Wayne RESA Medicaid Annual Quality Assurance Plan July 2024 – June 2025

School-Services Programs– Part I

Policy:

The Michigan Department of Health and Human Services (MDHHS) Provider Manual dated July 1, 2024, includes the following language regarding Quality Assurance for the Direct Service Claiming (DSC) and Caring 4 Students (C4S) programs. 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, and the impact of Medicaid enrollment on the school environment.

An acceptable quality assurance plan must address each of the following quality assurance standards:

A. *Covered services are medically necessary, as determined and documented through appropriate and objective testing, evaluation and diagnosis.*
B. *The Plan of Care (POC) identifies which covered services are to be provided and the service frequency, duration, goals and objectives.*
C. *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 education services.*
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 beneficiary participation exist outside of the POC team process in evaluating the impact of the SSP on the educational setting, service quality, and outcomes.*

WCRESA Plan:

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

The associated constituent school districts and public-school academies who participate in Michigan's School Services Program meet the requirements for appropriate and objective testing, evaluation, and diagnosis by following Michigan's Administrative Rules for Special Education (MARSE), Multi-Tiered System of Support (MTSS), and Safe and Healthy Schools Framework for identifying students with physical, social or emotional health-related service needs during the school day.

Qualified Medicaid staff develop, sign off on, and implement the medical plan of care services when the documented evaluations, assessments, tests, and other activities school staff perform demonstrate eligibility for Direct Service Claiming (DSC) or Caring for Students (C4S) services. Medicaid provider's also work with families, physicians, and Wayne RESA to meet the requirements for services that are tied to medical orders, prescriptions, or referrals. Finally, qualified providers will authorize personal care services when it is determined that students have disabilities or conditions that require assistance from a personal care aide.

B. The POC identifies which covered services are to be provided and the service frequency, duration, goals, and objectives.

A student's POC identifies the medically necessary services, delivery method, frequency, duration, goals, and objectives. MISTAR Q Forms (the electronic system that Wayne RESA uses) is programmed for compliance. Before staff can finalize and archive forms for documentation purposes, they must verify that the form is compliant. The support services are compliant when it reports the service delivery method, (Direct, Consultative, or Direct/Consultative) frequency, and duration and when the form identifies the plan goals and objectives of the service(s). In addition, Wayne RESA has internal audit processes for documentation and billing procedures. Throughout the school year, the Medicaid Reimbursement Office uses a random service audit to demonstrate Wayne RESA District/Academy School Services Program POC compliance.

Nursing Orders and Prescriptions: Identifies when nurses must develop and implement an Individualized Healthcare Plan (IHP). Per public health code and Medicaid rules, school nursing services are 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/IEPT/C4SP/etc.). Districts are reminded each year of the requirements for nursing services and Medicaid billing.

Physical Therapy Prescriptions: Required when the medical plan of care team lists direct physical therapy services in the student's medical plan of care (IEPT/IFSP). Under MARSE rules, "physical therapy" must be prescribed by a physician and provided by a state of Michigan licensed physical therapist under 1878 PA 368, MCL 333.1101 et seq. or a physical therapy assistant. PTs are reminded of the MARSE rules at the beginning, and throughout the school year. Each school year, the Medicaid reimbursement office reminds schools that prescriptions are required when PT, OT and O&M services are to be reported for Medicaid reimbursement and it is suggested that when students have a POC that list direct Physical and Occupational Therapy services, the family's prescription should include both services. Schools must obtain the PT prescription and provide copies to the Wayne RESA Medicaid Department annually.

Occupational Therapy and Orientation and Mobility Prescriptions: Required when the medical plan of care team lists occupational therapy or orientation and mobility services in a student's medical plan of care. 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 and O&M services are to be reported for Medicaid reimbursement. Schools must obtain the prescription and provide copies to the Wayne RESA Medicaid Department. If it's 30 days from the date of the POC and no OT or O&M prescription was obtained, the school should request help from Wayne RESA. The school will send the Wayne RESA Medicaid Reimbursement Office a copy of the student's POC and the student's most recent OT or O&M evaluation, not older than twelve months, for Wayne RESA to do so.

