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CMCS Informational Bulletin

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SUBJECT: **Accessing Enhanced Federal Medicaid Matching Rates for State Information Technology Expenditures to Improve Access to Mental Health and Substance Use Disorder Treatment and Care Coordination**

The Center for Medicaid and CHIP Services (CMCS) is issuing this CMCS Informational Bulletin (CIB) to provide examples of state Medicaid information technology expenditures to improve access to and coordination of treatment and support services for Medicaid beneficiaries with mental health (MH) conditions and/or substance use disorders (SUDs) that may qualify for enhanced federal matching rates. This CIB also reminds state Medicaid agencies how to apply for enhanced Medicaid matching rates for these types of expenditures.

Background[1]

Health information technology (IT) systems can increase access to MH and SUD services and support coordination with other types of health care and support services - both of which are key to efficiently, economically, and effectively delivering covered services to and improving outcomes for Medicaid enrollees. A high proportion of enrollees experience these conditions. In 2022, approximately 31.9 percent of Medicaid enrollees aged 18 or older had any mental illness in the past year, and 24.4 percent had an SUD in the past year.[2] However, only 55.1 percent of adult Medicaid enrollees with past-year AMI received mental health treatment in the past year and only 9.6 percent of adult Medicaid enrollees overall received substance use treatment in the past year.[3] Moreover, interactions between physical health and MH conditions and SUDs can complicate treatment and significantly drive up the overall costs of care. This dynamic demonstrates the need for improved care coordination.[4] There are opportunities for state Medicaid agencies to receive enhanced federal matching rates for certain expenditures supporting implementation and operation of health IT aimed at increasing access to MH and SUD treatment and improving coordination of care for co-occurring physical health conditions among enrollees.

One way health IT can help increase access to MH and SUD services and improve care coordination is by supporting greater integration of MH and SUD treatment into primary care

and other health care settings.[5] Research studies show that integration of physical and MH and SUD treatment can improve access to care and also help control costs among individuals with these conditions including Medicaid enrollees.[6] There are a variety of ways that technology can support integration of MH and SUD services in primary care and other health care settings. Examples noted by practitioners in the field include patient-facing technology (e.g., software applications, web services, text messaging that serve as practice extenders) and web-based platforms to support consultation with specialists, tele-mentoring, and provider education as well as telehealth to provide direct evaluation and therapy via virtual visits.[7]

A number of these examples incorporate telehealth as a key technology that can support integration of MH and SUD. Telehealth has proven to be particularly effective at improving access to MH and SUD treatment.[8] Health IT can be used to support increased availability of telehealth technology, improve access to existing MH and SUD treatment providers, and support integration as well as crisis response. CMCS has issued updated guidance and a toolkit to help state Medicaid agencies adopt telehealth coverage policies in their state's Medicaid and Children's Health Insurance Program (CHIP). In addition, health IT solutions, including electronic connections to health information exchanges (HIEs), can help improve coordination of care by practitioners addressing physical health with providers who specialize in treating MH conditions and SUDs.[9]

Provider-to-provider consultations by MH and SUD treatment specialists are a key feature of highly effective integration models.[10] The Health Resources and Services Administration's Pediatric Mental Health Care Access and Screening and Treatment for Maternal Mental Health and Substance Use Disorders programs support states to implement these models of care. To increase Medicaid support for these models, CMCS clarified in guidance issued in January, 2023 that state Medicaid and CHIP programs may pay MH and SUD treatment specialists (as well as other types of providers) directly for interprofessional consultations that help primary care and other health care practitioners to provide MH and SUD treatment.[11] Previous policy had stipulated that such payment had to be incorporated into the Medicaid payment for the treating provider who consulted with the specialist. Medicare also provides direct payment to specialists for inter-professional consultation services. Health IT solutions can support broader availability of these provider-to-provider consultations as well as tele-mentoring and some of the other innovations mentioned above that can increase access to care for MH conditions and SUDs.[12]

In addition, health IT can promote increased availability of MH and SUD crisis services by supporting the new, national 988 tollfree hotline and connections to mobile crisis response providers.[13] Callers to 988 may more quickly receive telephonic support and mobile crisis response through telehealth and health IT. These technologies can also connect crisis response providers to the broader emergency and health care system, including first responders and hospital emergency rooms as well as specialized MH and SUD treatment providers.[14]

