Quality Assurance Plan for Oakland Schools
7-1-2019

Policy

Medicaid Provider Manual, School Based Services, Section 3.1 Quality Assurance and Coordination of Services, dated July 1, 2019 states:

School Based Services (SBS) providers must have a written quality assurance plan on file. The SBS costs will be reviewed and/or audited by the Michigan Department of Health and Human Services (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 and the impact of Medicaid enrollment on the school environment.

According to the Michigan Department of Health and Human Services Medicaid Provider Manual for School Based Services, an acceptable quality assurance plan addresses each of the following:

1. Covered services are medically necessary, as determined and documented through appropriate and objective testing, evaluation and diagnosis.

2. The IEP/IFSP treatment plan identifies which covered services are to be provided and the service frequency, duration, goals and objectives.

3. 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 student to benefit from special education.

4. Billings are reviewed for accuracy.

5. Staff qualifications meet current license, certification and program requirements.

6. Established coordination and collaboration exits to develop plans of care with all other providers, (i.e., Public Health and Department of Human Services, (DHS), Community Mental Health Services Programs (CMHSPs), Medicaid Health Plans (MHPs), Hearing Centers, Outpatient Hospitals)

7. 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.

A. Covered Services

Covered services are medically necessary as determined and documented through appropriate and objective testing, evaluation and diagnosis. Direct health related services are provided in

accordance with each student's Individualized Education program (IEP) or Individualized Family Service Plan (IFSP) developed by medical professionals in the school setting.

Evaluations

- Evaluations are conducted by the Multidisciplinary Evaluation Team (MET) to determine eligibility for Special Education. The eligibility recommendation is documented in the MET report. The IEP meeting is then scheduled to allow the IEP team to review the MET report along with any other pertinent information and they decide if the child is eligible for special education services, including health related services such as Occupational, Speech, and Physical Therapy, Social Work etc...

Process for Obtaining Physician's Referrals and Prescriptions

- The OS Medicaid Billing Department obtains speech referrals, throughout the school year, for all Medicaid eligible Special Education Students with Speech services listed in their IEP/IFSP. The districts send copies of the most current Speech evaluations along with the following pages of the IEP/IFSP to the OS Medicaid office: Cover page, PLAAFP, Goal page, and Frequency page. These copies are reviewed by the OS Specialist, then scanned to a CD and sent to the physician to review in order to obtain a current Speech referral. The OS Medicaid Specialist also runs a monthly report for all the districts to show the students receiving direct speech services per their IEP/IFSP who are in need of a speech referral for billing Medicaid.

- The OS Medicaid Billing Department obtains prescriptions, throughout the school year for Occupational Therapy and Orientation and Mobility services for all Medicaid eligible Special Education Students who have these services listed in their IEPS/IFSPs. The process is the same as listed in the paragraph above.

B. IEP/IFSP

The IEP/IFSP treatment plan identifies which covered services are to be provided and the service frequency, duration, goals and objectives.

- Student IEPs and IFSPs list the covered services, service frequency duration, goals and objectives. This information is verified on a monthly basis as part of the review for speech referrals and prescriptions for OT and O&M, and throughout the year as part of the compliance monitoring process and when researching billing issues.

C. Monitoring Program

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.

- An annual compliance monitoring process, conducted by the OS Medicaid Department, is in place 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. Also, district Direct Services

staff and Case Managers are responsible for monitoring the appropriateness and effectiveness of services provided according to the IEP/IFSP treatment plan.

- OS Medicaid Department monitors the status of the random moment time studies on a daily basis to ensure the responses are submitted to PCG in a timely manner. We emphasize to staff during training sessions and in our monthly newsletters to complete the RMTS within 48 hours.

D. Billings are reviewed for accuracy.

- The billing software used by OS uses has a web based interface for district staff to record the services they provided and contains logic that allows users to enter only procedure codes allowed for their specific discipline, tracks service times frequencies and duration allowed by SBS policy.

- A monthly quality review process is in place to review all documentation submitted for billing from each district prior to submitting claims to MDHHS. Claims that do not meet the SBS requirements are not billed. Memos are sent to staff to explain rejected claims and how to correct and resubmit claims the following month if possible.

