required to perform these activities**:**

1. Informing families about wellness programs and how to access these programs.
2. Scheduling and promoting activities that educate individuals about the benefits of healthy life-

styles and practices.

3. Conducting general health education programs or campaigns that address life-style changes in the general population (e.g., dental prevention, anti-smoking, alcohol reduction, etc.).
4. Conducting outreach campaigns that encourage persons to access social, educational, legal or other services not covered by Medicaid.
5. Assisting in early identification of children with special medical/dental/mental health needs through various child find activities.
6. Outreach activities in support of programs that are 100 percent funded by state general revenue.
7. Developing outreach materials such as brochures or handbooks for these programs.
8. Distributing outreach materials regarding the benefits and availability of these programs.

Code 1.b. - Medicaid Outreach– TM/50 percent FFP

This code should be used by the central coder the time study participant indicates he/she was when performing activities that inform eligible or potentially eligible individuals about Medicaid and how to access it. Activities include bringing potential eligible individuals into the Medicaid system for the purpose of determining eligibility and arranging for the provision of Medicaid services. LEAs may only conduct outreach for the populations served by their affiliated schools, i.e., students and their parents or guardians. Examples include:

1. Informing Medicaid eligible and potential Medicaid eligible children and families about the benefits and availability of services provided by Medicaid (including preventive treatment, and screening) including services provided through the EPSDT program.
2. Developing and/or compiling materials to inform individuals about the Medicaid program (including EPSDT) and how and where to obtain those benefits. Note: This activity should not be used when Medicaid-related materials are already available to the schools (such as through the Medicaid agency). As appropriate, school-developed outreach materials should have prior approval of the Medicaid agency.
3. Distributing literature about the benefits, eligibility requirements, and availability of the Medicaid program, including EPSDT.
4. Assisting the Medicaid agency to fulfill the outreach objectives of the Medicaid program by informing individuals, students and their families about health resources available through the Medicaid program.
5. Providing information about Medicaid EPSDT screening (e.g., dental, vision) in schools that will help identify medical conditions that can be corrected or improved by services offered through the Medicaid program.
6. Contacting pregnant and parenting teenagers about the availability of Medicaid prenatal and well baby care programs and services.
7. Providing information regarding Medicaid managed care programs and health plans to individuals and families and how to access that system.
8. Encouraging families to access medical/dental/mental health services provided by the Medicaid program.

Activities which are not considered Medicaid outreach under any circumstances are: (1) general preventive health education programs or campaigns addressing lifestyle changes, and (2) outreach campaigns directed toward encouraging persons to access social, educational, legal or other services not covered by Medicaid.

Code 2.a. - Facilitating Application for Non-Medicaid Programs – U

This code should be used by the central coder the time study participant indicates he/she was informing an individual or family about programs such as Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), Women, Infants, and Children (WIC), day care, legal aid and other social or educational programs and referring them to the appropriate agency to complete an application. The following are examples:

1. Explaining the eligibility process for non-Medicaid programs, including IDEA.
2. Assisting the individual or family in collecting/gathering information and documents for the non-Medicaid program application.
3. Assisting the individual or family in completing the application, including necessary translation activities.
4. Developing and verifying initial and continuing eligibility for the Free and Reduced Lunch Program.
5. Developing and verifying initial and continuing eligibility for non-Medicaid programs.
6. Providing necessary forms and packaging all forms in preparation for the non-Medicaid eligibility determination.

Code 2.b. - Facilitating Medicaid Eligibility Determination-TM/50 percent FFP

This code should be used by the central coder the time study participant indicates he/she was assisting an individual in becoming eligible for Medicaid. Include related paperwork, clerical activities or staff travel required to perform these activities. This activity does not include the actual determination of Medicaid eligibility. Examples include:

1. Verifying an individual's current Medicaid eligibility status for purposes of the Medicaid eligibility process.
2. Explaining Medicaid eligibility rules and the Medicaid eligibility process to prospective applicants.
3. Assisting individuals or families to complete a Medicaid eligibility application.
4. Gathering information related to the application and eligibility determination for an individual, including resource information and third party liability (TPL) information, as a prelude to submitting a formal Medicaid application.
5. Providing necessary forms and packaging all forms in preparation for the Medicaid eligibility determination.
6. Referring an individual or family to the local Assistance Office to apply for Medicaid benefits.
7. Assisting the individual or family in collecting/gathering required information and documents for the Medicaid application.
8. Participating as a Medicaid eligibility outreach outstation, not including determining eligibility.

Code 3. - School Related and Educational Activities – U

This code should be used by the central coder for any other school related activities that are not health related, such as social services, educational services and teaching services; employment and job training. These activities include the development, coordination and monitoring of a student's education plan. Include related paperwork, clerical activities or staff travel required to perform these activities. Examples include:

1. Providing classroom instruction (including lesson planning).
2. Testing, correcting papers.
3. Developing, coordinating, and monitoring the academic portion of the Individualized Education Program (IEP) for a student, which includes ensuring annual reviews of the IEP are conducted, parental sign-offs are obtained, and the academic portion of the actual IEP meetings with the parents. (If appropriate, this would also refer to the same activities performed in support of an Individualized Family Service Plan (IFSP).)
4. Compiling attendance reports.
5. Performing activities that are specific to instructional, curriculum, and student-focused areas.
6. Reviewing the education record for students who are new to the school district.
7. Providing general supervision of students (e.g., playground, lunchroom).
8. Monitoring student academic achievement.
9. Providing individualized instruction (e.g., math concepts) to a special education student.
10. Conducting external relations related to school educational issues/matters.
11. Compiling report cards.
12. Carrying out discipline.
13. Performing clerical activities specific to instructional or curriculum areas.
14. Activities related to the educational aspects of meeting immunization requirements for school attendance.
15. Compiling, preparing, and reviewing reports on textbooks or attendance.
16. Enrolling new students or obtaining registration information.
17. Conferring with students or parents about discipline, academic matters or other school related issues.
18. Evaluating curriculum and instructional services, policies, and procedures.
19. Participating in or presenting training related to curriculum or instruction (e.g., language arts workshop, computer instruction).
20. Translating an academic test for a student.

