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Wayne RESA Medicaid Annual Quality Assurance Plan July 2023 – June 2024

School-Services Programs– Part I

Policy:

The Michigan Department of Health and Human Services (MDHHS) Provider Manual dated July 1, 2022, includes the following language regarding Quality Assurance for Direct Service Claiming (DSC) and Caring 4 Students (C4S). Collectively, these programs will be identified as "School Services Programs" (SSP), except where specifically identified (Section 3.1):

"School-services Program providers must have a written quality assurance plan on file. SSP 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:

- *A. Covered services are medically necessary, as determined and documented in the plan of care (POC) through appropriate and objective testing, evaluation, and diagnosis;*
- *B. The student's medical POC which includes, but is not limited to Individualized Education Plan/Individualized Family Service Plan/Individualized Healthcare Plan/Behavior Plan/Medical Management Plan, and Safety Plan; must identify the medical services to be provided, the delivery method, frequency, duration, goals, and objectives of those services;*
- *C. A monitoring program exists to ensure that services are appropriate, effective, and delivered in a cost-effective manner;*
- *D. Billings are reviewed for accuracy;*
- *E. Staff qualifications meet current license, certification, and program requirements;*
- *F. Established coordination and collaboration exist to develop POCs with all other providers, (i.e., Public Health, MDHHS, Community Mental Health Services Programs (CMHSPs), Medicaid Health Plans (MHPs), Hearing Centers, Outpatient Hospitals, etc.).*
- *G. Parent/guardian and student participation exist outside of the POC team process in evaluating the impact of the SSP program on the educational setting, service quality, and outcomes.*

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WCRESA Plan:

A. Covered services are medically necessary, as determined and documented in the plan of care through appropriate and objective testing, evaluation, and diagnosis.

Services are rendered in accordance with each student's POC developed by medical professionals in the school setting.

Special Education: Evaluations are conducted by the Multidisciplinary Evaluation Team (MET). Once the initial evaluations are completed, the evaluation team develops a written MET report with a special education eligibility recommendation. An Individualized Educational Program (IEP) meeting is then scheduled. The IEP team reviews the MET report and any other information and decides whether or not a child is eligible for special education services, which include medically-related services. In addition, local districts periodically conduct a Referral / Review of Existing Evaluation Data (REED). The purpose of the REED is to review existing data about the student and ascertain what additional evaluations are needed to determine/re-determine eligibility.

C4S – Students with Acute or Chronic Health Conditions:
A nurse will develop, implement, revise, and monitor the student's Individualized Healthcare Plan when it is determined that the student needs a Medical Management Plan, due to an acute or chronic healthcare need. This also includes an emergency medical plan for these students.

C4S – Students with Behavioral or Mental Health Conditions:
Evaluations are conducted by qualified medical professionals including, but not limited to; a Psychologist, Counselor, Social Worker, or Nurse. When it is determined that the student needs medically necessary behavioral/mental health services, the qualified provider(s) will develop, implement, revise, and monitor the student's Individualized POC annually.

Speech Referrals: The Medicaid Reimbursement Office will obtain physician speech referrals for all of the students with Speech services and those programs for which speech services are part of the program, based on their current POC. This will be completed by the 15th of each month.

Occupational Therapy and Orientation and Mobility Prescriptions: Districts are reminded each year that a physician's prescription is required when OT and O&M services are to be reported for Medicaid reimbursement. A prescription will be obtained by Wayne RESA, as a last resort, if the district is unable to obtain an OT or O&M prescription. The district will provide the Wayne RESA Medicaid Reimbursement Office with a copy of the student's POC and the student's most recent OT or O&M evaluation for Wayne RESA to do so.

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B. The student's POC must identify the medical services to be provided, the delivery method, frequency, duration, goals, and objectives of those services.

A student's POC identifies the medical services, delivery method, frequency, duration, goals, and objectives.This information is verified at various times throughout the school year during reviews for speech referrals, OT/O&M prescriptions, and when researching billing questions and issues. Programmatically, Wayne RESA added rules to our electronic POC forms which will generate an error if a service is added without a corresponding delivery method, (Direct, Consultative, or Direct/ Consultative) service frequency, and duration. Wayne RESA also reviews student files randomly throughout the year and annually during our internal quality review process.

C. A monitoring program exists to ensure that services are appropriate, effective, and delivered in a cost-effective manner.

District staff, including designated case managers and direct service staff, are responsible for monitoring the appropriateness and effectiveness of services provided according to the student's POC.

