SCHOOL BASED SERVICES - 101

2018 MI SBS CONFERENCE – BELLAIRE, MI

TOPICS OF DISCUSSION

- History of Medicaid & School Based Services
- Random Moment Time Study
- The Financial Process
- The Cost Settlement/Reimbursement Process
- Quality Assurance Plan
- File Transfer/CHAMPS/PCG
- SBS Resources

NOW …

History of Medicaid

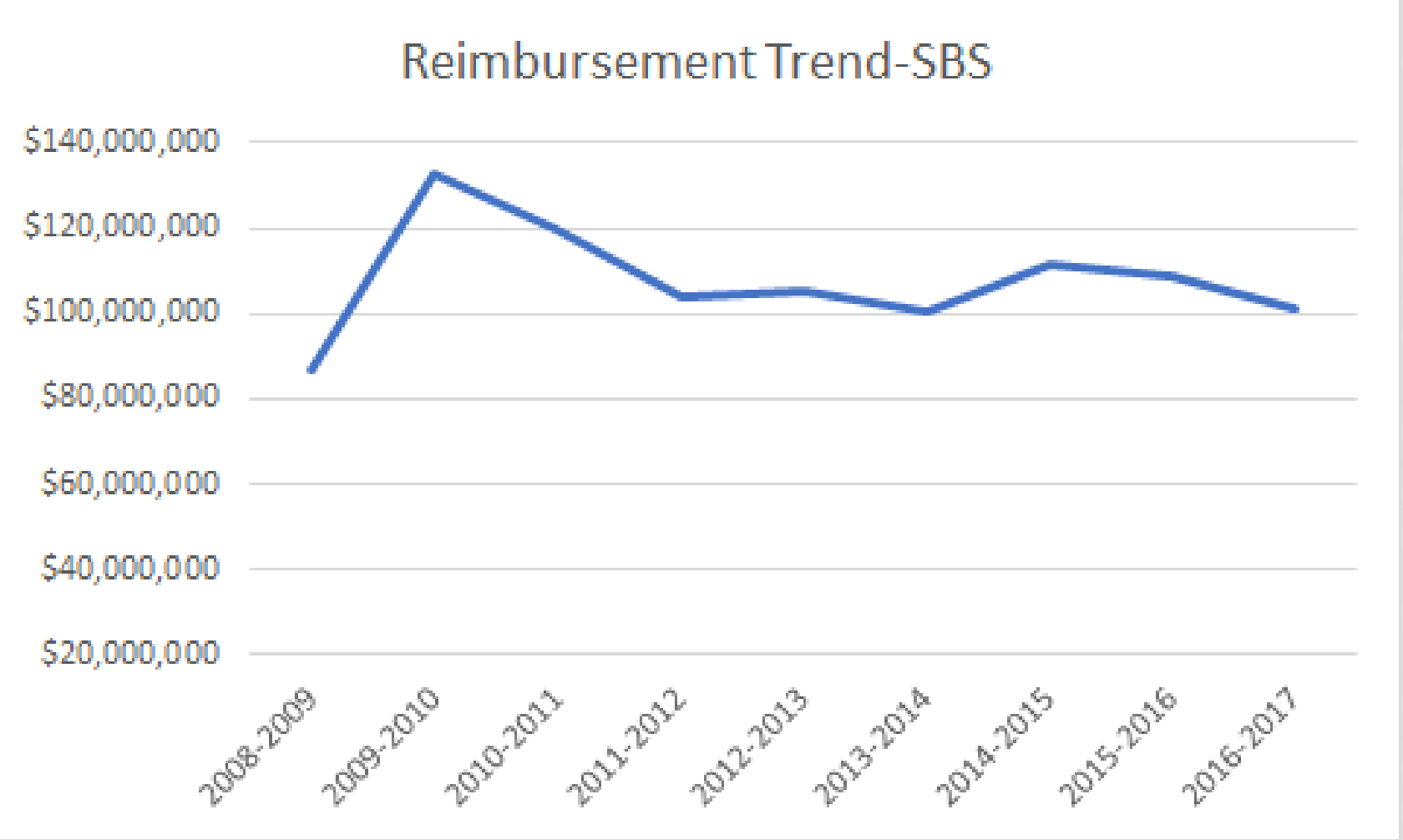
&

School Based Services

WHY IS THIS IMPORTANT?

- Reimbursement to Intermediate School Districts
  - 7/1/2008 – 6/30/2009: $86,424,569
  - 7/1/2009 – 6/30/2010: $132,423,912
  - 7/1/2010 – 6/30/2011: $119,794,856
  - 7/1/2011 – 6/30/2012: $103,592,595
  - 7/1/2012 – 6/30/2013: $105,459,655
  - 7/1/2013 – 6/30/2014: $100,360,853
  - 7/1/2014 – 6/30/2015: $111,499,171
  - 7/1/2015 – 6/30/2016: $108,791,753
  - 7/1/2016 – 6/30/2017: $100,796,416

REIMBURSEMENT TRENDS



MEDICAID - HISTORY

- Authorized by Title XIX of the Social Security Act, Medicaid was signed into law in 1965 alongside Medicare.
  - Although the Federal government establishes certain parameters for all states to follow, each state administers their Medicaid program differently, resulting in variations in Medicaid coverage across the country.
- The State of Michigan implemented Medicaid – October, 1966
  - 26 States by January 1967
  - 37 States by January 1968
  - 41 States by January 1969
  - 49 States by January 1970
  - Arizona implemented in October, 1982

MEDICARE VS MEDICAID

- Medicare
  - Is an insurance program
  - Run by the federal government
  - It is the same in all 50 states
  - Available to Americans age 65 and older, and sometimes to younger persons with disabilities
- Medicaid
  - Is an assistance program
  - Run by state and local governments within federal guidelines
  - It varies from state to state
  - Available to low-income Americans, pregnant women, people with disabilities, regardless of age

MEDICAID – BY THE NUMBERS (ENROLLMENT) (DATA BY KAISER FAMILY FOUNDATION)

- Medicaid and the Children's Health Insurance Program (CHIP) provide health and long-term care coverage to more than 74 million low-income children, pregnant women, adults, seniors, and people with disabilities in the United States
  - Michigan: As of May 2017, total Medicaid & CHIP Enrollment: 2,352,826
  - Medicaid Covers:
    - 1 in 7 adults under 65
    - 1 in 2 low-income individuals
    - 2 in 5 children
    - 3 in 5 nursing home residents
    - 2 in 5 people with disabilities

MEDICAID – BY THE NUMBERS (SPENDING) (DATA BY KAISER FAMILY FOUNDATION)

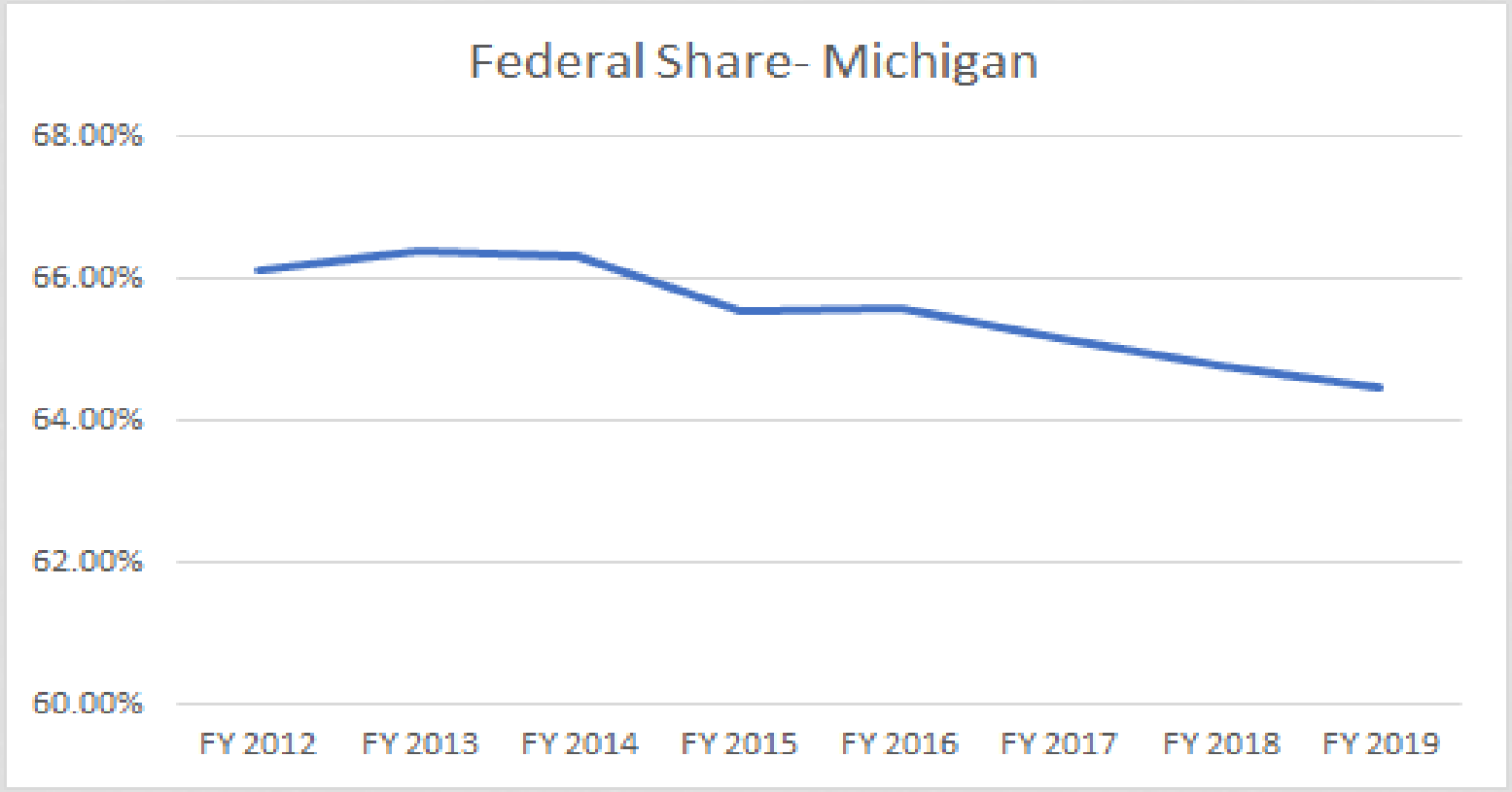
- In FY 2016, Medicaid spending in the United States was $553.5 billion
  - 19% of state general fund spending in the US is for Medicaid
  - 57% of all federal funds received by states is for Medicaid
- 10 million Medicare beneficiaries (21%) rely on Medicaid for assistance with Medicare premiums and cost-sharing and services not covered by Medicare, particularly long-term care
  - 36% of Medicaid spending is for Medicare beneficiaries

