

“Proper and Efficient:” Claiming Federal Financial Participation for National Core Indicator Activities

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Background

In 1997, the National Association of State Directors of Developmental Disabilities Services (NASDDDS), in partnership with the Human Services Research Institute (HSRI), launched a multi-state collaborative effort to gather and analyze information on key outcome and performance indicators within publicly financed developmental disabilities service systems. The National Core Indicators project (NCI) is supported by contributions from each participating state, with project activities organized by HSRI and NASDDDS and vetted through a Steering Committee comprised of representatives from each of the participating states. NCI is the only multi-state collaborative approach to collecting, analyzing, and maintaining a national data set on key developmental disabilities system performance measures. Since its inception, the project has consistently provided states with accurate, timely, and useful information on the status of developmental disabilities services. Currently, NCI outcome measures are being used by twenty-one (20) states to benchmark and track the performance of their developmental disabilities service systems, work out comparable data collection strategies, monitor progress and share results.

The core performance indicators form the foundation of the NCI project and consist of approximately 100 consumer, family, systemic, cost, and health and safety outcome measures. Data is gathered through a variety of mechanisms, including consumer surveys assessing empowerment and personal choice; family surveys documenting satisfaction with supports and providers; provider surveys focusing on staff turnover; and state systems data reviewing program expenditures, mortality rates, and other

indicators. Each measure is designed to track the effectiveness, utilization, and outcomes of services provided under the state's Medicaid program, as well as other services offered by public developmental disabilities agencies.

Issue

Over the past three years, many, if not most, states have had to respond to fiscal restraints due to declining state revenues and changing policy priorities. New states have joined the NCI project each year, and a few have had to withdraw or temporarily suspend participation because of budget cuts or departmental restructuring. From the beginning of the project, some state officials have indicated that they reduced their state's general fund expenditures by claiming the costs of conducting NCI activities as Medicaid related administrative expenses, which are eligible for federal financial participation (FFP) at the standard administrative reimbursement rate of 50 percent. Other states have not claimed FFP for NCI-related activities, but have requested information on the rules and requirements involved. This paper provides a short description of current state administrative claiming practices with respect to NCI related expenses, and outlines some of the key issues, policies and procedures involved in claiming FFP for such administrative costs.

State Practice

To document the extent to which the twenty (20) states participating in the NCI project claim administrative FFP for related costs, a brief questionnaire was sent to the directors of developmental disabilities services in each NCI participating state asking the following questions:

1. Does your state claim FFP for some or all of the costs related to the completion of NCI activities (Yes/No).
2. If the answer is yes, please indicate the activities that are claimed and those that are not claimed.
3. Under what category of administrative costs are NCI costs claimed?

Seventeen of twenty states responded to the survey (85%), with ten states (50%) indicating that they are currently claiming FFP to partially cover the costs of some or all of their NCI data gathering and analysis. Some states reported that FFP was claimed for all NCI-related tasks, including the project oversight and data management activities performed by HSRI under a memorandum of agreement with NASDDDS. Others indicated that they claimed FFP for the data collection costs, conducting individual interviews, etc., but not for the project coordination and data analysis/management

functions performed by HSRI under contract with NASDDDS. Follow-up conversations with several state directors and other agency staff suggest that the Medicaid administrative claiming process was not well understood and, while administrators knew that costs were being claimed, many were not familiar with the process or issues involved.

The remainder of this paper will summarize administrative claiming principles under Medicaid and will provide other, related information to states interested in claiming FFP for the costs of carrying out NCI activities.

Administrative Claiming Principles

Section 1902(a)(5) of the Social Security Act specifies that each participating state must designate a single state Medicaid agency (SSMA) to oversee implementation of the state's Medicaid program and submit financial claims to the Centers for Medicare and Medicaid Services (CMS). Under Title XIX of the Social Security Act, participating states are entitled to receive FFP for allowable administrative costs (see implementing regulations at 42 CFR 431.10). The SSMA is the only agency that may submit Medicaid financial claims.

