# **Medicaid 101: For LEA Legal & Compliance Leadership**

## **Slide 1: Medicaid 101: For LEA Legal & Compliance Leadership**

Welcome to the Medicaid one oh one [101] training series developed in partnership between MassHealth and the University of Massachusetts Medical School. This training is module six in the Medicaid one oh one [101] training series and is information needed for Local Education Agency legal and compliance leadership.

## **Slide 2: Distributed April 2021**

This training was distributed in April of twenty twenty-one [2021] and was accurate at the time of distribution. As always, Local Education Agencies are responsible for reviewing information on the School-Based Medicaid Program website located at mass dot gov slash MassHealth slash schools [[www.mass.gov/masshealth/schools](http://www.mass.gov/masshealth/schools)] to determine whether subsequent guidance has superseded the content shared here. MassHealth plans to update these trainings periodically as needed.

## **Slide 3: Introduction to Medicaid 101 Training Series**

The Medicaid one oh one [101] training series is designed to provide the essentials to understanding the School-Based Medicaid Program, referred to as S-B-M-P. Some modules are designed for a broad, general audience. Other modules are targeted to the learning needs of a specific audience within each Local Education Agency, referred to as an L-E-A. We hope that everyone will look at the series and think about what other modules may be relevant to your role and responsibilities at your L-E-A related to the Medicaid program.

I’m not going to read these all out as I’m sure everyone is most likely aware of the series, but the modules are shown here for your reference.

## **Slide 4: Introduction to Medicaid 101 Training Series**

And these are the additional modules to complete the series.

## **Slide 5: Training Agenda**

Here is today’s training agenda. Please note this module assumes that you have already reviewed the Introduction module in the Medicaid one oh one [101] series, which gives a broad introduction to the school-based Medicaid program. Therefore, the agenda for this training module builds upon that background knowledge.

* + We’ll review the training objectives,
  + Talk about your Contribution to Your L-E-A’s Medicaid team,
  + Talk about what we mean in this concept of a legal or regulatory leadership role,
  + Do a review of regulatory, sub-regulatory and program guidance sources and documents,
  + Also, a review of key legal, regulatory, compliance concepts and areas of impact in the S-B-M-P,
  + We’ll discuss next training steps,
  + And provide contact information and resources.

## **Slide 6: Training Objectives**

By the conclusion of this training, we hope that you will:

* Be familiar with the various regulatory, sub-regulatory, contractual, and program requirements impacting your L-E-A’s participation in the School-Based Medicaid Program.
* We hope that you’ll return to your L-E-A with ideas about areas of compliance to follow-up on to ensure that your L-E-A has appropriate processes, procedures and controls in place to make sure that you’re remaining compliant and prepared to respond to any potential audit or review that might occur.

Note that this training is an introductory one oh one [101] level. The intention is to provide an overall description of concepts and processes related to program compliance, but this training isn’t going to give you everything that you need to know. This training is intended to provide a great place to start to build foundational knowledge, and we’re going to direct you to other resources and training opportunities for additional information about compliance with the Medicaid program.

## **Slide 7: Identifying Your LEA’s Medicaid Team Members**

We’ve been talking throughout this Medicaid one oh one [101] training series about this concept that a really successful L-E-A participating in the School-Based Medicaid Program requires coordination and collaboration between a variety of people responsible for managing each of the key pieces of the Medicaid program.

Leadership support in the area of legal and regulatory compliance is really a key to ensuring that your S-B-M-P reimbursement program remains compliant with all requirements so that you can maximize your federal claiming while minimizing audit risks.

There is certainly opportunity for collaboration with other members of your L-E-A’s Medicaid team represented in this diagram. There’s pieces of program compliance that really touch all aspects of the program, and we definitely hear from a variety of L-E-A staff that they have questions about compliance as it relates to their areas of responsibility. So, the concept of a Medicaid team member that takes responsibility for compliance oversight for the L-E-A is what we’re sort of putting forth here, even if in reality at your L-E-A this is actually, might be a shared responsibility and not really filled by one person. The concept of responsibility for your L-E-A’s legal and regulatory program compliance is what we’re talking about here.