MEDICAID: FEDERAL-STATE PARTNERSHIP

	Federal Government	States
Administration	Oversight	Direct Administration
Financing	Pays 50% to 73% of costs	Pays a share of cost
Program Rules	Minimum standards; Strong benefit/cost sharing standards for children (EPSDT)	Sets provider payment rates and decides whether to cover beyond minimums
Coverage Guarantee	Required, if eligible	Cannot freeze or cap enrollment; can implement enrollment barriers

FEDERAL SHARE - MICHIGAN

- FY 2012: 66.14%
- FY 2013: 66.39%
- FY 2014: 66.32%
- FY 2015: 65.54%
- FY 2016: 65.60%
- FY 2017: 65.15%
- FY 2018: 64.78%
- FY 2019: 64.45%



HEALTHY MICHIGAN PLAN - HISTORY

- Important Dates
  - On September 16, 2013, Governor Rick Snyder signed into law Michigan Public Act 107 of 2013, which directs the creation of the Healthy Michigan Plan
  - On December 30, 2013, the Healthy Michigan Plan received approval from the Centers for Medicare and Medicaid Services
  - On April 1, 2014, the State of Michigan began accepting applications for the Healthy Michigan Plan

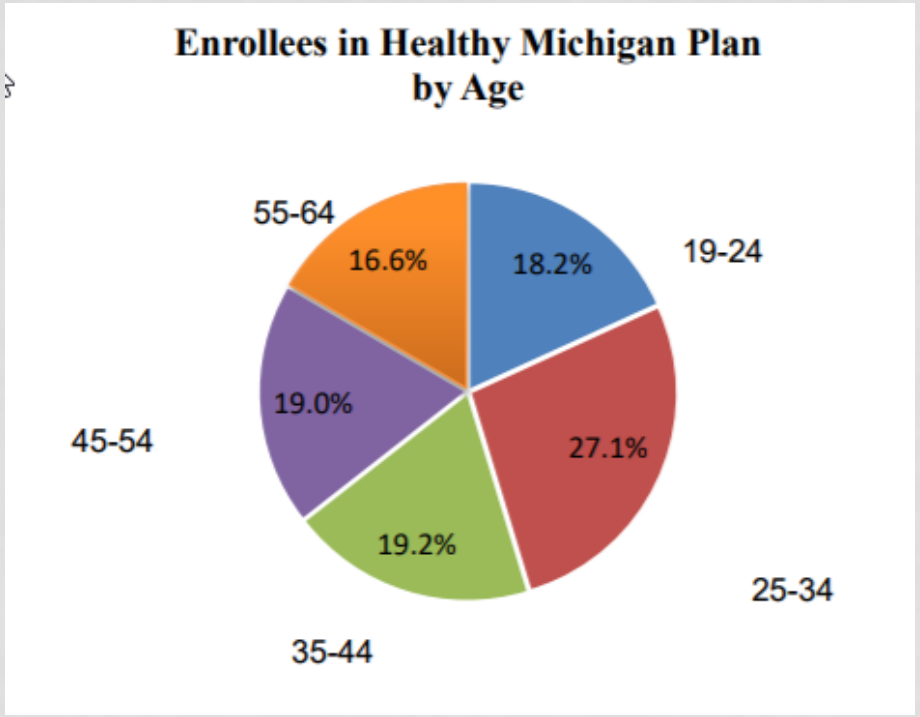
HEALTHY MICHIGAN PLAN – CONT.

- Eligibility
  - Are age 19-64 years
  - Have income at or below 133% of the federal poverty level under the Modified Adjusted Gross Income methodology
  - Do not qualify for or are not enrolled in Medicare
  - Do not qualify for or are not enrolled in other Medicaid programs
  - Are not pregnant at the time of application
  - Are residents of the State of Michigan

- Coverage (10 Essential Health Benefits)
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance use disorder treatment services, including behavioral health treatment
  - Prescription drugs
  - Rehabilitative and habilitative services and devices
  - Laboratory services
  - Preventive and wellness services and chronic disease management
  - Pediatric services, including oral and vision care

HEALTHY MICHIGAN PLAN – PROGRESS REPORT (JULY 31, 2018)

Total Healthy Michigan Plan Beneficiaries			
	Number of Females	Number of Males	Number Eligible
Age 19-24	63,512	60,889	124,401
Age 25-34	86,791	98,283	185,074
Age 35-44	60,219	70,694	130,913
Age 45-54	63,025	66,549	129,574
Age 55-64	58,982	54,306	113,288
Total	332,529	350,721	**683,250**
Percentage	48.67%	51.33%	100.00%



MICHIGAN SBS - HISTORY

- Agreement between Michigan Department of Social Services & Michigan Department of Education
  - Approval Date: 12/18/1993
  - It is the intent and purpose of the parties hereto, by entering into this agreement, to promote high quality of health care and services for recipients of Michigan's Medical Assistance Program, to assure the proper expenditure of public funds for health care services provided said recipients, and to conform with applicable state and federal requirements

MICHIGAN SBS - HISTORY

- In 2000, the DHHS, acting through the CMS, imposed a federal reimbursement disallowance for the SBS Administrative Outreach Program
- In 2002, the State of Michigan and DHHS/CMS negotiated a settlement agreement that required significant revisions to the SBS Administrative Outreach Program
- Effective January 1, 2004, the State of Michigan implemented a new claims development methodology for the SBS Administrative Outreach Program
  - The new methodology included the following:
    - A random moment time study using the Medicaid Administrative Claiming System (MACS) software
    - New time study activities
    - Two options for claims development
    - Establishment of central administrative responsibilities
    - A single method of determining the discounted Medicaid eligibility rate
    - A special monitoring system
    - A revised provider "Assurance of Understanding and Compliance" document

MICHIGAN SBS – HISTORY CONT.

- Effective July 1, 2008, the State of Michigan SBS Program will be reimbursed based on a cost-based, provider-specific and annually reconciled methodology
- The new methodology required some changes to the random moment time study methodology
  - Three new staff pools that time studies will be performed on:
    - Direct Medical Services
    - Personal Care Services
    - Targeted Case Management

YOUR ROLE

- Know the stakes – Over $100 million coming to MI each year to ISDs
- This is a statewide program with several partners, each of us has an essential role
- You are a “Medicaid Provider” expected to know both Special Education and Medicaid rules and requirements

NOW …

Random Moment Time Study

RANDOM MOMENT TIME STUDY

- In accordance with the Centers for Medicare & Medicaid Services (CMS) reimbursement policy, some activities performed by medical professionals and Intermediate School District (ISD) staff in a school based setting are eligible for federal matching funds.
  - These activities may be performed by staff with multiple responsibilities.
  - CMS reimbursement requirements include the use of a random moment time study (RMTS) as a component of the Medicaid reimbursement methodology.
    - The time study results are used to determine the amount of staff time spent on Medicaid-allowable activities.

STAFF POOL LIST

- Time studies are carried out over the following staff pools:
  - AOP Only Staff
  - Direct Medical Staff
  - Personal Care Services Staff
  - Targeted Case Management Services Staff

AOP ONLY STAFF

AOP Only Staff Pool:

- Administrators
- Counselors
- Early Identification/Intervention Personnel
- Physician Assistants
- Teacher Consultants
- School Psychologists (certified by the Michigan Department of Education but without Michigan licensure)
- Limited Licensed Speech Language Pathologists (without their American Speech-Language-Hearing Association Certificate of Clinical Competence)
- School Social Workers (certified by the Michigan Department of Education but without Michigan licensure)

DIRECT MEDICAL SERVICES

AOP & Direct Medical Services Staff Pool:

- Fully Licensed Speech Language Pathologists
- Audiologists
- Counselors
- Licensed Practical Nurses
- Occupational Therapists
- Occupational Therapist Assistants
- Orientation and Mobility Specialists
- Physical Therapists
- Physical Therapist Assistants
- Physician and Psychiatrists
- Psychologists (not School Psychologists)
- Registered Nurses
- Social Workers

PERSONAL CARE SERVICES

The following staff may be appropriate for inclusion in time studies if they are involved in Personal Care activities in the school setting:

- Bilingual Aides
- Health Aides
- Instructional Aides
- Paraprofessionals
- Program Assistants
- Teacher Aides
- Trainable Aides

TARGETED CASE MANAGEMENT

Staff with the following credentials may be appropriate for inclusion in time studies if they are involved in Targeted Case Management activities in the school setting:

- A bachelor's degree with a major in a specific special education area.
- Coursework credit equivalent to a major in a specific special education area.
- Minimum of three years' personal experience in the direct care of an individual with special needs.
- A licensed Registered Nurse (RN) in Michigan.

RMTS PROCESS

- All staff pools have 800 moment surveys for the summer quarter
- 12,200 moment surveys are sent out for the remaining three quarters
  - AOP – 3000
  - TCM – 3000
  - PC – 3200
  - DS – 3000
- The sample size of each cost pool ensures a quarterly level and annual level of precision of +/- 2% with at least a 95% confidence level

RMTS QUESTIONS

- Were you working during your sampled moment?

If yes, then…

- Who was with you?
- What were you doing?
- Why were you doing this activity?
- Does the Student have an IEP/IFSP in place for the services you are performing?

RMTS TRAINING

- Participants need to know that:
  - Their answers are coded by RMTS specialists in Chicago
  - They must be descriptive, so that the answers can be coded correctly
  - If their answer can't be understood, someone from PCG will call to clarify

- Give Examples:
  - Which response best describes what you were doing ?

BE DESCRIPTIVE - WHO

- Who was with you?
  - A social worker / An OT / the student's Case Manager
  - A [physically impaired] student
  - A group of ASD students
  - A student's parent(s)/guardian

BE DESCRIPTIVE - WHAT

- What were you doing?
  - Reviewing student behavior plan and IEP goals
  - Re-directing a student to stay on task
  - Meeting regarding accommodations for a student
  - Physical Therapy – range of movement – upper body
- Assisting student(s) during a math assignment
  - Okay (although not usable) for a Case Manager
  - Direct Service or Personal Care staff would might need to define assistance!

BE DESCRIPTIVE - WHY

- Why were you doing this activity?
  - Annual IEP – Speech and Social Work services will continue.
  - Chronic behavior issues are impacting progress toward his goals.
  - Student requires visual aides to participate in classroom activities.
  - Poor gross/fine motor skills impede mobility and ability to participate in classroom activities/assignments.
- Focus On: Personal Care
  - Monitoring swallowing as student ate their lunch.
  - Physically assisting child with boarding a bus.
  - Ensuring that student gets safely from one class to another.
  - Monitoring student's behavior and prompting to pay attention during a classroom activity.

