California School-Based SMAA Manual

<u>SECTION 4</u>

SMAA Overview

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Definition

The SMAA program authorizes governmental entities to submit claims and receive reimbursement for activities that constitute administration of the federal Medicaid program. The program allows school claiming units to be reimbursed for some of their administrative costs associated with school-based health and outreach activities that are not claimable under the LEA BOP or under other Medi-Cal programs. In general, the cost of school-based health and outreach activities reimbursed under SMAA consist of referring students/families for Medi-Cal eligibility determinations, providing health care information, referring, coordinating and monitoring health services, and coordinating services between agencies. 45 Code of Federal Regulation (CFR) Part 75 establishes cost principles and standards for determining costs for federal awards carried out through grants, cost reimbursement contracts, and other agreements with State and local government units.

Unlike the LEA BOP, individual claims for each service rendered to or on behalf of a student and the service documentation are not specifically required under the SMAA program. However, it is necessary to determine the amount of time school staff spend performing SMAA activities using the approved time survey methodology. The results of the time survey are then used in a series of calculations to determine the percentage of school costs that can be claimed under SMAA. Reimbursement to school claiming units is made from federal Medicaid funds.

LEAs Participating in SMAA

To participate in SMAA, all LEAs must;

1. Contract through either their regional Local Educational Consortium (LEC) or county Local Governmental Agency (LGA);
2. Submit a Time Survey Participant Universe list to their LEC/LGA for preapproval;
3. Submit school calendars and work schedules for their participants to their LEC/LGA;
4. Ensure participants are not 100% federally funded;
5. Complete a Roster Report;
6. Participate in a Random Moment Time Survey (RMTS);
7. Review LEA Coding Report and validate participant's time and cost;
8. Submit an invoice for reimbursement;
9. Maintain an operational/audit file; and
10. Review and validate participant's time and costs

RANDOM MOMENT TIME SURVEY (RMTS)

RMTS is the approved time survey methodology for determining the percentage of staff time that is considered reimbursable. A claiming unit staff member that participates in the time survey process is herein referred to as a Time Survey Participant (TSP). Time survey results represent all moment responses (whether allowable or unallowable) by

TSPs in the SMAA claiming program. Time survey codes distinguish between each activity a TSP is engaged in during a time survey moment. During a time survey moment, a TSP must fully describe the activity performed. The time survey result will then be used to identify, measure, and allocate the claiming unit staff time that is devoted to Medi-Cal reimbursable activities.

The Time Survey is considered a legal document, representing the SMAA activities reported in the invoice.

Invoicing for SMAA

Each claiming unit submits to the LEC or LGA a separate detailed quarterly invoice, which includes: the costs associated to the claiming unit; the LEAs Medi-Cal eligibility percentage; and the quarterly time survey results. The LEC/LGA must prepare and submit to DHCS a quarterly summary invoice for each claiming unit's detailed invoice. The detailed invoice is where the cost and revenue data are entered, adjustments to revenues are made, and the Medi-Cal discount percentage is applied to the time survey activity results, where appropriate.

The LEC/LGA must provide DHCS with complete invoice and expenditure information no later than 15 months after the end of the quarter for which SMAA were performed. For example:

FY	***Time Frame of Qtr.***	***Qtr.***	***Period Ending*** *Last day of Q + 15 months*	***Due Date from LEC/LGA***	***SMAA Due Date to DHCS Accounting****	*Accounting Due Date** (2 yrs. from last day of Q0 or 8Qs)*
14/15	*July 1 – Sept. 30, 2014*	*1st*	*Sept. 30 + 15 months*	*Dec. 31, 2015*	***Sept. 9, 2016***	*Sept. 30, 2016*
14/15	*Oct. 1- Dec 31, 2014*	*2nd*	*Dec. 31 + 15 months*	*March 31, 2016*	***Dec. 9, 2016***	*Dec. 31, 2016*
14/15	*Jan. 1 – Mar. 31, 2015*	*3rd*	*Mar. 31 + 15 months*	*June 30, 2016*	***March 9, 2017***	*March 31, 2017*
14/15	*Apr. 1 – June 30, 2015*	*4th*	*June 30 + 15 months*	*Sept. 30, 2016*	***June 9, 2017***	*June 30, 2017*