## **Slide 8: Legal/Regulatory Leadership**

L-E-As are responsible for compliance first and foremost with the terms of the L-E-A provider contract and then, of course, with state and federal regulations guidance which guide this program. Since there are so many moving pieces to monitor, it is really helpful to put forth this idea if an L-E-A can designate someone to be responsible for monitoring L-E-A compliance, addressing contract issues and providing audit responses.

* There is a model S-B-M-P provider contract published on the S-B-M-P Resource Center for easy reference. This is the direct link to the document. But you all really need to remember the MassHealth website is mass dot gov slash MassHealth slash schools [[www.mass.gov/masshealth/schools](http://www.mass.gov/masshealth/schools)]. That is the website where everything you need is always posted. We’ve posted a model provider contract there for easy reference, so that you don’t need to locate your L-E-A’s contract, which might be filed, I don’t know where it might be kept, but you can access the actual contract language from the contract posted on the website.
* In addition, of course, as an education institution, you have to follow fur-pah [FERPA] privacy regulations, but participation in the Medicaid program also requires compliance with any relevant provisions of the Health Insurance Portability and Accountability Act, or hip-pah [HIPAA]. So, when thinking about privacy and security of information, both fur-pah [FERPA] and hip-pah [HIPAA] requirements apply.
* The S-B-M-P mandatory School District Contact Information form, which is also available on the S-B-M-P website, is a form that L-E-As use to identify contacts at your L-E-A who are responsible for various aspects of the S-B-M-P for your L-E-A, so that we know who we should be contacting or talking to on various topics. This form requires L-E-As to identify a primary point of contact for audits, perm [PERM] reviews, program compliance, record requests, etcetera. So, if you don’t know who’s been designated by your L-E-A for this role, please reach out to the School-Based Medicaid Program Help Desk so we can look that up for you. You’ll want to be sure to keep this important contact information up-to-date by updating the form as needed, and the form can be downloaded from the S-B-M-P Resource Center at the link shown here.

## **Slide 9: Laws, Regulations, and Published Guidance**

There are laws, regulations, and published guidance that set forth the rules for participation in this program and they apply to any L-E-A or subcontractor of the L-E-A participating in the program. Some of the key things are:

* Section nineteen oh two-A [1902(a)] of the Social Security Act,
* Code of Federal Regulation, C-F-R Titles forty-two and forty-five [42 CFR and 45 CFR],
* The O-M-B Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards. That’s two C-F-R two hundred [2 C.F.R. §200]. We generally refer to this as the super circular, which provides the guiding principles for cost reporting.
* Also, O-M-B Circular A-one thirty-three [A-133] provides the guidance for audits of states and local governments,
* MassHealth School-Based Program bulletins,
* MassHealth School-Based Program instruction guides,
* And the provider contract itself.

So, these are the first places to start relative to regulatory guidance in this program.

## **Slide 10: Certification of Public Expenditure**

We wanted to start our conversation today by looking at the Certification of Public Expenditure as a way to frame our compliance discussion.

All L-E-A Administrative Activity Claims, which are your quarterly claims, and the Direct Service Cost Reports, which are filed annually, require a Certification of Public Expenditure that is signed by an officer of the L-E-A. So this is typically the superintendent, business manager, or finance director, and they certify several statements. As a leader for legal and regulatory and compliance issues, you should be evaluating the processes and controls in place to make sure that your L-E-A can confidently make all of these statements that your superintendent or business manager are making when they sign the certification of public expenditure. So, the statements that they are certifying are:

1. “…to the best of my knowledge and belief they are true and correct statements prepared from the books and records of the public agency in accordance with applicable cost report instructions.”
2. “The expenditures included in this statement are based on the actual cost of allowable expenditures for activities that support the implementation of the Medicaid state plan.”
3. “The required amount of public funds were available and used to pay for the total allowable expenditures included in this statement, and such public funds are not Federal funds, or are federal funds authorized by federal law to be used to match other federal funds.”

## **Slide 11: Certification of Public Expenditure**

1. “I understand that federal matching funds are being claimed on the expenditures identified in this report.”
2. “No expenditures claimed directly in this statement are duplicative of any costs included in the claim through the application of the Indirect Cost Rate.”
3. “I am the officer authorized by the referenced public agency to submit this form to the single state Medicaid agency and I have made a good faith effort to assure that all information reported is true and accurate.”
4. And finally, “I understand that this information will be used by the single state Medicaid agency as a basis for claims for federal funds and that falsification or concealment of a material fact by me may result in my prosecution under federal or state criminal law.”

