

This guide provides a high-level overview of the School-based Medicaid Program (SBMP). The program is far more complex than one document can explain. This guide should serve as the starting point for your SBMP knowledge, but it includes links to other resources in the [SBMP Resource Library](#). For any questions on the SBMP, email [sbmp@la.gov](mailto:sbmp@la.gov).

### **Medicaid Overview**

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 rules. 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 rules or SPAs the state chooses to make.

Medicaid is funded by combining state and federal dollars. The percentage of the total Medicaid cost the federal government pays is called the FMAP (Federal Medical Assistance Percentage). The amount of money the federal government pays is called the FFP (Federal Funds Participation). The FMAP and FFP are essentially the same thing – but the FMAP is a percentage and the FFP is a dollar amount.

The FMAP is determined by the percentage of a state's population that is eligible for Medicaid. The more individuals in a state who are eligible for Medicaid, the higher the FMAP is. In Louisiana, the FMAP is normally around 70% (it changes slightly every year). So, for every \$100 in Medicaid cost in Louisiana, the federal government pays around \$70 and the state government pays around \$30.

Louisiana uses something called *Managed Care*. This means that instead of Louisiana Medicaid paying the bill when a person on Medicaid goes to the doctor, Medicaid funds are used to purchase health insurance plans for people on Medicaid. This is why you see individuals who are enrolled in Medicaid on private plans like a Blue Cross Blue Shield plan.

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.

### **School-based Medicaid**

In schools, Medicaid works completely differently than most other places.

Medicaid includes a section known as EPSDT (Early and Periodic Screening, Diagnostic and Treatment). This is the section the school-based program falls under. You will sometimes hear some school-based services referred to as EPSDT services (particularly for health screenings).

CMS looks at schools and recognizes that they provide some health care services to students. Since many of those students are also on Medicaid, CMS has decided that schools should be able to get some level of Medicaid reimbursement.

However, they think about the methodology for this reimbursement in a different way than the rest of Medicaid.

CMS sees that schools are paying practitioners to provide these services in schools. Since schools are funded with state money, CMS has decided that those state funds will count towards the state portion of the Medicaid cost. This means the only portion of the funds schools can be reimbursed for is the federal funds share. This is why school-based Medicaid reimbursements will never cover 100% of the cost. The maximum amount of funds a school can be reimbursed for is the FMAP – in Louisiana, that means the maximum amount of the cost schools can be reimbursed for is around 70%. Because CMS views a school's general fund dollars as the state contribution, it is critical that schools use only general fund dollars and not federal dollars (like IDEA funds) to pay for services that are Medicaid eligible. When a school uses federal dollars (like IDEA funds) to provide these services, CMS will not pay the federal share because the state fund requirement has not been met. LEAs should make every effort to ensure that all Medicaid eligible services are paid for with general funds to ensure they can qualify for reimbursement.

This different approach is also why students are able to receive services in school without it affecting what they are able to receive outside of school. When Medicaid services are provided in a school setting, the school is essential billing and being reimbursed by CMS. This is because school-based services are “carved out” (addressed outside the purchased health insurance plan) of Louisiana Medicaid. When Medicaid services are provided outside a school setting by a private provider, they bill that students Medicaid plan (like Blue Cross Blue Shield). Since schools and private providers are billing different entities, both services can be provided.

### **What Services Can Be Reimbursed?**

As we discussed, the Statewide Medicaid Plan is an ever-evolving document. This means that the services that are covered and providers that are allowed to provide those services may change over time. In general, Medicaid covers two varieties of services: evaluation and treatment. Evaluations are always reimbursable. Treatment must be required by a written plan of care (click [here](#) for the written plan of care requirements). As of September 2021, Louisiana School-based Medicaid will cover the following services:

- Nursing and Physical Health Services
  - For students with a written plan of care requiring the service:
    - Medication distribution
    - Implementation of doctors orders
    - Respiratory therapy
    - Optometry services
  - For all students (whether or not they have a written plan of care):
    - Health evaluations
      - Hearing and vision screening
      - Medical evaluations to determine if further treatment is required
    - Annual immunization checks
    - Vaccine counseling
- Therapy Services
  - Audiology
    - Evaluations
  - Speech Therapy
    - Evaluations
    - Therapy services
  - Occupational Therapy
    - Evaluations
    - Therapy services