Unfortunately, MH and SUD treatment providers are far less likely to utilize health IT systems than most other types of health care providers: 13 percent of MH facilities and 8.5 percent of SUD facilities that accept Medicaid electronically share client data with other providers, and 6 percent of MH facilities and 28 percent of SUD facilities use electronic systems for basic clinical

functions.[15] The lack of utilization of health IT among MH and SUD providers contrasts sharply with physical health care providers and general health care systems. Among general health care providers, research shows utilization of health IT has led to significant improvements in quality.[16] One often cited reason for this disparity is that MH and SUD treatment providers were generally not eligible for incentive payments for meaningful use of health IT authorized by Congress in 2009.[17] As physical health care providers and general health care systems are increasingly moving to interoperable systems and electronic exchange of health care information, MH and SUD providers are likely to fall farther behind, thus exacerbating the existing challenges with care coordination between physical health care and MH and SUD treatment and with accessing MH and SUD treatment.

To increase utilization of health IT among MH and SUD providers, some states have developed Medicaid IT programs and systems that help to improve access to MH and SUD treatment and care coordination for Medicaid enrollees. State Medicaid agencies may qualify, under certain circumstances, for enhanced federal financial participation (FFP) of 90 percent for a state Medicaid agency's expenditures for designing, developing, or installing (DDI) mechanized claims processing and information retrieval systems that make up the Medicaid Enterprise System (MES). States may also qualify for enhanced FFP of 75 percent for the state Medicaid agency's expenditures for operating, including maintaining, the MES (referred to as expenditures for M&O).[18] The following questions and answers clarify and provide examples of the types of state Medicaid agency expenditures that may qualify for enhanced federal matching rates for health IT and also address how state Medicaid agencies may apply for CMCS approval that those expenditures qualify for enhanced matching rates. In developing these programs, Medicaid agencies and providers should comply with the Health Insurance Portability and Accountability Act (HIPAA), 42 CFR Part 2 and applicable state regulatory requirements.[19]

FREQUENTLY ASKED QUESTIONS

Examples of State IT Spending that May Qualify for Enhanced Federal Medicaid Matching Rates

Q1: What are some examples of state health IT expenditures that may be eligible for enhanced federal Medicaid matching rates?

A1: State Medicaid agency expenditures to design, develop, and install (DDI) IT innovations (including enhancements to existing systems) such as those listed below focused on improving care for Medicaid enrollees with MH conditions and/or SUDs may be eligible for enhanced federal Medicaid matching funds (assuming compliance with all applicable federal requirements, including those outlined below). In addition, state Medicaid agency expenditures for the maintenance and operation of these systems may qualify for a different enhanced federal Medicaid matching rate. Per section 1903(a)(3)(A) and (B) of the Social Security Act (the Act), the 90/10 matching rate for DDI and the 75/25 matching rate for M&O are available for systems operated by the state Medicaid agency.

This funding is not authorized for provider-owned system or technology solutions. To qualify for enhanced matching at the 90/10 rate for DDI and the 75/25 rate for M&O, state Medicaid agencies must show how these systems, enhancements, and technologies would benefit the Medicaid program.

Additionally, if these investments will benefit programs other than Medicaid, the state Medicaid agency must include a cost allocation plan (discussed below) in the request for approval. The same rules regarding cost allocation apply to both the 75/25 matching rate and the 90/10 matching rate. CMS approval and federal certification of the cost allocation plan may also be required.[20]

Following is a non-exhaustive list of examples of health IT that may be eligible for enhanced Medicaid matching rates if all applicable federal requirements including regulations and laws protecting the privacy of the individuals receiving MH and/or SUD treatment or services are met:

- Technology to facilitate information exchange between MH and SUD treatment providers and schools, hospitals, primary care, and criminal justice settings,
- Data-sharing capabilities between hospitals and community-based MH and SUD treatment providers such that an enrollee's records regarding inpatient or residential treatment could be available to a community-based MH or SUD provider who provides treatment to that individual as well and vice versa,
- Technology to make MH and SUD screening available in schools for Medicaid beneficiaries,[21]
- Smartphone applications that allow enrollees to access an educational/motivational video portal, relevant recovery supports and treatment services, a meeting locator, a sobriety calculator, an integrated wellness module, and/or a virtual recovery group functionality,
- Public-facing websites that link enrollees to social networks, peer support groups, resource sharing, and other functions, and/or provide access to a private-facing portal that includes individual-driven content like weekly questionnaires, a recovery plan, and a recovery calendar,
- Implementation and maintenance of an information exchange platform connecting Medicaid beneficiaries to a network of Medicaid-participating peer support specialists and substance use disorder treatment clinical staff who share resources and information to collectively support recovery through engagement and education,
- Establishment of an eConsent Management System, i.e., software to manage enrollees' consent to share health information, that could support exchange of MH and SUD treatment information using common health information exchange standards and application programming interfaces (APIs) to connect and support data exchange among users of an EHR system (potentially enabling providers to find information about an enrollee's care team, treatment plan, appointments, problem list, medications, vitals, lab results, and other clinical documentation such as medication reviews and clinical assessments), and

