DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

SMD #24-001

RE: Administrative Claiming for Nurse Advice Lines and for Skilled Professional Medical Personnel for Certain Behavioral Health Professionals

February 26, 2024

Dear State Medicaid Director:

This letter serves to amend two Centers for Medicare & Medicaid Services (CMS) policies regarding the availability of federal financial participation (FFP) for administrative expenditures. The first topic reverses long-standing CMS policy related to the availability of FFP for administrative expenditures for Medicaid nurse advice lines (NALs). The second topic amends CMS policy with respect to claims at the increased administrative federal matching rate for expenditures related to Skilled Professional Medical Personnel (SPMP) who are Masters of Social Work (MSWs) and other master's-level behavioral health professionals, provided they are licensed as independent practitioners under state law and meet all other requirements to qualify as SPMP, including being in an employer-employee relationship with the Medicaid agency in accordance with the definition of "skilled professional medical personnel" in 42 CFR § 432.2.

I. Nurse Advice Lines Claiming

A. *Background*

NALs are telephone services usually staffed by nurses that are typically available 24 hours per day, 7 days per week (often with physician back-up), that allow Medicaid beneficiaries to call for advice about appropriate medical action to take when a situation arises requiring medical attention. The telephone lines provide support and guidance to beneficiaries for non-emergency situations by assessing and triaging symptoms, using clinical judgment to offer care advice and referrals, and educating beneficiaries about their health. In the event that a caller presents information that suggests an emergency, NALs direct callers to seek emergency assistance, such as by calling 911 or the 988 Suicide and Crisis Lifeline as appropriate or going to the nearest emergency department (ED) for treatment. The 988 Lifeline provides easier access to mental health crisis care through a network of 200+ crisis call, text, and chat centers, separate from 911, where the focus is on dispatching emergency medical services, fire, and police, as needed, for public safety purposes. We remind states that Medicaid FFP may also be available in properly

allocated administrative expenditures for triaging crisis line calls and dispatching mobile crisis units, as well as for connecting callers to the 988 Suicide and Crisis Lifeline.

CMS policy has limited the availability of Medicaid administrative activity FFP for telephone services when those telephone services are available to all state residents and provide basic health information and/or advice.[1] However, CMS has carved out exceptions to the general limitation on FFP for telephone services that offer specific benefits to the health and well-being of Medicaid beneficiaries. This includes telephone lines that facilitate access to Medicaid-covered services and that direct beneficiaries to appropriate settings or resources for treatment. For example, CMS's policy allows FFP for properly allocated Medicaid administrative expenditures associated with smoking cessation quitlines that adhere to evidence-based protocols set forth in Public Health Service (PHS) Guidelines; for crisis call centers for people with mental health conditions or substance use disorders (SUDs); and for administration of mobile crisis intervention services.[2]

Significant evidence supports the cost-effectiveness of NALs, including their role in preventing inappropriate ED visits and promoting care delivery in appropriate settings or through other cost-effective means, such as telehealth. For example, a relatively large study of adults 65 years of age or older with an AARP Medicare Supplement Insurance plan concluded that the plan's NAL program was associated with a positive and statistically significant return on investment of about $1.59 per dollar spent on the program. This occurred even though nurses were three times as likely to recommend that callers seek a higher, rather than lower, intensity of care (e.g., ED v. urgent care) compared to what they would have sought on their own without seeking nurse advice.[3,4] In an evaluation of pediatric NALs, two-thirds of all calls for which a parent felt the patient should go to an ED or urgent care were deemed not to require an immediate face-to-face evaluation by the telephone triage nurse.[5] In another pediatric NALs study, ED visits made after nurse telephone triage referral were 33% more likely to be medically appropriate than patients

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[1] April 4, 1995, State Medicaid Director Letter on Administrative Claiming. Unavailable online.
[2] https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd11-007.pdf; https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf; and https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf
[3] Listening to the nurse pays off: an integrated Nurse HealthLine program was associated with significant cost savings; Jessica L. Navratil-Strawn MS, Kevin Hawkins PhD, Timothy S. Wells MPH, PhD, Ronald J. Ozminkowski PhD, Jean Hawkins-Koch BBA, Hungching Chan MPH; Stephen K. Hartley BS, Richard J. Migliori MD, Charlotte S. Yeh MD; 23 April 2013; https://doi.org/10.1111/jonm.12048.
[4] 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.
[5] In this study, 15% of calls from parents who intended to stay home were deemed urgent. The authors concluded that if call-center triage recommendations were followed in even half of all cases, then these results would translate into substantial cost savings for the health care system. Bunik M, Glazner J, Chandramouli V, et.al. Pediatric telephone call centers: how do they affect health care use and costs? Pediatrics. 2007 Feb;119(2):e305-13. https://pubmed.ncbi.nlm.nih.gov/17272593/

making their own decisions to go to the ED unassisted by an NAL (80% vs. 60% of visits deemed appropriate).[6]