- Physical Therapy
  - Evaluations
  - Therapy services
- Behavioral Health Services
  - Mental health services
    - Mental health evaluation
    - Mental health treatment
  - ABA services
- Personal Care Services
- Special Transportation Services

### **Who is Eligible for Services?**

In general, in order for services provided to a student to be eligible for reimbursement, that student must:

- Be enrolled in Medicaid on the date the service was performed
  - Schools can check a student’s Medicaid status using a search feature in SER (even if that student is not in Special Education). Click [here](#) for information on how to use SER for Medicaid lookup.
- Have a medical diagnosis (remember – behavioral health diagnoses are medical diagnoses)
- Have a written plan of care that addresses that diagnosis and that requires the specific service
- Have a licensed and allowed provider providing the services (click [here](#) for the list of allowable providers)
- Have parental consent to bill Medicaid

For Special Transportation, the following additional things are required:

- The student must have an IEP that has the “requires special transportation” box checked. (Note – unlike all other services – the IEP is the only allowable written plan of care for special transportation.)
- In order for the trip to be reimbursable, the student must have received a service on their written plan of care at school 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 changes from time to time. The most up-to-date list of authorized providers can be found [here](#). That resource also includes links to the license verification for each provider type. It is the responsibility of each LEA to ensure the individuals they are allowing to perform 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. They are the governing bodies for each different type of practitioner. If you are ever uncertain what a particular type of practitioner is allowed to do, you should ask their licensure board. The licensure board and not LDH or LDOE decides what each type of practitioner is allowed to do. Click [here](#) for a list of the different licensure boards with contact information for all practitioner types working in schools.

### **Reimbursement Overview**

While all the services above are eligible for reimbursement, LDH uses five different reimbursement methodologies to provide that reimbursement. The reimbursement methodologies are:

1. Reimbursement for employees providing nursing, therapy or behavioral health services
2. Reimbursement for vendors providing nursing, therapy or behavioral health services
3. Reimbursement for personal care services
4. Reimbursement for special transportation
5. Reimbursement for Medicaid Administrative Claiming (MAC)

There are three important phases to reimbursement:

1. Interim billing. This is the billing most akin to traditional medical billing. It is done in the moment using CPT codes (click [here](#) for the full list of CPT codes in the school-based program), a fee for the particular service is set by the fee schedule and then those funds are sent to the school 1-3 months after the service has been completed. This takes place on an ongoing basis.
2. Cost Report. This is the form that LEAs fill out at the end of the year to determine how much reimbursement they are eligible for. The details of the cost report are covered later in the next several sections. This completed form is filled out by the LEA and due November 30<sup>th</sup> each year.
3. Cost Settlement. This is the amount calculated by the Cost Report minus the Interim billing (and minus any audit finding fees that may have been levied against the LEA). It is the final amount of money an LEA gets 1-3 years after the school year the services were provided in.

In addition to the reimbursement methodology, LDH also bills an administrative fee on all reimbursements. For nursing, therapy, PCS and special transportation, this fee is 15%. For behavioral health, the fee is 5%. If your district uses a billing vendor that charges a fee for their services, you must also take that into account when thinking about your reimbursement.

All LEAs should be familiar with how reimbursements are calculated in order to design the best program for their schools.

### Reimbursement for Employees

For nursing/health services, therapy services and behavioral health services that are provided by an employee of the LEA, CMS uses a reimbursement methodology known as the Random Moment Study (RMS). We call this the Random Moment Time Study (RMTS). RMS and RMTS are essentially the same thing – RMS is the methodology and RMTS is the actual study. The RMTS has one purpose – to document what a provider was doing in a specific moment (date and time) and to determine if that thing was a Medicaid billable service (or related administrative activity). The time study and how it relates to reimbursement may be one of the more complicated aspects of this program. The section below provides an overview – but there is a significant amount of additional information you will need to truly understand the RMTS. That information can be found [here](#).