- The OS Medicaid Billing Department provides each local district with the following reports after the monthly billing has been submitted:

  - ❖ Missing Report- provides a list of staff and the Medicaid eligible students on their caseloads that they have not billed for.
  - ❖ Open Report- provides a list of staff and Medicaid eligible on their caseloads with unfinished billings or rejected billings students
  - ❖ Missing NPI report – shows list of Medicaid eligible students who need prescriptions, or physician's referrals

E. Staff Qualifications

Staff qualifications meet current license, certification and program requirements

- Staff qualifications are included on Tip Sheets provided to all staff that attend training sessions by the OS Medicaid Department. Attendees are asked to verify that they have the proper credentials and qualifications required to bill Medicaid. Tip Sheets are also posted on the OS Medicaid web page. Program updates, procedures and changes are communicated to staff monthly in the "Medicaid Matters" newsletters. The newsletters are distributed to all staff involved with Medicaid reporting and are also posted on our web page. Changes regarding staff qualifications are also shared with the districts via emails, and updates at the monthly Special Education Directors/Supervisors meetings. District Special Education Offices are responsible for ensuring that staff included on their Staff Pool Lists are on the appropriate lists and that those recording services for claiming meet the qualifications stated in policy.

  - Our student data system includes a "Faculty" module in which districts assign Medicaid "cert-types" to their staff based upon the qualifications stated in policy. The cert-types allow staff us to limit the procedure codes staff may use, control

frequencies and start and end times and require supervisory information for staff whose documentation require review.

F. Established Coordination and Collaboration Exists

Established coordination and collaboration exists to develop plans of care with other providers, (i.e., Public Health, MDHHS, Community Mental Health Services programs (CMHSPs), Medicaid Health Plans (MHPs), Hearing Centers, Outpatient Hospitals, etc.).

- The districts are responsible for the coordination of student services with outside agencies. OS Special Education Department is also available to assist districts with the coordination of services with various agencies.

G. Parent/guardian and student participation exists outside of the IEP/IFSP team process
Parent/guardian and student participation exists outside of the IEP/IFSP team process in evaluating the impact of the SBS program on the educational setting, services quality and outcomes.

- The OS Medicaid Department provides the districts with a " Parent Letter" at the beginning of each school year that explains the Medicaid School Based Services Program. This letter is given to all parents of all students receiving Special Education services. Parental Consent forms are also given to parents in order to obtain their approval for billing Medicaid.

- Districts only have to collect Medicaid parental consents one time as long as the student remains in the same county. Most districts seek parental consent at each IEP meeting. The parental consent form is included in our student data system's Special Education Forms module to facilitate the printing of the document along with the IEP forms. If consent is not received at the IEP meeting, it may be sought via a letter sent to parents by the district on their letterhead. Parent responses to the consent are logged by the district into the student data system. A refusal entered into the system will cause any services entered for the student to be filtered out of claim submissions.

- The local districts provide progress reports each card-marking to the parents which includes updates on both academic and health related services that the student is receiving in school.

Annual Record Review for Compliance Monitoring

The purpose of the annual record review, on site at the local districts is to the monitor their level of compliance with the MDHHS SBS policy for Medicaid reimbursement. The OS Medicaid Department conducts the monitoring as follows:

- At a minimum, 3 local districts are selected based on those with the highest, medium and lowest number of claims billed during the previous school year. No district will be reviewed more than once in any three year consecutive period

- At each of the districts chosen, three students will be selected according to those with the highest, medium and lowest number of claims billed.

- Service and Summary Notes record for one month of the previous school year are printed for each student. This information is entered and maintained in our MISTAR billing system.

- The service billing documentation for a period of one month and a cover letter are sent to each chosen district's Superintendent and Special Education Director along with a request to have the following records available on the date scheduled for the review:
    - ❖ The MET(s) and IEP(s) and evaluations related to the dates of services billed.
    - ❖ Student attendance records for the quarter
    - ❖ Parental consents for Medicaid billing
    - ❖ Personal Care and/or Transportation logs, if applicable
    - ❖ Staff certifications/licenses if not appearing on the LARA web site

