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Medicaid in Schools

Medicaid in Schools

- Medicaid is one of many federally funded programs that assist financially eligible children/families to receive health services.
- In 1988, Congress passed the Medicare Catastrophic Coverage Act to provide medically necessary services for children who have an individual educational plan (IEP) in conjunction with IDEA. In 1995, school districts became eligible under the federal Medicaid program to receive reimbursement for school-based services.
- The Medicaid Certified School Match (MCSM) program was authorized by the Florida legislature in 1997.
- Florida Statute was revised in 2017 to allow for participation in the program by charter/private schools.
- Reimbursement in regular Florida Medicaid is shared general revenue/federal dollars.

Medicaid Certified School Match Program

The purpose of the MCSM program is to provide reimbursement for medically necessary services provided by schools or school district employees or contractors by a school district or schools to Medicaid-eligible students.

AHCA and the Medicaid Fiscal Agent

- The Agency for Health Care Administration (AHCA)
  - Responsible for Medicaid in Florida
    - Bureau of Medicaid Policy
    - Bureau of Medicaid Quality
    - Bureau of Medicaid Program Finance
- The Medicaid Fiscal Agent provides assistance with:
  - Enrollment - 1-800-289-7799
  - Username(s) and Password(s) for the Florida Medicaid Managed Information System (FLMMIS)
    - NOTE: Internet Explorer must be used to access FLMMIS
  - District's Customary Charge
  - Denied Claims

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Florida Medicaid Information at AHCA Website

Florida Medicaid

Medicaid Rules

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Medicaid Health Care Alerts

Receive timely notification of rule development and other information

Sign up for:

Florida Medicaid Health Care Alerts

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Parental Consent and Annual Notification

Parental Consent and Notification

- Parental consent required one time
- Notification required annually
- Florida Department of Education (FDOE) approved model parental consent and notification forms (not required for use, but contain all requirements)
- Forms (sample) in English, Haitian-Creole, Spanish at http://sss.usf.edu/resources/topic/medicaid/index.html

Consent – Rule 6A-6.03028(3)(q)1.d., F.A.C.

d. Prior to accessing the student's or parent's public benefits or insurance for the first time, and after providing notification to the student's parent as described in sub-subparagraph e. of paragraph (3)(q), the school district must obtain written, parental consent that specifies:

(I) The personally identifiable information that may be disclosed such as records or information about the services that may be provided to the student;

(II) The purpose of disclosure, such as for purpose of billing for services;

(III) The agency to which the disclosure may be made; and

(IV) That the parent understands and agrees that the school district may access the parent's or student's public benefits or insurance to pay for services required under Rules 6A-6.03011–.0361, Florida Administrative Code (F.A.C.).

Notification – Rule 6A-6.03028(3)(q)1.e., F.A.C.

e. Prior to accessing a student's or parent's public benefits or insurance for the first time, and annually thereafter, the school district must provide written notification consistent with the requirements found in paragraphs 6A-6.03311(1)(a) and (b), F.A.C., to the student's parents that includes:

(I) A statement of the parental consent provision in sub-subparagraph d. of this paragraph;

(II) A statement of the no-cost provisions of subparagraph (3)(q)1.;

(III) A statement that the parents have the right to withdraw their consent to disclose their child's personally identifiable information to the agency responsible for the administration of the State's public benefits or insurance at any time; and

(IV) A statement that the withdrawal of consent or refusal to provide consent to disclose personally identifiable information to the agency responsible for the administration of the State's public benefits or insurance program does not relieve the school district of its responsibility to ensure that all required services are provided at no cost to the parents.

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Fee for Service

Options for Medicaid Financing Health Care in Schools – Medicaid Eligible Students

- Use providers in the community – they bill Medicaid
- County Health Departments (CHDs) or other health agencies – CHD or other agency bills Medicaid
- School district or school enrolls as Medicaid provider and bills for services provided by school district or contracted health staff

FFS Relevant Federal Regulations State Laws and Rules

- Title XIX of Social Security Act
- Chapter 59G, F.A.C. (Medicaid)
- Title 42 of the Code of Federal Regulations
  - Part 440.110
  - Part 440.130
- Chapter 409, Florida Statutes (F.S.) (Medicaid)
  - 409.9071 – School Districts
  - 409.9072 – Charter/Private Schools
  - 409.908 – Medicaid Reimbursement
- Section 1011.70, F.S. – Certified Funds

