LOUISIANA DEPARTMENT OF EDUCATION

Career and College Readiness /Safe and Healthy Schools

Louisiana School Based Medicaid Program 101

This guide provides an overview of the School-based Medicaid Program (SBMP). This guide serves as the starting point for school based Medicaid knowledge. It includes links to other resources in the SBMP Resource Library. For any questions on the SBMP, email sbmp@la.gov.

School-based Medicaid

The Center for Medicaid and Medicare Services (CMS) recognizes that schools provide vital health care services to students. "Health care services delivered in schools are an opportunity to meet children where they are and deliver services to children in a setting where they spend a majority of their time – in school. School based services (SBS) can include all services covered under the Early Periodic Screening Diagnostic and Treatment (EPSDT) Benefit, which provides a comprehensive array of preventive, diagnostic, and treatment services for eligible individuals under 21 enrolled in Medicaid. These services include, but are not limited to, preventive care, mental health and substance use disorder (SUD) services, physical and occupational therapy, and disease management" CMCS Informational Bulletin 5-2-23 .

Methodology for Louisiana school based service program reimbursement is different from traditional Medicaid. CMS understands schools are paying practitioners to provide these health services in schools and reimburses a portion of that cost. Louisiana utilizes a cost based reimbursement methodology to reimburse for school based services. School systems are reimbursed for the cost of providing the health services in schools including salaries, benefits and indirect costs associated with the health services.

Medicaid Overview

Did you know 💡

Medicaid reimburses the cost of providing the medical services, not just claims.

At the most basic level, Medicaid is a state and federal cost-sharing program that provides health care to low-income individuals. The Centers for Medicaid and Medicare Services (CMS) oversees the Medicaid program at the federal level and sets the basic rules. However, since the state also pays part of the cost, each state is also allowed to set its own unique rules as long as it follows the CMS guidelines. For this reason, each state has its own unique Medicaid policy, which is referred to as the Statewide Medicaid Plan. The Statewide Medicaid Plan can be changed if a state wants to change it and CMS approves the change. The process to change the plan is known as a State Plan Amendment (SPA). Changes in the program are often due to either changes that CMS makes to the overall guidance or changes to the SPAs the state chooses to make. For more information schools can refer to Overview of Medicaid in School Based Services.

Medicaid is funded by combining state and federal dollars. The percentage of the total Medicaid costs the federal government pays is called the FMAP (Federal Medical Assistance Percentage). The Louisiana Department of Health (LDH) manages the Louisiana Medicaid program. This includes making the rules for the program, setting the billing reimbursement rates, managing the audits and paying the reimbursements.

Since schools are funded with state money, CMS allows those state funds to count towards the state portion of the Medicaid cost. It is critical that schools use only general fund dollars and not federal dollars to pay for services that are Medicaid eligible.

This different approach is also why students are able to receive services in school without it affecting services students are able to receive outside of school. This is because school-based services are "carved out" (addressed outside the managed care plan) of Louisiana Medicaid. When Medicaid services are provided outside a school setting by a private provider, those providers bill that student's Medicaid plan. Since schools and private providers are billing different entities, both services can be provided as long as providers avoid duplication of services. To avoid duplication of services, care coordination is necessary.

What Services Can Be Reimbursed?

In general, Medicaid covers screenings, evaluations and services. Treatment must be required by a written plan of care. As of April 2020, Louisiana School-based Medicaid will cover the following services:

- Nursing and Medical Services
- Therapy Services (Occupational Therapy, Physical Therapy, Speech Language Audiology Services)
- Behavioral Health Services including Applied Behavioral Analysis Services
- Personal Care Services
- Transportation

Which students are eligible for services?

All students who are enrolled in Medicaid are eligible for reimbursement for services. Services must be medically necessary and provided by an eligible licensed provider.

For Special Transportation, the following additional things are required:

- The student must have an Individual Education Plan (IEP) that requires special transportation.
- In order for the trip to be reimbursable, the student must have received a service on the IEP that day.

Who Can Provide Services?

Only appropriately licensed practitioners can provide Medicaid-reimbursable services in schools. Just like the covered services, the list of providers who can provide services may change with state plan updates. It is the responsibility of each LEA to ensure the individuals performing health services on campus have active and appropriate licenses.

Each type of licensure is overseen by a different licensure board. The job of the licensure board is to determine what types of credentials are required in order to have the licensure, maintain a list of licensed individuals, determine what types of services providers can provide, and oversee their licensees. Boards are the governing bodies for each different type of practitioner. The licensure board and not LDH or LDOE determines practice guidelines.

