# Medicaid Update

Presented by Amy Willard, CPA

*7/17/18*

## April – June 2018 Quarterly Cost Reports

- The cost report window for the April-June 2018 Quarterly Medicaid cost report opened Friday, July 6, 2018.
- The due date for the quarterly cost report will be August 21, 2018.

# FY17 Cost Settlements – Expected Timeline

| SFY17 Cost Settlement | | | | |
|---|---|---|---|---|
| | **Task** | Responsible Party | Est. Start | Est. End |
| 1 | Review Cost Settlement Summary Template | DHHR/BMS and WVDE | 7/16/2018 | 7/20/2018 |
| 2 | Review and Revise Cost Settlements and Data, if necessary | PCG | 7/23/2018 | 7/27/2018 |
| 3 | Release Settlement and CPE Forms to LEAs | PCG | 7/30/2018 | 7/30/2018 |
| 4 | Review, Sign and Submit CPE Forms to PCG | LEAs | 7/30/2018 | 8/10/2018 |
| 5 | CPE Form Submission Deadline | LEAs | 8/10/2018 | 8/10/2018 |
| 6 | Compile Submitted CPE Forms | PCG | 8/13/2018 | 8/14/2018 |
| 7 | Process Payments | DHHR/BMS | 8/15/2018 | 8/30/2018 |
| 8 | Send Notification Letters | DHHR/BMS | 8/31/2018 | 8/31/2018 |

# CPE Sample Form

Annual CPE Form | Page 1 of 1

Certification of Public Expenditures for State of West Virginia Annual Medicaid Cost Report

**LEA Name:** RESA 1/Mercer County

**National Provider Identification (NPI):**
**Medicaid Provider Number:**

This statement of expenditures that the undersigned certifies are allocable and allowable to the State Medicaid program under Title XIX of the Social Security Act (the Act), and in accordance with all procedures, instruction and guidance issued by the single state agency and in effect during the state fiscal year. **Complete Section II and sign and date below. The form must be submitted with your claim.**

HEREBY CERTIFY that for the reporting period: From: Jul 01, 2014 To: Jun 30, 2015

**Section I:**

1. Total Expenditures $3,836,886.57
2. Total Medicaid Expenditures $589,569.25
3. Medicaid Interim Payments $471,468.94
4. Medicaid Cost Settlement (Line 2 minus Line 3) $118,100.31

**Section II:**
**LEA Financial Account Code**
The expenditures identified above as the match for the federal funds received from Medicaid are drawn from the following approved local account (s):

**CERTIFICATION STATEMENT BY OFFICER OF THE PROVIDER**
**INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED HEREIN MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.**

1. All expenditures presented should be allowable in accordance with federal and the State Plan agreement requirements.
2. I have examined this statement, the accompanying supported exhibits, the allocation of expenses and services, and the worksheets for the above indicated reporting period and to the best of my knowledge and believe they are true and correct statements prepared from our books and records in accordance with applicable instructions.
3. The expenditures included in this statement are based on the actual cost recorded expenditures.
4. The required amount of state and/or local funds were available and used to pay for total computable allowable expenditures included in this statement, and such state and/or local funds were in accordance with all applicable federal requirements for the non-federal share match of expenditures, including that the funds were not Federal funds in origin, or are Federal funds authorized by Federal law to be used to match other Federal funds, and that the claimed expenditures were not used to meet matching requirements under other Federally funded programs.
5. Federal matching funds are being claimed on this report in accordance with the cost report instructions provided by the West Virginia Department of Public Welfare effective for the above indicated reporting period.
6. I am the officer authorized by the referenced government agency to submit this form and I have made a good faith effort to assure that all information reported is true and accurate.
7. I understand that this information will be used as a basis for claims for Federal funds, and possibly State funds, and that a falsification and concealment of a material fact may be prosecuted under Federal or State civil or criminal law.

Signature of Signer (CEO, CFO, or Superintendent) | Title of Signer | Date

Joy Hubbard
Printed/Typed Name of Signer | Address of Signer (street or P.O. Box, city, state, 5-digit zip)

304-431-1229
Contact Phone Number | Fax Number | Email Address

https://claimingsystem.pcgus.com/wv/AnnualCPEForms?sessionId=d2e7078f-936b-45bb-b919-4ffabf06... 12/20/2016

## SB 231 – Medicaid Legislation

Senate Bill 231 became effective on July 1, 2017. This legislation provides flexibility to county boards of education regarding billing for Medicaid services. The legislation states the following under WVC §18-2-5b:

(b) The state board may delegate this provider status and subsequent reimbursement to regional education service agencies, county boards or both: *Provided*, That a county board is not required to seek reimbursement if it determines there is not a net benefit after consideration of costs and time involved with seeking the reimbursement for eligible services and that the billing process detracts from the educational program.