CODE 4.a. - Direct Medical Services – Not Covered as IDEA/IEP Service (FFS – Non IEP) - U

This code should be used by the central coder the time study participant indicates he/she was are providing direct client care services that are not IDEA and/or not IEP services. This code includes the provision of all non-IDEA/IEP medical services reimbursed through Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. This code includes pre and post activities associated with the actual delivery

of the direct client care services, e.g., paperwork or staff travel required to perform these services.

Examples of activities reported under this code include all non-IDEA and/or non-IEP direct client care services as follows:

1. Providing health/mental health services.
2. Conducting medical/health assessments/evaluations and diagnostic testing and preparing related reports.
3. Performing developmental assessments.
4. Performing routine or mandated child health screens including but not limited to vision, hearing, dental, scoliosis, and EPSDT screens.
5. Administering first aid or prescribed injection or medication to a student.
6. Providing counseling services to treat health, mental health, or substance abuse conditions.
7. Making referrals for and/or coordinating medical or physical examinations and necessary medical evaluations as a result of a direct medical service.
8. Immunizations and performance of routine or education agency mandated child health screens to the student enrollment, such as vision, hearing and scoliosis screens.
9. Nursing services and evaluations including skilled nursing services and time spent administering/monitoring medication when the service is not included on the student's IEP. For example, medication for a short-term illness or recent injury would not normally be included in an IEP. Time spent administering/monitoring medication that is not included as part of the IEP and not documented in the IEP such as administration/monitoring of maintenance drugs (example 1: insulin for a diabetic if the insulin administration/monitoring is not in the IEP; example 2: anti-seizure medication for a child if the anti-seizure medication is not in the IEP) and administration/monitoring of non-routine medications for acute conditions when the administering/monitoring of the medication is not included as part of the IEP and not documented in the IEP, should be included here.

CODE 4.b. - Direct Medical Services – Covered as IDEA/IEP Service (FFS – IEP) – IEP Ratio

This code should be used by the central coder if the time study participant indicates he/she was providing direct client services as covered services delivered by LEAs under the FFS Program. These direct client services may be delivered to an individual and/or group in order to ameliorate a specific condition and are performed in the presence of the student(s). This code includes the provision of all IDEA/IEP medical (i.e. health-related) services.

The list of services corresponds to all of the services outlined in the State Plan. This includes:

1. Audiology services including evaluation and therapy services (only if included in the student's IEP)
2. Occupational Therapy services and evaluations (only if included in the student's IEP)
3. Physical Therapy services and evaluations (only if included in the student's IEP)
4. Psychological services and evaluations (only if included in the student's IEP)
5. Nursing services and evaluations (only if included in the student's IEP), including skilled nursing

services on the IEP and time spent administering/monitoring medication only if it is included as part of an IEP and documented in the IEP. For example, administration of a medication such as Ritalin would only be included as an IEP-Related Service if the student IEP's actually contained a requirement for its provision; administration/monitoring of anti-spasmodic drugs for children with cerebral palsy, such as Baclofen, that is included as part of an IEP and documented in the IEP; insulin for a diabetic if the insulin administration/monitoring is in the IEP.

6. Speech-Language Pathology services and evaluations (only if included in the student's IEP)
7. Personal Care services (only if included in the student's IEP)
8. Targeted Case Management Services
9. Health Needs Assessment and Treatment Planning

It also includes functions performed pre- and post-direct client services (when the student may not be present), for example, paperwork or staff travel directly related to the direct client services. Please note that some of the following activities may be subject to the free care principle.

Examples of activities reported under this code include**:**

All IDEA/IEP direct client services with the Student/Client present including:

1. Providing health/mental health services as covered in the student's IEP.
2. Conducting medical/health assessments/evaluations and diagnostic testing and preparing related reports as covered in the student's IEP.

This code also includes pre and post time directly related to providing direct client care services when the student/client is not present. Examples of pre and post time activities when the student/client is not present include completion of all paperwork related to the specific direct client care service such as preparation of progress notes, translation of session notes, review of evaluation testing/observation, planning activities for the therapy session, travel to/from the therapy session, or completion of billing activities.

General Examples that are considered pre and post time:

1. Pre and post activities associated with physical therapy services, for example, time to build a customized standing frame for a student or time to modify a student's wheelchair desk for improved freedom of movement for the client.
2. Pre and post activities associated with speech language pathology services, for example, preparing lessons for a client to use with an augmentative communicative device or preparing worksheets for use in group therapy sessions.
3. Updating the medical/health-related service goals and objectives of the IEP.
4. Travel to the direct service/therapy.
5. Paperwork associated with the delivery of the direct care service, as long as the student/client is not present. Such paperwork could include the preparation of progress notes, translation of session notes, or completion of billing activities.
6. Interpretation of the evaluation results and/or preparation of written evaluations, when

student/client is not present. (Assessment services are billed for testing time when the student is present, for interpretation time when the student is not present, and for report writing when the student is not present.)