Speech, Language, and Hearing Referrals: 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.

Personal Care Authorizations: Required when a student's medical plan of care team indicates the need for assistance with daily living personal care services in the student's medical plan of care. In 2024, Wayne RESA updated the DSC Authorization for Medicaid Services to include personal care services. The authorization for personal care services is built into the medical plan of care form for the C4S program as well. Both forms are completed using MISTAR Q Forms.

As a best practice, Wayne RESA's Medicaid office regularly interrogates MISTAR Q Forms, Program Records, and Billing Application Data for up-to-date orders, prescriptions referrals, and authorizations.

C. 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 education services.

Medical Plans of Care help District staff, including designated case managers and direct service staff, oversee the appropriateness and effectiveness of physical and mental health services using progress monitoring and MISTAR Q Service Tracker claims that report when students require a change in treatment or status.

D. Billings are reviewed for accuracy.

Billing accuracy begins with MISTAR Q Service Tracker AKA the billing application for Wayne County District/Academy staff. Only District/Academy Direct Service, Designated Case Management, and Personal Care quarterly Staff Pool List staff can be:

- Assigned MISTAR Q Service Tracker permissions.
- Assigned to a policy-driven Medicaid faculty code.
    - Faculty codes restrict billing to the provider billable Medicaid codes, and they also identify the services that limited-licensed providers must provide under the supervision of or direction of a fully licensed provider.

Because MISTAR Q is the Wayne County Student Information System (SIS) the billing application lists information for the student's eligible program (C4S or DSC), personal care services, specialized transportation services, One-Time Consent, and medical plan of care service supports with delivery, frequency and duration and student attendance history.

Service Tracker's programmatic accuracy assures Wayne RESA submits billings with service times, group size, service and summary notes, frequency, and NPI orders/prescriptions/ referrals when they are required for the billing code. It also uses a frequency count feature and programmatic rules to prevent over-billing of a particular service.

In addition, the billing software is programmed to generate transportation claims to days when appropriate medical services were provided directly to a student.

To review for accuracy, Wayne RESA Medicaid Reimbursement Office regularly runs reports that check the validity of all the 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 Medicaid policy manual. In addition, every quarter, the RESA Medicaid office checks the licensure of all staff added to the Direct Service staff pool list for accuracy.

Staff qualifications are included on practitioner Tip Sheets. Tip sheets are provided at trainings, and they are available on the Wayne RESA Medicaid webpage. Attendees are asked to verify that they have the required qualifications before recording their services. Updates to the Tip Sheets and any changes in qualifications are communicated in a monthly "Medicaid Messenger" newsletter (which is sent to the districts for distribution to all staff involved in Medicaid reporting), posted on our website, district emails, and updates given 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 Medicaid 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.

The RESA Medicaid office 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 POCS with all 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/academies 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. When students require a C4S plan and service coordination, staff report the details for service coordination in the students care plan.

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 parental and student feedback on the SSP is monitored through case management. The SSP monitor has access to parent/guardian satisfaction through treatment and progress notes of case manager activities that discuss all health-related services. In addition, the parents of our Early On students are often active participants in the home therapy and classroom activities of our youngest populations. Our districts also encourage cooperation with outside agencies regarding the coordination of services. 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.

Wayne RESA's Medicaid Reimbursement Department provides districts/academies 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 to obtain their approval for billing Medicaid. Districts only need 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.

Wayne RESA has two processes for the One-Time Consent to Bill Medicaid requirement. The first lets school staff complete the *Medicaid One-Time Consent to Bill* form with the other MISTAR Q Programmed Special Education Forms like the REED, MET, IEPs, and IFSP. The second lets school staff track the student's Medicaid One-Time Consent to Bill status directly in the students Caring for Students Medical Plan of Care.

The Medicaid One-Time Consent and the Caring for Students Care Plans embedded section for Consent are both included in Wayne RESAs student data system known as MISTAR Q 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 in the system will cause any services entered for the student to be filtered out of the claim submissions.