The organization and day-to-day administration of the Medicaid program varies from state to state. The SSMA may assign to other state agencies, including the state developmental disability authority (SDDA), responsibility for carrying out various functions related to the provision of Medicaid-funded services to persons with developmental disabilities. The assigned state agency may act as the agent for the SSMA, provided that a written interagency agreement is in place between the SSMA and the SDDA describing the relationship between the respective agencies and the complementary responsibilities of each. This interagency agreement addresses the process by which an SDDA may file claims for FFP, through the SSMA, covering administrative costs that are necessary for the proper and efficient administration of the state Medicaid plan. The agreement should be comprehensive and also describe the oversight responsibilities of the SSMA, record keeping requirements, claiming procedures and methodologies and other issues relevant to the administration of Medicaid-financed services to persons with developmental disabilities.

Section 1903(a)(7) of the Social Security Act allows for the payment of FFP at differing matching rates for differing activities "found necessary by the secretary for the proper and efficient administration of the [state] plan." Regulations effectuating this part of the Act are found in the Code of Federal Regulations (CFR) at 42 CFR 430.1 and 42 CFR 431.15. The regulatory provisions governing Medicaid administrative claiming are

amplified by language in OMB Circular A-87 which notes that costs must be reasonable and necessary for the operation of a governmental unit or federal award. CMS has consistently interpreted these provisions as requiring that (a) allowable administrative claims be related to the administration of the Medicaid program, and (b) payment for allowable claims be restricted to the percentage of time that is directly attributable to Medicaid eligible individuals.

CMS has approved administrative cost allocation plans submitted by states that cover the following activities claimed by states as necessary for the “proper and efficient” administration of the State Medicaid Plan:

- a. Medicaid eligibility determination
- b. Outreach related to the Medicaid program
- c. Medicaid prior authorization
- d. Medicaid management information service (MMIS) development and operation.
- e. Early Periodic Screening, Diagnostic and Treatment administration (EPSDT)
- f. Third party liability activities
- g. Utilization review.

The requirement that administrative claims for FFP be related to the “proper and efficient” administration of the state’s Medicaid plan is operationalized by CMS in accordance with the following principles as identified in a letter to state Medicaid directors from Sally Richardson, then the director of the Medicaid Bureau at CMS¹ dated December 20, 1994 (see copy attached), and in the *CMS Medicaid School-Based Administrative Claiming Guide* released in May 2003.² Generally, administrative costs are allowable for FFP claiming if they:

- Are directly related to Medicaid state plan or waiver services – not including activities otherwise covered under administrative case management.
- Are included in a cost allocation plan approved by CMS and supported by documentation isolating the costs related to the support of the Medicaid program from other costs incurred by the agency.

¹ Formerly called the Health Care Financing Administration (HCFA).

² *Note:* The “Guide” includes the most up-to-date explanation of CMS policy on procedures for claiming FFP for administrative costs, even though the focus is on the provision of Medicaid funded school-based health services. The document can be accessed from the CMS Web site at:

<http://www.cms.hhs.gov/medicaid/schools/clmguide.asp>.

- Reflect an identifiable fraction of the activities of a non-Medicaid governmental agency that are exclusively directed to Medicaid administrative purposes and meet all other criteria for administrative claiming.

Administrative costs generally are not eligible for FFP matching funds if they:

- Include the costs of providing direct medical or remedial service.
- Are an integral part or extension of a direct medical or remedial service.
- Include funding for a portion of general public health initiatives.
- Include overhead costs of operating a provider facility.
- Reflect operating costs related to the operation of non-Medicaid related programs.
- Are incurred pursuant to services provided to “inmates of a public institution.”

Case Management

A state may perform a number of activities necessary for the proper and efficient implementation of its Medicaid state plan and waiver program services through case management. Case management is eligible for FFP matching funds under four conditions: (a) as an administrative cost when the activities involved are determined to be directly related to a Medicaid state plan or waiver service and necessary for the “proper and efficient administration of the state plan,” and (b) as a direct service when furnished as an optional state plan service to a targeted group of high risk eligible individuals,³ (c) case management claimed as a waiver service, and (d) case management as a component of another Medicaid-reimbursable service. Each of these options has specific requirements that prescribe the conditions under which FFP may be claimed. Although some NCI activities are closely tied to the administration of Medicaid waiver program and state plan services, others, such as conducting individual and family interviews, follow-up and quality assurance activities, may be better defined as services aimed at assisting individuals to gain access to needed medical, social, educational and related supports.