When considering how to reimburse schools, CMS looked at how schools functioned and recognized that as employees, practitioners who are providing health services are not just providing health services. They are also doing things like 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 their time that they spent providing health services (and the administrative tasks required to provide those services). In order to determine what that percentage of time was, they decided to use a RMTS. However, in order for the study to be statistically accurate they had to have an extraordinarily large number of data points (moments). The number of moments required is so large that no one LEA could provide all the moments needed. If they tried to – their providers would do nothing but spend their entire day answering the RMTS. To address this issue, the RMTS takes all the moments from across the state and combines them into one study.

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This means that how one LEA responds to the study has an impact on all other LEAs in the state. **To ensure the moments are answered, LEAs are required to answer a minimum of 85% of the moments they are sent. If they do not meet this threshold, 2 quarters in a row, they will not receive any reimbursement for that year.**

Every employee provider in 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

Each pool has its own study. At the end of the year, all the answers to all the moments are combined. From this data, a reimbursable percentage (the percentage of time spent providing health services and the administrative activities required to provide those services) for each pool is calculated. The reimbursable percentage is then used to calculate the overall reimbursement for an LEA.

Once the reimbursable percentage is determined by the RMTS, an LEAs reimbursement can be calculated. This process is complicated. LEAs use a form called the “Cost Report” to determine the reimbursement. The calculations take into account:

- The amount of general fund dollars the LEA spent on the service
- The RMTS determined reimbursable percentage
- The indirect cost percentage (a number specific to each LEA that is set by LDOE)
- Louisiana’s FMAP for that year
- The LEA’s Medicaid population (called the Medicaid Discount Factor)
- The LDH admin fee

Each of the pools gets its own cost report – one each for nursing, therapy and behavioral health – assuming they have providers in each of the pools. The following steps will walk you through how the cost settlement is calculated. A hypothetical LEA is used as an example. Don’t worry! You do not have to do these calculations yourself – the cost report does them for you – but it is important to understand the factors used to make the calculations.

1. Begin with the amount of general funds (remember – no federal funds count) the LEA spent on the services. This includes salaries and benefits.
  - a. Example: An LEA spent \$100,000 of general funds on salaries and benefits for nurses
2. From the amount of general funds spent, calculate what percentage of that was reimbursable based on the RMTS.
  - a. In 2020, the reimbursable percentage for nursing (as determined by the RMTS) was 42.69%. So, we say  $\$100,000 \times 42.69\% = \$42,690$
3. From there, CMS allows a set “indirect cost percentage” of the reimbursable amount to be paid. This percentage is unique to each LEA each year, is set by LDOE and the is same across all 3 pools. It is normally between 12%-17%.
  - a. Let’s say the 2020 indirect cost percentage for our LEA was 15.3269% so, we take  $\$42,690 \times 15.3269\% = \$6,543.05$
4. Next, we add the direct and indirect reimbursable amounts
  - a.  $\$42,690 + \$6,543.05 = \$49,233.05$
5. Now, we factor in the Medicaid population at the LEA. This is known as the Medicaid Discount Factor and it is determined by the percentage of Medicaid students an LEA has based on the 10/1 count.

- a. Let's say our example districts Medicaid Discount Factor is 80%. We take  $\$49,233.05 \times 80\% = \$39,386.44$
6. The cost report does not show the next several steps, but they are outlined here so that you can understand what they are. The next step is to determine what percentage of that is the federal governments responsibility by using the FMAP.
  - a. The 2020 FMAP in Louisiana was 73% so we take  $\$39,386.44 \times 73\% = \$28,752.10$
7. At this point, LDH takes an administrative fee for managing the program. For nursing, therapy, PCS and special transportation, this fee is 15%. For behavioral health, the fee is 5%.
  - a. So, since this example is for nursing, we take  $\$28,752.10 \times 15\% = \$4,312$
8. So we reduce the LEAs reimbursement by that admin fee
  - a.  $\$28,752.10 - \$4,312 = \$24,440.10$
9. Finally, we reduce the amount by whatever the LEA had already received in interim billing for these services.
  - a. Let's say our LEA had received \$8,000 in interim payments for nursing services during the year. We calculate the final cost settlement as  $\$24,440.10 - \$8,000 = \$16,440.10$
10. CMS will send the LEA a check for \$16,440.10 anywhere from 1-3 years after those services are provided.

