West Virginia Department of EDUCATION

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To: County Superintendents, County Special Education Directors, and County Chief School Business Officials

From: Pat Homberg, Executive Director of the Office of Special Programs PH
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Date: April 28, 2015

Subject: Medicaid School-Based Health Services

As you are aware, WVDE has been working with the West Virginia Department of Health and Human Resources (DHHR) since 2012 regarding changes to the Medicaid billing process. The School-Based Health Services State Plan Amendment (SPA) was approved by the federal Centers for Medicare and Medicaid Services (CMS) in November 2014 with an effective date of July 1, 2014. The biggest conceptual change as the result of the SPA is the annual cost settlement process that will be performed beginning with the 2014-15 school year. The cost settlement will compare each county's computed actual cost for performing the Medicaid eligible services based on the Random Moment Time Study (RMTS) results against the Fee-for-Service billing paid for services rendered during the fiscal year.

As WVDE has worked with DHHR to implement the changes contained in the SPA, there have been some changes already made during the current school year. However, there are many additional changes that are still upcoming. The detailed information outlined below is presented in separate sections to highlight the various changes and clarify what changes have already been implemented during the 2014-15 school year versus upcoming changes for the 2015-16 school year.

Targeted Case Management Fee-for-Service Billing Change (Effective 2014-15):

As the result of the final approval of the State Plan by CMS, there was a fee-for-service billing change from one monthly unit of Care Coordination per student to multiple fifteen minute units for Targeted Case Management (TCM) per student. If you review the differences in the billing rates, approximately seven units of TCM equals the one monthly unit of Care Coordination. However, the number of TCM units performed for each Medicaid eligible student will vary depending on the needs of the student. Some students will require less than seven units and other may require more**. LEAs cannot instruct their staff performing the TCM services that they are required to bill at least 7 units of TCM per month.** DHHR would consider that to be fraud and it would be a clear red flag to Medicaid auditors. Further, even though seven units of TCM would provide the same amount of fee-for-service billing as the one monthly unit we previously billed, our ultimate level of reimbursement for the service will be based on the annual cost settlement and our actual cost of performing the services per the RMTS. The allowable response rate for TCM has typically been low (approximately 2% to 3%) based on prior RMTS results, so the actual cost calculated on the cost report will likely be less than the amount billed through the fee-for-service billing, resulting in a payback to DHHR for the TCM cost pool.

Specialized Transportation Fee-for-Service Billing Change (Effective 2014-15):

The final approved state plan also necessitated a fee-for-service billing change related to specialized transportation. Previously, LEAs were able to bill for daily roundtrip specialized transportation so long as the Medicaid eligible student rode the bus in both the morning and the afternoon. **Effective for the 2014-15 school year, LEAs can bill for specialized transportation ONLY on days where another Medicaid eligible service is provided to the student (ex: Speech, OT, PT, TCM, etc.).** This change has had a significant negative financial impact for LEAs since the number of days for which specialized transportation can be billed per student decreased drastically. Although specialized transportation revenues are down, the billing process for specialized transportation is more complicated. The billing specialists have to match the transportation logs with the other Medicaid eligible services provided to each student to determine which days they can actually bill for specialized transportation. The billing is now based on one-way trips instead of roundtrips, which is actually beneficial because we can receive some reimbursement for days in which students have an alternate means of transportation to or from school. In addition, some RESAs have opted to take a conservative approach and wait until the other Medicaid eligible service claim is approved and processed by BMS before billing for specialized transportation for that date in order to reduce the number of claim denials for specialized transportation. While this approach will result in fewer denied and/or resubmitted claims, it also results in a delay in billing for specialized transportation which impacts the timing of the reimbursement from BMS.

Potential Sanctions for RMTS Response Rates Under 85% (Upcoming Change)

Although the general cost report methodology has already been approved by the federal Centers for Medicare and Medicaid Services (CMS), the West Virginia Department of Health and Human Resources (DHHR) is still negotiating the approval of a time study implementation guide which outlines the specific details. The WVDE Office of School Finance has reviewed a draft of the implementation guide and submitted a substantial list of questions/comments to DHHR.One significant new change in the draft time study implementation guide is in regards to potential sanctions if each LEA does not meet the minimum RMTS response rate of 85%. While DHHR had initially included quarterly sanctions for failure to meet the minimum response rate, CMS is pushing for sanctions lasting 12 months. If CMS prevails and the sanctions included in the final time study implementation guide are for 12 months, any county with a response rate of less than 85% will be prohibited from billing Medicaid for a period of 12 months most likely beginning with the first day of the following quarter. While DHHR is going to try to limit the sanctions to only the pool where the response rate is less than 85%, they are not certain that CMS will agree. Although this issue does not yet have a final resolution, **it is important that LEAs closely monitor their RMTS response rates for the remainder of the 2014-15 school year to ensure they do not drop below 85%.** CMS

is also requiring DHHR to increase the number of moments for each cost pool beginning in the 2016-17 year, which will make the achievement of the 85% response rate even more difficult to achieve.

Fee-for-Service Billing (Upcoming Change)

In addition to changes related to the time study/cost report, there will be significant changes related to the Fee-for-Service Medicaid billing as well. The WVDE Offices of Special Programs and School Finance have been working closely with DHHR's Bureau for Medical Services (BMS) on a School-Based Health Services Policy Manual which will detail each Medicaid covered service, the associated billing codes, the required qualifications of the individuals performing the service, etc. The goal is for this policy manual to be placed on public comment by BMS by May 20, 2015 with an effective date of at least August 1, 2015. This policy manual will be a valuable resource for LEAs once finalized. **Until the policy manual has been finalized by BMS after the public comment period, LEAs should not be making changes to their current procedures/documentation based on the draft manual unless specifically instructed to do so by WVDE.**

Throughout the development of this draft policy manual, WVDE and BMS have been consulting with the RESA billing specialists, county Special Education Directors, and other LEA staff for content level expertise. We have received reports that incomplete draft information is being passed back to the LEAs which is resulting in confusion among the various parties. BMS will provide detailed training on the policy manual once it is finalized. **Separate webinars will be provided for each category of Medicaid covered services (ex: Speech, Targeted Case Management, Personal Care Services, Nursing, etc.).** This will allow the individual service providers to access the training materials online prior to the start of the 2015-16 school year. **In addition, BMS plans to provide in person training for RESA billing personnel prior to the beginning of the school year.** Information regarding all available training opportunities will be provided upon finalization.

As a general reminder, all of the Medicaid billing changes are the result of federally mandated changes. DHHR did not seek to make these changes – CMS required them. DHHR recognizes that these changes are significant to LEAs and are attempting to make things as simple as possible whenever the federal regulations allow.

If you have questions regarding the Medicaid changes, please contact Jeremy Brunty, Coordinator from the Office of Special Programs at 304-558-2696 or Jeremy.brunty@k12.wv.us or Amy Willard, Executive Director of School Finance at 304-558-6300 or awillard@k12.wv.us.