

Medicaid & School Based Skills Development

August 8, 2011

MAC & Direct Services Combined

The purpose of the MAC time study

To identify activities/cost which qualify for Medicaid Administrative reimbursement. Examples of allowable Medicaid activities are Medicaid outreach, assistance with applications, program planning and coordination of Health Related Services. Jordan School District has taken the lead on submitting the Claim for payment and distributing funds to the enrolled school districts.

The purpose of the Health Related Services Time study

To make sure that the payments you receive for Health Related Services do not exceed your actual cost of providing those services. The federal government does not allow providers (schools) to make a profit. Payments are based on your district's payment rate and the services you have billed for. Cost is determined based on the percentage of time staff say they are performing direct services, the staff included in the time study and the percentage of students eligible for Medicaid. All of these factors are important to make sure the comparison of payments to cost is accurate.

Combining the time studies affects the district by

Reducing the number of time studies each year from 5 or 6 to 3.

The MAC process does not change. Time studies are completed three times each year, (Oct-Dec, Jan-Mar, Apr-June), using a random day generator.

The results from the time study will be used to claim Federal dollars under MAC and also determine if your Health Related payments exceed your cost. If your payments exceed your cost then you may have to pay money back to the state.

It doubles the importance of completing time studies. *Important: If participants do not complete the time study – their salary and benefits do not count!* This means you will not generate any MAC revenue for these people and it could also mean you might owe money back to the state.

You will still send in the enrollment numbers for self-contained classified (students receiving a minimum of 180 minutes per day of special education and related services combined), K-12 and pre-school each quarter to Medicaid as you have been doing.

Will there be two different lists for the time study?

No, we will use one list for both purposes. What this means is everyone that was in the Direct Services time study should be added into the MAC if you have not already done so.

What should I do with the Federally funded people that we have excluded from MAC?

Answer: That depends on your district rates and cost. If your costs well exceeds your payments we will continue to exclude federally funded from the time study. If your payments and cost are close, we should have a separate phone call with Medicaid to make that determination.

Ideally you should work with your business office to make sure individuals in the time study cost pool have some state/local funding; this will maximize your MAC money. There are about 9 districts that have 100% federally funded in the cost pool and the contractor will have a conversation with the business offices to see if some dollars can be shifted so there is some state/local dollars for these participants.

Will there be any different time study codes?

Answer: **Yes**. The only change will be code F – Direct Services. Code F will be separated into two subcategories. **F1 will be for Medicaid covered direct services for a health related IEP service** and **F2 will be direct service for non-IEP services**, e.g. administering first aid, treatment of a sick student, medication administration, etc. (I have a handout that we will go over in a bit.) Code F1 & F2 will be effective starting with Q1 2011 time study.

Will there be training available on line?

Yes. Participants must first have a User Id and password before they can access the training. There will be two modules. One on navigating the on-line system, which includes entering the codes, shortcuts, saving data and marking the time study complete. The second module is on the activity codes. Activity code content is identical to previous training without the video component. Participants can move as slowly as they would like through the module. It will take approximately 35-40 minutes to complete. I will have access to reports on training and exception reports for those that do not complete the on-line training.

Reminder: Participants can not be include in the claim if they have not participated in the training – even if they did a time study. This is now more important then ever with the combining of the time studies on line.

Can we include pre-school therapists and teachers in our time study?

Yes. All professionals that were participating in the Direct Services Time study should be included in the MAC time study. If you have not already sent John Mahoney your list, please do so as soon as possible.

On-Line Training

We recommend training the teachers and aides first as many of them have not been in the program as long as the therapists. Anyone new to the Time Study process needs to complete the on-line training.

MAC Timestudy

Code F - Changing to F1 & F2

Starting with the February 2011 time study, Code F will be separated into two sub codes. F1 is Health Related Services in an IEP and F2 is for all other direct service time (see examples below). This is in place of doing the separate direct services time study for the state. You still complete the time study on-line.

F1 - IEP - Health Related Direct Service activities:

Providing health/mental health services contained in an IEP.
 Medical/health assessment and evaluation as part of the development of an IEP
 Conducting medical/health assessments/evaluations and diagnostic testing and preparing related reports
 Providing speech, occupational, physical and other therapies
 Performing developmental assessments
 Providing counseling services to treat health, mental health, or substance abuse conditions
 Transportation (if covered as a medical service under Medicaid)

F2 – Non IEP - Direct Service activities:

Providing personal aide services
 Administering first aid, or prescribed injections or medications to a student
 Providing direct clinical/treatment services
 Developing a treatment plan (medical plan of care) for a student if provided as a medical service
 Performing routine or mandated child health screens including but not limited to vision, hearing, dental, scoliosis, and EPSDT screens
 Providing immunizations

NARRATIVE LOG INSTRUCTIONS

Please complete the narrative log on the 3rd day of the time study week. Please provide brief description of your activity for each 15-minute interval. Descriptions should convey a complete thought and contain a subject and verb.

Examples of good narrative descriptions:

Filled out Medicaid application for family
 Provided info on Medicaid to family
 Student assessment new services or ongoing services
 Student evaluation new services or ongoing services
 Provided individual therapy
 Provided group therapy
 Met with parent regarding related service progress
 Called parent regarding related services
 Call with student's primary care
 Coordinated meeting with team and parents
 Student observation – need for additional/new services
 Collaboration with team on service needs
 Collaboration with team on service delivery
 Preparation for team meeting
 Met with supervisor to discuss student goals/progress
 Consult with teacher on student therapy progress/needs
 Consult with parent on grades
 IEP preparation
 Lunch
 Break
 OT Assist Student on Bus
 Assist toileting
 Paid time off/sick leave

The purpose of the logs is to make sure you understand the activity codes. Narrative logs will be reviewed by the State Department of Health. If logs appear to be incomplete you may be asked to add additional detail. If it appears that the codes selected for the activities are incorrect you may be asked to complete the training program again.