TARGETED CASE MANAGEMENT

For school-based Targeted Case Management claiming in West Virginia, the targeted population includes Medicaid clients who have a disability or are medically at risk and are referred for or receiving services related to an IEP or IFSP.

Targeted Case Management services are a component of the IEP or IFSP. Targeted Case Management identifies and addresses special health problems and needs that affect the student's ability to learn, assist the child to gain and coordinate access to a broad range of medically-necessary services covered under the Medicaid program, and ensures that the student receives effective and timely services appropriate to their needs.

Recipients of Targeted Case Management services are eligible for the entire span of activities described as school health services in the West Virginia Medicaid State Plan. A unit of service must meet the description of a case management activity with or on behalf of the individual, his or her parent(s) or legal guardian.

Targeted Case Management services include the following activities:

1. Comprehensive Needs Assessment and Reassessment

   Reviewing of the individual's current and potential strengths, resources, deficits and identifying the need for medical, social, educational and other services that are related to Medicaid-covered services. If necessary to form a complete assessment of the client, information shall be gathered from other sources, such as family members, medical providers, social workers, and educators. Results of assessments and evaluations are reviewed and a meeting is held with the individual, his or her parent(s) and /or guardian, and the case manager to determine whether services are needed and, if so, to develop a care plan. At a minimum, an annual face-to-face reassessment shall be conducted to determine if the client's needs or preferences have changed.

2. Development and Revision of a Care Plan

   Developing a specific written care plan based on the assessment of individual's strengths and needs. The written care plan shall be a distinct component of the IEP or IFSP and shall identify the health-related activities and assistance needed to accomplish the goals collaboratively developed by the individual, his or her parents(s) or legal guardian, and the case manager. The service plan describes the nature, frequency, and duration of the activities and assistance that meet the individual's medical needs. Service planning may include acquainting the individual, his or her parent(s) or legal guardian with resources in the community and providing information for obtaining services through community programs.

3. Referral and Related Activities

Facilitating the individual's access to the care, services and resources through linkage, coordination, referral, and consultation. This is accomplished through in-person and telephone contacts with the individual, his or her parent(s) or legal guardian, and with service providers and other collaterals on behalf of the individual. This may include facilitating the recipient's physical accessibility to services such as arranging transportation to medical, social, educational and other services that are related to Medicaid-covered services; facilitating communication between the individual, his or her parent(s) or legal guardian and the case manager or other service providers; or, arranging for translation or another mode of communication. It may include advocating for the individual in matters regarding access, appropriateness and proper utilization of services; and evaluating, coordinating and arranging immediate services or treatment needed in situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for the individual.

4. Monitoring and Follow-Up Activities

As necessary, but at least annually, the case manager shall conduct monitoring and follow-up activities with the client or the client's legal representative. Monitoring and follow-up activities are necessary to ensure the care plan is effectively implemented and adequately addresses the needs of the client. The review of the care plan may result in revision or continuation of the plan, or termination of case management services if they are no longer appropriate. Monitoring may involve either face-to-face or telephone contacts with the individual and other involved parties. Results of the monitoring and follow-up activities shall be documented in the written care plan.

5. Case Record Documentation

Case record documentation of the above service components is included as a case management activity. Providers shall maintain case records that document for all individuals receiving Targeted Case Management: the dates of service; the nature, content and units of Targeted Case Management services received; status of goals specified in the care plan; whether client declined services in the care plan; the need for and coordination with other case managers; a timeline for obtaining needed services; and a timeline for reevaluation of the care plan.

SBHS Program Targeted Case Management services do not include:

- Activities related to IDEA functions such as scheduling IFSP team meetings, and providing prior written notice;
- Activities or interventions specifically designed to meet only the student's educational goals;
- Activities for which an individual may be eligible that are integral to the administration of another non-medical program, except for case management that is included in an IEP or IFSP;
- Program activities of the agency itself that do not meet the definition of Targeted Case

Management;

- Administrative activities necessary for the operation of the agency providing case management services other than the overhead costs directly attributable to Targeted Case Management;
- Treatment or instructional services, including academic testing;
- Services that are an integral part of another service already reimbursed by Medicaid; and
- Activities that are an essential part of Medicaid administration, such as outreach, intake processing, eligibility determination or claims processing.

Code 5.a. - Transportation for Non-Medicaid Services – U

This code should be used by the central coder the time study participant indicates he/she was assisting an individual to obtain transportation to services not covered by Medicaid, or accompanying the individual to services not covered by Medicaid. Include related paperwork, clerical activities or staff travel required to perform these activities.

1. Scheduling or arranging transportation to social, vocational, and/or educational programs and activities.

Code 5.b. - Transportation related to Medicaid Services – PM/50 percent FFP

This code should be used by the central coder the time study participant indicates he/she was assisting an individual to obtain transportation to services covered by Medicaid. This does not include the provision of the actual transportation service or the direct cost of the transportation, but rather the administrative activities involved in providing transportation. Include related paperwork, clerical activities or staff travel required to perform these activities. An example is:

1. Scheduling or arranging transportation to Medicaid covered services.

Code 6.a. - Non-Medicaid Translation – U

This code should be used by the central coder the time study participant indicates he/she was providing translation services related to social, vocational or education programs and activities as an activity separate from the activities referenced in other codes. Include related paperwork, clerical activities or staff travel required to perform these activities. Examples include:

1. Arranging for or providing translation services (oral or signing services) that assist the individual to access and understand social, educational, and vocational services.
2. Arranging for or providing translation services (oral or signing services) that assist the individual to access and understand state education or state-mandated health screenings (e.g., vision, hearing, and scoliosis) and general health education outreach campaigns intended for the student population.
3. Developing translation materials that assist individuals to access and understand social, educational, and vocational services.