In our example LEA, the total amount out of their \$100,000 on employee costs that was reimbursed was \$24,440.10. But since they had already received \$8,000 of that in interim billing, their final cost settlement was for only for \$16,440.10.

Notice that the amount an LEA receives in interim billing **does not** have any effect on the cost report – only on the cost settlement. Whether they had billed for \$10 or \$8,000 – the total amount of money they were going to get was always going to be \$24,440.10. The only thing the interim billing does is change *when* the LEA get those funds – not *how much* the LEA is going to get.

The factor that determines total reimbursement for employees is the RMTS – not billing.

### Reimbursement for Vendors

Vendors are practitioners an LEA hires to provide a specific service. Many LEAs use vendors to provide services like speech/OT/PT. They come in, provide their service, and leave. Because of this, CMS views them differently. Since these people aren't doing anything but providing health services, CMS does not require them to participate in the RMTS or take the RMTS into account when determining their reimbursement. They assume 100% of the cost is for health services. This results in significantly higher reimbursements for services provided by vendors as compared to those provided by LEA employees. Here is how the vendor reimbursement is calculated – using our same LEA as an example:

1. Begin with the amount of general funds (remember – no federal funds count) the LEA spent on the services. This includes salaries and benefits.
  - a. Example: An LEA spent \$100,000 of general funds on contracted nursing services.
2. Now, we calculate the reimbursable percentage of that amount. Since vendors are always reimbursed at 100%, this amount is always the same as the total cost
  - a.  $\$100,000 \times 100\% = \$100,000$
3. From there, CMS allows a set "indirect cost percentage" of the reimbursable amount to be paid. This percentage is unique to each LEA each year, is set by LDOE and the is same across all 3 pools. It is normally between 12%-17%.
  - a. Let's say the 2020 indirect cost percentage for our LEA was 15.3269% so, we take  $\$100,000 \times 15.3269\% = \$15,326.90$

4. Next, we add the direct and indirect reimbursable amounts
  - a.  $\$100,000 + \$15,326.90 = \$115,326.90$
5. Now, we factor in the Medicaid population at the LEA. This is known as the Medicaid Discount Factor and it is determined by the percentage of Medicaid eligible students an LEA has based on the 10/1 count.
  - a. Let's say our example districts Medicaid Discount Factor is 80%. We take  $\$115,326.90 \times 80\% = \$92,260.80$
6. The cost report does not show the next several steps, but they are outlined here so that you can understand what they are. The next step is to determine what percentage of that is the federal governments responsibility by using the FMAP.
  - a. The 2020 FMAP in Louisiana was 73% so we take  $\$92,260.80 \times 73\% = \$67,350.38$
7. At this point, LDH takes an administrative fee for managing the program. For nursing, therapy, PCS and special transportation, this fee is 15%. For behavioral health, the fee is 5%.
  - a. So, since this example is for nursing, we take  $\$67,350.38 \times 15\% = \$10,102.56$
8. So we reduce the LEAs reimbursement by that admin fee
  - a.  $\$67,350.38 - \$10,102.56 = \$55,247.82$
9. Finally, we reduce the amount by whatever the LEA had already received in interim billing for this service.
  - a. Let's say our LEA had received \$8,000 in interim payments for nursing services during the year. We calculate the final cost settlement as  $\$55,247.82 - \$8,000 = \$47,247.82$
10. CMS will send the LEA a check for \$47,247.82 anywhere from 1-3 years after those services are provided.

In our example LEA, the total amount out of their \$100,000 on vendor costs that was reimbursed was \$55,247.82. But since they had already received \$8,000 of that in interim billing, their final cost settlement was for only for \$47,247.82.

Notice that the amount an LEA receives in interim billing **does not** have any effect on the cost report. Whether they had billed for \$10 or \$8,000 – the **total** amount of money they were going to get was always going to be \$55,247.82. The only thing the interim billing does is change *when* the LEA get those funds – not *how much* the LEA is going to get.