Administrative Case Management. Some NCI tasks may qualify as administrative case management (see 42 CFR 433.15(b)(7)), including, as defined in Section 4302.2(G)(2) of the *State Medicaid Manual* the following Medicaid-related activities: (a) eligibility

³ For a complete description of administrative claiming procedures related to case management services see the NASDDDS publication, *Medicaid and Case Management for People with Developmental Disabilities: Options, Practices and Issues*, by Robin Cooper and Gary Smith, NASDDDS. April 1998.

determination and redetermination, (b) intake, (c) pre-admission screening for inpatient care, (d) prior authorization for Medicaid services, (e) utilization review, and (f) outreach.

The first rule of administrative claiming is that qualifying activities must be necessary for the “proper and efficient” administration of the State Medicaid Plan. That is, FFP may be claimed only for activities that are directly related to the administration of the State Medicaid Plan (including waiver programs approved in accordance with the plan and pursuant to the provisions of federal Medicaid law). It does not matter whether the particular activity is performed by SDDA or SSMA staff, by personnel from a separate organization or agency, or by an individual acting under contract with the state. The criteria for an acceptable claim is based on the specific nature of the activity and the costs incurred, rather than the entity which performs the specified functions.

With regard to National Core Indicator activities, states need to be able to provide a rationale describing how NCI activities are directly related to the proper and efficient administration of the state plan. For example, the National Core Indicator dataset gathers information on a number of key system performance indicators assessing the effectiveness, utilization, and outcomes of services furnished under the state’s Medicaid program. NCI outcome data is used by participating states to improve their program planning, policy development, and interagency coordination relative to Medicaid-funded services. Additional activities that should be able to be covered include analyzing Medicaid data related to a specific program, population or geographic area, working with other agencies that provide medical, dental, or “mental” services to improve coordination and delivery, increase provider performance, cost effectiveness and quality. The rationale could also address the need to improve the state’s Medicaid management information system, or to carry out administrative responsibilities related to data management or utilization review (see above).

A few state officials responding to the NASDDDS survey on claiming FFP for NCI activities indicated that their states claimed administrative FFP for intrastate activities involved in the collection of NCI data but did not include the shared project costs paid to NASDDDS to cover the data processing, analysis, and validation functions performed by HSRI. The functions performed by HSRI under contract with NASDDDS are an integral part of the process and are directly related to the interpretation of the information received. Based on the principles outlined by CMS, therefore, such expenses should be eligible for FFP under one of the several rationales discussed above. Further, it is important to note that Medicaid claims for the costs of administrative activities may include charges related to professional and consultant service. OMB Circular A-87 states (Attachment B, *Selected Items of Costs*; item 33.a):

Costs of professional and consultant services rendered by persons or organizations that are members of a particular profession or possess a special skill, whether or not officers or employees of the governmental unit, are allowable, subject to section 14 when reasonable in relation to the services rendered and when not contingent upon recovery of the costs from the Federal Government.

Costs related to technical assistance, support and training provided by HSRI and NASDDDS related to the collection and analysis of NCI data would appear to be allowable under this provision.

Targeted Case Management as a Direct Service. Other activities related to NCI also may be able to be covered under the Targeted Case Management (TCM) coverage option, depending on the nature of the tasks performed. Medicaid case management is defined as services that assist Medicaid eligible individuals gain access to needed medical, social, educational, and other services. Although CMS has never published final regulations implementing this coverage option, coverage of targeted case management is authorized under Sections 1905(a)(19) and 1915(g)(2) of the Social Security Act. CMS has issued guidance on targeted case management through State Medicaid Director letters and the *State Medicaid Manual*. In a State Medicaid Director letter dated January 19, 2001, CMS described targeted case management as follows:

“...services which will assist an individual eligible under the State plan in gaining access to needed medical, social, educational, and other services. Case management services are referred to as targeted case management (TCM) services when the services are not furnished in accordance with Medicaid statewideness or comparability requirements. This flexibility enables States to target case management services to specific classes of individuals and/or to individuals who reside in specified areas.”

As an optional state plan service, TCM services are not covered by requirements for statewideness or comparability, but can be “targeted” to specific classes of individuals and/or to individuals residing in specified geographical areas of the state. A state could, for example, elect to restrict targeted case management services only to individuals enrolled in a particular HCBS waiver program(s), or to individuals with a certain condition, such as a brain injury or autism. Similarly, a state can limit beneficiaries’ right to freely choose among qualified providers of TCM services *but only in the case of individuals with developmental disabilities or chronic mental illnesses*. Under the targeted case management benefit, the state may limit the choice of providers to certain agencies or organizations expressly assigned to deliver case management services to individuals with developmental disabilities or chronic mental illnesses. This limitation on freedom

of choice permits states to craft single point of entry case management systems that allow only designated agencies to perform case management functions or, in the case of NCI activities, limit the collection of data through interviews or other means to specific individuals or organizations.