YOUR ROLE

- Make sure the right people are on the SPL
  - Check staff licensure
- Train your staff on how to complete the RMTS
- Make sure ALL RMTS's are completed within 5 days
  - Check the Compliance Report on the PCG website
  - And if they don't complete it? (Every ISD has a process)
    - Go to the Special Ed Director
    - Go to the Superintendent of the district
    - Go to your ISD Superintendent

NOW …

The Financial Process

THE FINANCIAL PROCESS

- Two mechanisms for capturing costs
  - Quarterly Financials
  - Medicaid Allowable Expenditure Report (MAER)
- May include costs for staff pool participants ONLY
  - If name is on the wrong pool for any quarter, $0
  - If there was no placeholder for new/open position, $0
  - If staff were left off pool in error, $0
- Coordination of Funding
  - If staff are split funded (IDEA and Medicaid), you may claim only the non-federal portion of their costs

REIMBURSEMENT FORMULA

Allowable Costs (+ Medicaid Indirect costs)

x RMTS % (State-wide)

x SE Medicaid Eligibility Rate (ISD specific)

x FMAP or Federal Financial Participation %

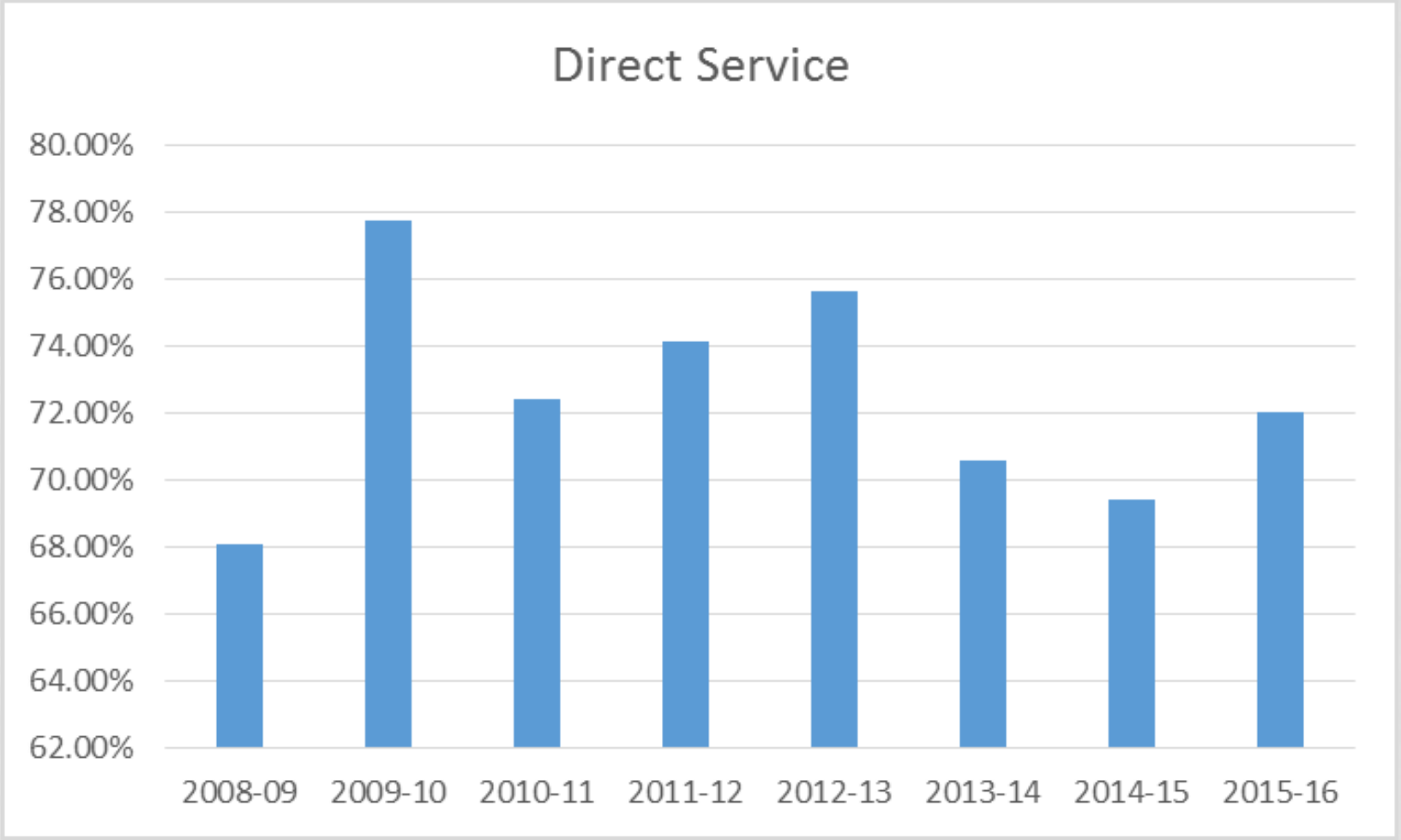
x ISD Reimbursement Rate (60%)

= Net Dollars to ISD

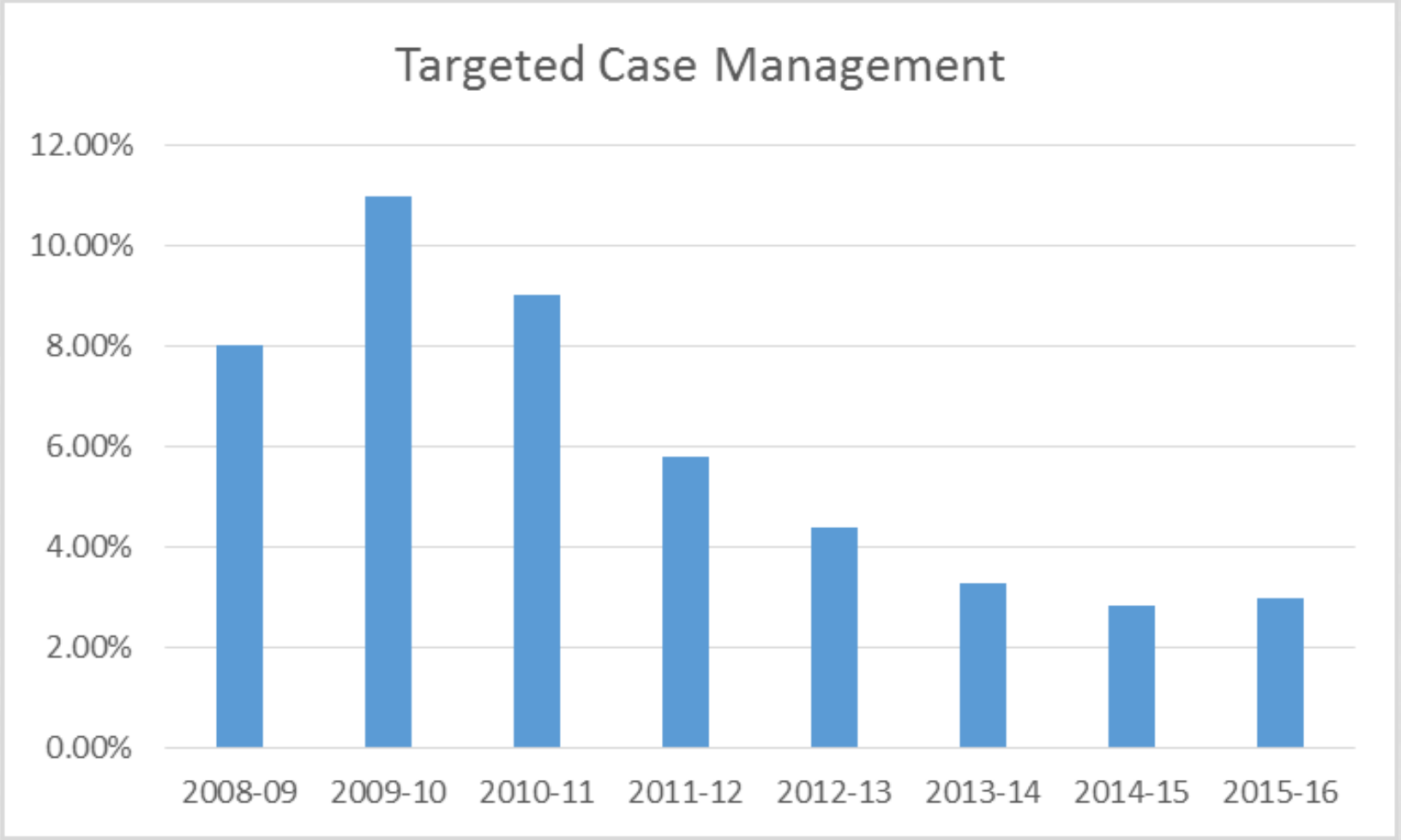
REIMBURSEMENT VARIABLES (RMTS %)

	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
Direct Service	68.10%	77.74%	72.41%	74.14%	75.64%	70.55%	69.38%	71.99%
Targeted Case Management	8.02%	10.97%	9.02%	5.80%	4.37%	3.26%	2.82%	2.97%
Personal Care	19.99%	31.17%	20.94%	22.00%	22.11%	20.61%	20.87%	23.28%