So, we really just wanted to put this out there to frame today’s training. Every claim filed, including the quarterly administrative claims and the annual cost report, are reports of public expenditures that are allowable for federal reimbursement under this program. Someone at your L-E-A is signing and certifying all of these statements. So, the confidence that these certified statements are accurate is what we’re talking about in this training module.

## **Slide 12: LEA Enrollment Overview**

L-E-A enrollment. By this, we mean how to enroll as a participating L-E-A in the School-Based Medicaid program.

* In order to participate and receive any of the federal reimbursement available through the School-Based Medicaid Program, L-E-As must enroll with MassHealth. After enrollment is completed and the L-E-A started to participate in its first quarter of the Random Moment Time Study, then the L-E-A may begin billing for direct services and may have costs reimbursed when the reimbursable services requirements are met. For detailed instructions about the Random Moment Time Study, please see the L-E-A R-M-T-S Coordinator Guide for Random Moment Time Study, which is on the S-B-M-P Resource Center website. The R-M-T-S is the very first thing that you’ll do as a new school district or L-E-A participating in the program.
* To actually enroll as an S-B-M-P provider, contact the MassHealth Customer Service Center at provider support at MassHealth dot net [[providersupport@mahealth.net](mailto:providersupport@mahealth.net)] or eight hundred eight four one twenty-nine hundred [800-841-2900] to initiate the enrollment process, including starting the provider contract.
* And finally, pursuant to hip-pah [HIPAA], all L-E-As must obtain a National Provider Identifier or N-P-I, and must include this ten-digit number on all claims and correspondence submitted to MassHealth. To register for an N-P-I, contact the National Plan and Provider Enumeration System, and you can’t begin participating as an L-E-A in the School-Based Medicaid Program until you first have an N-P-I.

## **Slide 13: Record Retention and Audit Preparedness**

* So, L-E-As are responsible for ensuring program compliance and must certify, as we showed you in the certification statements, that all Administrative Activity claims and annual cost reports are accurate.
* The federal government does regularly audit S-B-M-P providers, and all costs are subject to audit review by MassHealth and other state and federal agencies.
* LEAs are responsible for ensuring that the appropriate documentation can be produced in the event of an audit or other request by MassHealth or any of these other agencies. Failure to do so is a violation of the provider contract and may result in recoupment or termination from the program as described in the Provider Contract. A model contract again is available on the Resource Center for your review.
* The record retention period for the School-Based Medicaid Program is six years following the date of cost settlement for the fiscal year, which means seven years in practicality due to the timing of cost settlement, which occurs about one year after the close of the fiscal year. So, for practical purposes, think of it as a seven-year record retention period.

## **Slide 14: Claims Repayment and Disallowance of FFP**

Your L-E-A’s provider contract with MassHealth and Massachusetts General Law require L-E-As to provide any supporting documentation deemed necessary to support any claim for federal payments.

L-E-As historically had common and really avoidable problems when audit and desk reviews have occurred.

* First of all, failure to respond: The perm [PERM] audits, that are a federal audit that occurs, L-E-As in Massachusetts have had a terrible response rate with the majority of L-E-As simply failing to respond at all, which is a finding against the state and really is just unacceptable.
* Responding with inaccurate or incomplete information has occurred.
* Responding with incorrect or irrelevant information has been a problem, and
* Failure to comply with hip-pah [HIPAA] requirements for transmission of protected information when providing audit responses.

So, just a reminder that, per the terms of the provider contract, “In the event that a review by either E-O-H-H-S or C-M-S reveals that the provider did not administer this contract in accordance with the terms and requirements, E-O-H-H-S does retain the right to retroactively disallow the F-F-P claimed and recover the disallowed amount from the provider, and ultimately may result in termination of the L-E-A’s provider contract.” So, all of these things are what we want to avoid, and we’re really reviewing the legal and regulatory compliance issues in this training so that you can put processes and procedures in place to avoid audit risk. We want you to claim the maximum allowable federal reimbursement and we want you to keep it. That’s the goal.