- Creation of an email or other electronic alert system ensuring MH and SUD treatment providers receive information on admissions, discharge, or transfer (ADT) so that when an enrollee with serious mental illness (SMI) or serious emotional disturbance (SED) is being discharged from a hospital, that enrollee's records regarding treatment could more easily be transferred to a community-based treatment provider including:
  - Alerts triggered by an ADT event in a hospital information system sending a message to an HIE system,
  - The HIE system processing the message and transforming it into an alert sent to the MH or SUD provider, and
  - Encouraging the physician, care manager, or care management team to initiate an intervention, thus improving the post-discharge transition and supporting access to care for enrollees with MH or SUD conditions.

Q2: Can States qualify for 90 and 75 percent federal matching rates for state expenditures in support of telepsychiatry and telehealth?

A2: As previously highlighted by CMCS, states could qualify for enhanced federal Medicaid matching rates for some of their expenditures for designing, developing, and implementing telehealth-enabling technology, including patient-facing technology, to be used by MH and SUD providers for planning, coordinating, monitoring, and assessing care for their patients who are Medicaid enrollees.[22] This type of technology could, for example, improve enrollees' access to MH and SUD treatment via virtual treatment centers and remote counseling. In addition, some state Medicaid agency expenditures supporting the availability of medication assisted treatment (MAT)[23] via telehealth for Medicaid enrollees could qualify for enhanced matching rates.

Furthermore, telehealth technology focused on connecting care teams, as in, for example, the Collaborative Care Model (CoCM), to improve integration of MH and SUD treatment and primary care, could qualify for the 90/10 and 75/25 matching rates as long as all applicable federal requirements, including the processes described below (Qs and As 5 through 9), are met. CoCM is an evidence-based care delivery model in which a treating practitioner (e.g., a primary care provider) provides treatment for patients' MH conditions and SUDs while supported by a MH/SUD care manager and a psychiatric consultant.[24] CMS has established codes for payment for CoCM,[25] and CMCS recently clarified that a core component of CoCM, i.e., inter-professional consultations between the treating practitioner and the psychiatric consultant, may be directly covered by state Medicaid programs with the consultant being paid directly instead of through payment to the treating provider.[26] Enhanced federal matching rates may be available for State-funded and operated technology facilitating this communication and care coordination between providers for Medicaid enrollees.

Q3: Are state IT costs for operating a 988 call center and mobile crisis response eligible for enhanced federal matching rates?

A3: State Medicaid agency expenditures that may be eligible for enhanced federal Medicaid matching rates of 90 percent and 75 percent could include expenditures to support the following

activities (assuming compliance with federal requirements, including those outlined below and laws and regulations protecting privacy):

- Systems supporting establishment of and/or improvements to crisis call centers that enable Medicaid enrollees to access mobile crisis teams,
- Systems integration activities in support of the 988 activities,
- Providing state-owned mobile devices including phones and tablet computers to state-staffed mobile crisis teams to facilitate telehealth services for Medicaid enrollees to receive services from a clinician at another location during a crisis intervention,
- Developing and implementing software applications to facilitate communication between crisis call centers and mobile crisis providers and supervisory clinicians with mobile crisis team staff,
- Implementing text and chat technologies that many enrollees, including youth, may be more comfortable using as part of the services offered by crisis call centers, and
- Implementing accessible technologies for individuals with disabilities.[27]

More specifically, some state expenditures to develop and implement software applications and web-based portals to facilitate communication between call centers and mobile crisis providers and other clinicians may be eligible for enhanced federal Medicaid matching rates. For example, such software applications and web-based portals could include --

- A call center web-based platform enabled to:
    - Receive calls, texts, and chats via the 988 number,
    - Document the call information,
    - Share relevant information with a referral system, and
    - Create and share reports,
- A behavioral health integrated referral system enabled to:
    - Establish connections (e.g., between 988 and regional crisis lines),
    - Support information sharing and coordination (e.g., between regional crisis lines and crisis responders and between crisis responders and other providers),
    - Coordinate with American Indian/Alaska Native Tribal providers,
    - Facilitate referrals (e.g., between crisis providers and other providers),
    - Collect and analyze data to produce reports (including outcomes),
- An interoperability platform to facilitate information exchange supporting the following activities:
    - Registries for bed availability including real-time information regarding bed availability and other information that can be used by regional crisis lines to support referrals, and

- Provider resource directories including health, behavioral health, and social service information that both 988 and regional crisis lines can access.