D. Billings are reviewed for accuracy.

Wayne RESA's Service Tracker program, which is the software used by district staff to record reimbursable services, contains logic that only allows users to enter those procedure codes for their specific discipline. It also tracks, service times and frequencies, and prevents over-billing. In addition, the billing software links transportation to any appropriate medical services. The Medicaid Office conducts informal reviews and runs reports on a regular basis to check the validity of billed and unbilled encounters (see "Additional Reviews" below).

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

District Special Education Offices are responsible for ensuring that staff included on their Staff Pool Lists are on the appropriate list and that those recording services for claiming meet the qualifications stated in the policy. In addition, every quarter, the RESA Medicaid office checks the licensure of all staff added to the Direct Service staff pool list.
Staff qualifications are included on Tip Sheets for all staff that attend training sessions that are provided by the Wayne RESA Medicaid Reimbursement Office. Attendees are asked to verify that they have the required qualifications before recording their services. Updates to the Tip Sheets are communicated in a monthly "Medicaid Messenger" newsletter (which is sent to the districts for distribution to all staff involved in Medicaid reporting and also posted on our website). Changes regarding staff qualifications are also shared with districts via emails, a "Staff Pool List Tip Sheet," and updates at monthly Wayne County Coordinating Council meetings with Special Education Directors and Supervisors.

Our student data system includes a "staff editor" module, in which districts assign Medicaid "certifications" to their staff based upon the qualifications set forth in the policy. The certifications allow us to limit the procedure codes staff may use, control service frequencies and start and end times, and require supervisory information for limited licensed staff whose documentation requires review.

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The RESA Medicaid office staff checks to ensure limited licensed staff (as noted on the Direct Service Staff Pool List) are assigned the appropriate access level that requires a supervisor's signature before submitting services in Service Tracker. In addition, supervising clinicians are requested to submit a form to their district's Medicaid office that documents their supervision of limited licensed staff.

F. Established coordination and collaboration exist 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, and Outpatient Hospitals, etc.).

The districts are responsible for the coordination of student services with outside agencies.Wayne RESA's Special Education department is also available to assist districts with the coordination of services with various agencies.

G. Parent/guardian and student participation exist outside of the POC team process in evaluating the impact of the SSP on the educational setting, service quality, and outcomes.

The Wayne RESA's Medicaid Department provides the districts with an Annual Notification letter. This letter is given to all parents of students receiving either DSC or C4S services and explains the SSP program and the parent's rights regarding Medicaid billing. Parental Consent forms are also given to parents in order to obtain their approval for billing Medicaid. Districts only have to collect Medicaid parental consent one time as long as the student remains enrolled in the same county. Most districts seek parental consent at the POC 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 POC forms. If consent is not received at the POC 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 parent refusal entered into the system will cause any services entered for the student to be filtered out of the claim submissions. Also, the local districts provide progress reports each card-marking to the parents which include updates on both academic and health-related services that the student is receiving in school.

Additional Reviews

A. Annual Record Review for the Direct Service Claiming Program:

In an effort to monitor compliance in addition to the quality controls outlined above, Wayne RESA conducts an annual records review. The current parameters for the reviews are as follows:

- One student from each district or Public School Academy (PSA) for whom at least one medical service has been reported is selected at random
- Service logs for one quarter of the current school year are printed for each student
- A letter is sent to each district's/PSA's Special Education office requesting documentation of the services rendered

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- The documentation request includes:
  - The MET(s), POC(s) evaluations, and goals and objectives related to the selected quarter
  - Clinician notes pertaining to all services submitted for the quarter
  - Prescriptions/referrals/authorizations as necessary
  - Student attendance records for the quarter
  - Parental consent for Medicaid billing
  - Personal Care and/or Transportation logs, if applicable
  - Staff certifications/licenses
  - Documentation of “under the direction of” and/or “supervision of” limited licensed staff

- The documentation is then reviewed by the Medicaid Reimbursement Office as follows:
  - Student had an active POC in place for the dates of service
  - Student was in attendance on all dates for which direct services were billed
  - Services rendered were prescribed on the POC (or were inherent in the program for center-based services)
  - The number of services rendered was within the frequencies/durations prescribed on the POC
  - Personal Care and/or Transportation logs supported the services rendered
  - Parental consent for Medicaid billing was obtained
  - Prescriptions/referrals/authorizations were obtained for the reported services
  - Clinician notes provided sufficient documentation to support the selected procedure code(s) and supervision where required
  - 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 Messenger newsletter, training sessions, and/or written communications with district Special Education Directors/Supervisors and applicable staff.