Reimbursement Overview

While all the services above are eligible for reimbursement, LDH uses cost reporting reimbursement methodologies to provide reimbursement. CMS understands schools are paying practitioners to provide these health services in schools. Louisiana utilizes a cost based reimbursement methodology to reimburse for school based services. School systems are reimbursed for the cost of providing the health services in schools including salaries, benefits and indirect costs associated with the health services.

Reimbursement for Employees

LEA's complete a cost report to determine the maximum cost allowable for reimbursement. The calculations take into account:

- Amount of general fund dollars the LEA spent on the service (provider salary, benefits, etc.)
- Random Moment Time Study determined reimbursable percentage
- Indirect cost percentage (a number specific to each LEA that is set by LDOE)
- Louisiana's FMAP for that year
- LEA's Medicaid population (called the Medicaid Discount Factor)
- LDH administrative fee

There are three important phases to reimbursement:

1. Interim Claiming is documentation submitted for a fee for a particular service. LDH requires services documented using the EPSDT fee schedule. Fees are intentionally set lower to ensure a district does not claim more than the cost allowed in the cost reporting process. This is an interim payment until the cost settlement process is completed.
2. The cost report is the form that LEAs complete at the end of the year to determine how much reimbursement school systems are eligible for based on salaries/benefits of employees or funds paid to vendors for services. Results of the Random Moment Time Study are applied to the cost report to determine the percentage of reimbursement for each provider pool.
3. The cost settlement is the amount calculated by the Cost Report minus the paid interim billing (minus any audit finding fees that may have been levied against the LEA); it is the final amount of money reimbursed to the school system.

Random Moment Time Study

For nursing/health services, therapy services and behavioral health services that are provided by an employee of the LEA, CMS uses a cost allocation method known as the **Random Moment Study (RMTS).** The RMTS has one purpose – to document what a provider was doing in a specific moment (date and time) and to determine if that task was a Medicaid billable service or related administrative activity. CMS recognizes that as employees, practitioners providing health services may also be required to perform educational duties such as lunch duty, attending school assemblies, assisting with state testing and any number of other non-health related activities. CMS only wants to pay for the portion of time providers spend providing health services (and the administrative tasks required to provide those services). In order

to determine what that percentage of time was, the state implements a random moment time study.

Every provider that is an employee of an LEA who bills Medicaid must be enrolled in the RMTS. Because different provider types have their time divided up differently, there are 3 different provider pools. In Louisiana, the pools are:

- Nursing
- Therapy
- Behavioral Health

Did you know 💡
The time study is one of the most important factors determining reimbursement.

The RMTS takes all the moments from across the state and combines them into one study. This means that how one LEA responds to the study has an impact on all other school systems' reimbursement in the state. To ensure the moments are answered, LEAs are required to answer a minimum of 85% of the moments. If the LEA does not meet this threshold, 2 quarters in a cost report year, the LEA will not receive any reimbursement for that year.

Reimbursement for Vendors (contracted healthcare providers)

Vendors do not participate in the time study. Contracted vendors are required to invoice at a rate per service. The amount paid toward the medical services provided are listed in the cost report by the practitioner. Vendors are reimbursed in the same cost settlement process; however, do not participate in the RMTS and are reimbursed only for their services. The RMTS percentage is not applied to vendor cost reporting.

Reimbursement for Personal Care Services

Personal Care Services (PCS) are 1:1 child specific aides that are required for students to participate in the activities of daily living (ADL). Due to the nature of the services, 100% of the cost of these services is reimbursable – no time study is required – even if the people providing those services are employees. Personal Care Services have a separate Cost Report from the other programs. Providers are only reimbursed for the cost related to the time spent with an individual student. These services must be ordered and specific training, supervision and documentation is required.

Reimbursement for Special Transportation

Special Transportation reimbursement pays for transporting students on specially adapted vehicles to and from school. For the reimbursement methodology, several factors are considered:

- The total amount the LEA spent on special transportation
- The FMAP
- The indirect cost percentage
- The Medicaid/total trip ratio.

Note that a school's Medicaid Discount Factor is not considered in this methodology. The trip ratio includes Medicaid eligibility within it. The trip ratio is the ratio of Medicaid reimbursable trips to the total number of trips made on the special transportation. A trip is defined as each one way trip per student.

A Medicaid reimbursable trip is one where:

- The student has special transportation required by their IEP.
- The student is enrolled in Medicaid on the day of the trip.
- The student received a service ordered by the IEP at school that day.