* **Dates are subject to change**

Certified Public Expenditures (CPE)

According to 42 CFR section 433.51, "Public funds as the state share of financial participation. (a) Public funds may be considered as the state's share in claiming FFP if they meet the conditions specified in paragraph (b) and (c) of this section. (b) The public funds are appropriated directly to the state or local Medicaid agency or are transferred from other public agencies (including Indian tribes) to the state and local agency and under its administrative control, or certified by contributing public agency as

representing expenditures eligible for FFP under this section. (c) The public funds are not federal funds or are federal funds authorized by Federal law to be used to match other federal funds.

A CPE is an expenditure certified by an LEC/ LGA, or other certifying governmental agency, for expenditures paid by a claiming unit using eligible revenues for services that qualify for federal reimbursement. In order to meet CPE requirements and receive FFP, all claiming units must maintain in their audit file, or provide upon request, supporting documentation verifying:

1. 100 percent of the expenditures eligible for reimbursement are specifically related to performing the administrative activities and services of the Medi-Cal program;
2. The administrative activities and service expenditures eligible for reimbursement are restricted to the actual costs that have been expended prior to requesting FFP reimbursement; and
3. The funds expended accounting for the actual costs of performing Medi-Cal administrative activities are from revenue sources allowable under all applicable state and federal laws and regulations.

Examples of acceptable documentation include an itemized list of all claimed costs by accounting code, and the list of all participant moment responses and the assigned activity codes for the quarter.

The LEA must certify their allowable expenditures for the actual costs of providing services and/or activities. If a claiming unit has a question regarding eligible CPE or actual costs at the claiming unit, they should contact DHCS.

Contingency Fees

Pursuant to the CMS Medicaid School- Based Administrative Claiming Guide, Medicaid claims for the costs of administrative activities and direct medical services may not include fees for consultant services that are contingent upon recovery of costs from the federal government nor shall they include contingency fee arrangements. Should school districts or local educational agencies choose to use the services of consultants they must follow the policy as stated in 2 CFR Part 200 et seq., which states:

Costs of professional and consultant services rendered by persons who are members of a particular profession or possess a special skill, and who are not officers or employees of the governmental unit, are allowable, subject to subparagraphs b and c when reasonable in relation to the services rendered and **when not contingent upon recovery of the costs from the Federal Government**.

Medi-Cal claims for the costs of administrative activities and direct medical services should not include fees for consultant services that are based on, or include, contingency fee arrangements. Thus, if payments to consultants by schools are contingent upon payment by Medi-Cal, the consultant fees may not be used in determining the payment rate of school-based services and/or administration. If payments to consultants by schools are

based on a flat fee, the consultant fees may be used in determining the payment rate of school-based services and/or administration.

Claiming units may directly contract with consultants to administer parts of the SMAA program. Such contracts must comply with all applicable federal requirements (such as competition and sole source provisions, and certified public expenditures) and which are specified in accordance with 42 CFR §433.51. Claiming units may not reimburse vendors on a contingency fee basis and claim that cost on their SMAA invoices. If claiming units reimburse vendors using a flat fee schedule, they may claim that cost on their SMAA invoices.

Consultant/Consulting Firm/Vendor Fees

LECs/LGAs/LEAs may enter into agreements with Consultants/Consulting Firms/Vendors for the administration of the SMAA program. These agreements may be based on a per-person fee, or a flat fee reimbursement. However, if the fees are being claimed for reimbursement on any of the quarterly invoice(s), those fees will be limited depending on the details of the sub-recipient contract.

- Per-person fee reimbursement will be limited to: 1) no more than fifteen percent of the total amount claimed during a given fiscal year; and 2) only DHCS approved job classifications that participate in the quarterly Time Survey.

- Flat fee reimbursement will be limited to no more than fifteen percent of the total amount claimed during a given fiscal year.