B. Annual Record Review for the Caring 4 Students Program:

In an effort to monitor compliance in addition to the quality controls outlined above, Wayne RESA conducts annual record reviews. The current parameters for the reviews are as follows:

- One student from each district/PSA for whom at least one mental/behavioral/medical health service has been reported is selected at random
- Service logs for one quarter of the current school year are printed for each student
- A letter is sent to each district’s/PSA’s Special Education office requesting documentation of the services rendered

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- The documentation request includes:
  - POC(s) evaluations, and goals and objectives related to the selected quarter
  - Clinician notes pertaining to all services submitted for the quarter
  - Prescriptions/referrals/authorizations as necessary
  - Student attendance records for the quarter
  - Staff certifications/licenses
  - Documentation of "under the direction of" and/or "supervision of" limitedlicensed staff
- The documentation is then reviewed by the Medicaid Reimbursement Office as follows:
  - Student had an active POC in place for the dates of service
  - Student was in attendance on all dates for which direct services were billed
  - Services rendered were prescribed on the POC
  - The number of services rendered was within the frequencies/durations prescribed on the POC
  - Prescriptions/referrals/authorizations were obtained for the reported services
  - Clinician notes provided sufficient documentation to support the selected procedure code(s) and supervision where required
  - Staff met Medicaid qualifications to provide billed services

C. Annual Notes Review:

In an effort to monitor compliance with the quality controls outlined above, Wayne RESA conducts an annual notes review.
The current parameters for the reviews are as follows:

- In January, RESA will select one provider type from the current staff pool list and will download all Service and Summary Notes entered to date for the October – December quarter
- Notes will be reviewed for content and exceptions are noted and reported to the appropriate local Special Education Director
- Staff are given the opportunity to clarify their note, or the service will be voided
- Issues that appear to be systematic are addressed in the Medicaid Messenger newsletter, training sessions, and/or written communications with district Special Education Directors/Supervisors and applicable staff

D. Designated Case Manager (DCM)/Personal Care (PC) Cost Review:

In an effort to monitor compliance with the quality controls outlined above, Wayne RESA conducts an annual review of costs submitted for Personal Care Aides and Designated Case Managers.
The current parameters for the reviews are as follows:

- Wayne RESA reviews the PC and DCM staff pool lists against reported services for the school year in order to verify the PC and DCM information that will be submitted to the state for Facility Settlement cost reporting is correct
- Districts are asked to substantiate all costs submitted for staff that have not reported any services during the school year
- Districts will be given a deadline to submit changes to the PC and DCM costs if necessary

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E. Random Moment Time Study Compliance Reports:

The RESA Medicaid office monitors the PCG Claiming System Compliance Report daily to ensure random moment time studies are completed in a timely manner. RESA will notify local districts via e-mail and phone calls, if staff have not completed their time study, and contact the district Superintendent for assistance if necessary. The RESA Medicaid office will also assist PCG with contacting participants for follow-up questions regarding time study responses.

School-Services Program– Part II

Policy:

The Medicaid Provider Manual, School-Services Program Section 6 states:
"The financial data reported for the 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 allowable costs are to include actual non-federal expenditures incurred during the claiming period. These allowable expenditures include, but are not limited to salaries, wages, fringe benefits, and medically-related supplies, purchased services and materials."

Caring 4 Students: The Medicaid Provider Manual, School-Services Program Section 6 states: **"***It is the intent of this policy that the ISD, in cooperation with the local education agencies (LEAs), use both existing funding and those from this program to maintain and increase behavioral health and other health services for general education students. These increases can take place in the current or subsequent year and must supplement, and not supplant existing services. It is expected that these additional services for General Education Students be provided without negatively impacting services provided to Special Education Students."*

WCRESA Plan:

Quarterly Staff Pool lists are submitted electronically by each district's Special Education Director/Supervisor who receive instructions for review and updates from both Wayne RESA and PCG. Once the staff pool lists are certified by the local district, they are reviewed by the RESA Medicaid Reimbursement Office before certification by the ISD.

The Quarterly Financial website is opened to the local districts by PCG. District staff complete,certify and submit the report electronically directly to PCG.
Wayne RESA will review district reports as follows:

- Verify district Indirect Cost Rates
- Verify with the local district that the total reported costs are correct
- Verify by random sample that staff listed are reporting services
- Verify Direct Service licensure

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Facility Settlement: Local districts prepare the Facility Settlement (FS) Report and submit it to the Medicaid Reimbursement Office via the CHAMPS electronic system. Wayne RESA's Computer Services department has facilitated the process by creating a Payroll system report that allows districts to select staff from the SPL and export their salary and benefits data to Excel. The Medicaid Reimbursement Office will compile and review completed FSs for reasonableness by:

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

Cost Certification: Each local district certifies their own data. Wayne RESA compiles and reviews district data as noted above and submits the certification to the Michigan Department of Health and Human Services.

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