## **Slide 15: Other Contractual Obligations**

* Again, back to that School-Based Medicaid Program provider contract. For a comprehensive list of all the provider obligations in the terms of the contract, please refer to the contract directly. And, as we’ve stated before, it is available on the Resource Center for your reference at any time, and it’s a document that you really should be familiar with.

## **Slide 16: Data Management and Confidentiality**

Data management and confidentiality.

* As per the provider contract, in Appendix A, all L-E-As must comply with obligations relating to the privacy, security and management of personal and other confidential information, including compliance with the Privacy Rule defined by the Standards for Privacy of Individually Identifiable Health Information; forty-five C-F-R parts one sixty and one sixty-four [45 CFR [160](https://www.govinfo.gov/app/details/CFR-2004-title45-vol1/CFR-2004-title45-vol1-part160) & [164](https://www.govinfo.gov/app/details/CFR-2007-title45-vol1/CFR-2007-title45-vol1-part164)] are the codes of federal regulation that discuss this.
* L-E-As must implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Personally Identifiable information, and that prevent the use or disclosure of such data other than as specifically required for the operation of the School-Based Medicaid Program per the terms of the S-B-M-P provider contract.
* And, all obligations to protect the privacy and security of Protected Information from unauthorized release or disclosure apply to the L-E-A, its employees and agents, and to any subcontractors of the L-E-A, including any contracted staff or contracted billing agent engaged in the performance of any activities on behalf of your L-E-A related to the S-B-M-P, and it’s required to comply with privacy and security requirements.

## **Slide 17: Excluded Persons or Entities**

Excluded persons or entities.

* As per the Provider Contract, the L-E-A is required to make sure, using the U-S Department of Health and Human Services Office of the Inspector General’s (the U-S-O-I-G) maintains a List of Excluded Individuals and Entities that we call the L-E-I-E, and this database, here’s the website for your reference, lists the names of people who must be excluded from claiming in any federal Medicaid or Medicare program, due to fraud and abuse, and it is an L-E-A responsibility to search this database and make sure that no staff, employed or contracted, anyone that you’re working with in the School-Based Medicaid program, are found in the L-E-I-E database. You should do this at least monthly to ensure that E-O-H-H-S does not pay for services provided by excluded persons or entities.
* So, it’s each L-E-A’s responsibility to make sure that you’re not claiming for the costs of any staff who are unallowable because they’re on this exclusions database.

## **Slide 18: DESE Guidance Regarding Parental Consent**

* The Department of Elementary and Secondary Education, or deh-see [DESE] is the state agency responsible for overseeing fur-pah [FERPA], the Federal Education Rights and Privacy Act, as well as the Individuals with Disabilities in Education Act. So, both fur-pah [FERPA] and I-D-E-A in Massachusetts are overseen by deh-see [DESE]. As educational institutions, L-E-As must follow these regulations, but neither of these things come from Medicaid or MassHealth.
* Deh-see [DESE] is the state agency related to this guidance. Deh-see [DESE] has stated that parental consent is required before an L-E-A can access a student’s MassHealth benefits, so you can’t submit interim claims or include a student in the Medicaid eligibility statistics for calculating the annual cost report, if you don’t have parental consent to do so.
* For more information about parental consent, you can refer to deh-see [DESE]. That link to the area of their website where this parental consent information is here. Or you can contact them at this phone number or e-mail address.

## **Slide 19: Reimbursable Services Requirements**

Reimbursable services requirements.

We’re talking here about the Direct Service reimbursement portion of the program.