Code 6.b. - Translation Related to Medicaid Services-PM/75 percent FFP

Translation may be allowable as an administrative activity if it is not included and paid for as part of a medical assistance service. However, it must be provided by separate units or separate employees performing solely translation functions for the LEA and it must facilitate access to Medicaid covered services.

This code should be used by the central coder the time study participant indicates he/she was providing translation services related to Medicaid covered services as an activity separate from the activities referenced in other codes. Include related paperwork, clerical activities or staff travel required to perform these activities. Examples include:

1. Arranging for or providing translation services (oral and signing) that assist the individual to access and understand necessary care or treatment covered by Medicaid.
2. Developing translation materials that assist individuals to access and understand necessary care or treatment covered by Medicaid.
3. Providing translation services (oral and signing) that assist the individual to access and understand necessary care or treatment covered by Medicaid.
4. Developing translated materials, including Braille transcriptions, that assist individuals to access and understand necessary care or treatment covered by Medicaid.
5. Translation while the school nurse provides covered services to a student whose primary language is not English.
6. Sign language interpretation during provision of covered services to a deaf child.
7. Transcribing into Braille the fact sheet school nurses use to explain/practice steps/proper technique for using an inhaler.
8. Translation to help a school psychologist follow up with a student's non-English speaking parent on a mental health referral.

Code 7.a. - Program Planning, Policy Development and Interagency Coordination Related to Non-Medical Services – U

This code should be used by the central coder when the time study participant indicates he/she was performing activities associated with the development of strategies to improve the coordination and delivery of non-medical/non-mental health services to school age children and when performing collaborative activities with other agencies. Non-medical services may include social, education and vocational services. Only employees whose position descriptions include program planning, policy development and interagency coordination should use this code. Include related paperwork, clerical activities or staff travel required to perform these activities. Examples include:

1. Identifying gaps or duplication of non-medical services (e.g., social, vocational educational and state mandated general health care programs) to school age children and developing strategies to improve the delivery and coordination of these services.
2. Developing strategies to assess or increase the capacity of non-medical school programs.
3. Monitoring the non-medical delivery systems in schools.
4. Developing procedures for tracking families' requests for assistance with non-medical

services and the providers of such services.

5. Evaluating the need for non-medical services in relation to specific populations or geographic areas.
6. Analyzing non-medical data related to a specific program, population, or geographic area.
7. Working with other agencies providing non-medical services to improve the coordination and delivery of services and to improve collaboration around the early identification of non-medical problems.
8. Defining the relationship of each agency's non-medical services to one another.
9. Developing advisory or work groups of professionals to provide consultation and advice regarding the delivery of non-medical services and state-mandated health screenings to the school populations.
10. Developing non-medical referral sources.
11. Coordinating with interagency committees to identify, promote and develop non-medical services in the school system.

Code 7.b. - Program Planning, Policy Development and Interagency Coordination Related to Medical Services-PM/50 percent FFP

This code should be used by the central coder the time study participant indicates he/she was performing activities associated with the development of strategies to improve the coordination and delivery of medical/dental/mental health services to school age children, and when performing collaborative activities with other agencies and/or providers. Employees whose job functions include program planning, policy development and interagency coordination types of activities may use this code. This code refers to activities such as planning and developing procedures to track requests for services; the actual tracking of requests for Medicaid services would be coded under Code 9.b., Referral, Coordination and Monitoring of Medical Services. Include related paperwork, clerical activities or staff travel required to perform these activities. Examples include:

1. Identifying gaps or duplication of medical/dental/mental services to school age children and developing strategies to improve the delivery and coordination of these services.
2. Developing strategies to assess or increase the capacity of school medical/dental/mental health programs.
3. Monitoring the medical/dental/mental health delivery systems in schools.
4. Developing procedures for tracking families' requests for assistance with medical/dental/mental services and providers, including Medicaid. (This does not include the actual tracking of requests for Medicaid services.)
5. Evaluating the need for medical/dental/mental services in relation to specific populations or geographic areas.
6. Analyzing Medicaid data related to a specific program, population, or geographic area.
7. Working with other agencies and/or providers that provide medical/dental/mental services to improve the coordination and delivery of services, to expand access to specific populations of Medicaid eligible, and to increase provider participation and improve provider relations.

8. Working with other agencies and/or providers to improve collaboration around the early identification of medical/dental/mental problems.
9. Developing strategies to assess or increase the cost effectiveness of school medical/dental/mental health programs.
10. Defining the relationship of each agency's Medicaid services to one another.
11. Working with Medicaid resources, such as the Medicaid agency and Medicaid managed care plans, to make good faith efforts to locate and develop EPSDT health services referral relationships.
12. Developing advisory or work groups of health professionals to provide consultation and advice regarding the delivery of health care services to the school populations.
13. Working with the Medicaid agency to identify, recruit and promote the enrollment of potential Medicaid providers.
14. Developing medical referral sources such as directories of Medicaid providers and managed care plans, which will provide services to targeted population groups, e.g., EPSDT children.
15. Coordinating with interagency committees to identify, promote and develop EPSDT services in the school system.