Itinerant Nursing Services

School based skills development services provided to medically fragile students in special education who require continuous, one-to-one skilled nursing throughout their school day.

Itinerant Nursing Services are provided in accordance with physician orders to medically fragile children in special education who require continuous, one-to-one skilled nursing throughout their school day. Nursing Services are provided to an individual on a direct one-to-one basis within the school environment, such as:

Catheterization or catheter care;
 Care and maintenance of tracheotomies;
 Prescription medication administration that is part of the IEP;
 Oxygen administration;
 Tube feedings;
 Suctioning;
 Ventilator Care;
 Evaluations and assessments (RNs only).
Time considered stand-by in nature is not covered.

Billing codes and Rates
 RN T1002 Modifier TM \$9.64/15 minutes
 LPN T1003 Modifier TM \$7.52/15 minutes

Nursing Notes

Documentation of Nursing services needs to include

- the date of each billed service;
- the number of 15 minute units billed ;
- the nature and purpose of each billed service as it relates to the student's IEP; and
- the name of the individual(s) who provided the billed service.

Medicaid coverage is available for services identified only when these services are:

- provided to a Medicaid eligible recipient through an enrolled provider;
- identified as a related service in an eligible student's IEP;
- supported by documented, professional evaluation(s);
- specifically designed to enhance a student's health and functional abilities and/or to prevent further deterioration;
- necessary to assist the student to benefit from special education;
- provided as an individual or (with the exception of Itinerant Nursing Services) a group, therapeutic intervention by, or under the direct supervision of, qualified individuals; **and**
- provided and billed in amounts that are reasonable given the documented needs and condition of a particular student.

Prepayment of State Match

This is a Federal requirement which requires providers to pay the State Match prior to drawing down the Federal share. This match is calculated from the previous years expenditures and divided across the four quarters. A reconciliation is completed at the end of every quarter and the districts will receive a refund or an invoice for additional due - depending on the actual claims paid during that quarter.

Financial Services in the Division of Medicaid Health Financing prepares and mails prepayment invoices each quarter. These bills are sent approximately 45 days before the start of the quarter.

As prepayment checks are received from the districts they are tracked in a database.

If payments are not received 15 days prior to the beginning of the quarter (the Monday closest to the 15 day mark) the 305 edit is posted to the claims of the provider who has not submitted their match money. This places the claims in a suspense status (on hold for payment) until the prepayment is received at which time the claims will be released for payment.

12 Month Timely Filing

The following information is provided to clarify the 12-month rule, all claims and adjustments for services must be received by Medicaid within 365 days from the date of service. The start date for determining the 1-year timely filing period is the date of service or "from" date on the claim.

According to the federal rule 42 CFR 447.45, it states, "The time limitation does not apply to claims from providers under investigation for fraud or abuse. The agency may make payments at any time in accordance with a court order, to carry out hearing decisions or agency corrective actions taken to resolve a dispute, or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it."

"If a claim for payment under Medicare has been filed in a timely manner, the agency may pay a Medicaid claim relating to the same services within 6 months (180 days) after the agency or the provider receives notice of the disposition of the Medicare claim."

Therefore, all crossover claims will be required to have the Medicare paid date submitted on the claim, or the claim will be denied by Medicaid.

Providers may request the change to correct a claim outside of the timely filing deadline; however, no additional funds will be reimbursed.

New Federal Regulations

As of 2011 there are new federal regulations that will affect the school districts with regards to Excluded Providers

The School District shall not employ or subcontract with any provider i.e., individual or entity) who

- (1) is under a current federal debarment, sanction or exclusion from participation in Medicare, Medicaid, the State Children's Health Insurance Program (CHIP), or any other Federal health care program as defined in Section 1128B (f) of the Social Security Act (the Act), including any provider excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Act;
- (2) has had his or her license suspended or revoked by **any state**; or
- (3) has been sanctioned or excluded from participation in the Utah Medicaid program.

The DEPARTMENT shall notify the School District of any DEPARTMENT-initiated sanctions or exclusions of Medicaid providers.

Credentialing and Re-credentialing Policies and Procedures

The School District must maintain written policies and procedures for credentialing potential providers and for re-credentialing providers who have signed contracts or participation agreements that follow the DEPARTMENT's policy that requires:

Procedures for assuring that potential and current providers are appropriately credentialed, (e.g. that the provider has a current license, and/or accreditation as applicable, is in good standing with licensing boards, and and/or accreditation as applicable, etc).

Primary source verification of licensure and disciplinary status;

Procedures for reviewing public records for any adverse actions, including sanctioning and/or federal debarment, suspension or exclusions.

The School District must have a re-credentialing process for providers that is completed at least every five years and updates information obtained through the initial credentialing processes.

The School District must maintain documentation of credentialing and re-credentialing activities. Upon request from the DEPARTMENT, the School District must demonstrate that its providers are credentialed and re-credentialed following its written credentialing and re-credentialing policies and procedures.

Common Questions

When is the program going Fee For Service? This option is still under review. There are many factors that need to be addressed before this can happen such as: State Plan Amendment, rate setting, approval from the CMS (Centers for Medicare & Medicaid Services), computer programming changes, revisions to the provider manual, development of a monitoring plan processes, provider enrollment and regulatory issues.

What about Charter Schools? At this time we are unable to enroll Charter schools or any new districts. (Any new provider would be required to contract with Medicaid's Administrative Case Management contractor and would be required to participated in the MAC time study.)

Why are CHIP students not covered? School based services are not a covered benefit on the CHIP program.

Questions



Contact Information

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