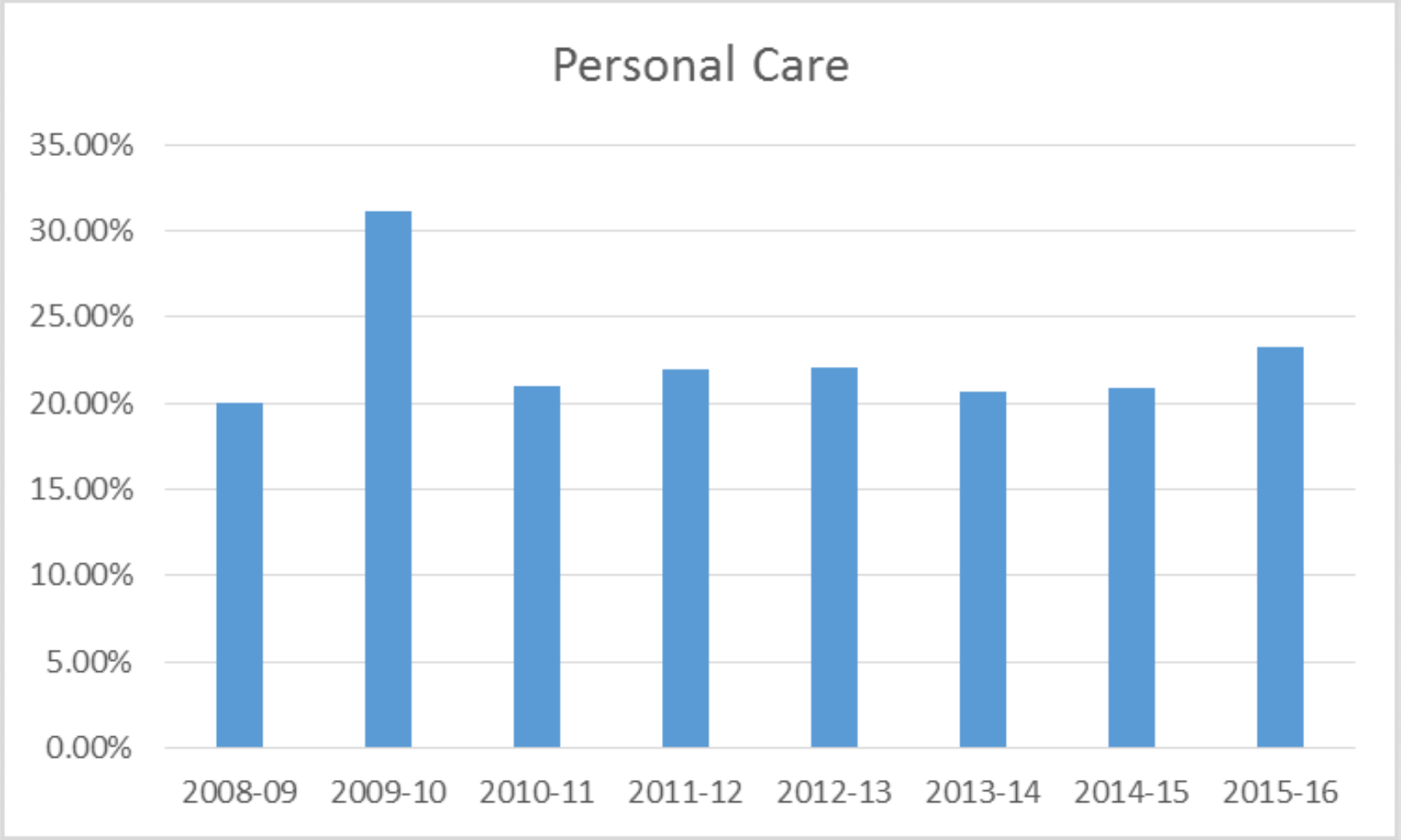
RMTS % - DIRECT SERVICE



RMTS % - TARGETED CASE MANAGEMENT



RMTS % - PERSONAL CARE



BE STRATEGIC

- Use non-Medicaid allowable staff for Federal Funding
  - "Educational" Aides, full-time "Release" Teachers (who do not coordinate IEPs)
  - If you can't allocate all federal funds using non-qualified staff, use AOP staff first (Administrators, Teacher Consultants, et cetera)
- Targeted Case Management vs Personal Care staff?
  - Depends on costs, but remember that Personal Care Staff generally report a LOT more services!
- Cost/benefit and availability of fully licensed staff.
  - All other things being equal, hire fully licensed Direct Service Staff!

REIMBURSEMENT EXAMPLE

	Direct Service	Targeted Case Management	Personal Care
Costs + Indirect Costs	$1.00	$1.00	$1.00
RMTS %	71.99%	2.97%	23.28%
SE MER (ISD Specific)	51.91%	51.91%	51.91%
FMAP	65.60%	65.60%	65.60%
ISD Reimbursement %	60.00%	60.00%	60.00%
Net $'s to ISD	$0.15	$0.01	$0.05

TRANSPORTATION REIMBURSEMENT

Allowable Costs (SE-4094)	$10,000,000
Divided by Total Trips	500,000
Cost Per Trip	$20 (per trip rate)
Multiply by Reimbursable One-Way Trips	$20 x 75,000 = $1,500,000
Multiply by Federal Funds Rate	$1,500,000 x 65.15% = $977,250
Multiply by ISD Rate (60%)	$977,250 x 60% = $586,350
Net Dollars to ISD	$586,350

YOUR ROLE

- Foster cooperation between Medicaid, Special Education & Business staff
  - Identify who should be federally funded to be in compliance with grant rules AND have minimal impact on Medicaid reimbursement
  - Share information discussed at Implementer meetings
  - Ensure person completing MAER compares costs to those reported on SE-4096 and SE-4094
    - If SE-4096 or SE-4094 are amended, you may have to amend your MAER

NOW …

The Cost Settlement/Reimbursement Process

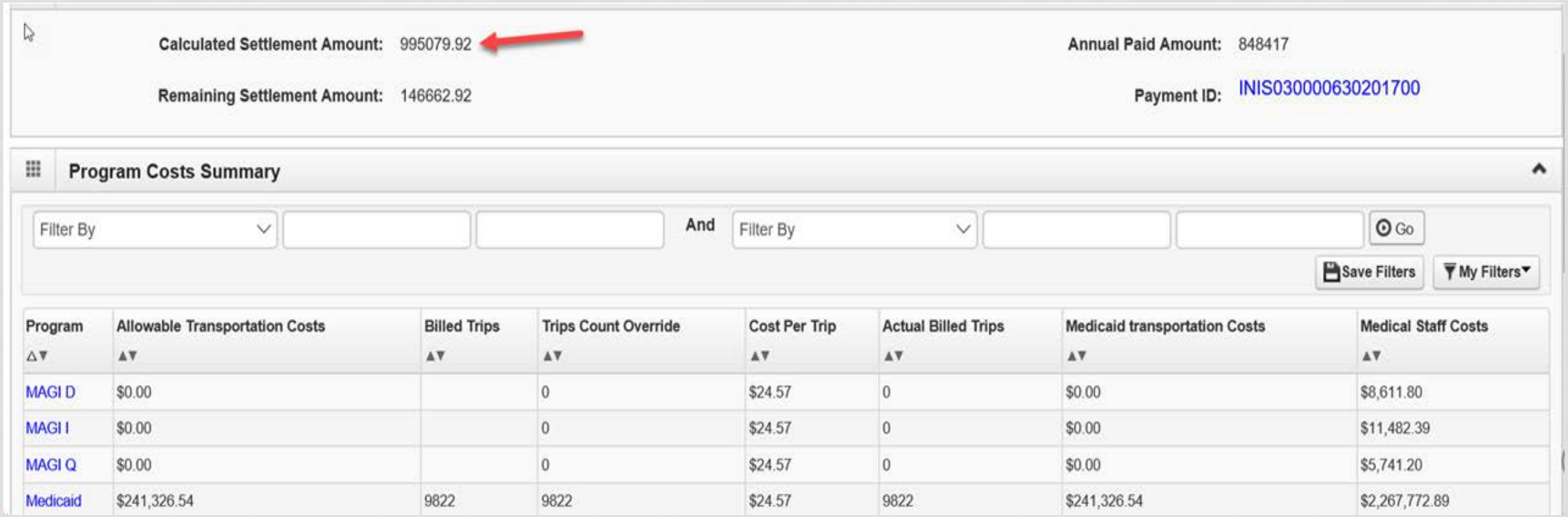
THE SETTLEMENT/REIMBURSEMENT PROCESS

- Monthly Interim Payment Process
- Settlement Process
- Monthly Claims Comparison Process

MONTHLY INTERIM PAYMENT PROCESS

- Interim Payment Determination
  - The calculated settlement amount from the prior year initial settlement is what drives the monthly interim payments for the current year. Once an initial settlement is approved the system will take the calculated settlement amount and subtract any interim payments made in the current fiscal year. The remaining amount is then divided by number of monthly interim payments remaining in the fiscal year. The quotient is the new interim payment.

MONTHLY INTERIM PAYMENT PROCESS



Calculated Settlement Amount: 995079.92

Remaining Settlement Amount: 146662.92

Annual Paid Amount: 848417

Payment ID: INIS030000630201700

Program Costs Summary

Filter By | And | Filter By | Go | Save Filters | My Filters

Program	Allowable Transportation Costs	Billed Trips	Trips Count Override	Cost Per Trip	Actual Billed Trips	Medicaid transportation Costs	Medical Staff Costs
MAGI D	$0.00		0	$24.57	0	$0.00	$8,611.80
MAGI I	$0.00		0	$24.57	0	$0.00	$11,482.39
MAGI Q	$0.00		0	$24.57	0	$0.00	$5,741.20
Medicaid	$241,326.54	9822	9822	$24.57	9822	$241,326.54	$2,267,772.89

MONTHLY INTERIM PAYMENT PROCESS

- Interim Payment Calculation
  - For example if the total interims is $843,463. In the top right of the settlement page there is the calculated settlement amount of $995,079.92. The total interim payments is listed next. The remaining balance of the calculated settlement amount is $151,616.61. This amount is then divided by the two remaining payments in order to determine new monthly interim payment.
    - $995,079.92 - $843,463.31 = $151,616.61
    - $151,616.61/2 = $75,808.31

MONTHLY INTERIM PAYMENT PROCESS

- Annual Interim Payment Calculation
  - The annual interim payment is based on the most recent calculated settlement amount from the initial settlement or final settlement as of the beginning of the new fiscal year. This amount is divided by the number of payments in the fiscal year (12) to determine the new interim payment. Calculated settlement amount/12 = new interim payment.
    - $995,079.92/12 = $82,923.33 interim payment.

MONTHLY INTERIM PAYMENT PROCESS

- Changes To Interim Payments
  - An interim payment will change whenever a settlement is processed. Say for instance in August a final settlement is processed with a calculated settled amount of $989,079.92.
    - $989,079.92 – Calculated settlement amount from final settlement
    - $165,846.65 – July & August payments ($82,923.33 x 2)
    - $823,233.27 – Calculated settlement amount less payments made in current fiscal year
    - 10 – Remaining payment cycles
    - $823,233.27/10 = $82,323.33 New interim payment

SETTLEMENT PROCESS

- Initial Settlement
  - Time for completion
  - Not the final settlement
- Final Settlement
  - Cannot be completed prior to one year after the ISD's FYE (June 30th of the following year)
  - Can be processed without an initial settlement

* No Settlement will be processed until MDHHS is reasonably confident that the figures presented in the Cost Report accurately reflect the ISD's expenditures.