* If a Covered Service (we’re talking about health care services) is delivered, the following requirements must be met to make that covered service considered a reimbursable service in the program. So, there are five essential requirements:
  1. The practitioner who delivered the service must be an R-M-T-S Direct Service Pool participant. That is for in-district services only. Out-of-district practitioners are exempt from the R-M-T-S requirement, but all of the remaining four requirements still apply. Also note that R-M-T-S participation applies to both contracted and employed staff members, when working in-district.
  2. Practitioner licensure qualifications are also in place for direct service providers.
  3. Services must meet Medicaid’s definition of medical necessity.
  4. Services have to be authorized.
  5. And services have to be documented.
* L-E-As must ensure that each of the five requirements is met before an interim claim is submitted to M-M-I-S, which is the Medicaid claims processing system.
* And the L-E-A must maintain and be able to produce upon request the documentation of compliance with these requirements for each reimbursable service. Failure to produce documentation for the five reimbursable services requirements in the event of a state or federal inquiry or audit could potentially result in recoupment.
* And a final note that, when responding to an R-M-T-S moment, if the staff member was providing a reimbursable service at the time of the random moment, when they certify their time study responses, participants are certifying that all of these five things are true in order to respond that they’re providing services in compliance with program guidelines. We cover this information in the module for clinical leaders and in the module for direct service practitioners, but from the compliance perspective, it’s about understanding that all of this is part of program compliance.

## **Slide 20: Signature Requirements**

Signature requirements. This question comes up fairly frequently, so we wanted to be sure to discuss this topic.

So, documentation that requires a signature related to documentation around providing health care services are things like orders, plans of care, treatment plans, evaluation reports, service documentation, progress notes, and discharge plans.

Both handwritten and electronic signatures are allowable from Medicaid’s perspective.

The guidelines for using an electronic signature, if your L-E-A does so, are that:

* Systems and software products that you’re using must include protections against modification. So, obviously, once someone has signed a document, it shouldn’t be editable or modifiable by anyone else, and you should apply administrative safeguards that correspond to standards and laws around electronic signature.
* The individual whose name is on the alternate signature method and the provider (meaning the L-E-A) bear the responsibility for the authenticity of the attested information.

L-E-As should check with legal counsel before using alternative (meaning non-handwritten) signature methods.

Handwritten signatures need to be legible or a printed name below an illegible signature can be provided or the illegible signature can be validated by comparing to a signature log or signature attestation statement.

All signatures (handwritten or electronic) must always be dated, and

* An order or plan of care can never be created after the fact or backdated.

## **Slide 21: Signature Requirements - Certification of Public Expenditure**

Signature requirements around the certification of public expenditure.

* So, the required Certification of Public Expenditure statements for quarterly Administrative Activity Claims and the annual Direct Services Cost Report can be provided electronically, via email, as a scanned or imaged document. The Administrative Activity Claiming System and the Cost Report system both generate a C-P-E letter for you that’s pre-populated with all the correct information. So, all you do is print it out on your L-E-A letterhead and have it signed and dated by an authorized person.
* That original wet ink signature copy of the C-P-E statement or letter should be retained by the L-E-A, along with all other supporting documentation and records that support the costs claimed, for the record retention period of six years that’s required by the provider contract.

## **Slide 22: Interim Billing Submission**

Interim billing submission. In the direct service portion of the program, L-E-As are expected to submit interim bills consistent with the rules specified here.

* So, claims must be submitted in an electronic format and in accordance with the Health Insurance Portability and Accountability Act, hip-pah [HIPAA], guidelines and using what’s called the eight thirty-seven pee [837P] claim format (this is a national standard format for all medical billing) or you can use the Direct Data Entry or D-D-E option that is available free of charge to all L-E-As on the Provider Online Service Center. The D-D-E option allows you to key in your claiming data directly to MassHealth’s claim processing system.
* L-E-As may perform your interim billing yourselves using the P-O-S-C-D-D-E option (which is easy to use and free of charge), or you can purchase software that will generate the required eight thirty-seven pee [837P] claim files, or you can contract with a third party to perform billing for the district.
* Interim claims must be submitted within ninety days of the date of service and must include the appropriate procedure code and a clinically appropriate I-C-D-ten diagnosis code.
* Claims must be submitted per S-B-M-P guidance, and for more information on all the details on direct service claiming, the Direct Service (Interim) Claiming Guide would be your source. That is, of course, published on the S-B-M-P website.
* And just as a reminder, all claims are subject to audit. So, L-E-As are responsible for ensuring that the appropriate documentation can be produced in the event of an audit or other request by MassHealth or another state agency or federal compliance agency. We’ve talked about this possibility and the consequences of non-compliance in this area already.

## **Slide 23: RMTS Supporting Documentation**

R-M-T-S supporting documentation. This is another area where we’re not sure how familiar L-E-As are with this requirement, so we wanted to review the requirements.