Additional Reviews

Annual Record Review for the Direct Service Claiming Program:
Each year, the Medicaid Reimbursement Department conducts an internal records review of Medicaid services that checks for billing accuracy and compliance with state-approved claims. 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
- The documentation request includes:
    - The student's POC that covers the quarter in review
    - 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
    - Authorization for Medicaid Services form
    - Personal Care Authorization, if applicable
    - Monthly Personal Care Activity Log, if applicable
    - 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
        - POC identifies the medically necessary services to be provided and the service frequency, duration, goals, diagnosis, and objectives
        - The number of services rendered was within the frequencies/durations prescribed on the POC
        - Services rendered were prescribed on the POC (or were inherent in the program for center-based services)

- Student was in attendance on all dates for which direct services were billed per student attendance report
- MET and/or REED is within the last 3 years and covered services are medically necessary, as determined and documented through appropriate and objective testing, evaluation, and diagnosis
- Parental consent for Medicaid billing was obtained and filled out correctly
- Authorization for Medicaid Services form completed and signed by an authorized provider, which is contingent on the need for Personal Care Services
- Personal Care Authorization and Monthly Activity logs are filled out, signed, dated and services provided match
- Transportation logs are signed and dated by the bus driver/bus aide
- 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 qualifications meet current license, certification, and program requirements
- The corresponding Documentation of "under the direction of" and/or "supervision of" limited licensed staff was filled out and signed

- 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.

Annual Record Review for the Caring 4 Students Program:

Each year, the Medicaid Reimbursement Department conducts an internal records review of Medicaid services that checks for billing accuracy and compliance with state-approved claims. 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
- The documentation request includes:
  - The student's POC that covers the quarter in review
  - 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
  - Authorization for Medicaid Services form
  - Personal Care Authorization, if applicable
  - Monthly Personal Care Activity Log, 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
    - The number of services rendered was within the frequencies/durations prescribed on the POC
    - Prescriptions/referrals/authorizations were obtained for the reported services
    - Parental consent for Medicaid billing was obtained and filled out correctly
    - Authorization for Medicaid Services form completed and signed by an authorized provider, which is contingent on the need for Personal Care Services
    - Personal Care Authorization and Monthly Activity logs are filled out, signed, dated and services provided match
    - Clinician notes provided sufficient documentation to support the selected procedure code(s) and supervision where required
    - Staff met Medicaid qualifications to provide billed services
    - The corresponding Documentation of "under the direction of" and/or "supervision of" limited licensed staff was filled out and signed

- 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.

Annual Notes Review:

To monitor compliance with the quality controls outlined above, Wayne RESA conducts an annual clinician 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 1st – December 31st quarter
- Notes will be reviewed for content and exceptions are noted and reported to the appropriate local Special Education Director and staff
- 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

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

To monitor compliance with the quality controls outlined above, Wayne RESA conducts an annual review of costs submitted for Designated Case Managers and Personal Care Aides.
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 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

Random Moment Time Study Compliance Reports:

The RESA Medicaid office monitors the Public Consulting Group 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 5.1 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 and be directly attributable to staff that are included on the staff pool lists. 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 Services allowable costs are to include actual non-federal expenditures incurred during the claiming period. These allowable expenditures include such things as salaries, wages, fringe benefits, medically related supplies, purchased services and materials"

Caring 4 Students: The Medicaid Provider Manual, School-Services Program Section 5.1 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

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 Facility Settlement Reports 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 the reported accrued staff salaries/benefits, purchased services, and other reported expenditures tie directly to the staff on the pool. Reported costs will be compared to District/Academy SE-4096 and General Ledger reports.
- Verifying transportation data ties directly to SE buses by comparing the reported costs to district/academy SE-4094s and General Ledger Reports.
- Verifying that staff costs are directly related to their regular shifts
    - Excludes unallowable costs for payment for after school activities like coaching and working concessions.
- Verifying that expenditures are directly related to transportation to from schools
    - Excludes unallowable costs like transportation to field trips, supervisor costs, etc. and costs that aren't considered Medicaid reimbursable costs.

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. Prior to the final settlement, MDHHS identifies Districts/Academies that have costs that exceed the SE-4096 or SE-4094. District/Academies must verify their costs and if necessary, they will resubmit a revised report for the final settlement.