In an era of workforce shortages, NALs can provide an opportunity for states to address critical issues of access to non-emergency care for pediatric and adult Medicaid beneficiaries, particularly in rural areas. NALs can provide high quality responses informed by evidence-based models of best clinical practice to beneficiaries or their caregivers in the caller's primary language, averting the use of 911 and/or EDs for non-acute medical needs, including mental health/substance use disorder (SUD) needs. Additionally, during the COVID-19 Public Health Emergency, the use of NALs and telehealth grew significantly, due to general reluctance to go to EDs and other in-person visits, further demonstrating the utility of NALs in the continuum of patient care. Based on these factors and as detailed below, we have determined that the use of NALs by Medicaid beneficiaries to address their care needs in a cost-effective manner is consistent with the proper and efficient administration of the Medicaid program. Therefore, costs for the operation of such NALs can be eligible for administrative FFP when properly allocated to the Medicaid program and adherent to federal claiming requirements.

Section 1903(a)(7) of the Social Security Act (the Act) provides for payment of FFP at a 50 percent federal matching rate in expenditures "found necessary by the Secretary for the proper and efficient administration of the State plan." In guidance issued in 1994,[7] we reiterated longstanding principles of allowable administrative costs, including that costs must be directly related to the Medicaid state plan or waiver services and that costs 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.

In April 1995, CMS issued a State Medicaid Directors Letter (SMDL), which stated that FFP was not available for administrative expenditures for general health telephone lines that could be considered a precursor to modern NALs. Specifically, that guidance concerned 24-hour, toll-free telephone services "for Medicaid beneficiaries who wish to hear taped medical information, or to consult with a nurse about appropriate action to be taken when a situation requiring medical attention arises in the home."[8] The letter concluded that such general health telephone lines were not necessary for the proper and efficient administration of the Medicaid program, citing "cost-effectiveness in the context of overall Medicaid costs, potential duplication of services in places where they are already available, and anticipated utilization patterns, or lack thereof, in relation to more expensive interventions, such as hospital emergency room visits in urban versus rural settings."[9]

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[6] Barber JW, King WD, Monroe KW, et.al. Evaluation of emergency department referrals by telephone triage. Pediatrics. 2000;105:819-821; Implementation of the telephone-based nurse triage service lowered utilization of hospital emergency department by 15%. O'Connell J, Johnson D, 1998 accessed at http://gateway.nlm.nih.gov/MeetingAbstracts/ma?f=102234357.html.

[7] https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD122094.pdf

[8] April 4, 1995, State Medicaid Director Letter on Administrative Claiming. Unavailable online.

[9] *Id.*

Since the 1995 SMDL, CMS has issued three guidance documents that have carved out exceptions to the general unavailability of FFP in state expenditures for medical hotlines. In SMDL # 11-007, entitled "New Medicaid Tobacco Cessation Services,"[10] CMS issued guidance that state expenditures for certain smoking cessation lines that meet PHS guidelines and are made available to Medicaid beneficiaries can be eligible for administrative FFP as they are an effective tool for making intensive, specialist-delivered tobacco cessation support available to smokers in a widespread, easily accessible manner. Additionally, in SMDL # 18-011, entitled, "Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance,"[11] we explained that "states may be able to access administrative match for crisis call centers as some states have done for tobacco quit lines… [provided] the state [can] justify in a reasonable manner how many callers are Medicaid beneficiaries in order to properly allocate costs to Medicaid." In State Health Official (SHO) letter # 21-008, entitled, "Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services,"[12] CMS stated that allowable administrative activities include establishing and supporting call centers, including the costs for state telephone connections to the 988 Suicide and Crisis Lifeline, and operating state crisis access lines to assist Medicaid beneficiaries.