Online Sunshine

FFS Relevant Policy/Handbooks

- Medicaid Certified School Match Coverage and Limitations Handbook
- Provider General Handbook
- Reimbursement Handbook
- Fee Schedules

AHCA Adopted Rules

School District Provider Enrollment

- District enrolls for each service for which it will seek reimbursement
- Each district obtains a base provider number used to seek reimbursement

  Example: Madison base number – 008053500

- Extensions to the base numbers are needed for therapies, behavioral and nursing services

  Therapy 008053501

  Transportation 008053512

  Nursing 008053515

  Mental Health-Psychology 008053517

  Mental Health-Social Work 008053518

- Enrollment is active for five years

Medicaid State Plan Amendment (SPA)

- SPA approved by federal Medicaid agency October 2, 2017
- Includes private and charter schools in the match program
- Incorporates concept of free care. Services can be provided to all Medicaid recipients with a plan (IEP, individual family support plan [IFSP], behavior, nursing – but not limited to those)
- Policy is following the rule development process

Charter/Private School Provider Enrollment

- School must enroll as an “08” group provider
- Unlike school districts, all rendering providers must enroll as an “84” Provider Type linked to the school
- Claims must contain either the NPI# or the Florida Medicaid Provider ID # for the school in conjunction with the Florida Medicaid Provider ID for the rendering provider to receive reimbursement
- Enrollment is active for five years

Fee for Service (FFS)

- All Medicaid service-specific policies are in state rule (Florida Administrative Code)
- Current fee for service policy handbook can be found at Medicaid Certified School Match Program Coverage and Limitations Handbook
- Districts have option of revising rates from existing fee schedule Medicaid Certified School Match 2021 Fee Schedule
- Medicaid **DOES NOT** require any one billing/reimbursement system to be used
  - FDOE service capture/billing system
  - State Medicaid FLMMIS
  - Vendors

Students Qualified for Certified Match

- Medicaid-eligible on date of service
- Under the age of 21
- Medicaid reimbursable services recommended by school district employees/contracted staff

Place of Service

Services may be provided:

- At school
- On school vehicle
- At school activities and programs away from campus
- At home

Required for Billing: ICD-10 Code and Procedure Code

ICD-10 Code

- ICD-10 Codes (International Classification of Diseases): all codes available to providers
- ICD-10 codes required for every service billing
- Centers for Medicare and Medicaid (CMS) guidance
- Some districts shared their commonly used codes: Shared District Resources

Procedure Code

- In handbook and in fee schedule Medicaid Certified School Match Program Fee Schedule 2021
- Correlate with the service type (i.e., 92508 – group speech therapy session)

Reporting of Service Units

- CMS Guidance

  1 unit: ≥ 8 minutes through 22 minutes

  2 units: ≥ 23 minutes through 37 minutes

  3 units: ≥ 38 minutes through 52 minutes

  4 units: ≥ 53 minutes through 67 minutes

  5 units: ≥ 68 minutes through 82 minutes

  6 units: ≥ 83 minutes through 97 minutes

  7 units: ≥ 98 minutes through 112 minutes

  8 units: ≥ 113 minutes through 127 minutes

District Reimbursement: Federal Medical Assistance Percentage (FMAP)

- MCSM program pays federal portion (FMAP) of fee schedule established in Florida rule
- FMAP changes annually on October 1
- FY 2020 (October 1, 2020–September 30, 2021) = 61.96%
- Change from FY 2019: ⇧ .49%
- FMAP example:
  - District bills four 15-minute units of speech therapy provided by SLP
  - 4 units x $16.97 per unit (current fee schedule) = $67.88
  - FMAP of 61.96% = $42.06 State of Florida Share of 38.04% = $25.82
  - District is reimbursed $42.06 and certifies it has matched the state share using non-federal dollars

FMAP State of Emergency

- FMAP Rate
  - FY 2020 – 61.47%
  - FY 2021 – 61.96%
  - State of Emergency – 6.2%
    - Section 6008 of the FFCRA
    - Trough the end of the quarter when the state of emergency ends
  - **Current Rate – 68.16%**

Audit Requirements

School district must maintain Medicaid documentation records for a minimum of five years -

- Provider staff – licenses, certification
- Service records – IEPs, paper/electronic documentation of service provision
- Records retention is in accordance with state law