Duplicate Payments

Federal, State, and local governmental resources must be expended in the most cost-effective manner possible. LEA providers shall adhere to and comply with all Federal Health and Human Services (HHS) and CMS requirements with respect to billing for services provided by other health care professionals under contract with the LEA and must avoid duplication of services and billing with other programs. In determining the administrative costs that are reimbursable under Medi-Cal, duplicate payments are not allowable. All direct services are identified as Code 2: Direct Medical Services and are non-billable and non-claimable for SMAA. LECs/LGAs may not claim FFP for the costs of allowable administrative activities that have been or should have been reimbursed through an alternative mechanism or funding source. The LEC/LGA must provide assurances to DHCS of non-duplication through its administrative claims and the claiming process. Furthermore, in no case should a program or claiming unit in a local jurisdiction be reimbursed more than the actual cost of that program or claiming unit, including state, local, and federal funds.

LECs/LGAs and claiming units are reimbursed FFP for costs that have already been paid for by allowable CPE. The LEC/LGA and claiming units may not draw down the same FFP reimbursement for identical costs from more than one FFP program. Claims for reimbursement shall not be duplicated, in whole, or part. LECs/LGAs and claiming units are required to verify that claims for reimbursement of Medi-Cal program expenditures have not previously been, or shall not subsequently be, used for federal match through an alternate funding source. Receiving reimbursement for the costs of Medi-Cal program activities or services that should be paid through an alternate funding source is also not allowed. Payments for SMAA shall not duplicate payments made to any public or private entities under other program authorities for the same purpose. LECs/LGAs and claiming units are required to submit claims for reimbursement to the appropriate FFP programs.

The LEC/LGA and LEA must certify that they have ensured no duplication of its claims. Public agencies may not make a profit by claiming for reimbursement for estimated costs which could exceed actual costs during a fiscal year. The LEC/LGA and LEA may not request reimbursement for more than the actual costs of expenditures during the fiscal year. Public agencies may not receive duplicate reimbursement for public expenditures through a claiming mechanism beyond the appropriate claiming mechanism. Any misrepresentation relating to the filing of claims for federal funds constitutes a violation of the Federal False Claims Act.

As a quality assurance measure to avoid duplication, activity codes are paired to capture 100 percent of time sampled for both reimbursable and non-reimbursable activities (See table below).

Parallel Codes

Non-Reimbursable	Reimbursable
Code 3 Non-Medi-Cal Outreach	Code 4 Medi-Cal Outreach
Code 5 Facilitating Application for non-Medi-Cal Programs	Code 6 Facilitating Medi-Cal Application
Code 7 Referral, Coordination, and Monitoring of non-Medi-Cal Services	Code 8 Referral, Coordination, and Monitoring of Medi-Cal Services
Code 9 Arranging Transportation for non-Medi-Cal Services	Code 10 Arranging Transportation in Support of Medi-Cal Services
Code 11 Non-Medi-Cal Translation	Code 12 Translation Related to Medi-Cal Services
Code 13 Program Planning, Policy Development, and Interagency Coordination Related to non-Medi-Cal Services	Code 14 Program Planning, Policy Development, and Interagency Coordination Related to Medi-Cal Services

Non-Parallel Codes

Code 1 - School-Related, Educational, and Other Activities
Code 2 - Direct Medical Services
Code 15 - Medi-Cal Claims Administration, Coordination and Training
Code 16 - General Administration/Paid Time Off
Code 17- Not Working/Not Paid
Code 18- Invalid/No Response

Coordinating Activities

Claiming unit staff must not claim for activities that are already being offered, or should be provided, by other entities or through other programs. Claims for duplicate activities can be avoided by close coordination between the school claiming units, COEs, DHCS, State Department of Education, providers, the County Health Care Agency, community and non-profit organizations, and other entities related to the activities performed.

Activities provided/conducted by another governmental entity shall also be excluded from claims. For example, CHDP educational materials that have already been developed such as pamphlets and flyers must not be claimed as SMAA if they are redeveloped by schools. Staff from school claiming units must coordinate and consult with EPSDT/CHDP to determine the appropriate activities related to EPSDT/CHDP and to determine the availability of existing materials.

Allocable Share of Costs

According to 2 CFR Part 200 et seq., “a cost is allocable to a particular cost objective if the goods or services involved are chargeable or assignable to such cost objective in accordance with relative benefits received.

Allowable SMAA activities might or might not be directed solely toward the Medi-Cal population. Therefore, some of the costs associated with allowable SMAA activities might require discounting. The DHCS-approved discounting methodology is the Actual Client Count (a.k.a. DHCS Data Match), based on the ratio of the total number of Medi-Cal eligibles to the total number of all individuals served by the claiming unit.

Unallowable Costs

Costs that may not be included in the claim are:

- Direct costs related to staff that are not in the TSP universe, not including direct charge (i.e. costs related to teachers, cafeteria, transportation, and all other non-School Based administrative areas);
- Costs that are paid with 100 percent federal funds;
- Any costs that have already been fully paid by other revenue sources (federal, state/federal, recoveries, etc.);

- Costs included in the indirect cost rate work sheet (indirect costs numerator) calculation; and
- Any costs funded out of Standard Account Code Structure (SACS) function codes 7120, 7190, 7200-7600, 7700, 8100-8400 and 8700. These costs are included in the Indirect Cost Rate (ICR) numerator.

Provider Participation in the Medi-Cal Program

Reimbursement for the cost of performing administrative activities that support medical services is available only when the following requirements are met:

1. The medical services are provided to a Medi-Cal eligible individual;
2. The medical services are reimbursable under Medi-Cal; and
3. The medical services are furnished by a Medi-Cal provider who bills, or will bill, for the services. Such billable services include those provided through the LEA BOP.

A claiming unit does not have to be a participating Medi-Cal provider to claim FFP for referring students to a Medi-Cal-covered service in the community. As long as the provider who renders such services participates in Medi-Cal and the service itself is Medi-Cal-reimbursable, the claiming unit can receive FFP for the administrative costs related to making the referrals. As long as the referral is made to a participating Medi-Cal provider, the two activities—referral and provision of the service—are not linked for administrative billing purposes.

If a claiming unit provider is not participating or chooses not to bill Medi-Cal for the service, then the service cannot be reimbursed and the administrative expenditures related to the service are not allowable. In California, most medically necessary services for children are Medi-Cal-eligible services; therefore, as long as a referral is made for medical reasons, SMAA time is allowable. If LEAs are not involved in the LEA BOP, they *will* be subject to a discount for district-employed medical providers who *are not* participating in the billing for services rendered.

Here are examples:

1. A school is a Medi-Cal-participating provider. The school provides and bills for LEA-billable medical services listed in Medi-Cal eligible children's IEP/IFSP that are covered under the California Medi-Cal state plan. Expenditures for school administrative activities related to school children's medical services billed under the LEA BOP and community Medi-Cal providers billed to Medi-Cal are allowable for SMAA. The activities would be reported under Code 8, "Referral, Coordination, and Monitoring of Medi-Cal Services."
2. A school is not a Medi-Cal-participating provider through the LEA BOP and, consequently, even though it provides medical services (such as speech/language and OT), it does not bill for any direct medical services, including those listed in children's IEPs/IFSPs. In this example, the costs of the

administrative activities performed with respect to the medical services delivered by school medical providers (like speech/language and OT) would not be allowable under the Medi-Cal program, and such activities would be reported under Code 7, "Referral, Coordination, and Monitoring of *Non*-Medi-Cal Services." Note: SMAA time spent referring to outside/non-school Medi-Cal billing providers is also billable. This will include time spent assisting an individual to obtain transportation to a Medi-Cal-covered service (reported under Code 10).

3. Regardless of whether or not the school is a Medi-Cal participating provider, the school program refers Medi-Cal eligible children to Medi-Cal-participating providers in the community. If the school performs administrative activities related to the services, which are billed to Medi-Cal by community providers, the costs of such activities are allowable under the Medi-Cal program, and such administrative activities would be reported under Code 8, "Referral, Coordination, and Monitoring of Medi-Cal Services (PM/50-percent FFP)."
4. Irrespective of whether a school participates in the Medi-Cal program or not, services provided to school children referred to community providers who do not participate in Medi-Cal are not billed to Medi-Cal. In this case, the costs of administrative activities related to medical services would not be allowable under Medi-Cal. These activities would be reported under Code 7, "Referral, Coordination, and Monitoring of *Non*-Medi-Cal Services."

Individualized Education Plan (IEP) Activities

Under the provisions of Part B of IDEA, school staff are required to perform a number of education-related activities that can generally be characterized as child find, evaluation (initial) and reevaluation, and development of the IEP. For purposes of the Medi-Cal program, these IDEA/IEP related activities are considered educational activities; therefore, they would not be considered allowable costs under the SMAA program. However, some of these costs are billable as direct-service Medi-Cal when medical evaluations or assessments are conducted to determine a child's health-related needs for purposes of the IEP development. These direct-service activities are coded as Code 2 activities on the Time Survey.

The development of an IEP is a requirement of the IDEA, the primary purpose of which is to facilitate an individual's education. Because it is an education requirement, these services shall not be billed for the administrative activities associated with the development of the IEP. Once the initial IEP meeting is completed and the IEP services are established and implemented, Medicaid shall pay for administrative activities that are directly related to the provision of those Medicaid covered services that are identified in the IEP, and which are furnished to Medicaid eligible children.

Section 411 (k)(13) of the Medicare Catastrophic Coverage Act of 1988 (P.L.100-360) amended section 1903(c) of the Act (42 U.S.C. 1396b(c)) to permit Medicaid payment for services provided to children under the IDEA through an IEP. IDEA provisions require school staff to perform a number of education-related activities that can generally be characterized as child find, evaluation (initial) and reevaluation, and development of an IEP. The IEP/IDEA related activities conducted by school staff are briefly described below:

"Child Find" All children with disabilities residing in the state who are in need of special education and related services must be identified, located, and evaluated.

"Initial Evaluations and Reevaluation" Before special education and related services are provided, an initial evaluation must be conducted by the LEA in order for the student's IEP/IFSP team to determine whether a child has a disability, and to determine eligibility for special education and related services as well as their special/specific educational needs. The evaluation results will be used to decide the child's eligibility for special education and related services and to make decisions about an appropriate educational program for the child. A re- evaluation is required for a student to remain eligible to receive special education and related services.

"Individualized Education Program (IEP)" For those children identified and determined to be disabled in accordance with Section 602 of the IDEA, an IEP must be developed by a team of individuals as defined in section 614. The IEP is statutorily defined as a written statement for each child with a disability that, among other elements includes:

- A statement of the child's present levels of educational performance;
- A statement of measureable annual goals, including benchmarks or short term objectives; and
- A statement of the special education and related services and supplementary aids and services to be provided to the child, or on behalf of the child, and a statement of the program modifications or supports for school personnel that will be provided to the child.

According to the Code of Federal Regulations (CFR) Part 34 Section 300.321, the makeup of the Child's IEP team includes:

- The Parent(s) of the child;
- Not less than one regular education teacher (if the child participates or may participate in regular education);
- Not less than one special education teacher, or when appropriate, not less than one special education provider of the child;
- A representative of the LEA who:
    - is qualified to provide or supervise the provision of, specially designed instruction to meet the unique needs of children with disabilities;
    - is knowledgeable about the general education curriculum, and
    - is knowledgeable of the availability of resources of the LEA;
- An individual who can interpret the instructional implications of evaluation results;
- At the discretion of the parent or LEA, other individuals who have knowledge or special expertise regarding the child including related services personnel as appropriate; and
- Whenever appropriate, the child with a disability.

When schools are conducting these initial activities listed above for the purpose of developing the IEP mandated under the IDEA, the associated costs of these activities are not allowable as administrative costs under the Medicaid program. For RMTS coders these education-related activities must be coded as non-Medicaid activities.