SETTLEMENT PROCESS - SUBMISSION

- Deadline – December 31st
- Settlements are processed in the order they are received
- Submitted through the Facility Settlement system
- Certification page is required and now done electronically

MONTHLY CLAIMS COMPARISON PROCESS

- CMS mandate – Claim volume must not be less than 85% of the previous year's submissions

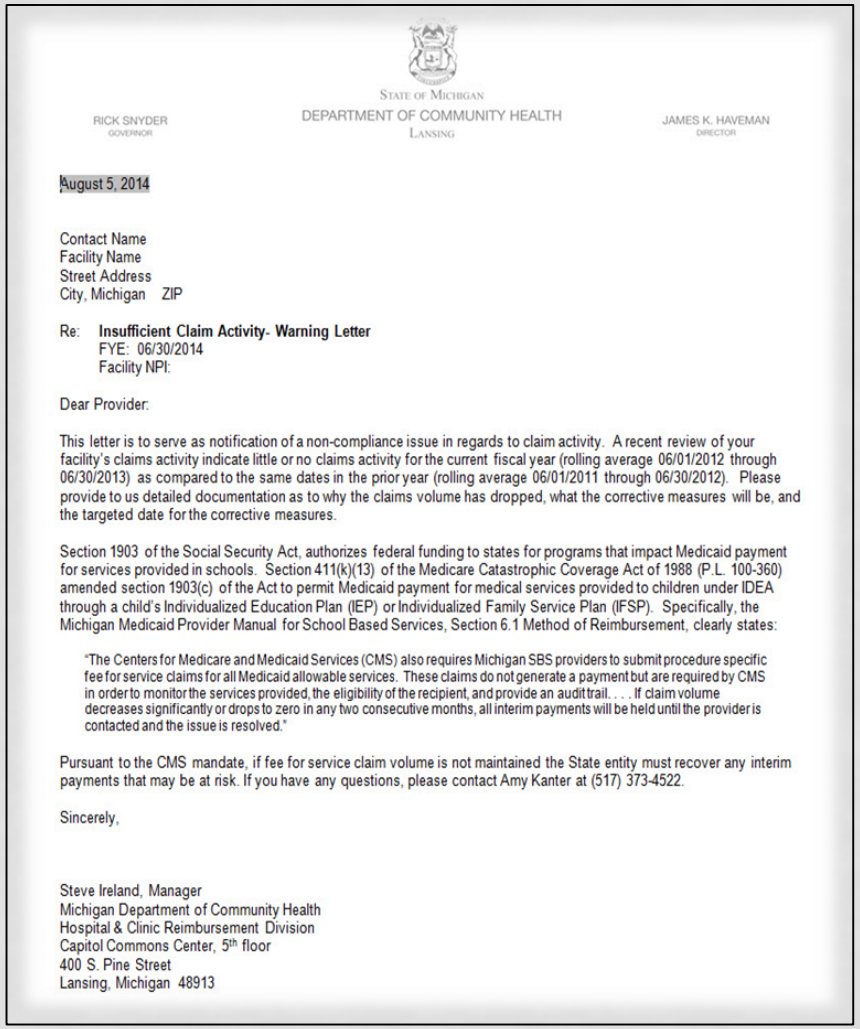
- Claims Comparison Process
  - Claims are pulled on the 18th of each month
  - Calculate rolling averages
  - Calculate a lag time in claims submissions to determine an average for a look back period to allow time for claims to be paid after submitted
  - Calculate percentages

LETTERS ISSUED & EFFECTS OF NON-COMPLIANCE

- Letter 1- Warning Letter
- Letter 2- 30 Day Letter
- Letter 3- Suspension Letter

- Effects of Non-Compliance
  - Interim payments can be suspended until the 85% level is reached
  - If an ISD comes into compliance at any time during this process, the process stops and missed monthly payments can be made up if requested in writing
- Risks of non-compliance on the part of MDHHS
  - CMS sanctions
  - Possible loss of the program

WARNING LETTER & 30 DAY NOTICE LETTER



STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

RICK SNYDER, GOVERNOR
JAMES K. HAVEMAN, DIRECTOR

August 5, 2014

Contact Name
Facility Name
Street Address
City, Michigan ZIP

Re: **Insufficient Claim Activity- Warning Letter**
FYE: 06/30/2014
Facility NPI:

Dear Provider:

This letter is to serve as notification of a non-compliance issue in regards to claim activity. A recent review of your facility's claims activity indicate little or no claims activity for the current fiscal year (rolling average 06/01/2012 through 06/30/2013) as compared to the same dates in the prior year (rolling average 06/01/2011 through 06/30/2012). Please provide to us detailed documentation as to why the claims volume has dropped, what the corrective measures will be, and the targeted date for the corrective measures.

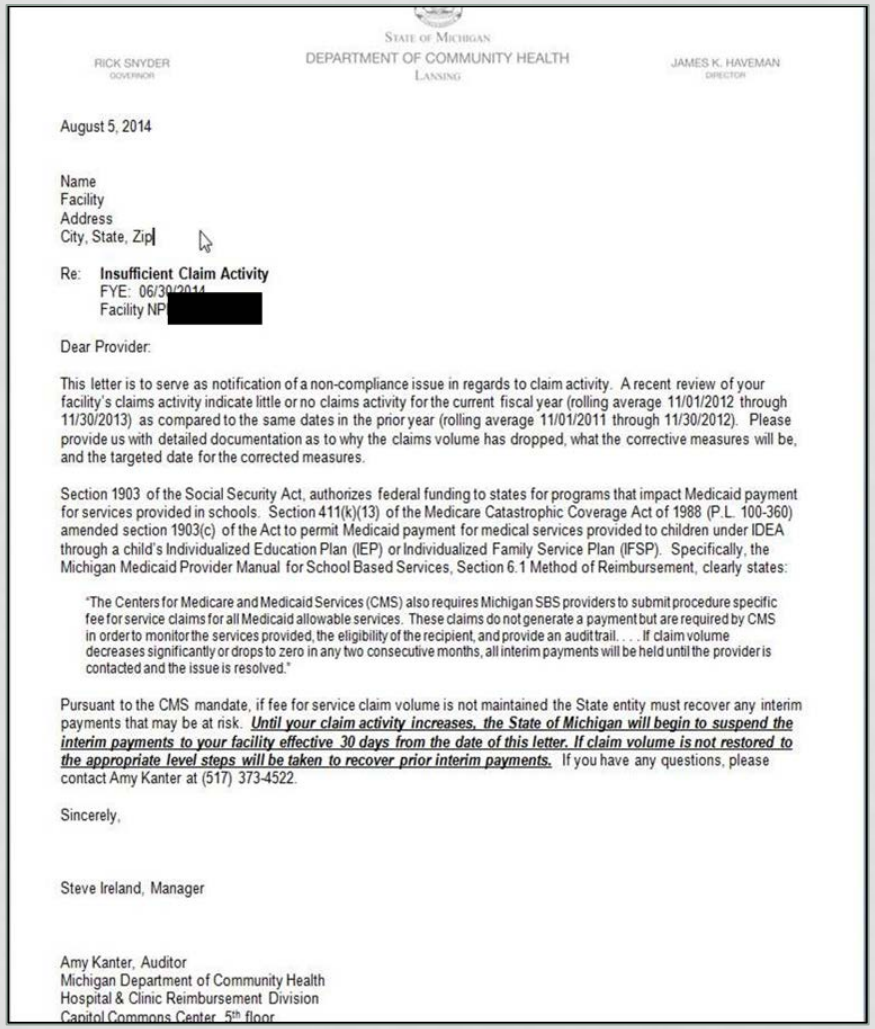
Section 1903 of the Social Security Act, authorizes federal funding to states for programs that impact Medicaid payment for services provided in schools. Section 411(k)(13) of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) amended section 1903(c) of the Act to permit Medicaid payment for medical services provided to children under IDEA through a child's Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP). Specifically, the Michigan Medicaid Provider Manual for School Based Services, Section 6.1 Method of Reimbursement, clearly states:

> "The Centers for Medicare and Medicaid Services (CMS) also requires Michigan SBS providers to submit procedure specific fee for service 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. . . . 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 is resolved."

Pursuant to the CMS mandate, if fee for service claim volume is not maintained the State entity must recover any interim payments that may be at risk. If you have any questions, please contact Amy Kanter at (517) 373-4522.

Sincerely,

Steve Ireland, Manager
Michigan Department of Community Health
Hospital & Clinic Reimbursement Division
Capitol Commons Center, 5th floor
400 S. Pine Street
Lansing, Michigan 48913



STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

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JAMES K. HAVEMAN, DIRECTOR

August 5, 2014

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Facility
Address
City, State, Zip

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FYE: 06/30/2014
Facility NP[redacted]

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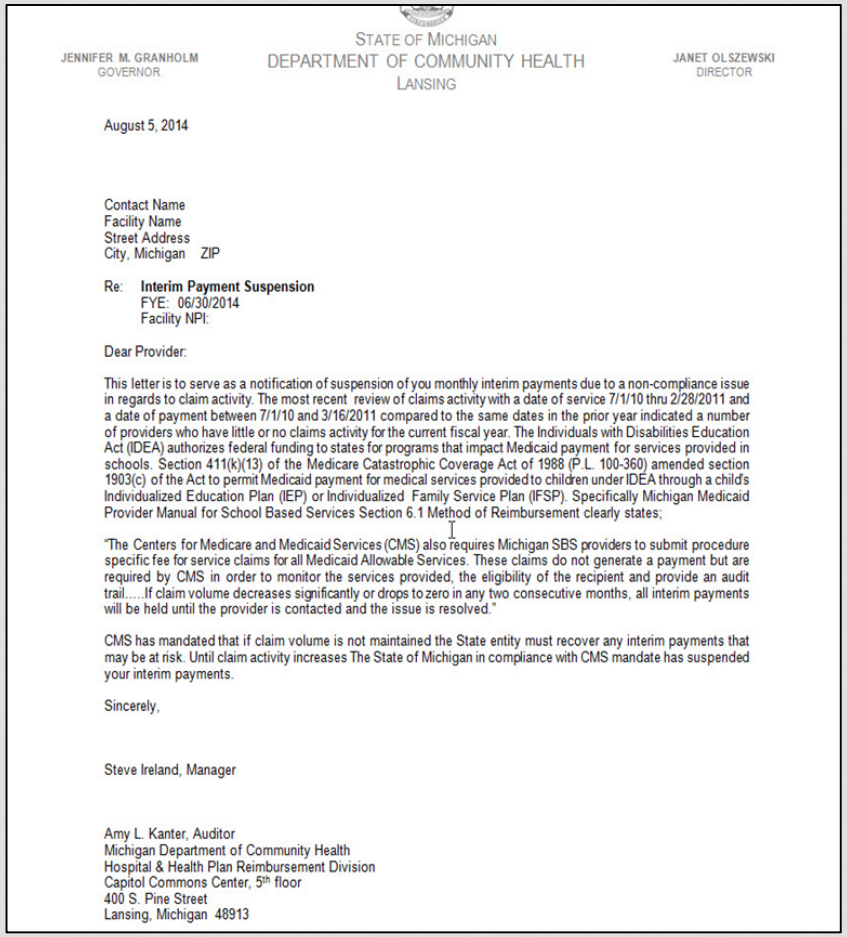
Pursuant to the CMS mandate, if fee for service claim volume is not maintained the State entity must recover any interim payments that may be at risk. ***Until your claim activity increases, the State of Michigan will begin to suspend the interim payments to your facility effective 30 days from the date of this letter. If claim volume is not restored to the appropriate level steps will be taken to recover prior interim payments.*** If you have any questions, please contact Amy Kanter at (517) 373-4522.