Code 8. a. - Non-Medical/Medicaid Training – U

This code should be used by the central coder the time study participant indicates he/she was coordinating, conducting or participating in training events and seminars for school-based services staff regarding the benefit of the programs other than the Medicaid program such as educational programs; for example, how to assist families to access the services of the relevant programs and how to more effectively refer students for those services. Include related paperwork, clerical activities or staff travel required to perform these activities. Examples include:

1. Participating in or coordinating training that improves the delivery of services for programs other than Medicaid.
2. Participating in or coordinating training that enhances IDEA child find programs.

Code 8.b. - Medical/Medicaid Specific Training – PM/50 percent FFP

This code should be used by the central coder if the time study participant indicates he/she was coordinating, conducting or participating in training events and seminars for regarding the benefits of the Medicaid program, how to assist families in accessing Medicaid services, and how to more effectively refer students for services. Include related paperwork, clerical activities or staff travel required to perform these activities. Examples include:

1. Participating in or coordinating training that improves the delivery of medical/Medicaid related services.
2. Participating in or coordinating training that enhances early identification, intervention, screening and referral of students with special health needs to such services (e.g., Medicaid EPSDT services). (This is distinguished from IDEA child find programs.)

3. Participating in training on administrative requirements related to medical/Medicaid services.

Code 9.a. - Referral, Coordination and Monitoring of Non-Medicaid Services –U

This code should be used by the central coder if the time study participant indicates he/she was making referrals for coordinating and/or monitoring the delivery of non-medical, such as educational services. Include related paperwork, clerical activities or staff travel required to perform these activities. Examples include:

1. Making referrals for and coordinating access to social and educational services such as child care, employment, job training, and housing.
2. Making referrals for, coordinating, and/or monitoring the delivery of state education agency mandated child health screens (e.g., vision, hearing, and scoliosis).
3. Making referrals for, coordinating, and monitoring the delivery of scholastic, vocational, and other non-health related examinations.
4. Gathering any information that may be required in advance of these non-Medicaid related referrals.
5. Participating in a meeting/discussion to coordinate or review a student's need for scholastic, vocational, and non-health related services not covered by Medicaid.
6. Monitoring and evaluating the non-medical components of the individualized plan as appropriate.

Targeted Case Management - Note that Targeted Case Management as an administrative activity involves the facilitation of access and coordination of program services. Such activities may be provided under the term Targeted Case Management or may also be referred to as Referral, Coordination, and Monitoring of non-Medicaid Services.

Targeted Case Management may also be provided as an integral part of the service and would be included in the service cost. This code should be used by the central coder the time study participant indicates he/she was making referrals for, coordinating, and/or monitoring the delivery of NON-Medicaid covered services.

Code 9.b. - Referral, Coordination and Monitoring of Medicaid Services–PM/50 percent FFP

This code should be used by the central coder the time study participant indicates he/she was making referrals for, coordinating, and/or monitoring the delivery of medical (Medicaid covered) services. Referral, coordination and monitoring activities related to services in an IEP are reported in this code. Activities that are part of a direct service are not claimable as an administrative activity. Furthermore, activities that are an integral part of or an extension of a medical service (e.g., patient follow-up, patient assessment, patient counseling, patient education, patient consultation, billing activities) should be

reported under Code 4A - Direct Medical Services - Not Covered as IDEA/IEP Services or 4B- Direct Medical Services - Covered as IDEA/IEP Services. Note that Targeted Case Management, if provided or covered as a medical service under Medicaid, should be reported under Code 4A - Direct Medical Services

- Not Covered as IDEA/IEP Services or 4B - Direct Medical Services - Covered as IDEA/IEP Services. Examples include:

1. Identifying and referring adolescents who may be in need of Medicaid family planning services.
2. Making referrals for and/or coordinating medical or physical examinations and necessary medical/dental/mental health evaluations.
3. Making referrals for and/or scheduling EPSDT screens, interperiodic screens, and appropriate immunization, but NOT to include the state-mandated health services.
4. Referring students for necessary medical health, mental health, or substance abuse services covered by Medicaid.
5. Arranging for any Medicaid covered medical/dental/mental health diagnostic or treatment services that may be required as the result of a specifically identified medical/dental/mental health condition.
6. Gathering any information that may be required in advance of medical/dental/mental health referrals.
7. Participating in a meeting/discussion to coordinate or review a student's needs for health-related services covered by Medicaid.
8. Providing follow-up contact to ensure that a child has received the prescribed medical/dental/mental health services covered by Medicaid.
9. Coordinating the delivery of community based medical/dental/mental health services for a child with special/severe health care needs.
10. Coordinating the completion of the prescribed services, termination of services, and the referral of the child to other Medicaid service providers as may be required to provide continuity of care.
11. Providing information to other staff on the child's related medical/dental/mental health services and plans.
12. Monitoring and evaluating the Medicaid service components of the IEP as appropriate.
13. Coordinating medical/dental/mental health service provision with managed care plans as appropriate.

Note: A "referral" is considered appropriate when made to a provider who can provide the required service, will accept the student as a patient, and will accept the student's source of payment for services.

Targeted Case Management

Note that Targeted Case Management as an administrative activity involves the facilitation of access and coordination of program services. Such activities may be provided under the term Targeted Case Management or may also be referred to as Referral, Coordination, and Monitoring of Medicaid Services.

Targeted Case Management may also be provided as an integral part of the service and would be included in the service cost. This code should be used by the central coder the time study participant indicates

he/she was making referrals for, coordinating, and/or monitoring the delivery of Medicaid covered services.

