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Medicaid in Schools

November 17, 2020

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 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 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 Medicaid Certified School Match program is to provide reimbursement for medically necessary services provided by district employees or contractors by a school district to Medicaid-eligible students.

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, IFSP, behavior, nursing-but not limited to those)
- Policy is following the rule development process

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 4 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
 - Rate will continue through January 21, 2021
 - **Current Rate – 68.16%**



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Parental Consent and Annual Notification

Parental Consent and Notification

- Parental consent required one time
- Notification required annually
- FDOE legal 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-6A-6.03028(3)(q)1.d.

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, F.A.C.

Notification-6A-6.03028(3)(q)1.e.

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 enrolls as Medicaid provider and bills for services provided by school district or contracted health staff

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

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 [2019 Medicaid Certified School Match Program Fee Schedule](#)
- FDOE/Medicaid **DOES NOT** require any one billing/reimbursement system to be used.
 - FDOE service capture/billing system
 - Vendors
 - State Medicaid FLMMIS (Florida Medicaid Managed Information System)

FFS Relevant Federal Regulations

State Laws and Rules

- Title XIX of Social Security Act
- Chapter 59G, Florida Administrative Code (Medicaid)
- Title 42 of the Code of Federal Regulations
 - Part 440.110
 - Part 440.130
- Chapter 409, Florida Statutes (Medicaid)
 - 409.9071
- 1011.70, Florida Statutes

[Online Sunshine](#)

FFS Relevant Policy/Handbooks

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

[AHCA Adopted Rules](#)

Students Qualified for Certified Match

- Medicaid-eligible on date of service
- Under the age of 21
- Considered disabled under the State Board of Education state rule definitions
- Entitled to school district services under IDEA
- Medicaid reimbursable services referenced in individual educational plan (IEP) or individual family support plan (IFSP)
- 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: Diagnosis Code and Procedure Code

Diagnosis Code

- ICD-10 Codes (International Classification of Diseases): all diagnosis codes available to providers
- Diagnosis codes required for every service billing
- Some districts shared their commonly used codes: [Shared District Resources](#)

Procedure Code

- In handbook and in fee schedule [2019 Medicaid Certified School Match Program Fee Schedule](#)
- Correlate with the service type (i.e., 92508-group speech therapy session)

CODE BLUE

There are more than 155,000 codes in the new ICD-10 set. Lest one doubts the specificity encompassed in that vast trove of categorization, consider this calamitous day out at sea.

V93.32xA – Fall on board fishing boat

W16.722A – Jumping or diving from boat striking bottom causing other injury

W56.01xA – Bitten by dolphin

W56.02xA – Struck by dolphin

W56.09xA – Other contact with dolphin

W56.09xD – Other contact with dolphin, subsequent encounter

W56.09xS – Other contact with dolphin, sequela

W56.11xA – Bitten by sea lion

W56.21xA – Bitten by orca

W56.31xA – Bitten by other marine mammals

Audit Requirements

School district must maintain documentation records for a minimum of 5 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



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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 4 students
- *Note: If only one student in group when service performed, it is billable as a group of “1”, when group is indicated on the POC/IEP*

Therapy Service Providers

- Speech-Language Pathologists
- Speech-Language Pathology Assistants (*SLPA must work under supervision of licensed SLP and SLP must be physically present in the same facility to be available for consultation and direction*)
- Physical Therapists
- Physical Therapist Assistants (*Supervision does not have to be on site-however, PT must be accessible by two-way communication*)
- Occupational Therapists
- Occupational Therapy Assistants (*Supervision does not have to be on site-however, OT must be available for consultation*)

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 (individual or group)
 - Frequency, 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-4 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
 - 1 unit=minimum 15 minute
 - 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
- Must be documented within 2 days of service

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 2 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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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



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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 Services

- 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

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 limitation=4 one way trips per day
- Medical condition that requires special transportation environment
- Student must have specialized transportation on IEP 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

Medicaid Update: OIG Audit

- AHCA is undergoing a U.S. Department of Health and Human Services Office of the Inspector General (OIG) audit for the school-based fee for service program
- Audit currently covers the 16-17 school year
- As part of audit, OIG has requested (through AHCA) service documentation records from districts
- All districts required to submit documentation have been notified by AHCA
- The audit will test compliance with current policy

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

- Additional telemedicine guidance received from AHCA on April 23, 2020

[Medicaid School-Based Behavioral Health Procedure Codes](#)

- For dates of service on or after January 1, 2020, all enrolled school districts, private schools, and charter schools may bill using the behavioral health codes listed on the 2019 fee schedule

Telemedicine Guidance

- Updated FAQ received from AHCA on:
 - May 22, 2020
 - Allowed for reimbursement of audio only behavior services
 - 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.
- Passed on March 12, 2020
- Approved by the Governor June 23, 2020
- 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 February 5, 2020?
- Are there any updates regarding the FFS federal audit?



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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

School District Administrative Claiming (SDAC)

- Policy Handbook can be found at [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
 - Department of Education EMACS system
 - 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- Random Moment Sampling (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

Fee for Service

- Review staff that are billing
- Review payment source of salaries/benefits-make sure not 100% federally funded
- Monitor billing
- Run Medicaid eligibility checks monthly
- Follow up on denied claims
- Review and understand the remittance advice received from AHCA

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?

SDAC

- Review district positions to make certain all that are performing claimable administrative activities are included on roster/sample pool listing
- Make certain all costs are being claimed on the back end of the process
- Compare roster at beginning of quarter to the personnel whose costs are listed on the claim
 - Look for staff who might have left and include the costs of their direct replacement
 - Understand what goes into the claim if you are not involved with the claim generation



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Florida Medicaid Information at AHCA Website

[Florida Medicaid](#)

[Medicaid Rules](#)



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Medicaid Health Care Alerts

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FDOE Can Help!

FDOE Products to Assist You

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

FDOE Contact Information

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Medicaid in Schools Website

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



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State Medicaid Agency Monitoring

Medicaid Certified School Match (MCSM)

- 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 (SDAC)

- 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 Random Moment Samples (RMS).