NCI activities carried out under TCM may include services that monitor or follow up on an individual's progress or status, activities related to service plan development, interventions that are designed to assure services are received, and supports that assist individuals in gaining access to needed medical, social, educational or other services. In some states, for example, consumer satisfaction surveys are completed by case managers. In this case, FFP is claimed under TCM since the survey results are used to: (a) monitor the individual's satisfaction with the supports provided, (b) assure that services related to the Medicaid plan of care are being received and that progress is being made, and (c) assure that the furnished supports assist the individual gain access to needed services.

Case Management as a HCBS Waiver Service. Case management may be provided as part of a covered service under a waiver granted in accordance with Sections 1915(c) and 1915(c)(4)(B) of the Social Security Act. To include case management under a HCBS waiver program, a state must define the service and specify provider qualifications as part of its HCBS waiver application. When offering case management services under a waiver program, the service must be available to all individuals enrolled in the program. Individuals also must be afforded freedom of choice among qualified providers—i.e., a state cannot limit providers of this service to a specific agency or type of agency, such as a county or community developmental disabilities board. Any entity or individual that meets the qualifications must be treated as an eligible provider of case management services.

Case Management Activities as Components of Another Title XIX Covered Service.

The duties that staff perform may range across a number of Medicaid and non-Medicaid funded direct service and administrative activities, each with its own funding source and documentation requirements. FFP for case management activities also may be claimed as a part of another Medicaid service. For example, since preparation of a service plan by a home health provider is a required activity, a separate payment cannot be made for this activity under Medicaid regulations. But, the state's home health payment rate may include the cost of service plan preparation. Under the HCBS waiver program authority, case coordination activities performed by residential service providers may be reimbursed as a part of the rate paid to the provider agency for residential habilitation services. This type of coverage is analogous to the "internal" service facilitation functions performed by community provider agencies under many

state’s HCBS waiver programs. This option makes the most sense when case management is an integral component of another direct service, rather than a stand-alone service.

To avoid duplicate claiming for the same service, states must use activity codes that clearly distinguish between the different types of activities, direct service, or administrative, funding sources, and the percent of time spent in each. The time spent in each of the various activities should be documented through standard time study procedures (see “Time Study Procedures” in OMB Circular A-87).

Service or Administrative Claim? The question of whether a particular activity is best claimed as a targeted case management service or an administrative function is addressed in the aforementioned monograph on “Medicaid and Case Management.”⁴

Deciding whether to obtain Medicaid funding by claiming case management as a service (under an HCB waiver program or the TCM option) or to employ administrative claiming instead involved several considerations.

Deciding whether to obtain Medicaid funding by claiming case management as an administrative cost or a service involves several considerations.

- In most states, the federal matching rate for “services” is higher than the matching rate for administrative claiming and it may be more advantageous from a financial perspective to claim a particular activity as a service.
- The restriction on administrative claiming means that FFP can only be applied to match costs related to the delivery of Medicaid-funded services. In this sense, administrative claiming may only permit a state to obtain federal financial participation for a portion of the overall costs of furnishing case management services.
- Administrative claiming may be easier to document because it does not involve the preparation and submission of recipient-specific Medicaid claims in order to obtain reimbursement.
- Administrative claiming as a primary avenue for obtaining Medicaid funding for case management services is best applied to systems where case management is provided by state case managers as a service.

⁴ Ibid.