B. *NAL Change in Policy*

Under section 1903(a)(7) of the Act, the Secretary has significant discretion to determine if administrative expenditures are necessary for the "proper and efficient administration of the state plan." Since the 1995 SMDL discussing health hotlines, NALs have become a widely used tool to coordinate and triage care. Today, 24-hour NALs are a common feature of private and public health plans, including many Medicaid managed care plans. Many managed care plans actively encourage enrollees to use these services, publishing advice line numbers directly on their member identification cards.

Given the effectiveness of NALs and their increasingly widespread use over the last thirty years, we now believe that NALs can be cost effective in the context of overall Medicaid expenditures, and that they can direct beneficiaries efficiently to the right level of care, ultimately streamlining care, managing risk of inappropriate use of health care resources, and increasing efficiency and appropriateness of setting for subsequent medical treatment. Considering the ongoing widespread use and success of NALs, we believe permitting states to claim FFP for the administrative costs of NALs will have a positive impact on health outcomes and health care equity for Medicaid beneficiaries. For example, beneficiaries may benefit from the fact that NALs are available 24/7, which means that beneficiaries can access assistance regardless of work schedules, childcare responsibilities, and/or transportation issues.

Considering all the above factors, we are issuing this letter to inform states that expenditures for NALs may be claimed for FFP as administrative expenditures when properly allocated to the Medicaid program. Such NALs may be operated by, or under contract or agreement with, the State Medicaid agency or a local agency administering the State plan, as applicable. This guidance supersedes the April 1995 SMDL that specifically prohibited FFP for administrative

[10] https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/SMD11-007.pdf
[11] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf
[12] https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf

expenditures for general health telephone lines that appear to be similar in nature and a precursor to NALs. CMS expects that NALs for which the state claims Medicaid administrative matching funds will be capable of referring Medicaid beneficiaries to participating providers of Medicaid-covered services where appropriate to address the beneficiary's needs, including through direct referrals to urgent care or mobile crisis interventions, as appropriate. We also expect NALs to have capacity to assist callers with mental health and SUD needs either directly or through connections to specialized hotlines, including the 988 Suicide and Crisis Lifeline and mobile crisis teams. As noted above, Medicaid FFP may also be available for various aspects of implementing the 988 Suicide and Crisis Lifeline.

To meet language access requirements, states may want to ensure NALs have active contracts with over-the-phone interpretation vendors and that staff are trained to access this service as well as how to effectively work with an over-the-phone, spoken language interpreter. To help ensure NALs are available in the caller's primary language, states can claim the increased 75 percent FFP for translation/interpretation services under section 1903(a)(2)(E) of the Act for children of families for whom English is not the primary language. States claiming this increased matching rate will need to use a methodology to properly allocate NAL costs between children of families for whom English is not the primary language and other Medicaid populations to ensure appropriate claiming for the increased administrative matching rate. For additional information on language access, states may want to review the CMS Guide to Developing a Language Access Plan, available at https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Lessons-from-the-Field-508.pdf.

States must also ensure individuals with disabilities can access the NALs. For example, states may want to ensure NALs have teletypewriters (TTY) capability and are able to facilitate American Sign Language live interpretation and video conferencing. For additional information on disability access, states may want to review disability access resources located at https://www.cms.gov/about-cms/agency-information/omh/resource-center/hcps-and-researchers/improving-access-to-care-for-people-with-disabilities.

Given the widespread availability of NALs, we understand that primary care providers or other providers may also operate NALs. However, states are not able to claim administrative match for private providers' hotlines as those often would be considered part of the providers' costs of furnishing services, and additional payment in this instance (beyond the service payments these providers receive for furnishing care to Medicaid beneficiaries) would be duplicative.[13] Rather, this guidance is applicable specifically for NALs operated by or under contract or agreement with the State Medicaid agency or a local Medicaid agency, as applicable.

In managed care programs, managed care plans may operate or contract with NALs to triage an enrollee's immediate health care concerns, educate enrollees on potential care options, and assist them to identify the most appropriate source of care to best meet their immediate needs. For any

[13] Depending on the state's payment methodology, a Medicaid-participating provider's cost of operating an NAL might not be included in the provider's Medicaid payments. In this case, the provider's NAL activities potentially could be covered as a medical assistance service for which the provider could claim and receive Medicaid payment directly. Such payments would be matched at the applicable federal medical assistance percentage, rather than an administrative federal matching rate.

costs included in managed care capitation rates, the costs must comply with the requirements in 42 CFR §§ 438.3(c)(1)(ii) and 438.4(a), including that the development of the capitation rates must only include reasonable, appropriate, and attainable expenses related to managed care plan administration associated with the provision of services identified in § 438.3(c)(1)(ii) to the populations covered under the managed care contract.