Costs Not Eligible for Enhanced Federal Medicaid Matching Rates

Q4: What are examples of health IT costs that are not eligible for the 90 and 75 percent enhanced federal Medicaid matching rates for certain Medicaid IT expenditures?

A4: States may not claim 90 or 75 percent matching rates for MH and SUD treatment providers' costs of implementing EHR technology into their individual practices due to limitations in statutory authority. These enhanced matching rates are not authorized for provider-owned systems and technology solutions or for any work on a provider's system. State Medicaid agencies are encouraged to reach out to their CMS Medicaid Enterprise Systems (MES) State Officer, and the Office of the National Coordinator for Health IT to discuss technologies that might be able to support Medicaid providers interested in implementing EHR technology and how such investments might be financed.

Payment Process for States' Medicaid Administrative Costs in General

Q5: How can state Medicaid programs qualify for the regular administrative federal matching rate of 50 percent of costs associated with providing Medicaid coverage in their states (as opposed to enhanced matching rates for DDI and M&O of MES supporting mechanized claims processing and information retrieval)**?**

A5: Title XIX of the Act authorizes federal grants to states for expenditures necessary for administration of the state plan.

Under section 1903(a)(7) of the Act, federal matching funds are available at a rate of 50 percent for amounts expended by a state, "as found necessary by the Secretary for the proper and efficient administration of the state plan."[28]

Certain administrative costs may be matched at higher federal financial participation (FFP) rates.[29] Claims for Medicaid administrative FFP must come directly from the single state Medicaid agency.

For Medicaid administrative expenditures to be claimed for federal matching funds, the following requirements must be met:

- Costs must be necessary for the "proper and efficient" administration of the state's Medicaid state plan,[30]
- Costs related to multiple programs must be allocated in accordance with the benefits received by each participating program[31] (with a method to assign costs based on the relative benefit to the Medicaid program and the other government or non-government programs),
- Costs must be supported by an allocation methodology that appears in the state's approved Public Assistance Cost Allocation Plan (PACAP),[32]

- Costs must 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 activities related to assisting Medicaid-eligible individuals are specifically identified and the state develops a methodology that appropriately allocates a portion of costs for those activities benefiting the Medicaid-eligible individuals to the Medicaid program.[33]
- Costs must not include the overhead costs of operating a provider facility, which are addressed instead through the provider's service payment rate, unless that provider facility directs some fraction of its efforts to performing state program administrative activities, and accurately identifies that fraction,
- Costs must not duplicate payment for activities that are already paid through other programs,
- Costs may not supplant funding obligations from other federal sources, and
- Costs must be supported by adequate source documentation.[34]

Moreover, to be eligible for federal administrative matching funds (including those paid at an enhanced matching rate), state Medicaid IT expenditures claimed may not reflect the cost of providing a direct medical or remedial service which should be claimed on Form CMS 64.9; for example, Medicaid IT cost claiming should exclude behavioral health counseling, clinical assessment, and case management services.

Funding for end user/business user training for personnel not directly engaged in eligibility determinations is also available at the 50 percent administrative matching rate for training regarding Medicaid systems.[35] Enhanced matching funds at the 90/10 rate for DDI are only available for expenditures for individuals directly involved in the design, development, or implementation of Medicaid Systems, and 75/25 percent for M&O is only available for expenditures for individuals directly involved in the operation of a Medicaid system.[36]

Federal Requirements to Qualify for Enhanced Federal Matching Rates for Certain Medicaid IT Expenditures

Q6: To qualify for enhanced federal Medicaid matching rates, what requirements must a state meet for DDI and/or M&O of Medicaid IT systems (including enhancements to existing systems)?

A6: State expenditures must meet all of the conditions specified in 42 CFR 433.112(b) to qualify for enhanced federal Medicaid matching rates of 90/10 for DDI.[37] These conditions include but are not limited to the following:

- The system is compatible with the claims processing and information retrieval systems used in the administration of Medicare for prompt eligibility verification and for processing claims for persons eligible for both programs;
- The State owns any software that is designed, developed, installed, or improved with 90 percent FFP;

- The Department of Health and Human Services has a royalty free, non-exclusive, and irrevocable license to reproduce, publish, or otherwise use and authorize others to use, for federal government purposes, software, modifications to software, and documentation that is designed, developed, installed, or enhanced with 90 percent FFP;[38]
- The technology uses a modular, flexible approach to systems development, including the use of open interfaces and exposed application programming interfaces, the separation of business rules from core programming, available in both human and machine-readable formats;
- The technology aligns to, and advances increasingly, in Medicaid Information Technology Architecture (MITA) maturity for business, architecture, and data;
- The agency ensures alignment with, and incorporation of, industry standards adopted by the Office of the National Coordinator for Health IT in accordance with 45 CFR part 170, subpart B, the HIPAA privacy, security and transaction standards, accessibility standards established under section 508 of the Rehabilitation Act (or standards that provide greater accessibility for individuals with disabilities and compliance with Federal civil rights laws), standards adopted by the Secretary under section 1104 of the Affordable Care Act, and standards and protocols adopted by the Secretary under section 1561 of the Affordable Care Act;
- The technology promotes sharing, leverage, and reuse of Medicaid technologies and systems within and among States;
- The technology produces transaction data, reports, and performance information that would contribute to program evaluation, continuous improvement in business operations, and transparency and accountability;
- The system supports seamless coordination and integration with the Marketplace, the Federal Data Services Hub, and allows interoperability with health information exchanges, public health agencies, human services programs, and community organizations providing outreach and enrollment assistance services as applicable;
- Systems and modules developed, installed, or improved with 90 percent match must include documentation of components and procedures such that the systems could be operated by a variety of contractors or other users; and
- For software systems and modules developed, installed, or improved with 90 percent match, the State must consider strategies to minimize the costs and difficulty of operating the software on alternate hardware or operating systems.

In order to qualify for federal Medicaid enhanced match of 75/25 for M&O, the state must comply with all of the conditions at 42 CFR 433.116. These conditions include but are not limited to the following:

- The State must obtain prior written approval[39] from CMS when it plans to acquire automatic data processing or ADP[40] equipment or hardware, when it anticipates the total acquisition costs will exceed thresholds;
- The system must have been operating continuously during the period for which FFP is claimed;

- The system must provide individual notices, within forty-five (45) days of the payment of claims, to all or a sample group of the persons who received services under the plan;
- The notice required must specify the service furnished, the name of the provider furnishing the service, the date on which the service was furnished, and the amount of the payment made under the plan for the service, and must not specify confidential services (as defined by the State) and must not be sent if the only service furnished was confidential;
- The system must provide both patient and provider profiles for program management and utilization review purposes; and
- If the State has a Medicaid fraud control unit certified under section 1903(q) of the Social Security Act and 42 CFR 455.300, the Medicaid agency must have procedures to assure that information on probable fraud or abuse that is obtained from, or developed by, the system is made available to that unit.[41]

Application Process to Qualify for Enhanced Federal Matching Rates for Certain Medicaid IT Expenditures

Q7: What additional requirements must state Medicaid agencies meet in applying for enhanced federal Medicaid matching rates for certain Medicaid IT expenditures?

A7: Approval for enhanced match for IT requires the submission of an Advanced Planning Document (APD).[42] A state may submit an APD requesting approval for a 90 percent enhanced federal match for the DDI of MES initiatives. Interested states should refer to 45 CFR Part 95, Subpart F – Automatic Data Processing Equipment and Services - Conditions for FFP, for the specifics related to APD submission. States may also request a 75 percent enhanced federal matching rate for the M&O of CMS approved systems. Interested states should refer to 42 CFR Part 433 Subpart C – Mechanized Claims Processing and Information Retrieval Systems, for the specifics related to systems approval. If there are questions related to these topics, CMS encourages states to contact their MES State Officer.

In general, administrative expenditure claims, including those for enhanced Medicaid matching rates, must not duplicate costs that have been, or should have been, paid through another source, including through claims for covered services matched at the applicable Federal medical assistance percentage (FMAP).