Code 10. - General Administration – R

This code should be used by the central coder if the time study participant indicates he/she was performing activities that are not directly assignable to WV SBHS program. Include related paperwork, clerical activities or staff travel required to perform these activities. Note that certain functions such as, payroll, maintaining inventories, developing budgets, executive direction, etc., are considered overhead and, therefore, are only allowable through the application of an approved indirect cost rate.

Below are typical examples of general administrative activities, but they are not all inclusive.

1. Taking lunch, breaks, leave, or other paid time not at work.
2. Establishing goals and objectives of health-related programs as part of the school's annual or multi-year plan.
3. Reviewing school or district procedures and rules.
4. Attending or facilitating school or unit staff meetings, training, or board meetings.
5. Performing administrative or clerical activities related to general building or district functions or operations.
6. Providing general supervision of staff, including supervision of student teachers or classroom volunteers, and evaluation of employee performance.
7. Reviewing technical literature and research articles.
8. Other general administrative activities of a similar nature as listed above that cannot be specifically identified under other activity codes.

Code 11. - Not Scheduled to Work – U

This code should be used if the random moment occurs at a time when a part-time, temporary or contracted employee is not scheduled to be at work. Please note that full time school staff should not use this code.

VII. Calculating the MAC Claim

In general terms, the federal share of the claim for Medicaid administration is calculated by:

Cost Pool Total	Multiplied by
% time claimable to Medicaid administration	Multiplied by
The Medicaid Eligibility Rate (MER) (where applicable)	Multiplied by
1 + Indirect Cost Rate (this percent is added to the value of the calculation at this stage in the process) equals the amounts of the claim request	Multiplied by
% FFP	

a) **Cost pools**

There are four cost pools (Direct Service Providers, Targeted Case Management Providers, Personal Care Providers, Administrative Service Providers) that will be utilized within the claiming process.

b) **% Time Claimable to Medicaid Administration**

The time study results are utilized to determine the amount or percent of time spent by LEA personnel conducting the identified outreach, care and coordination functions.

c) **The Medicaid Eligibility Rate (MER) and the Direct Service IEP Ratio**

The amount of the claim is affected by the MER. This factor is a critical component of the claim. MER data consist of eligibility information pertaining to the school year to which it relates. The MER is applied to the total claimable percentage (Codes 1b, 2b, 5b, 6b, 7b, 8b & 9b). This rate is calculated on an annual basis. The IEP Ratio (Direct Service (FFS) Medicaid eligibility rate), will be applied to Code 4b responses. The IEP Ratio is calculated annually for each of the three applicable cost pools.

d) **Indirect Cost Rate (ICR)**

Indirect costs will be claimed as part of the MAC Program. The LEA's state cognizant agency, the West Virginia Department of Education, (DOE) will use a consistent method to calculate the unrestricted ICR as outlined in OMB 2 CFR Chapter I, Chapter II, Part 200, et al. Claims for the LEA's indirect costs are only allowable when the entity has an approved indirect cost rate.

e) Federal Financial Participation (FFP) Rate

After the results of the time study are multiplied by the cost pool total, they are then multiplied by the FFP Rate.

MAC Claim Development

The administrating contractor will submit quarterly claims on behalf of participating LEAs directly to DHHR/BMS. After reviewing each claim, DHHR/BMS will review and as appropriate approve the MAC claim for payment processing. The claims will be based on the quarterly costs, the time study, the Medicaid eligibility rate, the indirect cost rate (ICR) and the FFP.

MAC Medicaid Eligibility Rate (MER)

For many of the MAC activities performed by LEA personnel, the costs associated with these activities are only reimbursable to the extent they are allocable to the Medicaid enrolled population. Therefore, these activities will be adjusted by the MER. This adjustment factor or "discount" reflects the nature of the administrative activity and the targeted population to which the administrative effort is directed.

The MER can be determined by computing the fractional value. The fractional value is identified by dividing the total number of Medicaid eligible school age children (the numerator) for each LEA by the

total student count (the denominator) for each LEA. This fractional value is applied to the total cost applicable to the DISCOUNT activity codes to determine the costs applicable to Medicaid administrative activities. The specific MERs will be calculated on an annual basis. The West Virginia Department of Education (WVDE) collects student data from every LEA no later than December 1st each year. WVDE will generate student data for each LEA. The student data will be matched against the Medicaid Eligibility Data provided by BMS. The match will identify the total number of students in each LEA that are eligible for Medicaid. The number of Medicaid eligible students in the LEA will be the numerator in the calculation and the denominator will equal the total number of students in the LEA. WVDE will be responsible for completing the Medicaid match and providing the Medicaid Eligibility Rate.

The MAC Medicaid eligibility rate calculation is:

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

Financial Data

The financial data to be included in the calculation of the MAC claim are to be based on actual expenditures incurred during the quarter. These costs must be obtained from actual detailed expenditure reports generated by the LEA's financial accounting system.

OMB 2 CFR Chapter I, Chapter II, Part 200, et al. specifically defines the types of costs: direct costs, indirect costs and allocable costs that can be included in the program. Sections 1 through 42 provide principles to be applied in establishing the allowability or unallowability of certain items of cost. These principles apply whether a cost is treated as direct or indirect. The following items are considered allowable costs as defined and cited below by OMB 2 CFR Chapter I, Chapter II, Part 200, et al.