Any state seeking to claim NAL costs as Medicaid administrative expenditures will need to amend its Public Assistance Cost Allocation Plans (PACAP) in accordance with 45 CFR Part 95 Subpart E. Once the state submits a PACAP amendment, CMS will evaluate NAL costs pursuant to current administrative claiming requirements, as well as federal cost allocation principles. NAL expenditures must be reasonable, allowable, and allocable to the Medicaid program (45 CFR §§ 75.402-75.405).[14] We understand that some states may make NALs available to populations other than solely Medicaid beneficiaries. If a state offers a call center for both Medicaid and non-Medicaid beneficiaries, the state will need to develop a methodology to allocate costs appropriately to Medicaid, such as determining the percentage of callers who are Medicaid beneficiaries. We encourage states to submit such Medicaid Administrative Claiming (MAC) plans to the Financial Management Group's (FMG) state plan amendment (SPA) mailbox at FMG_SPA_MAILBOX@cms.hhs.gov. CMS will review such cost allocation methodologies carefully to ensure that appropriate safeguards are in place and that all claimed costs are allocated appropriately to Medicaid.

II. Skilled Professional Medical Personnel (SPMP) Claiming for Independently Licensed MSWs and Other Master's-Level (or Higher) Behavioral Health Professionals

Medicaid agencies have long employed SPMP to ensure that the administration of the program is informed by, and aligned with, clinical best practices on behalf of Medicaid beneficiaries. Section 1903(a)(2)(A) of the Act provides for an increased federal matching rate of 75 percent for Medicaid administrative expenditures for the compensation or training of SPMP, and staff directly supporting these personnel, when certain conditions are met. The increased FFP for SPMP activities may support state Medicaid agencies to employ individuals who have the professional expertise necessary to ensure the program is administered based on clinically sound principles.[15] This increased matching rate can be used to support state Medicaid agencies hiring SPMP and ensuring their clinical expertise remains current (through paying for training) and available to the agency.

Longstanding CMS policy permits social workers to meet the criteria for SPMP only if they have an MSW degree and their degree specifically includes a medically specialized academic track or concentration.[16] Given changes in the field of social work and counseling in the last three

[14] See also 45 CFR § 75.303.
[15] CMS noted in the preamble to its 1985 regulation that "[p]rofessional medical knowledge is needed to shape the medical aspects of the program, including the determination of which medical services should be included in a well-balanced medical benefit program, coordination of available medical resources, and establishment of working relationships with the professional medical community." 50 *Fed. Reg.* 46652, 46655 (Nov. 12, 1985).
[16] CMS policy is based on the HHS Departmental Appeals Board decision in *Mont. Dep't of Soc. & Rehab. Servs.*, DAB No. 1024, 1989 WL 509348(1989), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/1989/dab1024.htm.

decades, as well as our own regulatory criteria that recognize national or state licensure or certification,[17] we are now changing CMS policy to allow states to claim the increased SPMP matching rate with respect to expenditures for employees who have obtained a master's degree in social work or a master's degree in another behavioral health field, or a higher degree, provided they are licensed as independent practitioners by the state and that all other SPMP requirements are met. Examples of such other behavioral health practitioners may include Marriage and Family Therapists, Mental Health Counselors, and Professional Counselors.

During a time when the country is facing an unprecedented behavioral health crisis, it is essential that state Medicaid agencies have every tool available to meet the needs of their beneficiaries. This policy will support states to reach the goals set forth in the CMCS Mental Health and Substance Use Disorder Action Plan,[18] through hiring and maintaining the specialized expertise needed to administer a robust Medicaid program that can meet beneficiaries' mental health and SUD needs.

A. *Background*

Under section 1903(a)(2)(A) of the Act, state expenditures for the compensation and training of SPMP and of staff directly supporting these personnel, which are necessary for the proper and efficient operation of the Medicaid program, are federally matched at 75 percent, in contrast to the 50 percent "regular" administrative matching rate available for qualifying expenditures under section 1903(a)(7) of the Act. The term SPMP is defined in federal regulations as "physicians, dentists, nurses, and other specialized personnel who have professional education and training in the field of medical care or appropriate medical practice and who are in an employer-employee relationship with the Medicaid agency. It does not include other nonmedical health professionals such as public administrators, medical analysts, lobbyists, senior managers or administrators of public assistance programs or the Medicaid program" (42 CFR § 432.2).