Allocating Costs

Administrative activities may be completed by SDDA staff members, or by personnel acting under a state contract with another organization or individual, or through other purchase agreements that are “reasonable and necessary” for the operation of the governmental unit or federal award, and integral to the proper and efficient administration of the state Medicaid plan. In claiming federal financial participation, states must employ an allocation methodology approved by the U.S. Department of Health and Human Services (DHHS) to document the portion of time or, of the project activity, that is directly related to the administration of the state Medicaid plan. The allocation methodology typically used is based on time studies indicating: (a) the totality of the scope of the work performed, and (b) the proportion of the work that is directly related to the Medicaid program. The aforementioned *CMS Medicaid School-Based Administrative Claiming Guide* describes the specific issues or principles that must be addressed in the development of time studies documenting the proportion of time claimable for FFP. Time studies or other documentation procedures must:

- Reflect all of the time and activities performed, Medicaid related and other.
- Clearly distinguish Medicaid activities from similar tasks performed for other individuals or purposes.
- Not duplicate payments from other sources. In other words, activities may not be double billed to more than one organization.
- Be coordinated with the activities or duties of other organizations as appropriate.
- Clearly differentiate between direct service and administrative activities.
- Show that costs are allocated to the Medicaid program in accordance with the “proportional Medicaid share” to establish the proportion of the costs that are directly related to the Medicaid program.

The application of this principle in the determination of the Medicaid share essentially involves five basic steps. The box below offers a hypothetical example of the process for determining the “proportional Medicaid share” of an NCI activity such as assessing the effectiveness, satisfaction, and quality of services.

1. Determine the total number of individuals receiving the service and the number of those individuals who are Medicaid recipients. It is important to note that the total number of individuals and the number of Medicaid recipients must be identified for the same time period. In the example below, a total of 6,000 individuals are reviewed as a part of the NCI assessment process. Of this total, 5,000 individuals are Medicaid recipients. The number of Medicaid recipients must be obtained from or verified by the Medicaid Agency.

2. Determine the proportion of the service that was provided to Medicaid recipients by dividing the total number of people reviewed (6,000) by the total number of Medicaid recipients reviewed (5,000). In this example, the Medicaid share is 83 percent.

3. Determine the Costs to be allocated to Medicaid. The administrative costs that can be allocated to the Medicaid program are typically identified through the use of “time studies” indicating the proportion of staff time devoted to specific activities conducted in accordance with the guidelines provided by OMB Circular A-87. In the hypothetical example at right, \$10,000 represents the estimated costs related to one staff member paid at a rate of \$40,000 per year who spends one-quarter, or 25 percent, of her total work time on NCI related activities.

Determining the Medicaid Share
Hypothetical Example

1. Proportion
Total number of individuals covered: 6,000
Number of Medicaid recipients covered: 5,000

2. Medicaid Share
Medicaid Share Factor = The number of Medicaid recipients divided by the total number of recipients:
5,000/6,000 = 83%.

3. Costs to be Allocated
Cost of conducting NCI activities = \$10,000

4. Proportional Medicaid Cost
Gross claimable amount = \$10,000
Medicaid share rate = .83

Medicaid Activity
Administrative Activity Claimed: Monitoring Medicaid services covered at 50% FFP

5. Claim
Proportional Medicaid Cost \$ 8,300
FFP Rate (50%) x .50
Net claimable amount: \$ 4,150

4. Determine the Proportional Medicaid Cost by multiplying the costs of conducting NCI activities based on time study data (\$10,000) by the Medicaid Share Factor (83%). The resulting amount, \$8,300, represents the total costs applicable to Medicaid administrative activities.

5. Determine the amount that can be claimed for FFP by multiplying the proportional Medicaid cost of NCI activities (\$8,300) by the rate of federal financial participation for the particular activity performed, fifty percent (50%) in this example. This yields the net claimable amount of \$4,150.

In summary, FFP is being claimed based on the portion of Medicaid recipients whose services were being monitored and evaluated through the NCI project. Six thousand

individuals are reviewed. Five thousand or eighty-three percent are Medicaid recipients. The percentage of Medicaid recipients is applied to the total costs of conducting NCI activities (\$10,000 in this example), yielding a cost for the Medicaid group of \$8,300. FFP can be claimed for this amount at a rate of fifty percent, yielding a final claimable amount of \$4,150.

Administrative Claiming Plan

CMS requires that the state Medicaid agency submit an administrative claiming implementation plan describing the procedures and mechanisms used for claiming Medicaid administrative costs. As described in the *CMS Medicaid School-Based Administrative Claiming Guide*, the plan should provide documentation that designated matching funds are not also being used to match other federal funds or are derived from other federal sources, and additionally describe: (a) interagency agreements, (b) the treatment of indirect costs, (c) current administrative activities covered by Medicaid, (e) time study methodologies used to determine the proportion of time allocated to Medicaid and, (f) the monitoring process used to verify the accuracy of the methodologies used.