Reimbursement for Medicaid Administrative Claiming (MAC)

In addition to paying for direct services, Medicaid will also pay for some very specific administrative activities. The CMS guide to school-based Medicaid Administrative Claiming provides an overview of allowable activities. The RMTS is used to determine the percentage of time that can be allocated to administrative activities. MAC payments are based on the three cost reports for direct services (nursing, behavioral health and therapy) and instead of using the direct service percentage from the time study data, the cost report uses the MAC percentage data and also only takes into account 50% of the costs – in keeping with the CMS regulations. In addition to a cost settlement for the three direct service pools, LEAs will also receive a cost settlement for MAC.

Documentation

Most clinicians understand "*if it was not documented, it did not happen*". Proper documentation not only plays a vital role in Medicaid reimbursement but, for most health care providers, it is required by the scope of practice. There are several categories of documentation that are required by Medicaid.

- Written Plan of Care – this is the document that authorizes the service.
- Service Documentation – this is the document that shows that the services were provided.
- RMTS Documentation – this is documentation required to back the answer to the RMTS moment.
- Licenses – these are the licenses held by each provider that come from the licensure boards.
- Parental consent:
    - Consent to bill Medicaid for IDEA services and consent to share student information in claiming of services under FERPA
    - Consent to provide services
- Payroll and expenditure records – to support cost reported.

Monitoring

The purpose of monitoring is to check documentation for program integrity. LDH makes an effort to monitor every LEA at least once every 4 years. When an LEA is selected for monitoring, the LEA will receive an email from LDH's contracted third party auditor. Specific documentation will be requested for review. Typically, the documentation requested would include, but is not limited to:

For selected direct service Random Moments:

- The written plan of care for that moment (must be dated prior to the service date)
- The service documentation
- The licensure for the person who provided the service (must be active at the time the service was provided)
- Payroll records
- Expenditure reports

Monitoring of other services can require:

- PCS requirement documentation
- Bus logs
- Student attendance records
- IEP records

Financial Penalties:

There are financial penalties for not complying with program regulations:

- Unsupported Time Study Moments. LEAs will be penalized the lessor of $1,000 times the number of unsupported moments or 50 percent of the cost report. This only applies to LEAs that cannot support at least 50 percent of the moments selected for testing.
- Delinquent cost reports that have not been received by November 30, and an extension was not received, will be deemed non-compliant and may be subject to a nonrefundable reduction of 5 percent of the total cost settlement. This reduction may be increased an additional 5 percent each month until the completed cost report is submitted or the penalties total 100 percent. LEAs that have not filed the cost report by six months or more beyond the due date cannot bill for services until the cost report is filed.

Payment Schedules

In order to implement this program effectively, LEAs must understand and plan for the timing of the funds. There are two different ways LEAs receive funds: interim claims and cost settlement.

Interim payments are the funds an LEA receives for the claims for services provided. The amount of these payments varies based on the fee schedule. These funds typically come to an LEA 1-3 months after the claim is submitted. These funds can provide LEAs some assistance with cash flow.

Cost settlement is the bulk of the funds that comes later, typically 1-2 years after the cost report is submitted. The cost settlement is determined by the cost report process detailed above. Cost settlements are only provided after the monitoring for that school year is completed.

Parental Consent Requirements

IDEA and FERPA requirements

- Joint Guidance on the Application of the Family Educational Rights and Privacy Act (FERPA) And the Health Insurance Portability and Accountability Act of 1996 (HIPAA) To Student Health

IDEA requirements:
Parents must provide consent to claim for IDEA services and share student information. School districts are required to have prior to claiming:

- One time annual consent
- Written annual notice of consent

Parental consent and annual notice must make it clear that:

- The school billing Medicaid will not have an impact on their ability to receive other services.
- Will not cost parents anything.
- The school will still provide the services regardless of Medicaid parental consent.
- The parent can withdraw consent at any time.

Each LEA should work with legal counsel and the board to determine policy and procedures around parental consent.

Licensure requirement to provide services:

- Almost all licenses require parental consent to provide services to minors.
- Each provider should know practice requirements.

LEAs requirements to provide services:

- Most LEAs will require some kind of consent prior to providing services.
- Some LEAs may have different requirements for regular services vs emergency services.
- These requirements were likely determined by school board or administration policy and procedures and should be taken into account when determining parental consent policy.

LDH requirement:

LDH requires this statement be provided to all parents of students receiving services:

"Your child is eligible to receive services to meet his/her needs. The services may be provided by the school system or you may take your child to another provider that accepts Medicaid."

There is a tenant in Medicaid called "Freedom of Choice" which essentially exists to ensure that individuals on Medicaid are still able to choose their own providers. This clause is meant to make sure LDH is meeting that standard as required by CMS.

A student is allowed to have services from **both** the school and a private provider. School systems should be prepared to help explain that students can receive services both in the school day and outside of school as long as care coordination is in place and services are not duplicated.