Quality Assurance Plan for Oakland Schools
7-1-2026

Policy

Medicaid Provider Manual, School Services Program (SSP), Section 3.1 Quality Assurance and Coordination of Services, dated July 1, 2026, regarding Quality Assurance for Direct Service Claiming (DSC) and Caring 4 Students (C4S) programs which will be identified as School Services Programs (SSP) except where specifically identified states:

School Services Program (SSP) providers must have a written quality assurance plan on file. The SSP 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 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 plan of care 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 licenses, certification, and program requirements.

6. 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.).

7. Parent/guardian and beneficiary participation exist outside of the IEP/IFSP or plan of care team process in evaluating the impact of the SS Program on the educational setting, service quality and outcomes.

OAKLAND SCHOOLS PLAN

A. Covered Services

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

Qualified Medicaid staff members develop, sign and implement a medical plan of care when documented assessments, tests and other activities school staff members perform demonstrate the student is eligible for Direct Service Claiming (DSC) or Caring for Students (C4S) services. The Medicaid providers also work with families, physicians and Oakland Schools to meet requirements for services that are included in physicians' orders, prescriptions or referrals. Lastly, qualified providers working in the scope of their practice will authorize personal care services when it is determined that the students have disabilities or conditions that require assistance from a personal care aide.

B. The Plan of Care includes the covered services that will be provided, service frequency, duration, goals and objectives.

- A student's plan of care identifies the medically necessary services, delivery method, frequency, duration, goals, and objectives. Our electronic system (MIStar) is programmed with filters to ensure compliance. Before documentation can be finalized and archived, staff must verify the information is compliant. Services are compliant when the delivery method is Direct or Consult, a frequency and duration is listed, and the form includes goals and objectives for services. This information is verified monthly as part of the review for speech referrals and prescriptions for OT and throughout the year as part of the compliance monitoring process and when researching billing issues. The initial IEP/ IFSP must include the signed offer of FAPE and signatures of all people in attendance. If electronic signatures is utilized, then authentication page must be included in the document .

Physician's Referrals, Authorizations and Prescriptions

- Speech Referrals are required when a medical plan of care team lists speech, language, or hearing services in the student's medical plan of care. To meet the requirement, each month the Medicaid Reimbursement Office will obtain a physician speech referral for all the students based on their current POC.

- Occupational Therapy Prescriptions are required when the medical plan of care team lists Occupational Therapy or Orientation. When students have a POC that lists direct Physical and Occupational Therapy services, the family's prescription should include both services. Each school year, the Medicaid reimbursement office reminds schools that prescriptions are required when OT services are to be reported for Medicaid reimbursement. Schools must obtain the prescription and provide copies to the Oakland Schools Medicaid Department. If it's 30 days from the date of the POC and no OT prescription was obtained, the school should request help from Oakland Schools. The school will send Oakland Schools Medicaid Office a copy of the student's POC and the student's most recent OT evaluation.

- Physical Therapy Prescriptions – When the students medical plan of care requires physical therapy services, under MARSE rules, "physical therapy" must be prescribed by

a physician and provided by a State of Michigan licensed Physical Therapist or Physical Therapy Assistant. OS Medicaid Billing Department obtains a copy of the prescription from the district to enter into MISTAR which will be used to filter out any billings that are not compliant.

- Physicians Orders and Nursing Care Plan – Identifies when nurses must develop and implement an Individualized Healthcare Plan (IHP). Per public health code and Medicaid rules, school nursing services are considered medically necessary when they are ordered/prescribed by the student's personal physician, physician assistant, nurse practitioner or clinical nurse specialist and when the nursing goals and objectives are listed in the student's medical plan of care (IHP/IFSP/C4S plan, etc.). Districts are reminded of the requirements for nursing services and Medicaid billing on an annual basis.

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 daily to ensure the responses are submitted to PCG in a timely manner. We emphasize to all 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 SSP 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 SSP 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 referrals, prescriptions, or physician's orders.

E. Staff Qualifications

Staff qualifications meet current licenses, 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 shared drive. 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" mode in which districts assign Medicaid "cert-types" to their staff based upon the qualifications stated in policy. The cert types allow us to limit the procedure codes staff may use, control frequencies and start and end times and require supervisory information for staff whose documentation requires review.

F. Established Coordination and Collaboration Exists

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, 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 or plan of care team process in evaluating the impact of the SSP 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 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.

  The Caring 4 Students medical plan of care (POC) is an important starting point for delivering services within the school setting. To ensure compliance with Medicaid Caring

4 Students billing and reimbursement rules, Direct Service Providers (Social Workers, MDE-Credentialed Psychologists, Professional Counselors, Registered Nurses, etc.) should use the Oakland Schols C4S POC to track results and findings that relate to the service needs for referred, crisis intervention, and existing plan of care (BP/IHP/MMP) students.

The medical POC establishes medical conditions when they list the students' medically necessary interventions and supports that LARA-licensed, MDE-Credentialed, and Paraprofessional staff must provide at school.

For those reasons, the student's POC must be developed, maintained, updated, and signed by a licensed medical provider acting within the scope of their practice. A new plan

- Districts will 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 include updates on both academic and health related services that the student is receiving in school.

Annual Record Review for Compliance Monitoring

Annual Record Review for the Direct Claiming Service and Caring 4 Students Programs

The purpose of the annual record review is to monitor their level of compliance with the MDHHS SSP policy for Medicaid reimbursement. The OS Medicaid Department conducts the monitoring as follows:

- At a minimum, five local districts will be reviewed within a fiscal year. No district will be reviewed more than once in any three-year consecutive period.

- At each of the districts chosen, five 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 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), care plans and evaluations related to the dates of services billed.
- ❖ Student attendance records for the quarter
- ❖ Parental consent for Medicaid billing
- ❖ Personal Care and/or Transportation logs, if applicable
- ❖ Staff certifications/licenses, if not appearing on the LARA website.

- The documentation is then reviewed by the Medicaid Billing Department as follows:

  - ❖ Student had an active IEP or plan of care in place for the dates of service
  - ❖ Students were in attendance on all dates for which direct services were billed
  - ❖ Services rendered were prescribed on the IEP or plan of care (or were inherent in the program for center-based services)
  - ❖ The number of services rendered was within the frequencies/durations prescribed on the IEP or plan of care
  - ❖ 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
  - ❖ Physicians 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."

Failure to comply with documentation requirements or timelines may result in delayed or denied Medicaid reimbursements, removal from the Staff Pool List, removal of salary and benefits from semester financial reporting, retraining requirements, increased monitoring and corrective action procedures.

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.

Semester 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 semester financials match the semester 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 semester 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 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.

FACILITY SETTLEMENT: Local districts prepare the facility settlement and submit the information CHAMPS to the OS Medicaid Billing Department and we, along with the OS Finance Department will compile and review completed facility settlements 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 Manager certifies the Total Computable Expenditure amount 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.