Avoid Duplication of Services

- Medicaid will only reimburse for one provider for the same service on the same day
- If district bills for the same service as community provider on the same day, the first one received in AHCA's payment system will be paid and payment denied on other claim
- Tips to avoid duplication of services (these are not in Medicaid rule)
  - Ask parent at IEP meeting if student is receiving therapy services outside of school
  - Best practice: coordinate the services with private providers, when known
  - Delay billing to allow for community provider to bill

Occupational, Physical, Speech Language Therapy

Therapy Services

- Only “face time” with student is billable
- Services must be based on evaluation that was performed by an SLP, OT or PT
- Evaluation must be provided during AHCA audit or monitoring of services billed
- If SL services performed in group, group size limited to 8 students
- If OT or PT services performed in group, group size limited to four students

Therapy Service Providers

- Speech-Language Pathologists
- Speech-Language Pathology Assistants
- Physical Therapists
- Physical Therapist Assistants
- Occupational Therapists
- Occupational Therapy Assistants

Therapy Plan of Care Requirement (POC)

- POC required for PT, OT, SL
- IEP may suffice as POC as long as components below are included:
  - Student Name
  - Description of medical condition
  - Goals and objectives related to functioning of student
  - Type of therapy (Speech, OT, PT)
  - Frequency, **estimated** length and duration of treatment
    - Example: “treatment necessary for 60 minutes (length of treatment) per week (frequency) for one year (duration)”
    - Example: “treatment necessary two times per week (frequency) for 30 minutes (length of treatment) for six months (duration)”

Note: POC or signed attachment may serve as required recommendation of service

Plan of Care Approval and Review

- Must be signed, titled, dated by PT, OT, SL
- If therapist is not at IEP meeting, may file with the IEP a statement of concurrence with the services in the IEP (must be signed, titled, dated)
- Must be reviewed annually
- No Medicaid reimbursement for time spent developing the plan of care

Service Limitations

- Each service has service limitations (for example – four units of service per day)
- Service limitations are on AHCA fee schedule
- Services must be billed within one year from date of service
- Services must be medically necessary and must not duplicate another provider's service

Therapy Reimbursement Service Limitations

- Therapy Services
  - Minimum of 15 minutes
  - Service limitation: 4 units per day per provider (procedure code) per student
  - Service limitation: 1 evaluation every 6 months

Documentation Requirements – Therapy Evaluations

- Student name
- Diagnostic testing and assessment
- Written report with needs identified

Note: Although not listed in policy, there must be a date on the evaluation

Documentation Requirements – Therapy Sessions

- Student name
- Date of service
- Type of service (OT, PT, Speech)
- If group, number of students in group
- Length of time therapy performed (start/stop time OR length of time)
- Description of therapy activity or method used
- Student's progress toward established goals
- Signature of provider, title, date

Note: Must be documented within two days of service

Additional Reimbursable Services Performed by OT, PT, SLP

- Wheelchair evaluation and fitting – OT, PT
- Application of casting or strapping/splinting – must be prescribed by physician, ARNP, PA and included in the plan of care – OT, PT
- Augmentative and alternative communication (AAC Services – OT, PT, SLP)
  - AAC initial evaluation
  - AAC re-evaluation
  - AAC fitting, adjustment and training visit

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Questions

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Nursing Services

Nursing Services

- Includes “face time” and other “non-face time”
  - Health assessments, individual student health training and counseling, catheterizations, tube feedings, maintenance of tracheostomies, oxygen administration, specimen collection, ventilator care, health monitoring and management, health care treatments and procedures, management of chronic health care, health care coordination and referrals, crisis intervention, compilation of health histories, screenings, emergency health care, consultation and coordination
- No reimbursable group services
- Consultation/Coordination is a Medicaid Administration-covered service

Nursing Service Providers

- Registered Nurses
- Licensed Practical Nurses *(must be performed under the direction of a licensed registered nurse)*
- School Health Aides *(must be performed under the direction of a licensed registered nurse)*
  - School health aides must complete the following courses/trainings:
    - first aid
    - CPR
    - medication
    - patient specific" training

Note: Only requires training, not certification. Document all trainings!