Summary and Recommendations

This paper provides guidance to states regarding procedures for claiming administrative FFP for the costs of participating in the National Core Indicators program. More detailed information is available in the referenced documents. In summary, responsibility for claiming FFP for appropriate Medicaid administrative expenses rests with the single State Medicaid Agency, but the administrative activities performed by other states agencies on behalf of Medicaid beneficiaries also qualify for FFP, whether they are performed directly by state DD agency staff or carried out by other organizations, agencies or individuals acting under contract with the state. The overarching requirement is that any claimed activity must be clearly described and determined to be necessary for the “proper and efficient” administration of the state’s Medicaid plan. To support this requirement the state must be able to identify the specific costs incurred and separate costs related to Medicaid recipients from those attributable to non-Medicaid recipients. Participating states which have not already done so should carefully review NCI related activities to determine the extent to which they may be claimable as an administrative expense or as a case management/service coordination expense under either the targeted case management state plan option or as a covered service under a CMS-approved HCBS waiver program.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

6325 Security Boulevard
Baltimore, MD 21207

DEC 20 1994

Dear State Medicaid Director:

As the result of a recent examination of claims for administrative match which included some inappropriately claimed activities, we believe it is important to reiterate our long-standing policy on allowable administrative costs. Moreover, because the situation prompting this examination included activities identified as administrative case management (ACM), as well as other administrative functions performed by State and local governments, we would like to amplify our policy with specific reference to such situations.

Section 1903(a) of the Social Security Act directs payment of Federal financial participation (FFP), at different matching rates, for amounts "found necessary by the Secretary for the proper and efficient administration of the State plan." The Secretary, rather than the State, is the final arbiter of which activities fall under this definition. We have consistently held that allowable claims under this authority must be directly related to the administration of the Medicaid program. Thus, activities directed toward services not included under the Medicaid program, although such services may be valuable to Medicaid beneficiaries, are not necessary for the administration of the Medicaid program, and therefore are not allowable administrative costs. In addition, with regard to any allowable administrative claim, payment may only be made for the percentage of time spent which is actually attributable to Medicaid eligible individuals.

The Health Care Financing Administration (HCFA) has approved cost allocation plans from States which include the following types of administrative costs necessary for the proper and efficient administration of the State plan (Note: this list is not all-inclusive):

- o Medicaid eligibility determinations;
- o Medicaid outreach;
- o Prior authorization for Medicaid services;
- o Medicaid Management Information System development and operation;

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- o Early and Periodic Screening, Diagnostic, and Treatment administration;
- o Third Party Liability activities; and
- o Utilization review.

In 1986, Congress recognized case management as a separate service eligible for matching at the Federal Medical Assistance Percentage (FMAP), when such services were provided to a targeted group of high risk individuals and the State submitted an amendment to its Medicaid State plan. As Medicaid agencies expanded their use of individual case management activities, both for targeted case management and for the general Medicaid population, they asked whether some of the case management activities which were not claimable as targeted case management were instead claimable as administrative costs. In Section 4302 of the State Medicaid Manual (SMM), HCFA identifies the following case management activities which may be properly claimed as ACM (but not as targeted case management):

- o Medicaid eligibility determinations and redeterminations;
- o Medicaid intake processing;
- o Medicaid preadmission screening for inpatient care;
- o Prior authorization for Medicaid services;
- o Utilization review; and
- o Outreach activities to inform or persuade beneficiaries or potential beneficiaries to enter into care through the Medicaid system.

(NOTE: This group of services which States may identify as ACM was not intended to be all-inclusive.)

This SMM section did not authorize a new category for administrative claiming but only recognized that existing types of coverable administrative costs could be understood as falling under the general concept of case management. For example, the costs for time spent by a State employee who worked specifically on conducting a prior authorization review for a Medicaid service could be claimed as an administrative

cost even though this activity may be referred to as ACM by the State. In our view, such services could have always been claimed as administrative costs because of their direct connection to the proper and efficient administration of the Medicaid State plan. While some case management activities may fall within the scope of both administrative and targeted case management, a State may not claim the same costs both as targeted case management and ACM at the same time.