As you can see, the difference in the reimbursement between employee's vs vendors is significant. For the same \$100,000 in costs, the employee was reimbursed at \$24,440.10 vs the vendor that was reimbursed at \$55,247.82. The sole determining factor in that difference is the RMTS.

While that reimbursement differential is startling large – remember – the employee did things other than provide health services whereas the vendor only provided health services. All LEAs should carefully consider how their district functions and what their needs are when deciding whether to use employees, vendors or a combination of both to provide services. For most LEAs, some version of a combination is the best choice.

### Reimbursement for Personal Care Services

Personal Care Services (PCS) are child specific aides that are required for 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 and are reimbursed as follows:

1. Begin with the amount of general funds (remember – no federal funds count) the LEA spent on the services. This includes salaries and benefits.
  - a. Example: An LEA spent \$100,000 of general funds on salaries and benefits for PCS.

2. Now, we calculate the reimbursable percentage of that amount. Since PCS are always reimbursed at 100%, this amount is always the same as the total cost
  - a.  $\$100,000 \times 100\% = \$100,000$
3. From there, CMS allows a set “indirect cost percentage” of the reimbursable amount to be paid. This percentage is unique to each LEA each year, is set by LDOE and the is same across all 3 pools. It is normally between 12%-17%.
  - a. Let’s say the 2020 indirect cost percentage for our LEA was 15.3269% so, we take  $\$100,000 \times 15.3269\% = \$15,326.90$
4. Next, we add the direct and indirect reimbursable amounts
  - a.  $\$100,000 + \$15,326.90 = \$115,326.90$
5. Now, we factor in the Medicaid population at the LEA. This is known as the Medicaid Discount Factor and it is determined by the percentage of Medicaid enrolled students an LEA has based on the 10/1 count.
  - a. Let’s say our example districts Medicaid Discount Factor is 80%. We take  $\$115,326.90 \times 80\% = \$92,260.80$
6. The cost report does not show the next several steps, but they are outlined here so that you can understand what they are. The next step is to determine what percentage of that is the federal governments responsibility by using the FMAP.
  - a. The 2020 FMAP in Louisiana was 73% so we take  $\$92,260.80 \times 73\% = \$67,350.38$
7. At this point, LDH takes an administrative fee for managing the program. For nursing, therapy, PCS and special transportation, this fee is 15%. For behavioral health, the fee is 5%.
  - a. So, since this example is for PCS, we take  $\$67,350.38 \times 15\% = \$10,102.56$
8. So we reduce the LEAs reimbursement by that admin fee
  - a.  $\$67,350.38 - \$10,102.56 = \$55,247.82$
9. Finally, we reduce the amount by whatever the LEA had already received in interim billing for this amount.
  - a. Let’s say our LEA had received \$8,000 in interim payments for PCS during the year. We calculate the final cost settlement as  $\$55,247.82 - \$8,000 = \$47,247.82$
10. CMS will send the LEA a check for \$47,247.82 anywhere from 1-3 years after those services are provided.

Think of PCS reimbursement being just like vendor reimbursement. With no time study requirement – a large portion of the costs can be covered by Medicaid reimbursement.

### Reimbursement for Special Transportation

Special Transportation reimbursement pays for transporting students on specially equipped vehicles to and from school. It is a documentation heavy program and there are a number of factors to consider before deciding to bill for special transportation. LEAs should carefully review the requirements, how their special transportation services work and make estimates about how much they can claim in reimbursement to determine if participating in the program is worthwhile to them.

For the reimbursement methodology, several factors are considered:

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

Note that a schools Medicaid Discount Factor is not considered in this methodology. That is because the trip ratio includes Medicaid eligibility within it. The most complicated aspect of this is the trip ratio.

