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Medicaid Overview for LEAs & Update on Current Payments

Presented by:
Lori Elliott, CPA

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Fee-For-Service Billing

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Fee for Service Billing

- Fee-for-Service Billing guidelines can be found at the link below. The link is for Chapter 538 of the West Virginia Department of Health & Human Resources (DHHR), Bureau for Medical Services (BMS) Provider Manual. Chapter 538 applies to School-Based Health Services (SBHS). There are other, more general chapters of the Provider Manual that schools must follow as well, including Chapters 100, 200, 300, and 800. (NO new updates or changes since Aug 1, 2019)

  https://dhhr.wv.gov/bms/Pages/Chapter-538-School-Based-Health-Services.aspx

Fee for Service Billing

- Chapter 538 outlines specific requirements, including but not limited to the following:
  - Provider enrollment
  - Provider exclusions to rendering services
  - Provider reviews/audits
  - Administrative requirements
  - Telehealth
  - Documentation (including Sample Billing Forms)
  - Specific information regarding each billable service allowed under the SPA (state plan amendment) for SBHS:
    - Procedure Codes
    - Service Units (ex: event, number of minutes, etc.)
    - Whether Telehealth is available for the service
    - Service Limits (max number of times a service can be billed per eligible student)

Fee for Service Billing

- The fee-for-service billing side of Medicaid is normally handled by the county Special Education Department.
- Individual service providers (nurses, speech therapists, etc.) complete the required billing paperwork on the appropriate forms and turn in the paperwork to the Special Education Department.
- The paperwork is generally reviewed to ensure completeness, appropriate signatures, etc.
- Once all paperwork is determined to be in order, the paperwork is typically forwarded to the Medicaid Billing Specialist who completes the billing process via the Molina billing system from DHHR.
- Some county boards of education do their own Medicaid billing, while other counties utilize a Medicaid Billing Specialist through an Educational Services Cooperative (ESC).

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Fee for Service Billing

- It is important to remember that all fee-for-service Medicaid claims must be submitted via Molina no later than one year from the date of service in accordance with federal regulations.
- Corrections and other adjustments can be made after the one-year time limit, but the initial claim deadline must be met for the claim to be considered.
- It is important that fee-for-service billing be submitted throughout the school year instead of waiting until the end of the year.
- **In order to receive a cost settlement, fee-for-service billing must continue to be submitted. It is not permissible to simply complete the cost report without also performing the required fee-for-service billing.**

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Random Moment Time Study (RMTS)

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Random Moment Time Study (RMTS)

- Quarterly, each county must develop a staff pool list (SPL) for participation in the statewide random moment time study (RMTS).
- Currently, the RMTS is only performed for the Oct-Dec, Jan-Mar and Apr-Jun quarters. No RMTS is performed for Jul-Sep.
- **A July-Sept quarter roster is maintained, even though a time study is not completed for that quarter.**

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Random Moment Time Study (RMTS)

- **No new positions can be added for the July-Sept roster.**
- When certifying the July-Sept quarter, you can certify any known vacant positions which have been filled or any replacements which can be made for existing positions.
- **No costs can be claimed for July-September on the quarterly or annual cost reports for any individual not included and certified on the July-September rosters.**

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Random Moment Time Study (RMTS)

- The SPL should include all staff who perform Medicaid eligible services but who are not 100% federally funded. The SPL should NOT be limited to only those who work directly with Medicaid-eligible students; it should be based on the services the individuals are performing.
- **CSBOs are encouraged to review the SPL developed by the Special Education Director to ensure all applicable staff have been included and that 100% federally funded staff are excluded from the roster.**
- Independent contractors utilized by a county board of education are not required to participate in the RMTS.

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Random Moment Time Study (RMTS)

- Once the SPLs are set for the quarter and the quarter begins, individuals periodically receive emails from DHHR's contractor, PCG, asking specifically what they were doing at a particular moment in time (i.e. at 9:52 am on October 2nd).
- There is no advance notice of when an individual may receive a moment. The individual will receive an email notification regarding the moment at the exact time of the moment. They are then given a 2-day (48 hour) window in which to respond to the "moment" indicating exactly what they were doing at the specified time.

Random Moment Time Study (RMTS)

- Based on the responses provided by the RMTS participants, PCG calculates what percentage of time is spent performing Medicaid allowable services for each cost pool.
- These percentages are utilized in the cost settlement calculation – they are multiplied by the salaries of the individuals reported on the annual cost report based on the applicable cost pool.
- This is intended to determine what portion of the salaries are related to Medicaid-eligible services.

RMTS Best Practices

- Please remember to monitor your compliance percentage for each of your cost pools. Each staff pool must answer at least 2,401 valid working moments. If the statewide response is less than 85%, BMS will send out a non-compliance warning letter for each county that didn't hit the 85% requirement.

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Annual Cost Settlement Process

- The annual Medicaid cost report is designed to calculate the actual cost of performing Medicaid-eligible services as reported by the LEAs.
- The actual cost of performing services per the annual cost report is compared to the fee-for-service interim payments received throughout the year for the same dates of service.
- If the actual cost of performing services exceeds the fee-for-service interim payments received, DHHR will owe the LEA additional funding to make up the difference.
- If the actual cost of performing services is less than the fee-for-service interim payments received, the LEA will owe DHHR the difference.

Annual Cost Settlement Example Results

The following example outlines the final cost settlement results for three LEAs and how to interpret the results.