Medicaid Policy

Given the results of our examination of claims for administrative match and based on recent inquiries from States and comments received from the publication of the Notice of Proposed Rulemaking (NPRM) on targeted case management, we believe that the general principles governing Medicaid reimbursement of administrative costs and particularly ACM, as set out in the SMM and in the NPRM on targeted case management, require additional amplification. By addressing the application of this policy in several particular situations we hope that States will better understand which costs may be identified and claimed as administrative costs under the Medicaid program.

As cited earlier, the overarching policy guiding such decisions is that the costs must be "found necessary by the Secretary for the proper and efficient administration of the State plan." (Emphasis added.) HCFA exercises the Secretary's authority to determine what is necessary and proper for the efficient administration of the State plan.

The following principles reflect determinations made by HCFA in applying this policy. States should follow these principles in evaluating the legitimacy of their claims for administrative match. An allowable administrative cost:

- o must be directly related to Medicaid State plan or waiver services. Allowable administrative costs do not include gaining access to or coordinating non-Medicaid services even if such services are health-related. Also, allowable administrative costs do not include gaining access to or coordinating social, educational, vocational, legal, or other non-Medicaid services. The cost of gaining access to or coordinating non-Medicaid services may be claimable as targeted case management if applicable State plan requirements are met.

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- o cannot reflect the cost of providing a direct medical or remedial service, such as immunizations or psychological counseling.
- o cannot be an integral part or extension of a direct medical or remedial service, such as patient follow-up, patient assessment, patient education, counseling (including pharmacy counseling), or other physician extender activities. Such services are properly paid for as part of the payment made for the medical or remedial service. Because Medicaid providers have agreed to accept service payment as payment in full, such providers may not claim an additional cost as administrative cost under the State plan.
- o may not include funding for a portion of general public health initiatives that are made available to all persons, such as public health education campaigns, unless the campaign is explicitly directed at assisting Medicaid eligible individuals to access the Medicaid program.
- o may not include the overhead costs of operating a provider facility, such as the supervision and training of providers.
- o may not include the operating costs of an agency whose purpose is other than the administration of the Medicaid program, such as the operation of a probation department.

However, to the degree that a governmental agency directs some fraction of its efforts exclusively to Medicaid claimable administrative services, and can accurately identify that fraction, it may claim an appropriate portion of its operating costs to support that function if all other criteria for administrative claiming is satisfied (e.g., direct relationship to the State plan, health-related, etc.).

- o must be included in a cost allocation plan that is approved by HCFA and supported by a system which has the capability to isolate the costs which are directly related to the support of the Medicaid program from all other costs incurred by the agency.

- o must, if claimed at the enhanced matching rate for activities rendered by skilled professional medical personnel (SPMP), include only administrative activities performed by the SPMP which require the level of medical expertise of such SPMP in order to be performed effectively and meet all requirements of Federal regulations at 42 CFR 432.50(d).
- o cannot be incurred with regard to any services provided to individuals who are "inmates of a public institution" as this exclusion is specified in regulations and interpreted by HCFA. This would include juveniles as well as adults detained temporarily in locked public facilities awaiting disposition. (Individuals whose disposition has already been determined, but who are housed temporarily in such facility until placement to other than inmate status elsewhere is available, are not considered inmates.)

Prior to implementation of State or local systems for claiming administrative costs, States should ensure that their methodologies for distinguishing administrative activities eligible for FFP conform to the guidelines outlined above and are included in the State's cost allocation plan submitted to and approved by the Director of the Division of Cost Allocation (after consultation with HCFA) in accordance to Federal regulations at 45 CFR, Subpart E. Many case management activities which are not allowable under these guidelines may be allowable as targeted case management services, through an approved amendment to the State plan. Guidelines for targeted case management may be found in the SMM, Section 4302.

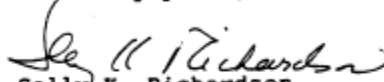
Furthermore, States should ensure that State and local agency time coding systems used to determine Medicaid utilization are designed to distinguish allowable administrative costs from non-allowable expenses. These time coding systems must also be approved by HCFA prior to State and local implementation and must meet the simplicity of administration requirements of the Social Security Act.

We plan to issue an expanded list of policy interpretations to guide States' decision making regarding allowable costs for Medicaid administrative match for ACM and other functions performed by State or local governments in a SMM issuance. We also intend to incorporate these interpretations in regulations.

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We hope States find this material helpful and would welcome your input on areas in which you believe further policy interpretation would be useful.

Sincerely yours,


Sally K. Richardson
Director
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