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The trip ratio is the ratio of Medicaid reimbursable trips to the total number of trips made on the special transportation. A trip is considered for one student, a one-way drive – so most students take two trips a day – one to school and one home from school. A Medicaid reimbursable trip is one where:

- The student has special transportation required by their IEP
- They are enrolled in Medicaid on the day of the trip
- They received a service ordered by the IEP at school that day (this can include medication administration and/or PCS services)

To calculate the Special Transportation reimbursement, the following methodology is used (again – the cost report form does this for you):

1. Begin with the amount of general funds (remember – no federal funds count) the LEA spent on special transportation. This includes salaries, benefits, fuel, maintenance ect. For special transportation, this full amount counts as the direct cost.
  - a. Example: An LEA spent \$500,000 of general funds on special transportation. \$500,000 is the direct cost.
2. From there, CMS allows a set indirect cost percentage of the reimbursable amount to be paid. This percentage is unique to each LEA each year, is set by LDOE and the is same across all 3 pools. It is normally between 12%-17%.
  - a. Let's say the 2020 indirect cost percentage for our LEA was 15.3269%, so we say  $\$500,000 \times 15.3269\% = \$76,634.50$
3. Next, we add the direct and indirect cost together
  - a.  $\$500,000 + \$76,634.50 = \$576,634.50$
4. Now, we factor in the trip ratio.
  - a. Let's say for the 2020 school year, our example LEA ran 488 special transportation trips and of those, 256 trips met the criteria to be considered eligible for reimbursement.
  - b. Our trip ratio would be 256/488
  - c. To find the Medicaid eligible costs we say  $(256/488) \times \$576,634.50 = \$302,496$
5. The cost report does not show the next several steps, but they are outlined here so that you can understand what they are. The next step is to determine what percentage of that is the federal governments responsibility by using the FMAP.
  - a. The 2020 FMAP in Louisiana was 73% so we take  $\$302,496 \times 73\% = \$220,822$
6. At this point, LDH takes an administrative fee for managing the program. For nursing, therapy, PCS and special transportation, this fee is 15%. For behavioral health, the fee is 5%.
  - a. So, since this example is for special transportation, we take  $\$220,822 \times 15\% = \$33,123$
7. So we reduce the LEAs reimbursement by that admin fee
  - a.  $\$220,822 - \$33,123 = \$187,699$
8. CMS will send the LEA a check for \$187,699 anywhere from 1-3 years after those services are provided.

For a cost of \$500,000, our LEA was reimbursed \$187,699. The biggest factor in determining this reimbursement was the trip ratio. At 256/488 – it was right around 52%.

If all other factors remained the same:

- With a trip ratio at 80% the LEA would have gotten back \$286,241
- With a trip ratio at 10% the LEA would have gotten back \$35,780

The higher the trip ratio, the higher the reimbursement.

### 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 (see the [RMTS Guide](#) for more detailed examples of MAC activities). These calculations are done by Postlewaite & Netterville and **do not require any additional work on the part of the LEA**. They 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, they use the MAC percentage data (which is found in cell D37 on the time study results page of the cost report). They also only take 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. If you do not receive this, please reach out to [sbmp@la.gov](mailto:sbmp@la.gov).

### **Documentation**

As far as Medicaid is concerned, if you did not document it, 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 their scope of practice. There are several categories of documentation that matter for Medicaid reimbursement:

- Written Plan of Care – this is the document that authorizes the service (click [here](#) for the detailed requirements)
- Service Documentation – this is the document that shows that the services was provided (click [here](#) for the detailed requirements)
- RMTS Documentation – this is documentation that is required to back up what you said you were doing in your RMTS moments. Mostly, this is just the written plan of care and service documentation – but for some answers – additional documentation may be required. (click [here](#) for the detailed requirements)
- Licensures – these are the licensures held by each of your providers that come from their licensure board (click [here](#) for the links to each licensure search portal)
- Parental consent – two types of parental consent are required:
  - Consent to bill Medicaid
  - Consent to provide services
- Payroll and expenditure records – these are supplied by your business office and document that you spent the amount of funds you said you did

When in doubt, write it down, sign it, date it and store it.