- The documentation is then reviewed by the Medicaid Billing Department a s follows:
    - ❖ Student had an active IEP in place for the dates of service
    - ❖ Student was in attendance on all dates for which direct service were billed
    - ❖ Services rendered were prescribed on the IEP (or were inherent in the program for center-based services)
    - ❖ The number of services rendered was within the frequencies/durations prescribed on the IEP
    - ❖ Personal Care and/or Transportation logs supported the services rendered
    - ❖ Parental consent for Medicaid billing was obtained
    - ❖ Physician referrals, and/or scripts, were obtained for the reported services
    - ❖ Physician's or other medical staff working under their scope of practice have provided orders for Personal Care Services
    - ❖ Clinician notes provided sufficient documentation to support the selected procedure code(s)
    - ❖ Staff met Medicaid qualifications to provide billed services

    - ❖ Exceptions are noted and reported to district Special Education Directors/Supervisors. Exceptions are resolved via corrective action or claim cancellations/voids, depending upon the severity of the issue. Issues that appear to be systematic are addressed in the Medicaid Matters newsletter, training sessions, and via written communications with district Special Education Directors/Supervisors and applicable staff.

Financial Reporting and Compliance

"The financial data reported (salaries, benefits, supplies, purchased services, and other expenditures) must be based on actual detailed expenditures from local district's payroll and financial systems. Payroll and financial system data must be applied using generally accepted governmental accounting standards and principles or applicable administrative rules. The expenditures accumulated must correlate to the claiming period."

OS Medicaid Department Plan:

Each local district's Special Education Office completes the Quarterly Staff Pool lists according to the schedule established by Public Consulting Group (PCG). This task is typically handled by the Special Education Secretaries and reviewed by the Special Education Directors and Supervisors. Updates and process changes are distributed to each district's Special Education Director/Supervisor and their secretaries with instructions from PCG and from the OS Medicaid Billing Department when further clarification is needed. The Medicaid Billing Department monitors their status for completing the staff pool lists to make sure they meet the deadlines. We provide technical assistance when needed.

Quarterly Financials are distributed to the local districts by PCG. District financial staff complete, certify and return directly to PCG. The OS Medicaid Department will:

- Verify that staff on the quarterly financials match the quarterly staff pool lists and note discrepancies (i.e., 100% federally funded, removed from SPL)
- Verify district Indirect Cost Rates
- Verify by random sample that staff listed are reporting services
- Verify licensure by random sample

- Cost Certification: On a quarterly basis, the OS Medicaid Department will request that each local district financial staff review the accuracy of the total costs and indirect costs rate reported by PCG approximately two weeks before the quarterly claim is submitted to MDHHS . We require that they sign our Quarterly Certification Form to confirm the figures are correct or they will note corrections that we will report to PCG.

MAER: Local districts prepare the Medicaid Annual Expenditure Report and submit via email to the OS Medicaid Billing Department and we, along with the OS Finance Department will compile and review completed MAERs for reasonableness:

- Verify that staff on the quarterly financials match the quarterly staff pool lists and note discrepancies (i.e., 100% federally funded, removed from SPL)
- Verify district Indirect Cost Rates
- Verify reasonableness of staff salaries/benefits including comparison to district SE-4096 reports
- Verify transportation data using district SE-4094 forms

OS Medicaid Department compiles and reviews district data for the MAER. The OS Finance Director certifies the Total Computable Public Expenditure form and submits the certification to the Michigan Department of Health and Human Services.

CONFIDENTIALITY

The Oakland Schools Medicaid Billing department staff as well as the LEAs, PSAs and OS are responsible for adhering to the Health Insurance Portability and Accountability Act of 1966 (HIPAA, Title II) to protect the privacy of student's protected health information.

All LEA/PSA/OS staff submitting Medicaid claims using MISTAR/Zangle and the electronic Service Tracker record must obtain a secure Username and Password and are required to have a signed and dated physical copy of their signature on file with Oakland Schools. Their signature on the "Electronic Signature Verification" form confirms their intent to maintain the security and confidentiality of the Username and Password chosen.

The ISD/OS maintains all original "Electronic Signature Verification" forms completed by LEA Providers and compares those submitted with current Staff Pool Lists. The LEA is notified of any missing forms by the Medicaid Billing department. For any Provider without an "Electronic Signature Verification" form on file, an original, signed Service Tracker report must be maintained in the LEA's student file. For Providers working under the supervision of a qualified Provider, both the Provider of the service and the Supervising staff must sign the Service Tracker report and maintain these in the appropriate student record.