Sincerely,

Steve Ireland, Manager

Amy Kanter, Auditor
Michigan Department of Community Health
Hospital & Clinic Reimbursement Division
Capitol Commons Center, 5th floor

PAYMENT SUSPENSION & RESPONSE LETTER



JENNIFER M. GRANHOLM
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JANET OLSZEWSKI
DIRECTOR

August 5, 2014

Contact Name
Facility Name
Street Address
City, Michigan ZIP

Re: **Interim Payment Suspension**
FYE: 06/30/2014
Facility NPI:

Dear Provider:

This letter is to serve as a notification of suspension of you monthly interim payments due to a non-compliance issue in regards to claim activity. The most recent review of claims activity with a date of service 7/1/10 thru 2/28/2011 and a date of payment between 7/1/10 and 3/16/2011 compared to the same dates in the prior year indicated a number of providers who have little or no claims activity for the current fiscal year. The Individuals with Disabilities Education Act (IDEA) authorizes federal funding to states for programs that impact Medicaid payment for services provided in schools. Section 411(k)(13) of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) amended section 1903(c) of the Act to permit Medicaid payment for medical services provided to children under IDEA through a child's Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP). Specifically Michigan Medicaid Provider Manual for School Based Services Section 6.1 Method of Reimbursement clearly states;

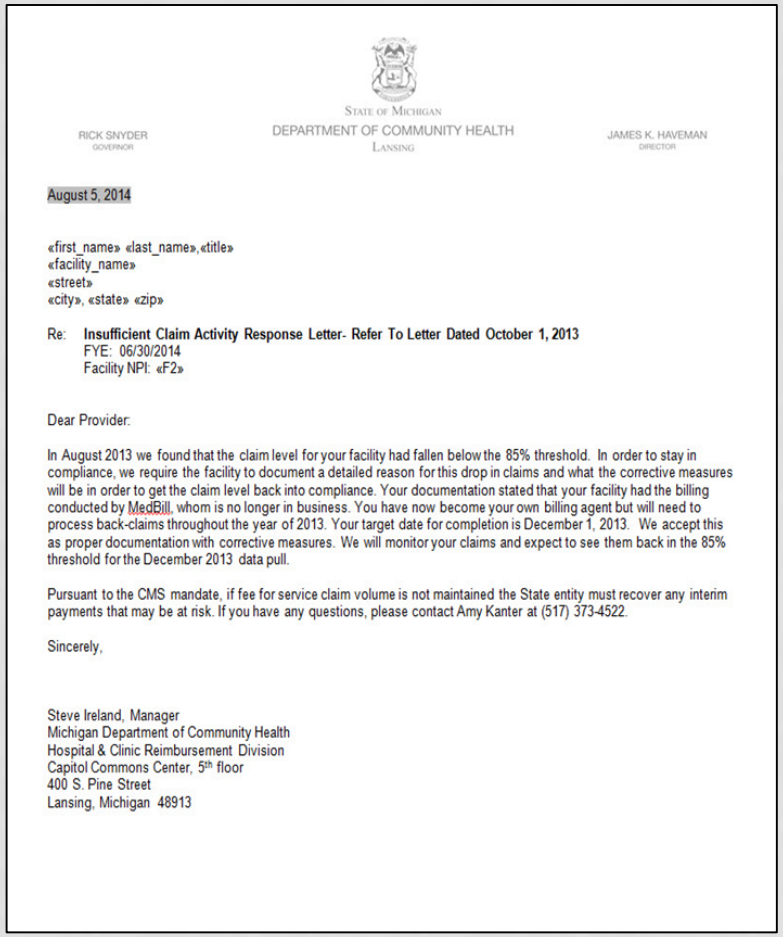
"The Centers for Medicare and Medicaid Services (CMS) also requires Michigan SBS providers to submit procedure specific fee for service claims for all Medicaid Allowable Services. These claims do not generate a payment but are required by CMS in order to monitor the services provided, the eligibility of the recipient and provide an audit trail.....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 is resolved."

CMS has mandated that if claim volume is not maintained the State entity must recover any interim payments that may be at risk. Until claim activity increases The State of Michigan in compliance with CMS mandate has suspended your interim payments.

Sincerely,

Steve Ireland, Manager

Amy L. Kanter, Auditor
Michigan Department of Community Health
Hospital & Health Plan Reimbursement Division
Capitol Commons Center, 5th floor
400 S. Pine Street
Lansing, Michigan 48913



RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JAMES K. HAVEMAN
DIRECTOR

August 5, 2014

«first_name» «last_name»,«title»
«facility_name»
«street»
«city», «state» «zip»

Re: **Insufficient Claim Activity Response Letter- Refer To Letter Dated October 1, 2013**
FYE: 06/30/2014
Facility NPI: «F2»

Dear Provider:

In August 2013 we found that the claim level for your facility had fallen below the 85% threshold. In order to stay in compliance, we require the facility to document a detailed reason for this drop in claims and what the corrective measures will be in order to get the claim level back into compliance. Your documentation stated that your facility had the billing conducted by MedBill, whom is no longer in business. You have now become your own billing agent but will need to process back-claims throughout the year of 2013. Your target date for completion is December 1, 2013. We accept this as proper documentation with corrective measures. We will monitor your claims and expect to see them back in the 85% threshold for the December 2013 data pull.

Pursuant to the CMS mandate, if fee for service claim volume is not maintained the State entity must recover any interim payments that may be at risk. If you have any questions, please contact Amy Kanter at (517) 373-4522.

Sincerely,

Steve Ireland, Manager
Michigan Department of Community Health
Hospital & Clinic Reimbursement Division
Capitol Commons Center, 5th floor
400 S. Pine Street
Lansing, Michigan 48913

REQUIRED DOCUMENTATION

- Communication is important!
- Documentation requires detail of the reason for the drop in claims
  - (Examples) Reduction in staff/students, changes in federally funded employees
- Documentation required the details on the corrective measures that will be put in place
- Documentation requires a date of which the corrective measure will start taking place and claim volumes should start to rise

YOUR ROLE

- Be proactive
- Ensure Figures Are Accurate
- Take Corrective Actions
- Ask Questions
- Stress Importance To Staff

NOW …

Quality Assurance Plan

QUALITY ASSURANCE PLAN & AUDITOR CHECKLIST

- SBS providers must have a written quality assurance plan on file
  - Necessary Elements
  - Purpose behind quality assurance plan
  - Tools/ideas for creating/revamping a quality assurance plan
- Audits of SBS
  - Auditor Checklist
    - Auditor can/will ask to see specific records, for specific students, for specific dates
    - Record retention is seven years

QUALITY ASSURANCE PLAN - ELEMENTS

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

- Covered services are medically necessary, as determined and documented through appropriate and objective testing, evaluation and diagnosis.
- The IEP/IFSP treatment plan 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 consistent with the reduction of physical or mental disabilities and assisting the beneficiary to benefit from special education.
- Billings are reviewed for accuracy.
- Staff qualifications meet current license, certification and program requirements.
- Established coordination and collaboration exists to develop plans of care with all other providers, (i.e., Public Health, MDHHS, Community Mental Health Services Programs (CMHSPs), Medicaid Health Plans (MHPs), Hearing Centers, Outpatient Hospitals, etc.).
- Parent/guardian and beneficiary participation exists outside of the IEP/IFSP team process in evaluating the impact of the SBS program on the educational setting, service quality and outcomes.

PURPOSE – QUALITY ASSURANCE PLAN

- Purpose – Medicaid Provider Manual
  - To establish and maintain a process for monitoring and evaluating the quality and documentation of covered services, and the impact of Medicaid enrollment on the school environment
- Benefits of a well-written Quality Assurance Plan
  - Sets high standards
  - Establishes and maintains a compliant and knowledgeable environment
  - Creates a positive team atmosphere
    - Annual Trainings, Newsletters, Period Emails, et cetera
  - Sail through an audit successfully

CREATING QUALITY ASSURANCE PLAN

- Resources for Quality Assurance Plan
  - Other Intermediate School Districts
  - MI SBS Dropbox

Developing the Quality Assurance Plan

  - See what other ISDs have done and adapt
  - Involve everyone in ISD and LEAs that you need
    - Must have support throughout your ISD—Superintendent, Special Education Directors, principals, clinicians, teachers, administrative support, time study participants, business officials, bus drivers/staff
- Review the Quality Assurance Plan
  - Yearly - No changes, few changes, many changes

AUDIT CHECKLIST – STUDENT CLAIMS

- Treatment Plan (IEP/IFSP)
- Special Education Evaluation & Assessment Reports
- Staff Certifications/Licensures
- Provider/Clinician Notes
- Prescriptions/Referrals/Authorizations
- Attendance Logs
- Transportation Logs
- Monthly Activity Checklist (Personal Care Services Log)

YOUR ROLE

- You are the heart of your ISD's Medicaid SBS program – you set the tone
- Ask for, get help from the top of your organization; allows you to be the gentle enforcer
- As complex and ever-changing as the Medicaid SBS Program may be, when your team pitches in and complies, success results

NOW …

File Transfer/CHAMPS/PCG

FILE TRANSFER/CHAMPS/PCG

- MILogin
- File Transfer
- CHAMPS
  - Resources
- Public Consulting Group
  - PCG's Role
  - Contact Lists

MILOGIN

- Users must register with MILogin prior to accessing File Transfer and CHAMPS
  - MILogin replaced Single Sign On
    - Goal: Improve overall functionality, security and compliance with federal and state regulations, such as HIPAA
- Technical Assistance
  - DTMB Client Service Center at 1-800-968-2644

FILE TRANSFER

- Purpose
  - The File Transfer application offers the ability to share files and collaborate with others while keeping those files secure and easily tracked
- Users
  - Minimum of 2, Maximum of 4
  - Indicate primary user
  - File transfer is not available to billers/vendors

FILE TRANSFER FEATURES

- Upload
  - Upload file option allows transferring files from the user's PC to an Area Folder defined on the State of Michigan destination server
- Download
  - Download file option allows File Transfer users to download files shared by other users in specific areas
- File Upload/Download Log
  - Users can monitor their upload files by selecting the 'Upload Log' or 'Download Log' link in the Browse menu

CHAMPS

- Community Health Automated Medicaid Processing System
  - Web-based claims processing system
  - Comprised of multiple subsystems:
    - Provider Enrollment
      - Users can enroll and update provider enrollment data quickly and easily
    - Prior Authorization
      - Users can initiate new and modify existing PA requests through our online web portal or through a 278 HIPAA Transaction
    - Claims and Encounters
      - Users can submit claims directly online through a batch upload process or through Direct Data Entry (DDE). Users can also view claims online and complete claim adjustments or replacements.
    - Facility Settlement
      - Users can submit their cost reports annually with the system performing data checks and submission requirements.

CHAMPS RESOURCES

- For CHAMPS Navigation issues:
  - CHAMPS Helpline: 1-888-643-2408 or champs@michigan.gov
- For Billing Questions:
  - Provider Inquiry: 1-800-292-2550 or providersupport@michigan.gov
  - Provider Enrollment: 1-800-292-2550 or providerenrollment@michigan.gov
- Training Inquiry:
  - provideroutreach@michigan.gov

PCG'S ROLE

- RMTS Quarterly Process
  - Staff Pool Lists
  - Random Moments
  - Financial Collection
- Generate AOP Claim
  - Claim Breakdown sent to ISDs
- Collect PCS/TCM costs to be verified by ISDs

CONTACT LISTS

- All contacts are managed in the PCG Claiming System
  - There are many user types available
- ISD Administrator
  - Copied on all communications
  - Responsible for distributing information to appropriate LEA contacts and ensuring compliance
  - Can edit and certify financials, staff pool lists, and calendars
- Time Study Contact (can be same person as ISD Administrator)
  - Responsible for following up on moment completion
  - Copied on Moment Notification emails
  - Distributes Paper Moment Notifications

CONTACT LIST – CONT.