Nursing Reimbursement Service Limitations

- 1 unit = maximum of 15 minutes
- Number of minutes – total for day per provider and round up
- Service limitation: 32 units per day per provider (procedure code)
- No service limitation for medication administration

Documentation Requirements – Nursing Services

- Student name
- Date of service
- Length of time service performed
- Description of service
- Student's reaction to service (unless consultation, compilation of health history)
- Nurse's or school health aide's signature, title and date

Documentation Requirements – Medicaid Administration

- Student name
- Date of service
- Name of medication
- Time medication
- Dosage and route
- Nurse's or school health aide's signature, title and date

Note: Log-type format may be used: sign, title, date by each entry in log or initial each entry and sign, title, date log on weekly basis

Behavioral Services

Behavioral Services

- Therapy, behavioral analysis, treatment, intervention, counseling, consultation, coordination and follow-up referrals
- Testing, assessment, evaluation (includes behavior evaluations and functional assessments) to appraise cognitive, developmental, emotional, social and adaptive functioning including time spent in:
  - Interviews
  - Interpretation of test results
  - Development of evaluative reports
- Consultation/Coordination is a Medicaid Administration-covered service

Behavioral Service Providers

- School Psychologists
- Psychologists
- Certified Behavior Analysts
- Certified Associate Behavior Analysts (under supervision of CBA)
- School Counselors (formerly guidance counselors)
- Licensed Mental Health Counselors
- Marriage and Family Therapists
- Social Workers
- Provisionally licensed and Board registered Interns – Mental Health Counselors/Marriage and Family Therapists

Documentation Requirements – Behavioral Evaluations

- Student name
- Date of service
- Description of tests, assessments or other evaluative methods such as interviews, observations and record reviews or description of consultative or referral activities
- Length of time service performed
- Provider's signature, title and date

Documentation Requirements – Behavioral Services

- Student name
- Date of service
- Description of therapy or counseling session
- Description of the student's progress toward any established goals, if appropriate (can be weekly)
- Length of time the service was performed
- Identify if group or individual therapy
- School district staff member's signature, title and date

Behavioral Reimbursement Service Limitations

- 1 unit = maximum of 15 minutes
- Number of minutes – total for day per provider and round up
- Service limitation: from 8-32 units per day per provider (based on procedure code)

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Transportation

Transportation

- Reimbursed by one-way trip when Medicaid-covered service provided at school
- Service 4 one-way trips per day
- Medical condition that requires special transportation environment
- Student must have specialized transportation meeting one of following criteria
  - Medical or vehicle adaptive equipment required
  - Attendant required due to physical or behavioral disability and specific need of student

Documentation – Transportation

- Student's name
- Bus or loading dock attendant's daily initials on the date of each trip verifying student rode the bus
- May keep information on logs with multiple students on each daily log
- Preprinted logs may be used
- Must have capacity to match trip logs to health care records to document that Medicaid-covered service was provided on the day of the transportation

Transportation Rates

- Initial transportation rates were set in the 1990s
- Districts are allowed to do paperwork to establish higher rates
- Link to Transportation Rate Calculation Guide and Transportation Rate Calculation Sheet:

AHCA Transportation Rate Calculations

Transportation Rates Examples: ISRD Member Districts – Panhandle

District	Rate One Way Trip		District	Rate One Way Trip
Calhoun	$4.47 (2008)		Liberty	$5.08
Franklin	$6.65		Madison	$3.75
Gadsden	$4.25		Taylor	$5.85
Gulf	$4.11		Wakulla	$3.95
Holmes	$4.71 (2015)		Walton	$4.24
Jackson	$7.40 (2013)		Washington	$6.11 (2015)
Jefferson	$6.04			

All rates set in 1997-2003 unless different year indicated above.

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Medicaid Update

Telemedicine Guidance

- Telemedicine guidance for school-based services received from AHCA on March 31, 2020

  Telemedicine Guidance for School-Based Services

  - Allowed for reimbursement of therapy and behavior services using uninterrupted video and audio
  - Must append the GT modifier to the procedure code for audio and video services
  - Group and individual services allowed
  - Non face-to-face services may continue for behavior and nursing
  - No telemedicine guidance received for nursing services

Telemedicine Guidance

- Updated FAQ received from AHCA on:
  - May 22, 2020
    - Allowed for reimbursement of audio-only behavior services when video is not available
    - Must append the CR modifier to the procedure code for audio-only behavioral services
  - October 2, 2020
    - Consent requirements for telemedicine services delivered in schools

AHCA Updated Telemedicine FAQ

HB 81: Health Care for Children

- The bill aligns Florida law with the 2014 CMS guidance by eliminating the requirement that Medicaid recipients receiving services through the Florida Medicaid Certified School Match Program qualify for Part B or H of the IDEA, or for exceptional student services, or have an IEP or IFSP

- Effective July 1, 2020

Medicaid Update: AHCA Addressing School District Concerns

- What is the process for districts to resubmit denied claims exceeding one year?
- Has AHCA reviewed the fee schedule comments submitted?
- Are there any updates regarding the new coverage policy?
- Outstanding district/school questions