- **LEA A, LEA B and LEA C**, have the same amount of NET Medicaid Allowable cost, in this example, **$100** each, as determined through the annual cost report.

	Net Medicaid Allowable Costs	Net Medicaid Interim FFS Payments	Cost Settlement
LEA A	$100	$75	$25
LEA B	$100	$50	$50
LEA C	$100	$125	-$25

- The **total reimbursement for all three LEAs is $100** based on the calculation of their NET Medicaid Allowable Costs through the Medicaid cost report.
  - **LEA A** receives $75 through Medicaid Interim Payments for FFS claims plus $25 through Cost Settlement
  - **LEA B** receives $50 through Medicaid Interim Payments for FFS claims plus $50 through Cost Settlement
  - **LEA C** receives $125 through Medicaid Interim Payments for FFS claims minus $25 through Cost Settlement

Annual Cost Settlements: LEA owes DHHR

In situations where a county board of education cost settlement shows they owe funds back to DHHR, there will be multiple payback options available. County boards will be able to choose from the following:

- Write a check for the full amount
- Have the payback amount withheld from future claims
- Enter into a 12-month repayment plan (which has the potential to be extended under certain circumstances).

Annual Cost Settlement Process

- Quarterly Random Moment Time Studies for three cost pools:
  - Direct Services (Nursing, Speech Therapy, Occupational Therapy, Physical Therapy, Psychological Services, etc.)
  - Personal Care Services (normally one-on-one or classroom aides)
  - Target Case Management (normally special education teachers)

    **Note that there is also an Administrative Cost Pool utilized for MAC Claiming instead of the Annual Cost Settlement Process.

- Calculation of various ratios:
  - IEP ratio for each of the three cost pools
  - Specialized Transportation ratio
  - One-Way Trip ratio

IEP Ratio

- An IEP ratio is calculated as follows for each cost pool:

  Number of Medicaid-eligible Students with Services (Direct, Personal Care or TCM) in their IEP

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  Total Number of Students with Services (Direct, Personal Care or TCM) in their IEP

- The IEP ratio for each cost pool is used in the cost settlement process. The ratio is applied to the salaries that were determined to be associated with Medicaid-eligible services to determine what portion of the salaries were actually spent working with Medicaid-eligible students.

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Specialized Transportation Ratio

- The specialized transportation ratio is calculated as follows:

  Total Number of Medicaid-eligible students with specialized transportation in their IEP

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  Total Number of Students Who Ride the Bus

- This ratio is applied to the total non-specialized transportation costs reported on the annual cost report to determine the portion of those transportation costs associated with Medicaid-eligible students receiving specialized transportation services.

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One-Way Trip Ratio

- The one-way trip ratio is calculated as follows:

$$\frac{\text{Total Number of Medicaid Paid Trips}}{\text{Total Number of Trips for Medicaid Eligible Students Receiving Specialized Transportation}}$$

- This ratio is applied to both the non-specialized transportation and specialized transportation costs reported on the annual cost report. It reduces the transportation costs to the cost to provide specialized transportation on dates when Medicaid students are receiving other Medicaid-eligible services.

Annual Cost Report

- The annual cost report is generally performed within 6 months of the end of the fiscal year (due December 31st).

- The cost reported is prepared electronically through the PCG website.

- The annual cost report is prepared using the **accrual** basis of accounting, which means that adjustments must be made to allocate wages throughout the year for those individuals with 200-day contracts who elect to have 24 pays instead of 20 pays during the year.

Annual Cost Report

- Once the appropriate total salary amount is determined from the sequel queries, there is a template that helps spread the salary costs by calendar quarter based on the number of working days in each quarter. This is needed because there are instances where individuals are only reported for a portion of the school year.

- Although no RMTS is performed for the July-September quarter, county boards of education are required to maintain a SPL for that quarter (which is based on the previous April – June quarter and updated for changes in staffing). Costs will be claimed for the July – September quarter based only on the individuals included on the SPL. **It is very important that counties update and maintain that quarterly SPL for all staffing changes that take place over the summer.**

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Medicaid Administrative Claiming (MAC)

Quarterly Medicaid Cost Reports and Medicaid Administrative Claiming (MAC)

- Medicaid Administrative Claiming (MAC) is a separate revenue source from the annual cost settlement process.
- MAC funding is based on the submission of a quarterly Medicaid cost report.
- PCG uses the responses from the RMTS for the Administrative Cost Pool to determine the portion of administrator time spent doing activities such as Medicaid outreach. PCG also determines an administrative percentage for the other three main cost pools based on the RMTS responses provided.

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Quarterly Medicaid Cost Reports and Medicaid Administrative Claiming (MAC)

- Medicaid Billing Specialists:
  - Administrative Contractor Costs are allowable on the Medicaid Administrative Claim (MAC)/Quarterly Cost Report for Medicaid billing specialists.
  - Even though they may not be employees of the county board of education, they need to be included on the LEA's RMTS administrative staff pool list and be eligible to receive moments during the time study.

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Quarterly Medicaid Cost Reports

- The Quarterly Medicaid Cost Reports are submitted for all quarters (including the July-September quarter).
- The Quarterly Cost Reports are calculated on the **cash** basis of accounting (instead of the accrual basis like the annual cost report).
- This means that the deferred pays all show up in the Apr-June quarter like they do in the WVEIS system and no spreading of the salaries to the remainder of the year is needed.
- Sequel queries have also been developed for the quarterly cost reports. The two options are very similar to the ones developed for the annual cost reports.

Quarterly Medicaid Cost Reports

- