

MEDICAID POLICY INFORMATION SHEET

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Initial ☐

Public Comment ☒

Final ☐

Brief description of policy:

This policy establishes the Caring 4 Students (C4S) program to include nursing and behavioral health services to general education students; and expands the current School-Based Services (SBS) program to include general education students while adding additional services. This policy also specifies the claim error rate as 15%.

Reason for policy (problem being addressed):

This policy addresses the need for increased behavioral health and nursing services in the school setting. It will also incorporate many aspects of Free Care into the school setting.

Budget implication:

☐ budget neutral

☒ will cost MDHHS \$ 10 million In 31(n) funds through the Michigan Department of Education (MDE), and is budgeted in current appropriation

☒ will save MDHHS \$ 5.8 million. Increases to the current SBS program should result in \$5.6 million to the Medicaid general fund, with the schools gaining \$8.4 million. Senate appropriated 31(n) funds of \$16.5 million for the C4S program should result in an increase of \$200,000 to the Medicaid general fund, with the schools gaining \$4 million.

Is this policy change mandated per federal requirements?

No

Does policy have operational implications on other parts of MDHHS?

Yes, because this policy's primary focus is behavioral health, there may be unexpected implications for Behavioral Health and Developmental Disabilities Administration (BHDDA). The exact nature of those implications are unknown as this time.

Does policy have operational implications on other departments?

Yes, because this policy affects the schools, there are implications for MDE.

Summary of input:

☐ controversial

☐ acceptable to most/all groups

☐ limited public interest/comment

Supporting Documentation:

State Plan Amendment Required: ☒ Yes ☐ No If Yes, please provide status: ☐ Approved ☒ Pending ☐ Denied Date: Approval Date:	Public Notice Required: ☒ Yes ☐ No If yes, Submission Date: 12/21/18
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DRAFT FOR PUBLIC COMMENT Michigan Department of Health and Human Services		
	Project Number: 1917-SBS	Date: July 22, 2019

Comments Due: August 26, 2019
Proposed Effective Date: October 1, 2019
Direct Comments To: Kevin Bauer
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Policy Subject: Caring 4 Students (C4S) Program Affected Programs: School Based Services, Caring 4 Students Distribution: School Based Services Providers Summary: This policy establishes the C4S program and expands the current School Based Services (SBS) program to include general education students, while adding additional services. This bulletin also sets the allowable claim error rate at 15%. Purpose: To establish the C4S program, expand the current SBS program, and clarify the claim error rate. Cost Implications: Will save MDHHS \$5.8 million; however, \$10 million GF in 31(n) funds from the Michigan Department of Education (MDE) will be routed to the schools Potential Hearings & Appeal Issues: None	
State Plan Amendment Required: Yes ☒ No ☐ If yes, date submitted: December 27, 2018	Public Notice Required: Yes ☒ No ☐ Submitted date: December 21, 2018
Tribal Notification: Yes ☒ No ☐ - Date: September 26, 2018	
THIS SECTION COMPLETED BY RECEIVER	
☐ Approved ☐ Disapproved	☐ No Comments ☐ See Comments Below ☐ See Comments in Text
Signature:	Phone Number
Signature Printed:	
Bureau/Administration <i>(please print)</i>	Date

Proposed Policy Draft

Michigan Department of Health and Human Services
Medical Services Administration

Distribution: School Based Services Providers

Issued: September 1, 2019 (Proposed)

Subject: Caring 4 Students (C4S) Program

Effective: October 1, 2019 (Proposed)

Programs Affected: School Based Services, Caring 4 Students

Note: Implementation of this bulletin is contingent upon approval of a State Plan Amendment by the Centers for Medicare & Medicaid Services (CMS)

I. General Information

This policy describes the coverage and reimbursement for Intermediate School District (ISD) nursing and behavioral health services for general education students (hereafter referred to as “Caring 4 Students” or “C4S”) and for the expansion of the existing School-Based Services (SBS) program. Collectively, these programs will be identified as “school-services programs.” Except where specifically identified, the provisions in this bulletin apply to both programs. Coverage is based on medically necessary, Medicaid-covered services that may be provided in the school setting and enables these services to be billed to Medicaid. This ensures federal participation in the funding of these Medicaid-covered services.

Federal matching funds generated through C4S activities are restricted and must be used to expand current or future C4S services. Funds generated through SBS activities remain unrestricted. Refer to the Reimbursement Fund Restriction section of this policy for further information.

Enrollment as a Michigan Medicaid provider for services delivered in the school setting is limited to the ISDs, Detroit Public Schools Community District (DPSCD), and Michigan School for the Deaf (MSD). Throughout the remainder of this policy, any reference to “ISD” pertains to all these entities unless stated otherwise. The ISDs are required to establish a memorandum of understanding to facilitate coordination and cooperation with other human service agencies operating within the same service area if services are delivered within the school setting.

II. Eligibility of Beneficiaries

School services coverage applies to Medicaid or Healthy Michigan Plan-eligible individuals under the age of 21 who are enrolled as a student in an ISD, DPSCD, or MSD.

A. C4S Beneficiaries

C4S beneficiaries are Medicaid-eligible general education students who require medical or behavioral health services identified as medically necessary including, but not limited to, those identified in a section 504 accommodation plan pursuant to 34 CFR §104.36, or an individualized health care plan. Documented consent for medically necessary services must be obtained from the C4S beneficiary or parent/guardian in accordance with state law.

B. SBS Beneficiaries

SBS beneficiaries are Medicaid-eligible special education students who require medical or behavioral health services identified as medically necessary including, but not limited to, those identified in an Individualized Education Program (IEP) or an Individualized Family Service Plan (IFSP).

III. Provider Enrollment

A. Enrollment

The ISDs are the only providers eligible to bill Medicaid for services provided by school-services programs. Providers must be enrolled and revalidated via the Community Health Automated Medicaid Processing System (CHAMPS) Provider Enrollment subsystem. Any applications or updates must be made through CHAMPS.

B. Certification of Qualified Staff

The Michigan Department of Education (MDE) must provide the Michigan Department of Health and Human Services (MDHHS) with documentation to support that enrolled ISDs meet the regulatory requirements set forth for staff providing services in the school setting. Enrollment as a provider is predicated on certification to MDE that the educational and professional requirements and credentials of all staff (e.g., licensure, certification, registration, etc.) who may be performing claimable services meet current state law and applicable professional standards. MDE will assist the ISDs in this certification process and will verify the status of provider licensure and certification. Documentation must be submitted by MDE to MDHHS.

IV. Covered Services

A. Psychological, Professional Counseling, Behavioral, and Social Work Services

Psychological, professional counseling, behavioral, and social work services are available to all Medicaid-eligible students enrolled in an ISD when deemed medically necessary. Medicaid-covered services must require the skills, knowledge, and education of a qualified psychologist, counselor, or social worker.

Covered psychological, professional counseling, behavioral, and social work services may include, but are not limited to, medically necessary screening, diagnosis and assessment, treatment, and other services to correct or ameliorate a behavioral health or medical condition. These services are intended for the benefit of the Medicaid-eligible beneficiaries and include:

- services provided to assist the student or parents/guardians in understanding the nature of the student's diagnosis;
- services provided to assist the student or parents/guardians in understanding the behavioral health needs of the student;
- services provided to assist the student or parents/guardians in understanding the student's development;
- health and behavior interventions to identify the psychological, behavioral, emotional, cognitive and social factors important to the prevention, treatment, or management of physical health problems;
- developing, implementing, revising, and monitoring an individualized plan of care (POC), including an emergency plan, for students with acute or chronic health care needs;
- care coordination;
- counseling services;
- psychotherapy services to include interactive, insight-oriented or supportive psychotherapy;
- administering psychological and developmental tests and other assessment procedures, interpreting testing and assessment results;
- obtaining, integrating, and interpreting information regarding a student's behavior and conditions related to learning, functional needs and supports necessary for success in school, and the planning and managing of psychological services;
- evaluating a student for the purpose of determining their needs for specific psychological, health or related services;
- assessing the effectiveness of the delivered services toward achieving the goals and objectives of the student's individualized POC;
- assessing needs for additional counseling services;
- crisis intervention;
- suicide intervention/prevention; and
- substance use prevention/screening services.

Psychological, professional counseling, behavioral, and social work services may be provided in an individual or group setting by qualified providers who meet the requirements of, and in accordance with, 42 CFR §440,50 through §440,60(a) and other applicable state and federal laws or regulations. Psychological, professional counseling, and social work services may be provided by:

- a licensed physician or psychiatrist;
- a licensed master's level psychologist;
- a limited licensed master's level psychologist, under the supervision of a licensed master's level psychologist;
- an MDE-credentialed master's level school psychologist;
- a licensed master's level marriage and family therapist;
- a board-certified behavior analyst (BCBA)
- a board-certified assistant behavior analyst (BCaBA), under the supervision of a BCBA
- a licensed master's level professional counselor;
- a limited licensed master's level professional counselor under the supervision of a licensed master's level professional counselor;
- a licensed master's level social worker;
- a licensed master's level school social worker;
- a limited licensed master's level social worker under the supervision of a licensed master's level social worker; and
- a temporary limited licensed psychologist under the supervision of a fully licensed psychologist.

B. Nursing Services

Nursing services are available to all Medicaid-eligible students when deemed medically necessary. Nursing services include, but are not limited to, medically necessary screening, treatment, and other services to correct or ameliorate a behavioral health or medical condition. Services must be within the professional scope of practice of the nurse, as defined by state law and regulation, and provided under the delegation and supervision of a physician or qualified non-physician practitioner (nurse practitioner [NP], clinical nurse specialist [CNS], or physician assistant [PA]) as applicable. Nursing services may include:

- developing, implementing, revising, and monitoring an individualized POC, including an emergency plan, for students with acute or chronic health care needs;
- care coordination;
- assisting in a school-related emergency, such as a playground accident, a school bus accident or some other critical incident that affects the health and safety of students;
- participating in chronic disease management services for students with chronic conditions such as sickle cell, asthma, diabetes, and epilepsy;

- providing medical and behavioral health nursing interventions to identify and support psychological, behavioral, emotional, cognitive and social well-being of the student;
- providing education to assist the student, parents/guardians, and staff in understanding the purpose and potential side effects of prescribed medication;
- providing health services for a student with acute medical needs;
- providing one-on-one or group health counseling to students;
- administering immunizations in coordination with a local health department; and
- administering medications under the order of a physician or qualified non-physician practitioner.

The nurse is also responsible for organizing and maintaining health-related documents, such as immunization records and health appraisal forms for each student.

Services must be provided by qualified providers who meet the requirements of, and in accordance with, 42 CFR §440.50 through §440.60(a) and other applicable state and federal laws or regulations. Nursing services may be provided by any of the following providers:

- a licensed practical nurse (LPN);
- a registered nurse (RN);
- a qualified school nurse, as defined by Public Act 269 of 1955 as amended;
- a certified nurse practitioner (NP); or
- a certified clinical nurse specialist (CNS).

C. Other Medical Services

The following medical services are available to all Medicaid-eligible students enrolled in an ISD when deemed medically necessary:

- occupational therapy;
- physical therapy;
- speech, language and hearing services;
- physician and psychiatrist services; and
- personal care services.

Medical services may be provided in an individual or group setting by qualified providers who meet the requirements of, and in accordance with, 42 CFR §440,50 through §440,60(a) and other applicable state and federal laws or regulations.

Services are covered and provided as described for School Based Services. Refer to the Medicaid Provider Manual, School Based Services Chapter for additional information. The Medicaid Provider Manual is available on the MDHHS website at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

D. C4S Non-Covered Services

The following services are limited to special education students only and are not covered for general education students:

- targeted case management; and
- special education transportation.

V. Plan of Care (POC)

It is the expectation that an appropriate provider, acting within their scope of practice, develop an individualized POC for students, including those who require ongoing behavioral health or medical services. The POC must indicate areas of risk or concern, specific objectives or goals, and specific interventions.

For covered services, the POC must include all the following information:

- student name and birth date;
- description of the student's medical or behavioral health condition and, when applicable, diagnosis;
- time-related goals that are measurable and significant to the student's health;
- long-term goals that identify specific achievement to serve as indicators that the service is no longer necessary;
- anticipated frequency and duration of interventions or services required to meet the goals;
- plan for reaching the goals;
- a statement detailing coordination of services with applicable providers; and
- all services are provided with the expectation that the student's primary care provider (PCP) and, if applicable, the student's case manager are informed on a regular basis.

It is the expectation that communication occurs with the student's PCP, health plan and, if applicable, the student's care coordinator as necessary to ensure there is coordination of interventions and services. For services that have time-specific procedure codes, the provider must indicate the actual begin and end times of the service in the school clinical record. The record must indicate the interventions or services provided. The student's school clinical record should include documentation of the coordination of services for the student.

Medicaid services provided by the ISDs are to be provided as outlined in the student's POC and are not expected to replace or substitute for services provided by other health care providers. When an evaluation indicates that Medicaid-covered services are required, the qualified staff must develop and maintain a POC for the student. Only qualified staff may initiate, develop or change the student's POC. The POC must be signed, titled and dated

by the qualified staff prior to billing Medicaid for services. The POC must be retained in the student's school clinical record.

When ongoing services are provided in the absence of a POC due to the urgency of the student's medical needs, the expectation is that a POC will be developed within 30 calendar days from the first date that services are provided for a specific condition.

If services are being provided by another program, ISDs are expected to coordinate the services to prevent duplication and to ensure continuity of care. Enrollment as a school-services program provider is not expected to result in any change in the education agency's set of existing services or service utilization beyond the services included in this policy. MDHHS periodically evaluates the impact of Medicaid enrollment on school programs through review of service utilization and other program data and information.

Covered services do not require prior authorization but must be provided and documented by qualified providers. (Refer to the General Information for Providers Chapter of the Medicaid Provider Manual for additional information regarding clinical record requirements.

VI. Medical Necessity

Medicaid services provided by an ISD are determined to be medically necessary when the following criteria are met:

- the services are evidence-based and provided within generally accepted standards of medical practice to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms; and
- the services are ordered, in writing, by a physician or other qualified licensed practitioner acting within the scope of their practice as defined in State law. The written order/referral must be updated at least annually. A stamped signature is not acceptable.

VII. Supervision of Limited Licensed Professionals

"Supervision of" a limited licensed behavioral health professional consists of the practitioner meeting regularly with another professional-of their same discipline at an interval described within the professional administrative rules to discuss the POC and other professional issues in a structured manner. This is often known as clinical or counseling supervision, or consultation. The purpose is to assist the practitioner to learn from their experience and expertise, as well as to ensure quality service to the client or patient. This level of supervision will be in effect until the provider is fully licensed.

VIII. Referrals

All ISDs participating in school-services programs must have agreements to refer students for further follow-up care and treatment. Communication of protected health information must adhere to rights and protections within State law and the Health Insurance Portability

and Accountability Act (HIPAA) Privacy Rule (refer to 45 CFR, §164.510[b] and §164.50). The school may contract with a federally qualified health center, local health department, hospital or health system, rural health center, tribal health center, community mental health services program (CMHSP), and/or private outpatient clinics. It is the expectation that referrals occur in collaboration with the student's parent/guardian, PCP, and health plan when permitted by law and regulation. It is expected that the provider will facilitate treatment, referrals, and related activities to assist the student in obtaining needed services. If services are being provided by another program, ISDs are expected to coordinate the services to prevent duplication of services and to ensure continuity of care.

IX. Quality Assurance and Coordination of Services

A. Quality Assurance

School-services programs providers must have a written quality assurance plan on file. School-services programs costs will be reviewed/audited by MDHHS for determination of medical necessity and to verify that all services were billed and paid appropriately. The purpose of the quality assurance plan is to establish and maintain a process for monitoring and evaluating the quality and documentation of covered services.

An acceptable quality assurance plan must address each of the following quality assurance standards:

- covered services are medically necessary as determined and documented in the POC through appropriate and objective testing, evaluation, and diagnosis;
- the POC identifies which covered services are to be provided and the service frequency, duration, goals and objectives;
- a monitoring program exists to ensure that services are appropriate, effective, and delivered in a cost-effective manner;
- billings are reviewed for accuracy;
- staff qualifications meet current licensure, certification, and program requirements;
- established coordination and collaboration exists to develop POCs with all other providers, (i.e., Public Health, MDHHS, CMHSPs, Medicaid Health Plans, outpatient hospitals, etc.).

B. Service Coordination and Collaboration

Students have access to services that are available in both the outpatient and in-school treatment settings. If treatment is provided in both settings, the goals and purpose for the two must be distinct. Outpatient services are provided to optimize the student's functional performance in relation to needs in the home or community setting and must not duplicate those provided in the school setting. Collaboration between the school and community providers is expected in order to coordinate treatment and to prevent duplication of services. This collaboration may take the form of documented phone calls, written communication logs, or documented participation in team POC meetings.

If coordination cannot be established, the school should retain documentation of their coordination attempts.

C. ISD Responsibilities

ISDs must establish an implementation plan that includes explicit quality control review mechanisms to ensure full staff training and compliance, accuracy and completeness of the random moment time study (RMTS) staff pool list (designated employees), adherence to MDHHS-published methodology, and accurate financial and staffing reports. Claiming entities must also fully cooperate with any review requested by the U.S. Department of Health & Human Services (HHS), maintaining all necessary records for a minimum of seven (7) years after submission of each quarterly claim.

D. Sanctions

It is the intent of the state to pursue, when necessary, remedial action or implement a corrective action plan if ISDs or their vendors are not in compliance with Medicaid policy and procedures. If these actions are not successful, a payment freeze will be implemented, and sanctions put in place until the matter is resolved. ISDs are responsible for the actions of their vendors.

The following are examples of causes for sanctions. The list is not all-inclusive.

- Repeated errors in completing the RMTS forms or filing of the claims.
- Providing insufficient data or incomplete reports to the State Contractor.
- Failure to submit requested information, reports, or data to the State Contractor, CMS, MDHHS, MDE, or failure to cooperate with representatives of these agencies during site visits, reviews or audits.
- Failure to comply with the federal mandate to submit procedure-specific claims through CHAMPS.

X. Financial Data Requirements and Unallowable Costs

A. Financial Data Requirements

The financial data reported for Direct Medical Services (salaries, benefits, supplies, etc.) must be based on actual detailed expenditure reports obtained directly from the participating ISD's financial accounting system. The financial accounting system data is applied using generally accepted governmental accounting standards and principles or applicable administrative rules. The expenditures accumulated for calculating the Direct Medical Services allowable costs must include actual non-federal expenditures incurred during the claiming period. These allowable expenditures include, but are not limited to, salaries, wages, fringe benefits, medically related supplies, purchased services and materials.

B. Unallowable Costs

Providers are not allowed to report any costs that are federal funds or non-federal funds that have been committed as local match for other federal funds or programs. Funds received by the ISDs for direct medical services are not federal funds. They are reimbursement for prior expenditures and become, upon receipt, local funds.

XI. School Services Reimbursement

A. Reimbursed Fund Restrictions

Federal matching funds generated through C4S activities are restricted and must be used to expand C4S services. Funds received as reimbursement for C4S behavioral health services must be used to expand current or future behavioral health services. Funds resulting from C4S non-behavioral health services must be used to expand current or future C4S services, which may include behavioral health and non-behavioral health services.

Federal matching funds generated through SBS activities remain unrestricted. ISDs may use unrestricted funds at their discretion.

B. Method of Reimbursement for Direct Medical Services

Payment for Michigan's school services provided by the ISD are a cost-based, provider-specific, annually reconciled and cost-settled reimbursement methodology. CMS also requires Michigan school-services programs providers to submit procedure-specific direct medical services claims for all Medicaid-allowable services. These claims do not generate a payment but are required by CMS in order to monitor the services provided, the eligibility of the recipient, and provide an audit trail. Interim monthly payments are tied to the submission of the direct medical services claims. If claim volume decreases significantly or drops to zero in any two consecutive months, all interim payments will be held until the provider is contacted and the issue resolved. MDHHS will monitor provider claim volume to make sure that this mandate is followed.

Claims are submitted and processed through CHAMPS; however, the procedure code fee screens are set to pay zero. ISDs receive payments from the interim monthly reimbursement process described below.

The interim monthly payments are based on prior year actual costs and reconciled on an annual basis to the current year costs. Cost reporting and reconciliation are based on the school fiscal year, which is July 1 through June 30 of each year.

The reimbursement process for direct medical services is comprised of the following processes and components:

- the direct medical services procedure code-specific billing process;
- RMTS component;
- the interim payment process, and;
- the cost reconciliation and cost settlement process.

CHAMPS combines all cost information and the RMTS results, the unrestricted indirect cost rate, and the Medicaid Eligibility Rate (MER) to calculate the total allowable costs. The MDHHS Hospital and Clinic Reimbursement Division performs the cost reconciliation and cost settlement process.

C. Direct Medical Services Procedure Code Specific Billing

MDHHS follows the American Medical Association's manual and guidelines for Current Procedural Terminology (CPT) numeric codes, and the Healthcare Common Procedure Coding System (HCPCS). To be reimbursed for services, the ISD must bill the appropriate CPT/HCPCS procedure code and modifier. Medical documentation must support the services billed. Claim documentation must identify the patient clearly, justify the diagnosis and treatment, and document the results accurately. Documentation must be sufficiently detailed to demonstrate that the service was provided and that the service followed the approved plan of treatment. Direct medical services must be identified in the student's POC. For tracking purposes, all C4S claims should be billed with the HA modifier.

The ISD may purchase software for the claims submission function or utilize the services of a billing agent. The cost of this process is the responsibility of the ISD.

D. Random Moment Time Study

The RMTS for school services will be accomplished in accordance with the following guidelines:

- For the RMTS, all ISDs will be required to utilize the services of the State Contractor who will conduct the statewide time studies.
- The quarterly RMTS sampling results are produced by the State Contractor who converts them to percentages. This percentage is applied to program costs to determine reimbursement. Once complete, the time study results are provided to MDHHS where they are uploaded into the cost settlement program.
- Costs are reported for direct medical services on the Local Education Agency (LEA) Cost Report.
- The ISDs and State Contractor must comply with all conditions set forth by MDHHS policy.
- The ISD portion of the cost for the State Contractor is charged back to the ISDs based on the State Contractor's projected cost per ISD (after federal match).

For detailed description and instructions regarding the RMTS, refer to the School Based Services Program Random Moment Time Study chapter of the Medicaid Provider Manual.

i. Summer Quarter Process

The summer quarter months are July, August and September. There is a break period between the end of one regular school year and the beginning of the next regular school year during which only a few staff are working. Most school staff work during the school year and do not work for part of the summer quarter (9-month staff). However, there are some 9-month staff who opt to receive their pay over a 12-month period. Therefore, different factors must be applied to the summer formula in order to accurately reflect the activities that are performed by the staff.

Since no RMTS is performed during the summer quarter, the RMTS results from the three previous quarters will be used to calculate the claim for the July – September quarter.

E. Interim Payment Process

Interim payments are calculated based on an estimated monthly cost formula. The monthly cost formula utilizes prior year costs. After the final cost reports have been reviewed and reported to MDHHS, reconciliation will be performed, and settlements will be made to make the providers whole.

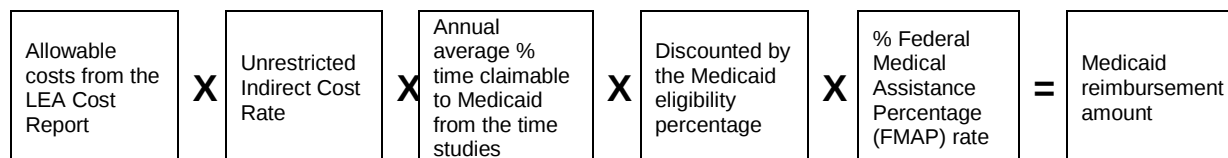
Interim payments are issued on the first pay cycle of each month based on costs from the most recently completed settlement. To justify an increase in the interim payment, providers must submit written documentation of significant changes in coverage, service utilization, or staff costs. Providers may request an increase or decrease in their interim payment amount at any time throughout the year. Any written inquiries should be addressed to the MDHHS Hospital and Clinic Reimbursement Division. (Refer to the Directory Appendix of the Medicaid Provider Manual for contact information.)

All payments and adjustments are issued by the MDHHS Hospital and Clinic Reimbursement Division. Once the payments are issued to the ISDs the interim payment revenue is distributed at the discretion of the ISDs.

F. Cost Reconciliation and Settlement

Medicaid reimbursement will be based on the following components:

- Costs from the LEA Cost Report
- MDE Unrestricted Indirect Cost Rate
- Random Moment Time Study Percentage
- Health-Related MER
- Federal Medical Assistance Percentage (FMAP)



The LEA Cost Report is utilized to collect allowable costs for the medical professional staff.

To report direct service-related costs, providers will utilize the LEA Cost Report. This cost report template may be obtained from the CHAMPS Facility Settlement sub-system. Cost reports from the LEA will be submitted to their ISD for summation utilizing the CHAMPS Facility Settlement sub-system. Providers must register and have access to the secure MILogin in order to utilize the CHAMPS Facility Settlement sub-system. MILogin registration instructions are also available on the MDHHS website at www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> School Based Services.

The filed cost data is used to calculate an initial settlement within 90 days after receipt of the initial cost report data. The initial settlement may result in either an over or under adjustment to the provider interim payment.

Within six months after the close of the school fiscal year, the ISDs will review, certify, and finalize the LEA Cost Report and transmit the report to the MDHHS Medical Services Administration for reconciliation. The cost certification form (CMS-10231 – Certification of Public Expenditures) must be signed and on file with MDHHS before a final settlement will be processed. The final settlement process will begin within 12-15 months after the close of the school fiscal year. Settlements may take several months for completion.

ISDs/LEAs may submit revisions to the LEA Cost Report until the final settlements are processed.

XII. Unrestricted Indirect Cost Rate (UICR)

The ISD/LEA UICR is calculated using the Federal Office of Management and Budget (OMB) Title 2 CFR Part 200. The methodology used to determine the UICR specific to each district is approved by the Federal cognizant agency. UICRs are updated annually by MDE.

XIII. Cost Certification

Once all cost reports and financial worksheets have been approved, the summary worksheet of the LEA Cost Report will be completed. The summary report will combine the allowable cost data submitted by the ISDs for each LEA. The total will be entered into the CMS-10231 as the "Total Computable Expenditure". By submitting the cost report, the ISD

is certifying electronically that the total amount of expenditures for covered services has been expended and that none of the expenditures have been used as match for other programs or services. MDHHS will utilize the CMS-10231 for this purpose.

XIV. Cost Allocation Factors

A. Federal Medical Assistance Percentage (FMAP) Rate

Federal regulations allow for payments to states on the basis of a FMAP for part of their expenditures for services under an approved State Plan. The formula for calculating this annual percentage is described in section 1905(b) of the Social Security Act.

B. Medicaid Eligibility Rate (MER)

Michigan's RMTS activity codes are designed to reflect the actual direct medical and behavioral health services activities that occur in a school on any given day. Since these services are provided for students who are both Medicaid and non-Medicaid eligible, it is necessary to develop and apply a formula that properly allocates which students are being supported and what services are being provided. For this reason, it is necessary to calculate two separate Medicaid eligibility rates.

i. C4S MER

The C4S MER percentage is determined by the percentage of the public student population that are Medicaid eligible in each ISD in comparison to the total student population in the ISD. The eligibility rate is determined once each year utilizing the Student Count Report. The calculation for the C4S eligibility rate is as follows:

$$\frac{\text{Medicaid Eligible Students}}{\text{Total Student Population}}$$

ii. SBS MER

The SBS MER percentage is determined by the percentage of the special education student population with a health-related support service in their IEP that are Medicaid eligible in each ISD in comparison to the total Special Education student population with a health-related support service in the ISD. The eligibility rate is determined once each year utilizing the Student Count Report. The calculation for the SBS eligibility rate is as follows:

$$\frac{\text{Medicaid eligible Special Education students with a health-related support service in their IEP}}{\text{Total Special Education students with a health-related support service in their IEP}}$$

C. Allocation of Salaries and Benefits of Personnel Providing Direct Care Services

Actual expenditures for salaries and benefits of all personnel are to be obtained from each participating ISD's financial accounting system. Expenditures related to the performance of approved Medicaid contracted service providers who also provide direct care services must also be obtained from each participating ISD's financial accounting system.

XV. Documentation

A. Medical Documentation

Medical records must clearly document all information pertinent to Medicaid-covered services provided to beneficiaries. The medical record must be sufficiently detailed to allow reconstruction of what transpired for each service billed. All documentation for services provided must include the following:

- the beneficiary name and date of birth;
- the actual date of service;
- be signed and dated by the rendering health care professional;
- indicate the medically necessary service provided and specific findings or results of diagnostic or therapeutic procedures;
- the beneficiary response to treatment; and
- changes to the course of treatment with rationale as applicable.

For services that are time-specific according to the procedure code billed, providers must indicate in the medical record the actual begin time and end time of the particular service. (Refer to the General Information for Providers chapter of the Medicaid Provider Manual for additional clinical documentation requirements.)

B. RMTS Documentation

Each participating LEA must maintain a separate audit file for each quarter containing the financial data used to establish cost pools. Each participating ISD must maintain a separate audit file for each quarter.

ISDs/LEAs must cooperate fully with any review requested by MDHHS and CMS and must maintain all necessary records for a minimum of seven (7) years.

XVI. Audit and Recovery Procedures

A. School Service Audit Activities to be Performed by MDHHS Bureau of Audit Staff

MDHHS audit review of selected ISDs'/DPSCD/MSD cost reports for school services may include the following activities:

- Verification that the ISDs accurately reported the allowable costs incurred for the appropriate period.
- Verification that the salaries listed for employees/positions included in the RMTS staff pool match the payroll records for the same period as the time study.
- A review of the salaries of employees who changed positions during the time study period.
- If a replacement was hired/transferred, the auditor may verify that only the salary earned while working in a position on the staff pool list was reported, and that salaries for both the original and replacement employees were not duplicated on the report for the same period.
- Confirmation that none of the direct costs reported were also claimed as an unrestricted indirect cost, that the proper unrestricted indirect cost rate was used, and the rate was applied only to costs in the base. The employees in non-standard job categories are the most likely to be considered indirect type employees; therefore, documentation may be reviewed for these individuals.
- Verification that no federal funds were claimed on cost reports and that costs were not accepted for cost-sharing.
- A standard review of other areas, such as confirmation that reported costs were actually paid, support documentation was maintained as required, and costs were properly charged to the correct accounts may occur.
- Any other area deemed necessary.

ISDs should be prepared to direct the auditor to any document used to support and identify the reported costs.

B. Student Claims Audit Activities to be Performed by MDHHS Bureau of Audit Staff

MDHHS audit review of selected ISD, DPSCD and MSD for approved school-services programs student claims may include the following activities:

- Verification that appropriate prescriptions/referrals/authorizations or standing orders are updated annually or more often, as necessary and ordered by the appropriate individual.
- Verification that medical necessity has been established.
- Confirmation that services requiring the student to be in attendance have support documentation (i.e., attendance records) on file.
- Confirmation that the providers performing the service have the required licensure/certification.

- Verification that the providers requiring supervision both "under the direction of" and "under the supervision of" have the necessary support documentation on file.
- Verification that group therapy or treatment was provided in groups of two to eight.
- A standard review of the POC, as defined in the Plan of Care (POC) section of this policy.
- Any other area deemed necessary.

The ISD/DPSCD/MSD should be prepared to direct the auditor to any document used to support and identify the reported student claims.

C. Audit Findings and Resolution

Audit findings and resolution may include the following:

- Identified overstatement of expenditures on the cost report will require the revision of the cost report and a revised final settlement for all specifically identified overstatements.
- For claim error rates identified, the recovery may be the error percentage over 15% multiplied by total Medicaid paid to the ISD during the period covered by the audit.

Recoveries and re-filings are limited to fiscal years considered within five years from the last date of payment for that period.