An administrative cost must be related to a covered Medicaid service to be eligible for Medicaid matching funds. The State Medicaid Manual, Section 11276.9 provides that --

> "Only direct costs allocable to the development or operation of an MMIS [Medicaid Management Information System] are eligible for reimbursement at enhanced FFP rates. Such costs include utilities, rent, telephone service, etc., necessitated by either the development or operation of an MMIS."

> "Costs which cannot be specifically identified with the development or operation of an MMIS are matched at the 50 percent FFP rate. Such costs are usually indirect costs including the staff costs associated with agency-wide functions such as accounting, budgeting, legal affairs, general administration, etc." Moreover, Medicaid expenditures must be reasonable, allowable, and allocable.[43]

Allowable costs must also be allocated in accordance with the relative benefits received by the Medicaid program,[44] e.g., Medicaid can support crisis call response functions only to the extent and proportion that these functions serve Medicaid enrollees.

CMS will review state allocation methodology proposals using existing administrative claiming criteria, as well as federal cost allocation principles.[45]

In addition, states must have a methodology to identify and allocate costs for Medicaid beneficiaries that are not covered by or duplicative of other fundings sources.

Q8: How should states allocate costs of MH and SUD IT investments to demonstrate eligibility for enhanced federal Medicaid matching rates?

A8: The principles of cost allocation for state administered technology to facilitate, for example, information exchange, data-sharing, coordinating care, referral to other providers, access to treatment-related information, and linkages to treatment-related resources for providers and/or patients are consistent with the principles described in CMS and OMB guidance.[46]

Steps for determining the amount that may be claimed include identifying all costs incurred (direct and indirect) and applying an allocation ratio.

45 CFR 75.413 defines direct costs as "those costs that can be identified specifically with a particular final cost objective, such as a federal award, or other internally or externally funded activity, or that can be directly assigned to such activities relatively easily with a high degree of accuracy." Examples of direct costs include but are not limited to salaries and benefits, equipment, and depreciation. Direct costs must be reduced by "applicable credits" which are those receipts or reduction-of-expenditure-type transactions that offset or reduce expense items allocable to the Federal award, to arrive at total direct costs.

45 CFR 75.2 defines indirect costs as those, "incurred for a common or joint purpose benefiting more than one cost objective, and not readily assignable to the cost objectives specifically benefitted, without effort disproportionate to the result achieved." Examples of indirect costs include but are not limited to budgeting, accounting, janitorial, clerical, equipment, and depreciation.

When claiming for allowable administrative activities for a population consisting of both Medicaid-eligibles and non-eligibles, administrative expenditures may only be claimed for the portion of costs attributable to Medicaid-eligible individuals; for example, to claim a portion of the cost of administering a 988 MH and SUD crisis hotline –

- States must demonstrate the proportion of activities that are for Medicaid enrollees (e.g., the proportional share of Medicaid enrollees to the total number of callers) - also known as the Medicaid eligibility rate (MER), Medicaid percentage, or discount ratio;[47] and

- States could determine an appropriate allocation of costs for a 988 MH and SUD crisis hotline to Medicaid by using, for example, a ratio with --

  - The total number of Medicaid beneficiaries in the state as the numerator and the total number of state residents as the denominator (assuming all residents can use the hotline),

  - The total number of Medicaid beneficiaries in the state with a MH or SUD condition over the total state residents with a MH or SUD condition, or

  - The number of Medicaid beneficiaries going to emergency departments for treatment for MH or SUD conditions as the numerator and number of total residents going to emergency departments for MH or SUD conditions as the denominator.

Documentation must clearly demonstrate that the activities support the administration of the Medicaid program. In addition, section 42 CFR 433.32(a) requires that states maintain an accounting system and supporting fiscal records to ensure that claims for Federal funds are in accord with applicable federal requirements. Furthermore, subsections (b) and (c) of 42 CFR 433.32 require that states retain records for three years from the date of submission of a final expenditure report, and likewise retain records beyond the three-year period if audit findings have not been resolved.

States interested in claiming enhanced federal administrative matching rates for DDI of certain Medicaid IT systems must identify the proposed cost allocation methodology within an APD for CMS review and prior approval (45 CFR 95.631). Documentation should include a narrative section, tables or spreadsheets with calculations, and any other documentation needed by CMS to make a determination on the approvability of the APD. Approval is contingent upon CMS determining the methodology is consistent with all applicable federal requirements, including those in 45 CFR Part 95, and approval determines the effective date.[48]

States interested in claiming enhanced federal administrative matching rates for M&O of certain Medicaid IT systems must submit Medicaid Administrative Claiming Methodologies to CMS as well as their Public Assistance Cost Allocation Plans discussing all their program costs and methodologies to the U.S. Department of Health and Human Services' Program Support Center's Division of Cost Allocation Services.[49] Documentation should include a narrative section and tables or spreadsheets with calculations, and any other documentation needed by CMS to make a determination on the approvability. Approval is contingent upon CMS and CAS determining the PACAP is consistent with all applicable federal requirements, including those in 45 CFR Part 95, and this approval determines the effective date.