- LEA Administrator
  - Can edit and certify LEA financials, staff pool lists, and calendars
- LEA RMTS
  - Can edit and certify staff pool lists and calendars
- LEA Financials
  - Can edit and certify financials
- LEA Financials Editor
  - Can edit but not certify financials
- LEA View Only

*Contacts can only certify financials if they have completed the electronic signature form

YOUR ROLE

- CHAMPS
  - Examine your RA
  - Question Claim Results (If denied)
    - Why was the claim denied? Is the denial valid?
    - Monitor volume every time claims are submitted
- PCG
  - Update contact lists as staff changes occur in your ISD (update in the PCG Claiming System)
  - Follow up with providers to ensure they complete random moments
  - Ensure LEAs complete SPLs and Financials by the posted due dates

NOW …

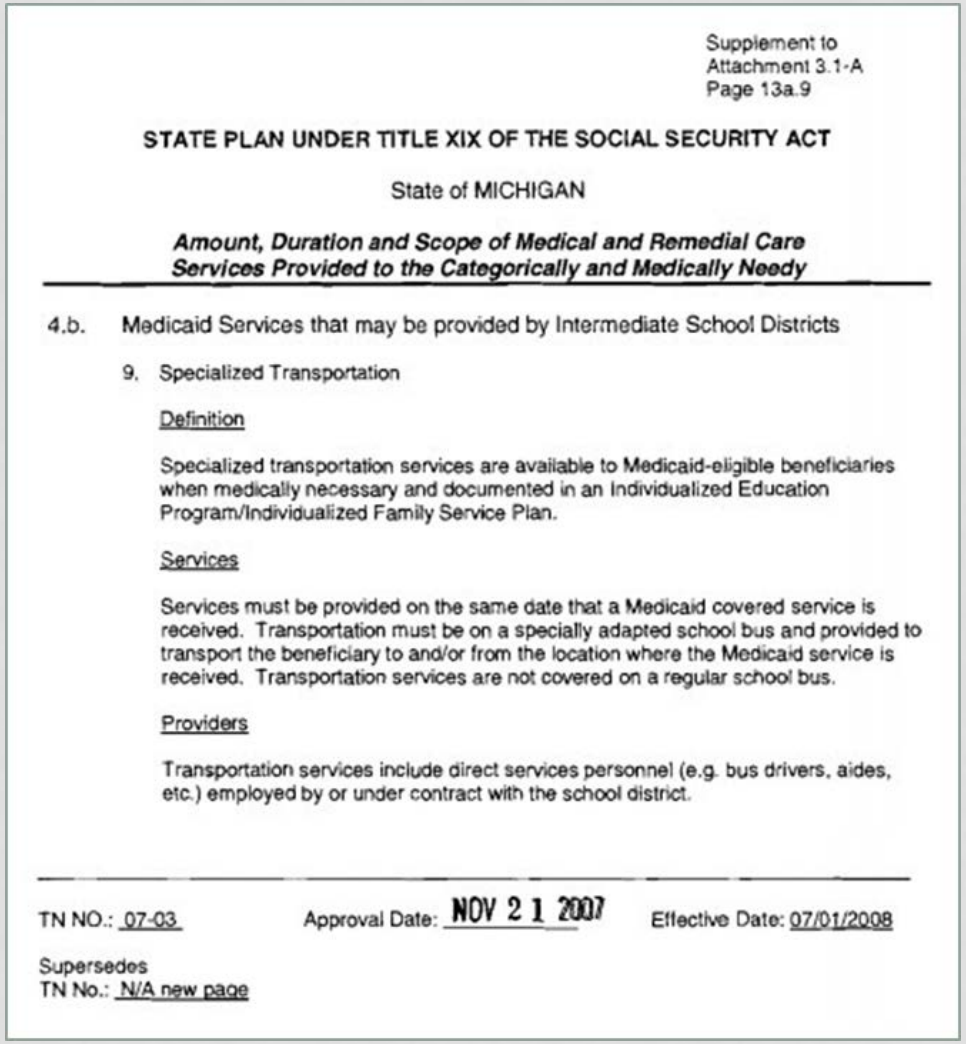
SBS Resources

SBS RESOURCES

- MDHHS Policy
  - State Plan, Medicaid Provider Manual, Medicaid Policy Bulletins, Provider “L” Letters
- Provider Outreach
  - Site Visits, Regional Meetings, Implementer’s Meetings, Policy Workgroup, MI SBS Conference
- NAME Conference
- MI SBS Dropbox
- MDHHS SBS Website

MICHIGAN STATE PLAN

- The Michigan Medicaid State Plan is an agreement between the state and federal government that identifies the general health care services, reimbursement, and eligibility policies in effect under Michigan Medicaid.
  - It is the basis for the federal government (CMS/HHS) to pay its federal financial participation (FFP) for the program's operation.
  - The plan is written on a more general level than contained in program policy.



Supplement to
Attachment 3.1-A
Page 13a.9

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

Amount, Duration and Scope of Medical and Remedial Care Services Provided to the Categorically and Medically Needy

4.b. Medicaid Services that may be provided by Intermediate School Districts

9. Specialized Transportation

Definition

Specialized transportation services are available to Medicaid-eligible beneficiaries when medically necessary and documented in an Individualized Education Program/Individualized Family Service Plan.

Services

Services must be provided on the same date that a Medicaid covered service is received. Transportation must be on a specially adapted school bus and provided to transport the beneficiary to and/or from the location where the Medicaid service is received. Transportation services are not covered on a regular school bus.

Providers

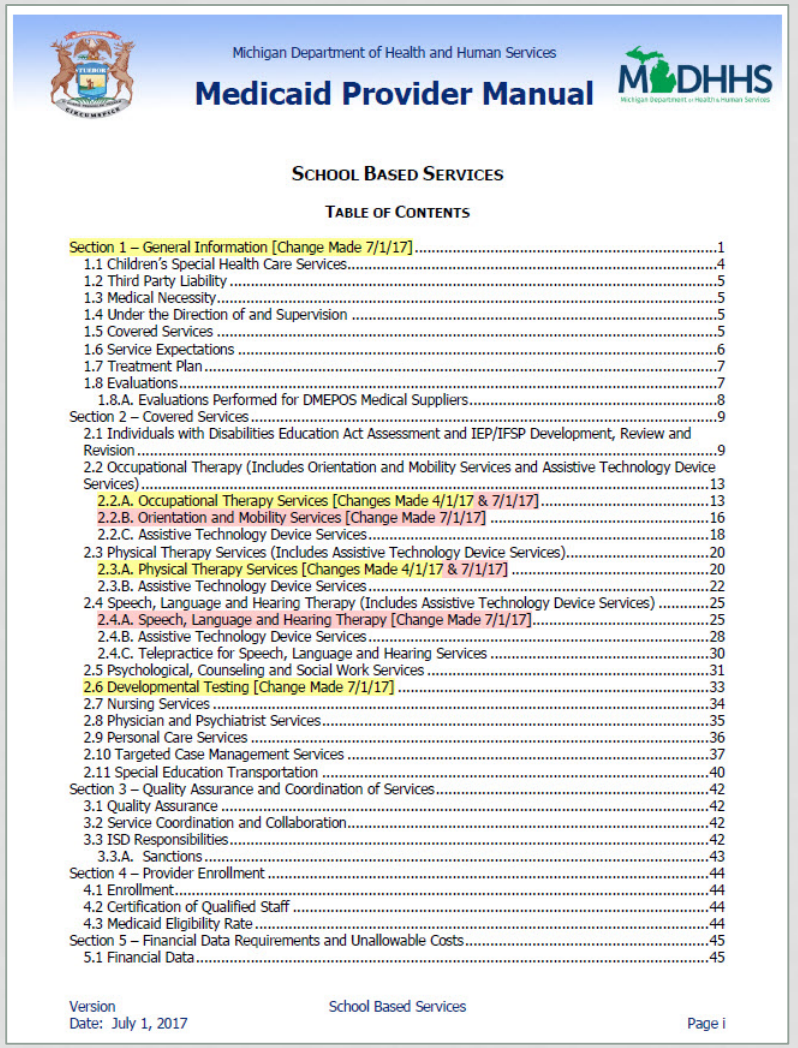
Transportation services include direct services personnel (e.g. bus drivers, aides, etc.) employed by or under contract with the school district.

TN NO.: 07-03 Approval Date: NOV 21 2007 Effective Date: 07/01/2008

Supersedes
TN No.: N/A new page

MEDICAID PROVIDER MANUAL

- Provides guidance for <u>all providers</u>
  - Updated Quarterly
    - January, April, July, and October
    - Latest changes are color-highlighted and dated
- Three dedicated chapters to SBS
  - School Based Services
  - SBS Administrative Outreach Program
  - SBS Random Moment Time Study



Michigan Department of Health and Human Services

Medicaid Provider Manual

MDHHS

SCHOOL BASED SERVICES

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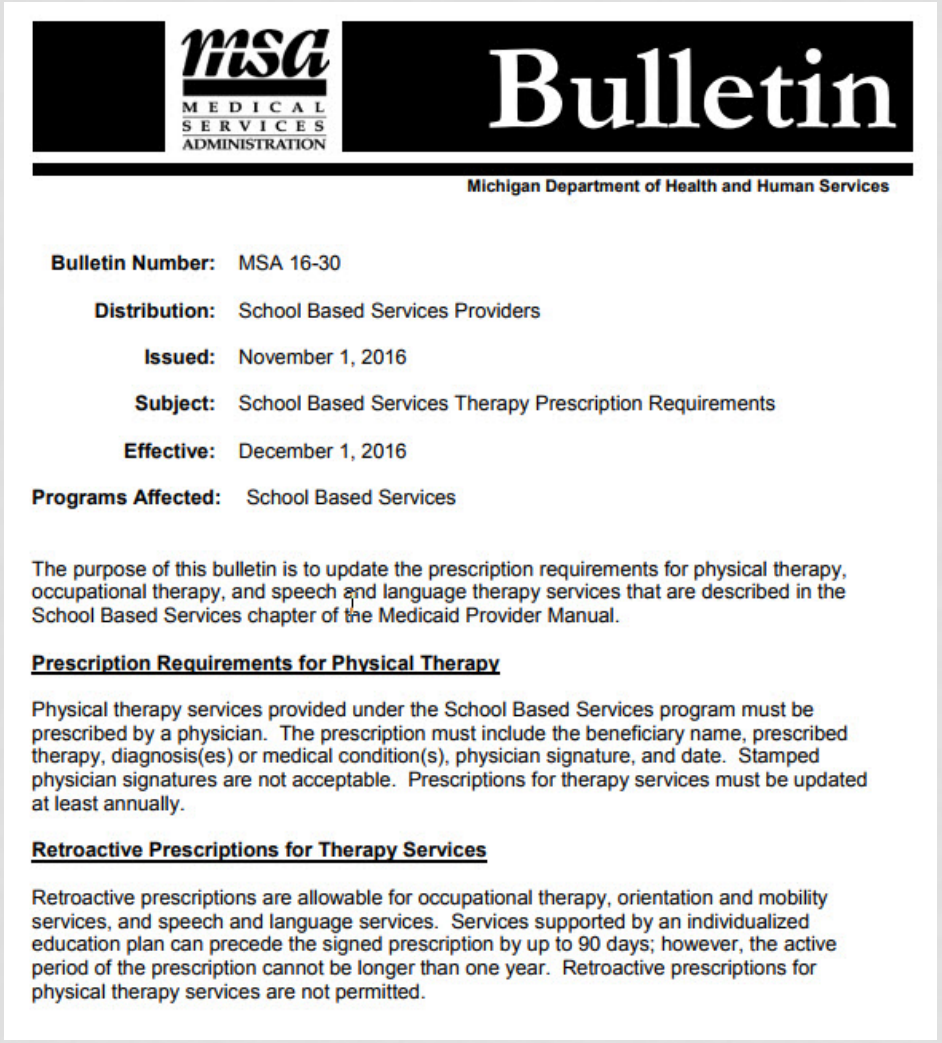
MEDICAID POLICY BULLETINS

- The Michigan Department of Health and Human Services periodically issues notices of policy.
  - These documents inform providers of changes in Michigan Medicaid policy.



MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Health and Human Services

Bulletin Number: MSA 16-30

Distribution: School Based Services Providers

Issued: November 1, 2016

Subject: School Based Services Therapy Prescription Requirements

Effective: December 1, 2016

Programs Affected: School Based Services

The purpose of this bulletin is to update the prescription requirements for physical therapy, occupational therapy, and speech and language therapy services that are described in the School Based Services chapter of the Medicaid Provider Manual.

Prescription Requirements for Physical Therapy

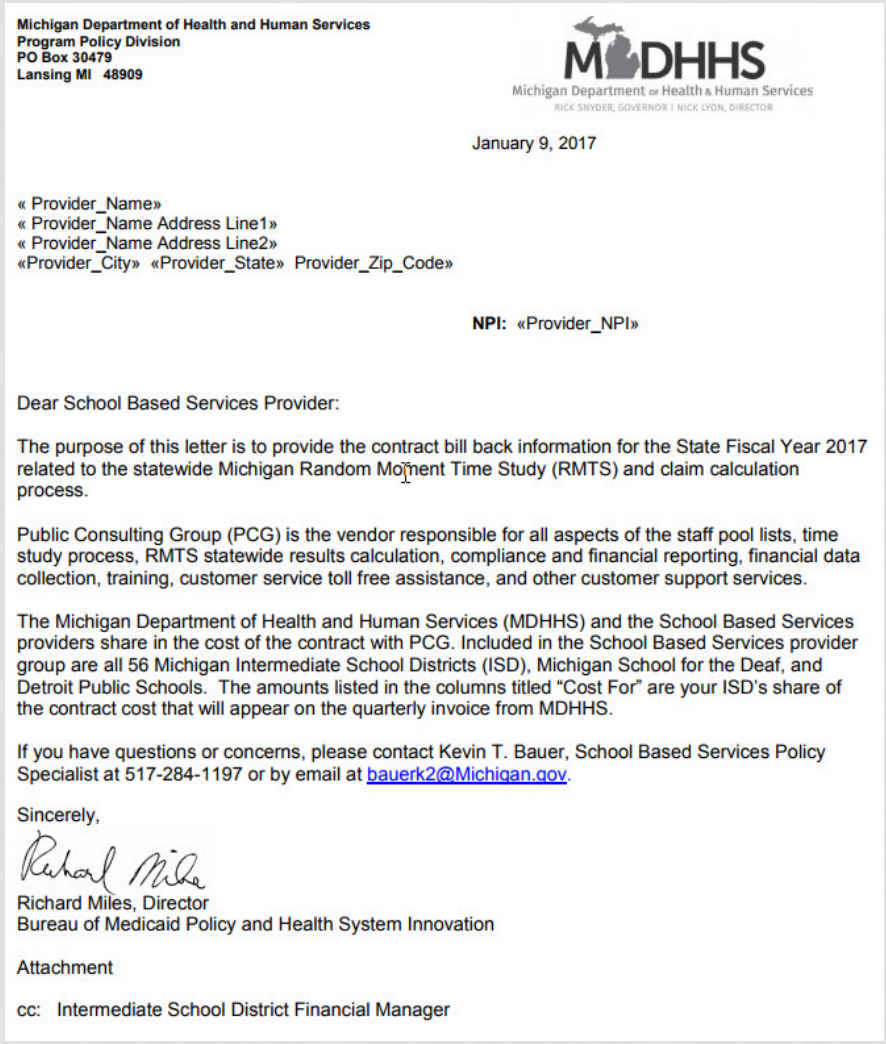
Physical therapy services provided under the School Based Services program must be prescribed by a physician. The prescription must include the beneficiary name, prescribed therapy, diagnosis(es) or medical condition(s), physician signature, and date. Stamped physician signatures are not acceptable. Prescriptions for therapy services must be updated at least annually.

Retroactive Prescriptions for Therapy Services

Retroactive prescriptions are allowable for occupational therapy, orientation and mobility services, and speech and language services. Services supported by an individualized education plan can precede the signed prescription by up to 90 days; however, the active period of the prescription cannot be longer than one year. Retroactive prescriptions for physical therapy services are not permitted.

PROVIDER "L" LETTERS

- Provider "L" letters do not represent promulgated policy
  - Provided to communicate:
    - new developments, information, policy clarifications, et cetera
    - Example – SBS Bill Back



Michigan Department of Health and Human Services
Program Policy Division
PO Box 30479
Lansing MI 48909

MDHHS
Michigan Department of Health & Human Services
RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

January 9, 2017

« Provider_Name»
« Provider_Name Address Line1»
« Provider_Name Address Line2»
«Provider_City» «Provider_State» Provider_Zip_Code»

NPI: «Provider_NPI»

Dear School Based Services Provider:

The purpose of this letter is to provide the contract bill back information for the State Fiscal Year 2017 related to the statewide Michigan Random Moment Time Study (RMTS) and claim calculation process.

Public Consulting Group (PCG) is the vendor responsible for all aspects of the staff pool lists, time study process, RMTS statewide results calculation, compliance and financial reporting, financial data collection, training, customer service toll free assistance, and other customer support services.

The Michigan Department of Health and Human Services (MDHHS) and the School Based Services providers share in the cost of the contract with PCG. Included in the School Based Services provider group are all 56 Michigan Intermediate School Districts (ISD), Michigan School for the Deaf, and Detroit Public Schools. The amounts listed in the columns titled "Cost For" are your ISD's share of the contract cost that will appear on the quarterly invoice from MDHHS.

If you have questions or concerns, please contact Kevin T. Bauer, School Based Services Policy Specialist at 517-284-1197 or by email at bauerk2@Michigan.gov.

Sincerely,

Richard Miles, Director
Bureau of Medicaid Policy and Health System Innovation

Attachment

cc: Intermediate School District Financial Manager

PROVIDER OUTREACH

- Regional Meetings
  - 9 regions
- Implementer's Meetings
  - Two Meetings – December & March.
  - Began in December 2008
- Policy Workgroup
  - Previously "Fee For Service Rate Methodology Workgroup"
  - Quarterly Meetings – Began in June 2005
- MDHHS SBS Conference
  - Annual Conference – Began in August 2014

REGIONAL MEETINGS

- Why have regional meetings?
  - (Communication) between providers, MDE, and MDHHS is critical to a successful program
  - (Problem Solving) when issues have been noted
  - First round of meetings – Spring 2018
- How many ISDs attended 2018 regional meetings?
  - 47 Intermediate School Districts & Detroit Public Schools
- What is the duration of a regional meeting?
  - A regional meeting will last from two hours to three hours.

NAME - BACKGROUND

- National Alliance for Medicaid in Education, Inc.
  - Mission Statement: NAME Advocates Program Integrity For School Based Medicaid Reimbursement
- Organizational Structure
  - Five officers: an elected President, President-Elect and Immediate Past President plus a Secretary and Treasurer appointed by the Board of Directors
  - Three at-large representatives (each representing a Medicaid agency, a State Education Agency and a Local Education Agency)
  - Nine representatives elected from three geographical regions (three Medicaid, three SEA and three LEA representatives from each region)
- Keeping Informed On Everything School Based Medicaid
  - NAME flash
    - Online updates
  - Conference Calls/Webinars

NAME REGIONS

- Region 1 States
  - Connecticut, Delaware, District of Columbia, Kentucky, Maryland, Massachusetts, Maine, New Hampshire, New Jersey, New York, North Carolina, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont,, Virginia, West Virginia
- Region 2 States
  - Alabama, Arkansas, Florida, Georgia, Illinois, Indiana, Iowa, Louisiana, **Michigan**, Minnesota, Missouri, Ohio, Mississippi, Oklahoma, Texas, Puerto Rico, US Virgin Islands, Wisconsin
- Region 3 States
  - Alaska, Arizona, California, Colorado, Hawaii, Idaho, Kansas, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Utah, Washington and Wyoming

ANNUAL CONFERENCE

- 16th Annual Conference in Baltimore, MD
  - October 14-17, 2018
    - NAME website has information on registration, hotels, and conference program
  - Other activities besides conference include:
    - Conference Social Events
      - After hours tour of the National Aquarium
    - 6th Annual Anysia Drumheller Memorial Run/Walk
    - Silent Auction
      - Adopt a School in Puerto Rico

MI SBS DROPBOX

- Cloud application allows sharing a few or hundreds of files
  - Saves space on computers by avoiding huge attachments to emails
  - View on your desktop computer, smart phone, tablet
- By invitation only
- Any member of the shared account may open, edit and save the file, so most current information is contained for everyone to see and use

MDHHS SBS WEBSITE

- A wealth of knowledge is a click away
  - Databases (lists of codes allowed)
  - Prior conference materials
  - Cost reports and training documents
  - RMTS Results

YOUR ROLE

- Ask Questions
- Share Resources
- Attend all Implementer Meetings, Consider a Site Visit

QUESTIONS

CONTACTS

- Michigan Department of Health & Human Services
  - (Policy) – Kevin Bauer
    - Phone: 517-284-1197
    - Email: BauerK2@Michigan.gov
  - (Settlement & Reimbursement) – Amy Kanter
    - Phone: 517-241-4240
    - Email: KanterA@Michigan.gov
  - (Audit) – Kabeer Singh
    - Email: singhk2@Michigan.gov
- Michigan Department of Education
  - Dana Billlings
    - Phone: 517-335-2250
    - Email: billingsd1@Michigan.gov
- Public Consulting Group
  - (Help Desk)
    - Phone: 877-395-5017
    - Email: miaop@pcgus.com