Our longstanding policy with respect to claiming federal matching funds for expenditures for social workers employed by the state Medicaid agency was based, in part, on a 1989 HHS Departmental Appeals Board (DAB) decision, *Montana Department of Social & Rehabilitation Services,* DAB Decision 1024. In that case, the DAB concluded that social workers with a two-year graduate degree in social work could qualify as SPMP "if their education (including training received as part of academic work) specifically included the health care and/or medical applications of the social work field."[19] After the Montana DAB decision, CMS's policy has been to require MSWs for whom expenditures are claimed as SPMP compensation and/or training expenditures to have a specialization (track or concentration) in clinical practice, health care practice, other medical application, or its equivalent, as part of the course work for the individual employee's master's degree.

B. *Development of Behavioral Health Professionals as Health Care Professionals*

Over the decades since we adopted this policy, the role of social workers has shifted from providing social welfare support to being one of the primary provider types for mental health and

[17] See, e.g., 42 CFR 432.50(d)(ii).
[18] https://www.medicaid.gov/sites/default/files/2023-07/cmcs-mntl-helth-substnce-disrdr-actn-plan-overview.pdf.
[19] *Mont. Dep't of Soc. & Rehab. Servs.*, DAB No. 1024, 1989 WL 509348, at *9 (1989), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/1989/dab1024.htm.

SUD treatment in the US. In December 1989, (notably *after* the 1989 DAB decision discussed above), the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239) added Clinical Social Workers to the list of providers eligible to bill Medicare Part B for providing outpatient mental health services.[20] 42 CFR § 410.73 defines Clinical Social Workers for Medicare Part B payment purposes as individuals with a master's or doctor's degree in social work who, after obtaining the degree, have performed at least 2 years of supervised clinical social work and meet state licensure or certification requirements for clinical social workers.

The inclusion of Clinical Social Workers as health care providers who can enroll and bill independently for professional services under the Medicare program helped lay the foundation for the development of social work as a health care profession. Today, MSWs and other master's-level behavioral health professionals provide most of the behavioral health treatment in the US. In 2017, the US Department of Labor, Bureau of Labor Statistics data showed that mental health and substance use social workers are notably abundant in the mental health workforce.[21]

Furthermore, section 4121 of the Consolidated Appropriations Act, 2023 (P.L. 117-328), amended the Act to establish similar status for Marriage and Family Therapists and Mental Health Counselors (which includes Professional Counselors) under Medicare Part B, effective January 1, 2024.

C. *Change in Policy with Respect to Independently Licensed Behavioral Health Professionals and Administrative Claiming at the SPMP Match*

The regulations in 42 CFR § 432.50(b)(1) provide that the federal matching rate for qualifying expenditures for SPMP and directly supporting staff is 75 percent. As noted above, SPMP are defined in 42 CFR § 432.2, in part, to include specialized personnel "who have professional education and training in the field of medical care or appropriate medical practice." 42 CFR § 432.50(d)(1)(ii) elaborates on this requirement, providing that "Professional education and training" means "the completion of a 2-year or longer program leading to an academic degree or certificate in a medically related profession. This is demonstrated by possession of a medical license, certificate, or other document issued by a recognized National or State medical licensure or certifying organization or a degree in a medical field issued by a college or university certified by a professional medical organization."

Today, not only are most MSWs and other master's-level behavioral health care professional degrees generally two-year programs, but also MSWs and other master's-level behavioral health care professionals typically must complete approximately two years of supervised clinical work to be independently licensed by state licensure boards.[22] Accordingly, we are updating our policy regarding the qualification as SPMPs of MSWs and other master's-level (or higher) behavioral health professionals who have completed at least a 2-year course of study leading to this academic credential and who are licensed or certified in their state to practice independently as health care professionals, whom we now consider may qualify as SPMPs regardless of their

[20] https://www.govinfo.gov/content/pkg/STATUTE-103/pdf/STATUTE-103-Pg2106.pdf
[21] US DOL, BLS, "Occupational Employment Statistics, Occupational Employment and Wages, May 2017, Mental Health and Substance Abuse Social Workers," https://www.bls.gov/oes/current/oes211023.htm.
[22] See https://www.aswb.org/regulation/laws-and-regulations-database

academic track or concentration. As noted, the state licensing or certification requirement generally will ensure that individuals have spent a certain number of practice hours (including supervised practice hours) in a clinical field, in addition to the graduate program.[23] With the two years of post-baccalaureate MSW classroom training (regardless of any concentration) and the required hours of supervised clinical practice that are typically required of MSWs and other master's-level behavioral health professionals through most current curricular and state licensure/certification requirements, MSWs and other master's-level (or higher) behavioral health professionals generally have the professional education and clinical training qualifications to function as health professionals educated and trained in medical care or appropriate medical practice.