States must include, as part of their APD submission requesting enhanced funding, an estimated total project cost and a prospective State and Federal cost allocation/distribution, including

planning and implementation. In addition, for implementation APDs, states must, include an estimate of the prospective cost allocation/distribution to the various State and Federal funding sources and the proposed procedures for distributing costs.[50] HHS regulations governing this process are at 45 CFR Part 75 and 45 CFR Part 95.

States are required to provide data to support their proposed cost allocation methodologies; for example, it might be appropriate to cost-allocate for a state administered information exchange platform that supports care coordination based on percentage of Medicaid providers who would leverage the proposed technology.[51]

Except where otherwise authorized by statute and regulations, costs must meet the following general criteria in order to be allowable under federal awards:

- Necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles,
- Conform to any limitations or exclusions set forth in these principles or in the federal award as to types or amount of cost items,
- Consistent with policies and procedures that apply uniformly to both federally financed and other activities of the non-Federal entity,
- Accorded consistent treatment, meaning a cost may not be assigned to a federal award as a direct cost if any other cost incurred for the same purpose in like circumstances has been allocated to the Federal award as an indirect cost,
- Determined in accordance with generally accepted accounting principles (GAAP),
- Not included as a cost or used to meet cost sharing or matching requirements of any other federally financed program in either the current or a prior period, and
- Be adequately documented.[52]

Q9: Can states weight cost allocation for resource intensive Medicaid enrollees?

A9: Yes. In the interest of accurate cost allocations, it would be appropriate to account for the greater amount of time spent coordinating care for high-need Medicaid enrollees as long as there is published data supporting the greater level of effort needed to coordinate care for patients with, for example, a MH and/or SUD diagnosis, lack of social support, and/or experiencing homelessness.[53] States must provide data demonstrating the added level of effort needed to coordinate care for Medicaid enrollees with multiple chronic conditions, including MH conditions and SUDs, in order to support weighting the cost allocation to reflect the higher level of effort for this population.

Furthermore, members of the public with a variety of payers and those who are uninsured may have complex diagnoses, SUDs, lack social supports, lack housing, lack adequate nutrition, and/or access to other needed services and supports. Therefore, these factors must also be considered and applied to individuals who are not enrolled in Medicaid when allocating costs to Medicaid; for example, if a multiplier is applied to the numerator to reflect the proportion of

Medicaid enrollees with these intensifying factors, an analogous multiplier needs to be constructed and applied to the denominator to reflect the proportion of the broader population to whom these factors apply. A cost allocation plan and methodology must be approved by the HHS Program Support Center-Cost Allocation Services.

As noted in the regulations on factors affecting allowability of costs, and also noted above, except where otherwise authorized by statute, costs must meet the following general criteria in order to be allowable under Federal awards:

- Necessary and reasonable for the performance of the federal award and be allocable thereto under these principles,
- Consistent with policies and procedures that apply uniformly to both federally financed and other activities of the non-Federal entity,
- Accorded consistent treatment, meaning a cost may not be assigned to a federal award as a direct cost if any other cost incurred for the same purpose in like circumstances has been allocated to the Federal award as an indirect cost,
- Determined in accordance with GAAP, except, for state and local governments and Indian tribes only, as otherwise provided for in this part,
- Not included as a cost or used to meet cost sharing or matching requirements of any other federally-financed program in either the current or a prior period,[54] and
- Be adequately documented.[55]

For Additional Information

For additional information on these Medicaid authorities and opportunities, state Medicaid agencies should contact their CMS MES State Officer.

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[1] NOTE: This document contains links to non-United States Government websites. We are providing these links because they contain additional information relevant to the topic(s) discussed in this document or that otherwise may be useful to the reader. We cannot attest to the accuracy of information provided on the cited third-party websites or any other linked third-party site. We are providing these links for reference only; linking to a non-United States Government website does not constitute an endorsement by CMS, HHS, or any of their employees of the sponsors or the information and/or any products presented on the website. Also, please be aware that the privacy protections generally provided by United States Government websites do not apply to third-party sites.