Direct Costs

Typical direct costs identified in OMB 2 CFR Chapter I, Chapter II, Part 200, et al. include:

- Compensation of employees
- Staff professional dues and fees
- Cost of materials acquired, consumed, or expended
- Equipment
- Travel expenses incurred
- Contracted staff costs

Indirect Costs

Indirect costs included in the claim are computed by multiplying the costs by the LEAs' approved unrestricted indirect cost rate. These indirect rates are established by the LEAs' state cognizant agency, West Virginia Department of Education (DOE), and are updated annually. The methodology used by the respective state cognizant agency to develop the indirect rates has been approved by the cognizant federal agency, as required by the CMS guide. Indirect costs are included in the claim as reallocated costs.

DOE, through the approval of the LEA indirect cost rates, and the LEAs, through the certification of the quarterly financial submissions, will certify that costs included in the MAC financial data are not included in the LEA's unrestricted indirect cost rate, and no costs will be accounted for more than once.

Unallowable Costs

Costs that may not be included in the claim are: direct costs related to staff that are not identified as eligible time study participants (i.e., costs related to teachers, cafeteria, transportation, and all other non-school based administrative areas) and costs that are paid with 100 percent federal funds (i.e., costs that have already been fully paid by other revenue sources such as federal, state/federal, recoveries, etc.).

Revenue Offset

Expenditures included in the MAC claim are often funded with several sources of revenue. Some of these revenue sources require that expenditures be offset, or reduced, prior to determining the federal share reimbursable by Medicaid. These "recognized" revenue sources requiring an offset of expenditures are:

- Federal funds (both directly received by the LEA and pass through from state or local agencies)
- State expenditures that have been matched with federal funds (including FFS). Both the state and federal share must be used in the offset of expenditures.
- Third party recoveries and other insurance recoveries

Claim Certification

LEAs will only be reimbursed the federal share of any MAC billings. The Chief Financial Officer (CFO), Chief Executive Officer (CEO), or Superintendent (SI) will be required to certify the accuracy of the submitted claim and the availability of matching funds necessary. The LEA designee is certifying that the claim amount submitted includes only actual and allowable expenditures. The certification statement will be included as part of the invoice and will meet the requirements of 42 CFR 433.51.

LEAs will be required to maintain documentation that appropriately identifies the certified expenditures used for MAC claiming. The documentation must also clearly illustrate that the funds used for certification have not been used to match other federal funds. Failure to appropriately document the certified funds could result in non-payment of claims.

Direct Service or Fee for Service (FFS) Medicaid Eligibility Rate (IEP Ratio)

The direct service Medicaid eligibility rate, referred to as the Individualized Education Program (IEP) Ratio will be calculated annually and used to apportion cost to the Medicaid fee-for-service (FFS) program. The numerator will be the number of Medicaid IEP students in the LEA who have an IEP that includes an FFS reimbursable service and the denominator will be the total number of students in the LEA with an IEP that have an FFS reimbursable service as outlined in their IEP. Direct medical services are those services billable under the FFS program. The West Virginia Department of Education (WVDE) collects student data from

every LEA by no later than December 1st each year. The data collected also includes information on the Special Education status of each student. In addition to the Special Education status, the (WVDE) collects service level data for each Special Education Student. The LEAs, report which students are eligible for Special Education, and also which students have an IEP that includes a reimbursable direct medical service. The WVDE will generate a file that identifies student data for each LEA for the Special Education students with an IEP that includes a reimbursable direct medical service. The student data will be matched against the Medicaid Eligibility Data provided by DHHR/BMS. The match will identify the total number of Special Education students with an IEP that includes a reimbursable direct medical service in each LEA that are eligible for Medicaid. The number of Medicaid eligible students with an IEP that includes a reimbursable direct medical service in the LEA will be the numerator in the calculation and the denominator will equal the total number of students in the LEA with an IEP that includes a reimbursable direct medical service. WVDE will be responsible for calculating the IEP ratio utilizing the data provided by the LEAs.

The IEP Ratio calculation is:

[Number of Medicaid Eligible Students with an IEP that includes a reimbursable direct medical service]
[Total Number of Students with an IEP that includes a reimbursable direct medical service]

Documentation & Recordkeeping Requirements

It is required that all MAC LEAs maintain documentation supporting the administrative claim. The LEAs must maintain and have available upon request by state or federal entities the Memorandum of Understanding with the state to participate in the MAC program. Some documentation must be maintained quarterly. This information must be available upon request by state or federal entities. Each participating LEA will maintain a quarterly audit file containing, at a minimum, the following information:

- A roster of eligible individuals, by category, submitted for inclusion in the participant sample pool
- Copy of licensure and credential information for SBHS staff
- Financial data used to develop the expenditures and revenues for the claim calculations including state/local match used for certification of expenditures
- Documentation of the LEA's approved indirect rate (if applicable)
- A copy of the completed and signed certification form

Retention period

Documentation must be retained for the minimum federally required time period. Federal guidelines (OMB 2 CFR Chapter I, Chapter II, Part 200, et al.) state the retention period is three years unless there is an outstanding audit. The state's requirement is for LEAs to maintain the administrative claiming documentation for five years or until such time all outstanding audit issues and/or exceptions are resolved.

Oversight and Monitoring

Federal guidelines require the oversight and monitoring of the administrative claiming programs. This oversight and monitoring must be done at both the LEA and state level.

State Level Oversight and Monitoring

The state is charged with performing appropriate oversight and monitoring of the time study and MAC program to ensure compliance with state and federal guidelines. DHHR/BMS is the responsible agency for this required monitoring and oversight effort. DHHR/BMS will develop a Memorandum of Understanding (MOU) with WVDE. The MOU clearly states the responsibilities for all parties.