It is important to distinguish child find activities from Medicaid outreach for the purposes of claiming FFP under Medicaid. In accordance with the IDEA statute, schools conduct child find activities to identify children with disabilities who need special education and related services. Regardless of whether the child find activities result in finding eligible children for whom an IEP is developed, the child find costs are not allowed under Medicaid as administration. This type of outreach can be distinguished from outreach to identify children who might be eligible for Medicaid; such Medicaid outreach activities are allowable.

Various education-related statutes obligate schools to furnish or make payment for services provided in the school setting for which Medicaid payment is not available. While section 1903(c) of the Social Security Act clarifies that Medicaid payment is available for medical services contained in a child's IEP established under the IDEA (so long as the child is eligible and the services are otherwise reimbursable under Medicaid), no other education-related statutes obligate Medicaid payment.

Individualized Family Service Plan (IFSP)

A written plan for providing early intervention services to children from birth to three years of age eligible under Title 34, Code of Federal Regulations, Section 303.340, and the child's family. The IFSP enables the family and service provider(s) to work together as equal partners in determining the early intervention services that are required for the child with disabilities and the family.

Medicaid Payment for Services Provided without Charge (Free Care)

Medicaid reimbursement is available for covered services under the approved state plan that are provided to Medicaid beneficiaries, regardless of whether there is any charge for the service to the beneficiary or the community at large. As a result, FFP is available for Medicaid payments for care provided through providers that do not charge individuals for the service, as long as all other Medicaid requirements are met.

As is the case more generally, FFP for Medicaid payments is available only when all of the following elements are satisfied:

- The individual is a Medicaid beneficiary.
- The service is a covered Medicaid service, provided in accordance with the approved state plan methodologies, including coverage under the Early and Periodic Screening Diagnostic and Treatment (EPSDT) benefit provided to children.
- The provider is a Medicaid-participating provider and meets all federal and/or state provider qualification requirements.

- The state plan contains a payment methodology for determining rates that are consistent with efficiency, economy, and quality of care.
- Third party liability (TPL) requirements are met.
- Medicaid payment does not duplicate other specific payments for the same service.
- The state and provider maintain auditable documentation to support claims for FFP.
- The state conducts appropriate financial oversight of provider billing practices.
- All other program requirements (statutory, regulatory, policy) for the service, payment, and associated claiming are met.

Third Party Liability (TPL) - Medi-Cal as Payer of Last Resort

The Medicaid statute at section 1902(a)(25) of the Social Security Act (the Act) requires that states take all reasonable measures to ascertain and pursue claims for payment of health care items and services against legally liable third parties. Regulations at 42 CFR 433 subpart D describe the TPL provisions for the Medicaid program. In general, Medicaid beneficiaries are required to cooperate with the state Medicaid program in identifying available third party resources and assigning their rights to third party payments to the Medicaid program. Providers, in turn, are generally required to bill legally liable third parties prior to billing Medicaid, and bill Medicaid only the difference between the third party's payment liability and Medicaid's payment rate established in the Medicaid state plan (although there are some regulatory exceptions permitting Medicaid to pay providers in full and separately pursue TPL).

Public agencies or programs that are carrying out general responsibilities to ensure access to needed health care, such as schools, public health agencies, and child protective services agencies, are not viewed as legally liable third parties at the federal level for purposes of Medicaid reimbursement, except to the extent of liability that is more specific in nature, such as a tort claim or employer responsibility for employee health benefits, or when legal liability is specified by state law. A third party is defined in regulations at 42 CFR 433.136 as "any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a state plan." While the term "entities or programs" includes schools and similar agencies, typically these entities have general responsibilities to ensure that their students or clients obtain necessary services. This general responsibility to ensure access to needed care does not necessarily mean that these entities or programs have legal liability for payment for services when there are other available payers, such as Medicaid (even though their general responsibility may be supported by authority to make payment for such services).

Under this guidance, schools would also not be considered to be legally liable third parties to the extent that they are acting to ensure that students receive needed medical services to access a free appropriate public education consistent with section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §794.