[2] Saunders H, Rudowitz R. Demographics and Health Insurance Coverage of Nonelderly Adults with Mental Illness and Substance Use Disorders in 2020. Kaiser Family Foundation. June 6, 2022. https://www.kff.org/medicaid/issue-brief/demographics-and-health-insurance-coverage-of-nonelderly-adults-with-mental-illness-and-substance-use-disorders-in-2020/#:~:text=As%20of%202020%2C%20an%20estimated,privately%20insured%20people%20(16%25)

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[29] See section 1903(a) of the Act and 42 CFR 433.15(b).

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[31] See 45 CFR 95.501, Cost Allocation Plans. https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-A/part-95/subpart-E.

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[35] See State Medicaid Manual Section 11276.5, Training of Users (of Medicaid systems); and Center for Medicaid and CHIP Services, State Medicaid Director Letter, "Mechanized Claims Processing and Information Retrieval Systems-Enhanced Funding", Appendix B (SMDL # 16-004).

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[39] See 45 CFR 95.611(a) for requirements specifically regarding prior approval conditions.

[40] Automated Data Processing or ADP Equipment or Hardware is defined in 45 CFR 95.605 as "automatic equipment that accepts and stores data, performs calculations and other processing steps, and produces information. This includes -
(a) Electronic digital computers,
(b) Peripheral or auxiliary equipment used in support of electronic computers,
(c) Data transmission or communications equipment, and
(d) Data input equipment.
Automatic Data Processing Services or ADP Services means -
(a) Services to operate ADP equipment, either by agency, or by State or local organizations other than the State agency, and/or
(b) Services provided by private sources or by employees of the State agency or by State and local organizations other than the State agency to perform such tasks as feasibility studies, system studies, system design efforts, development of system specifications, system analysis, programming, system conversion and system implementation and include, for example, the following:
(1) Systems Training,
(2) Systems Development,
(3) Site Preparation,
(4) Data Entry, and
(5) Personal services related to automated systems development and operations that are specifically identified as part of a *Planning ADP* or *Implementation ADP.* As an example, a personal service would be the service of an *expert individual* to provide advice on the use of ADP software or hardware in developing a State automated management information system.

[41] See 42 CFR 455.21, Cooperation with State Medicaid fraud control units.

[42] 45 CFR 95.610, Submission of Advanced Planning Documents; 42 CFR 433.112, FFP for design, development, installation or enhancement of mechanized processing and information retrieval systems; 42 CFR 433.116, FFP for operation of mechanized claims processing and information retrieval systems.

[43] See Section 11276.9, State Medicaid Manual, Chapter 11, Medicaid Management Information System. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS02192 .

[44] See 45 CFR 75.405(d); Instructions on Cost Allocation Plans can be found at 45 CFR Part 95 Subpart E, Cost Allocation Plans.

[45] 45 CFR 75 et seq; 45 CFR 95.611; State Medicaid Manual (SMM) Chapter 11, Sections 265 and 276 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927; Center for Medicaid and CHIP Services. State Medicaid Director Letter, "Mechanized Claims Processing and Information Retrieval Systems – Enhanced Funding" (SMD # 16-004). March 31, 2016. https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/SMD16004.pdf.

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[47] Center for Medicaid and CHIP Services. State Medicaid Director Letter, "Mechanized Claims Processing and Information Retrieval Systems – APD Requirements" (SMD #16-009). June 27, 2016. https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/smd16009.pdf; 42 CFR 433.112 (DDI) and 42 CFR 433.116 (M&O).

[48] 45 CFR 95.610, APD Submissions; 45 CFR 95.611, Prior Approval Requirements; Center for Medicaid and CHIP Services. State Medicaid Director Letter, "Mechanized Claims Processing and Information Retrieval Systems – APD Requirements" (SMD #16-009). June 27, 2016. https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/smd16009.pdf; 42 CFR 433.112 (DDI) and 42 CFR 433.116 (M&O).

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[52] See 45 CFR 75.403; See also 45 CFR 75.300 through 75.309.

[53] "Time and effort in care coordination for patients with complex health and social needs: Lessons from a community-based intervention". https://www.sciencedirect.com/science/article/pii/S2405452618302027.

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[55] See 45 CFR 75.403; See also 45 CFR 75.300 through 75.309.