DHHR/BMS will monitor and review various components of the MAC program operating in the state. The areas of review include, but are not limited to:

- Participant List / Roster– ensure only eligible categories of staff are reported on the participant list based on the approved RMTS categories in the implementation plan.
- RMTS Time Study – sampling methodology, the sample, and time study results
- RMTS Central Coding – review at a minimum a 5% sample per quarter of the completed coding
- Training – Compliance with training requirements: program contact, central coder and LEA staff
- Financial Reporting – Costs are only reported for eligible cost categories and meet reporting requirements.

Each LEA already has a provider agreement in place with BMS, and an addendum will be put in place to state the responsibilities for all parties.

Frequency

All LEAs will be monitored at least once every three (3) years. This monitoring will consist of either an on-site, desk, or combination review. Following the selection of the LEAs to be reviewed during each year of the three year cycle, DHHR/BMS will identify one quarter of claims as the focus for this in-depth review. Any discrepancies revealed during the review will be noted and addressed with the LEA. Based on the findings from the review of the one quarter of claims, additional quarters may be selected for further review. Participating LEAs will be required to fully cooperate in providing information and access to necessary staff in a timely manner to facilitate these efforts. LEAs that do not fully cooperate in the review process may be subject to sanctions.

In addition to the monitoring described above, trends will be examined as a component of an ongoing review process. Examples of the trends to be monitored include: total claims and reimbursement levels. Any significant variations from historical trending will be communicated to the LEAs for explanation of the variance.

DHHR/BMS is in constant communication with the contractor, often daily, to discuss any issues that may arise. DHHR/BMS will schedule and participate in regular meetings and/or conference calls (at least monthly) with their contractor to discuss time study trends, the 85% LEA compliance level, coding and any other MAC or time study issues.

Remedial Actions

The state will pursue remedial action for LEAs that fail to meet MAC program requirements or fail to correct problems identified during review. Examples of actions that will cause implementation of sanctions include, but are not limited to:

- Repeated and/or uncorrected errors in financial reporting, including failure to use the Contractor provided financial reporting worksheets
- Failure to cooperate with state and/or federal staff during reviews or other requests for information
- Failure to maintain adequate documentation
- Failure to provide accurate and timely information to the Contractor as required

Sanctions the state may impose include suspending payment of MAC and FFS claims, conducting more frequent reviews, and the recoupment of funds. Once an LEA has been notified of the need for remedial action, the LEA will be given thirty (30) days to submit a corrective action plan to the state, and the state will have an additional thirty (30) days to approve or amend the corrective action plan.

VIII. Contractor Level Oversight and Monitoring

Quarterly Tasks

Training regarding RMTS

- Ensure LEA has participated in required RMTS training in order to participate in RMTS
- Review of RMTS compliance rate and ensure each LEA meets the 85% compliance level requirement
- Ensure the LEA coordinator understands how critical the response rate is per LEA and that he/she is aware of applicable sanctions for non-compliance.

Roster Updates

- Prepare roster update and email to LEA contact
- Receive updated roster from LEA
- Review and perform quality checks on the updated roster
- Upload individual LEA rosters into database with all other participating LEAs

Time Study Tasks

- Randomly select time study participants from database
- Notify LEA contact of staff from their LEA who were selected for the quarter
- Notify selected participants 24 hours prior to their selected moment and send reminders one day after the moment if it has not been completed with a copy to the supervisor and/or LEA Coordinator.
- Review documented responses and code time study received from selected participants. Conduct follow-up if necessary for the determination of the appropriate time study code.
- Quality Check received and coded time study data
- Follow up with participants who submitted incomplete data, correcting the data so it can be used.
- Scan all data and prepare it for the claim.

- Identify LEAs that received greater than 10 moments in the quarter and have a response rate below 85%. Work with DHHR/BMS and WVDE to ensure that the LEA(s) understand the importance of the required response rate and the potential repercussions of non-compliance through the sanction process.

Financial Tasks

- Conduct financial training with LEA, as needed
- Prepare quarterly financial workbook for the designated financial contact.
- Receive completed workbook and quality check the workbook for errors
- If necessary, resubmit the workbook to the LEA's financial contact for revisions
- Prepare financial information for the MAC claim
- Prepare Certification of Public Expenditure (CPE) form and send to the LEA's financial contact for completion.
- Receive completed CPE forms from LEA and submit to DHHR/BMS

Miscellaneous Tasks

- Participate in quarterly MAC update meetings
- Answer general questions from the LEA throughout the quarter
- Collect annual Non-Restricted indirect cost rate (ICR) from (WVDE)
- Obtain the Medicaid Eligibility Rate (MER) from the WVDE.
- Obtain annual IEP Ratio from the (WVDE).
- Develop the quarterly MAC claim and submit to DHHR/BMS
- Send copy of claim to LEA for their records
- Follow up with DHHR/BMS to ensure LEA receives payment
- Conduct quality assurance reviews as needed
- Serve as liaison between LEA and DHHR/BMS

Local LEA Level Oversight and Monitoring

Each LEA participating in the MAC program must take appropriate oversight and monitoring actions that will ensure compliance with MAC program requirements.

Actions must be taken to ensure, at a minimum, that:

- The time study is performed correctly
- The time study results are valid
- The financial data submitted is true and correct
- RMTS training requirements are met
- Appropriate documentation is maintained to support the time study and the claim

Required Personnel

Each LEA must designate an employee as the LEA coordinator or MAC program contact. This single individual is designated within the LEA to provide oversight for the implementation of the time study and to ensure that policy decisions are implemented appropriately. The LEA must also designate an Assistant LEA coordinator to provide back-up support for time study responsibilities.