School District Administrative Claiming

School District Administrative Claiming (SDAC)

- Allows reimbursement for some of costs associated with school-based health and outreach activities that are not claimable under FFS
- To determine amount of time school district staff spend on these activities, a quarterly time study is performed
- Examples:
  - Referral of students/families for Medicaid eligibility
  - Provision of health care information and referral
  - Coordination and monitoring of health care services
  - Interagency coordination

SDAC, continued

- Policy Handbook can be found here School District Administrative Claiming Guide
- FFS billing requirement: one reimbursable therapy, nursing and behavioral service
- Required to have 75% valid responses completed
- Some districts still use paper forms
- No billing/reimbursement system required to be used
  - FDOE Electronic Administrative Claiming System (EMACS)
  - Individual district system
  - Vendors

SDAC Direct Billing Requirement

- District must submit at least one claim for the following services
  - Therapies (PT, OT, SL)
  - Behavioral
  - Nursing
- Can refer students to providers in the community to meet this requirement if they are a Medicaid-eligible provider.
- If claims are not submitted for the services referenced above or if there is no documentation of referrals to community providers, activity code 5 cannot be reimbursed for the quarter.

Time Study – RMS

- RMS method measures work effort of entire group of approved staff that are in the sample
- Samples and analyzes work efforts of only a cross-section of the group
- “Polls” selected staff at random moments (one minute) over given time and tallies results of polling over that period
- There are notification timeframes to assure the integrity of the sampling:
  - Notification to participant on the day of the sample that he/she has been selected
  - Participant has 7 days to complete the information from the “moment” in electronic system or 30 days on paper

Time Study – Random Moment Sampling

- Electronic information or paper form reviewed or coded by district staff, then are reviewed by EMACS staff or vendor staff
- Forms turned in to AHCA, or AHCA reviews in electronic system
- All are sent to AHCA staff where results of the sample are tabulated and sent back to EMACS or vendors, who then distribute to districts
- District generates claim and sends to AHCA
- AHCA reviews, then pays claim

SDAC – Time Study Turn Around

- For electronic sampling, sample participants have 7 working days to complete their moments and 30 days for paper.
- If a participant does not complete the moment within 7/30 day timeframe, the RMS moment will be invalid and will not count towards the 75% participation.
- Especially important for ISRD districts to monitor completion of moments, as they receive fewer sample moments than larger districts and easier to fail to meet the 75% requirement.

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Maximizing Your Reimbursement

School District Administrative Claiming

- Review approved state and district-specific job codes
- Complete job certification form
- Review costs attributed to the non-sampled supervisory and clerical staff
- Review cost center start and end times
- Train sample poll staff
- Train district contact
- Review the claiming workbook

Fee for Service

- Medicaid fiscal staff
- Review billing system
- Monitor provider documentation
- Review and understand the remittance advice
- Follow up on denied claims
- Run Medicaid eligibility checks
- Review billable provider's funding source

Fee for Service

- Obtain parental consent from those missing
- Address concerns of parents who do not provide consent
- Know what you are missing!!
  - Use the potential revenue maximization worksheet
- Look at your transportation and other rates to see if they can be increased from the fee schedule
  - Example: Jackson went from $4.79 to $7.40 (2013)
    Washington $6.11 (2015)
- Other ideas from districts?

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FDOE Can Help!

FDOE Products to Assist You

- Medicaid Tracking System (MTS) 2.0 – paper-based fee for service billing
- MTS 3.0 – electronic fee for service documentation and billing
- EMACS – administrative claiming
- Fully supported by FDOE staff, including training, technical support, day-to-day assistance

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State Medicaid Agency Monitoring

Medicaid Certified School Match

- Medicaid Quality completes a desk review of 2 paid claims per service type (PT, OT, ST, AAC, behavioral health, nursing, and transportation). Initial results are shared with the district and additional documentation is gathered (if necessary) before the report is submitted to AHCA management.
- Medicaid Policy is responsible for all Medicaid rules and requirements, including the MCSM Handbook.

School District Administrative Claiming

- Medicaid Program Finance reviews districts quarterly sample pool of participants, verifies billing requirements, and processes invoices.
- Medicaid Quality completes a desk review and approval of school/district's quarterly RMS.

FDOE Contact Information

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Medicaid in Schools Website

http://sss.usf.edu/resources/topic/medicaid/index.html