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## SB 231 – Cost Benefit Analysis

Before a county board of education makes a determination that they will discontinue Medicaid billing, a cost benefit analysis must be performed in order to ascertain that there is no net benefit to the county.

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## SB 231 – Cost Benefit Analysis

- County boards of education are not required by SB 231 to share copies of their cost benefit analysis with the WVDE Office of School Finance, but they are encouraged to do so in order for OSF to help review for completeness/accuracy and to confirm the conclusion reached.
- County boards MUST retain a copy of the cost benefit analysis for their records in the event that the county's determination to stop billing is questioned in the future by the Legislature, CMS, etc.

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## SB 231 – Other Reminders

- If a county board of education performs a cost benefit analysis and determines that they are going to stop billing for Medicaid altogether or stop billing for particular Medicaid services, the county must not include individual providers on the RMTS for those services in the next available quarter.
- If a roster as has already been submitted for the upcoming quarter at the time a determination is made to stop billing for a particular service, changes cannot be made to the quarterly RMTS after the deadline has passed for the particular quarter.
- All employees originally included on the roster will be expected to continue their participation in the RMTS for that quarter and to respond to all moments received from PCG.
- Failure to respond to moments will impact the overall response rate for the State as a whole for the cost pool in which the employee was included, which could unfairly penalize other county boards of education.

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## SB 231 – Other Reminders Cont'd

- If a county stops billing on the fee-for-service side for particular services, no costs should be claimed on the quarterly or annual cost reports even if the employees must continue to respond to moments due to the timing of when the decision to stop billing was made.
- Because the employees are still participating in the RMTS for the quarter, county boards could also choose to continue billing fee-for-service for the remainder of the quarter and claim those costs on the quarterly and annual cost reports.
- Rule of Thumb:
  - If you stop billing fee-for-service for a particular service type, you aren't entitled to claim costs for those services on the cost report.

## SB 231 – Unintended Consequences

An unintended consequence of dropping out of the Medicaid billing process is that the employees of county boards who remain in the RMTS each quarter will receive more random moments. There are a set number of moments required statewide in order to have a valid sample size, so having fewer participants in the RMTS pool means that each remaining employee will receive more moments.

## Cost Implementation Guide

- The Centers for Medicare and Medicaid Services (CMS) have approved the "Time Study Implementation Guide & School Based Health Services Process Guide for Direct Services and Medicaid Administrative Claiming."
- CMS has indicated that a letter dated April 24, 2017 was their official approval of the Implementation Guide.
- It was not clear that the letter was approval of the full Implementation Guide. It appeared to DHHR to simply be an approval of their request to continue with a 24-hour advance notification to time study participants and have a three business day response period.

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## MAC Claiming

- DHHR received a letter from CMS dated April 27, 2018 acknowledging that both the State Plan Amendment and Implementation Guide were initially submitted on September 12, 2012 and granting special permission for West Virginia to use the effective date of the State Plan Amendment, which was July 1, 2014, as the effective date for MAC Claiming.

- However, in an email from CMS transmitting the letter to DHHR on April 30, 2018, CMS indicated that "due to the delay of roughly one year since the approval of the MAC Implementation, WV should be aware that earlier periods are now two year time-barred in the absence of a Good Cause Waiver."

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## MAC Claiming

- The April 30th email means that MAC claims from quarters prior to April-June 2016 cannot be paid by DHHR unless CMS approves a Good Cause Waiver for why those quarters weren't submitted for payment earlier.
- DHHR has circulated drafts of the Good Cause Waiver request with WVDE and PCG. They hope to have the Good Cause Waiver request submitted to CMS within the next few weeks.
- While awaiting approval from CMS on the waiver, DHHR and PCG will begin processing the quarterly MAC claims subsequent to the April-June 2016 quarter that was processed in the last few days of June 2018. They hope to have those MAC claims caught up within the next calendar quarter.
- Processing MAC claims may involve desk reviews of some of the quarterly cost reports by PCG and all quarters will require submission of the CPE form.

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## Other CMS Requirements

- As part of the CMS approval of the Implementation Guide, DHHR must submit updates to CMS regarding response times from LEAs to the RMTS. DHHR and PCG are gathering that required information and will submit it to CMS at the same time as the Good Cause Waiver.
- We hope that CMS will continue to approve the 24-hour advance notification and 3-day response window based on the data provided, but their standard policy is no advanced notification and a 2-day response window.

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