### **Audits and Financial Penalties**

#### Audit

The purpose of any audit is to check to see if you did what you said you did. For Medicaid, this means looking at your documentation. LDH makes an effort to audit every LEA at least once every 4 years. You may be audited for one or more programs. When your LEA is selected for audit, you will receive an email from LDH's contracted third party auditor – Postlethwaite and Netterville. They will tell you what program is being audited and what documentation you will need to provide. Normally, the documentation you will need to provide includes (but is not limited to):

- For selected direct service Random Moments (click [here](#) for the RMTS guide)
  - 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)
- For selected administrative Random Moments (click [here](#) for the RMTS guide)
  - Documentation unique to each moment type
  - Generally speaking – any documentation that can back up that you were doing what you said you were doing
- Payroll records
- Expenditure reports
- PCS requirement documentation
- Bus logs

### Financial Penalties

There are financial penalties for not complying with program regulations. They are different by program and are calculated as follows:

1. For programs in the time study:
  - You must adequately support 50% of the moments selected for the time study of the cost report being audited
  - If you do not support at least 50% of the moments, you will be penalized \$11,000 or half the amount on the cost report – whichever number is less.
2. For special transportation:
  - If a trip selected was not supported by an IEP that required special transportation, the auditors will take out every trip that student took from being Medicaid eligible, recalculate the trip ratio and then recalculate the cost report. You will only be funded at the new cost report level.
  - If the trip selected for audit was deficient in any other (lacking documentation of trips, the student not being Medicaid eligible ect), the trip ratio is reduced by the percent of the sampled moments that were found deficient and the cost report recalculated.
3. Time Study Completion:
  - If your LEA fails to meet the 85% threshold for two quarters of the year, you cannot claim and reimbursement for that cost pool for that year.
4. For failing to submit the cost report by November 30th:
  - Cost reports that have not been received by the due date will be deemed non-compliant and may be subject to a non-refundable 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 their cost report by six months or more beyond the due date cannot bill for services until the cost report is filed.

Remember – while the Louisiana audit will likely happen within 1-3 years, CMS can still audit the program for up to 5 years back. That is why it is critical to retain all your documentation for 5 years – even after the Louisiana audit is complete.

## Payment Schedules

The payment schedule of the Medicaid reimbursement can be one of the more challenging logistical aspects of the program for LEAs because it can take up to 3 years to get all of the funds due. 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 billing and cost settlement.

Interim billing are the funds an LEA receives when they bill for their service in the moment. The amount of these payments varies based on the [fee schedule](#). These funds typically come to an LEA 1-3 months after the billing is submitted. They are generally much smaller than the amount the LEA will receive from the cost settlement, but they come much faster. And remember – they are intentionally smaller to keep the LEA from getting so much back in interim billing that they end up owing money on the cost settlement. These can provide LEAs some assistance with cash flow.

Cost settlement is the bulk of the funds that comes significantly later – sometimes up to 3 years after the service is provided. The cost settlement is determined by the cost report process detailed above. Cost settlements are only provided after the audits for the year are complete which is why there is a delay in their arrival.

## Parental Consent Requirements

The parental consent requirements for this program can be complicated because a number of different laws and agency regulations must be met. If you plan it correctly, you can cover all the required consents with a single form. Keep in mind that if your LEA has specific things they want in parental consent, you may need to add to these forms.

Regulations and Considerations:

- Licensure requirement to provide services
  - Almost all licensures require parental consent to provide services to minors. Some behavioral health licensures may allow students to provide their own consent after a certain age. That consent would only be applicable to the provider being able to provide their service. You would still need to meet the other requirements listed here for that student – even if the provider did not require consent to provide their specific service.
  - Each provider should know their requirements – and if they are unsure they can reach out to their [licensure board](#).
- Your 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
  - Each LEA may have unique aspects to they type of consent they require
  - These requirements were likely determined by your board or administration and should be taken into account when determining your 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.”*

  - This may confuse parents because it does not make a lot of sense for this program.
  - 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.

- Remember – a student is allowed to have services from **both** the school and a private provider. Be aware that the required statement from LDH may confuse parents and be prepared to help explain that despite what that statement says, they can receive services both in the school day and outside of school.
- IDEA requirements:
  - Parents must provide consent to bill Medicaid for IDEA services
  - Once you have this consent, you must send out an annual reminder that you have it (although this does not have to be signed)
  - Your 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 them anything
    - The school will still provide the services – even if they don't provide the consent
    - The parent can withdraw consent at any time