We believe that providing incentives for states to hire independently licensed MSWs and other master's-level behavioral health professionals, including those from underserved or underrepresented populations in the behavioral healthcare workforce, to use their clinical expertise to inform Medicaid programmatic policy will help bolster state resources to provide appropriate behavioral health care coverage and service delivery, aligning with state agency priorities. Indeed, broadening our SPMP policy will help MSWs and other master's-level (or higher) behavioral professionals contribute to the improvement of their states' Medicaid programs based on their understanding of social and welfare supports, social justice orientation, community organizing, and cultural responsiveness, among other things.[24]

It is also important to note that while broadening our policy would make more individuals potentially eligible as SPMP, the independently licensed MSWs or other master's-level (or higher) behavioral health professionals would still need to meet the other Medicaid requirements under 42 CFR § 432.50. In particular, we remind states that SPMP must be "in positions that have duties and responsibilities that require those professional medical knowledge and skills" obtained through their qualifying education and training (42 CFR § 432.50(d)(1)(iii)). Thus, unless the individual has a need to use their medical knowledge and skills for their duties related to the administration of the Medicaid program, the state would not be able to claim FFP at the 75 percent SPMP matching rate.

We note that we will still allow states to claim expenditures at the SPMP match rate if an individual who is a social worker or other behavioral health professional has a 2-year master's degree (or higher), demonstrates that their graduate school course credits include the medical applications necessary to satisfy the education and training requirements for SPMP, and meets all other requirements of SPMP, regardless of whether the individual is licensed or certified to practice independently, consistent with our policy to date. That said, CMS believes that this historic standard is a difficult one to meet (i.e., it requires states to ask prospective hires to present their graduate education transcript even if they graduated a number of years ago) and most social work or counseling graduate schools do not have specific medical tracks or concentrations.

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[23] *Id.*

[24] See "Social Work's Role in Medicaid Reform: A Qualitative Study," Bachman, Sara S. et. al. The paper argues that there is a gap between social work's practice level and systems level involvement in Medicaid innovations; and that social workers can help Medicaid promote access, integration, high-quality affordable care, and prevention. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5731069/

We also would like to remind states that even though SPMP are medical personnel, states may not claim medical assistance expenditures as Medicaid administrative costs to receive FFP. [25] Claims for FFP for Medicaid administrative costs, like all claims, must be supported by adequate documentation.[26] Documentation maintained in support of claims for administrative FFP must be sufficiently detailed to permit CMS to determine whether the activities are necessary for the proper and efficient administration of the Medicaid State plan.[27] Moreover, as the Departmental Appeals Board has stated, "…enhanced funding is special, and … a state's ever-present burden to document the allowability of its costs is especially heavy when FFP is being claimed at an enhanced rate, requiring a clear showing that all claimed costs meet applicable reimbursement requirements."[28] Therefore, for example, if an employee is using a time study log to document administrative activities that require the employee's medical knowledge and skills, the sampled time study employees should clearly document the use of their medical knowledge and skills, as well as the administrative purpose of the activity, when performing activities eligible for increased matching rate, to support the state's claim for expenditures the increased matching rate.

Closing

We look forward to working with states on claiming Medicaid FFP for properly allocated administrative expenditures related to NALs and certain behavioral health professionals as SPMP. Questions regarding this guidance may be directed to: Rory Howe, Director, Financial Management Group, at Rory.Howe@cms.hhs.gov.

Sincerely,

/s/

Daniel Tsai
Deputy Administrator and Director

[25] See https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD122094.PDF.
[26] 45 CFR § 75.403(g).
[27] See sections 1902(a)(4),) (a)(6) and 1903(a)(2)(A) of the Act; 42 CFR § 433.32; and 45 CFR §§ 75.400(d) and 75.430(i).
[28] New Jersey Department of Human Services, DAB No. 2518, at 4 (2013), https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2013/dab2518.pdf.