* So, when your staff are answering the random moment time study and documenting their work activity, there is a requirement in section four point two [4.2] of the provider contract that L-E-As must retain records to support activities recorded in response to the Random Moment Time Study for at least six years after the date of submission of the Administrative Claim or Cost Report which is supported by such documentation. So again, that’s seven years for record retention in practical terms due to the timing of when your cost report is filed.
* L-E-As are expected to identify and implement internal processes and procedures (if you haven’t already established them, this would be a great takeaway) to oversee compliance to ensure that R-M-T-S participants provide supporting documentation for the activities recorded in any assigned R-M-T-S moments. These records should be maintained by the L-E-A in an organized and retrievable fashion to be available upon audit. This actually came out of a federal O-I-G audit finding from several years ago when the O-I-G came in and randomly selected some moments for audit review, and then the O-I-G requested supporting documentation for the work activities that were happening at the time of the random moments and most L-E-As were unable to produce any supporting documentation. So, we had an audit finding on this, and we’ve been training on this ever since.

## **Slide 24: Pathway to Compliance**

Let’s take a look at some best practices for remaining compliant with the School-Based Medicaid Program:

* So, in regards to R-M-T-S: Collaborating with your L-E-A R-M-T-S Coordinator, Human Resources, clinical leaders, billing vendors and others who have a role in the R-M-T-S process to ensure compliance with all requirements (including accuracy of all the data collected related to the eligibility of R-M-T-S participants, as well as supporting documentation for R-M-T-S responses).
* For service delivery, this would be collaborating with clinical leaders, direct service staff, software vendors, and others who have a role in the processes and documentation required to support Medicaid reimbursement for direct health care services.
* In the area of interim billing, collaborating with clinical leaders, billing vendors, and any other related software vendors or others who have a role in the submission of interim claims to ensure compliance with all claiming requirements (including documentation to support that claiming is in good order).
* Expenditure reporting. For the quarterly Administrative Activity Claims and Annual Direct Services Cost Reports, this might look like collaboration with L-E-A financial leaders or billing vendors, I-T, and others who contribute data and expenditures for claiming to ensure compliance.
* And the audit goal is to develop processes and controls to ensure that your S-B-M-P reimbursement program remains compliant with all requirements, so that at the end of the day, this is all about maximizing your federal reimbursement, so that you can receive the maximum federal reimbursement through this program while minimizing audit risks and disallowance of costs.

## **Slide 25: Next Training Steps**

There may be other modules in the Medicaid one oh one [101] training series that apply to your specific training needs. As we mentioned, there is a module specifically designed for each of the key Medicaid team members, and as you think about compliance in the various areas of the School-Based Medicaid Program, accessing some of the trainings in these various areas may be relevant and helpful to you.

## **Slide 26: Next Training Steps**

And finally, the S-B-M-P Resource Center, with the website listed here, includes a lot of additional information and resources. Of particular interest to the topics that we talked about during this training would be:

* The model contract,
* The Direct Service Claiming Guide,
* The Administrative Activity Claiming Guide,
* The instructions for the Direct Service Cost Report, and
* The Local Education Agency Covered Services and Qualified Practitioners document.

Additionally, all MassHealth Program Bulletins for the School-Based Medicaid Program are also available on the website, and that is the direct link to where the bulletins are found.

## **Slide 27: Contact Information & Resources**

And finally, some contact information and additional resources:

For MassHealth School-Based Medicaid Program information, mass dot gov slash MassHealth slash schools [[www.mass.gov/masshealth/schools](http://www.mass.gov/masshealth/schools)] is where everything you need you will find.

If you have questions or require assistance with anything at all, please contact the U-Mass School-Based Help Desk by e-mail at school-based claiming at U-Mass med dot E-D-U[[SchoolBasedClaiming@umassmed.edu](mailto:SchoolBasedClaiming@umassmed.edu)] or by phone. Our eight hundred [800] number is one eight hundred five three five six seven four one [1-800-535-6741]. We are here Monday through Friday, from seven-thirty [7:30] in the morning until seven-thirty [7:30] in the evening to assist you with any questions.

Thank you so much for joining today’s webinar.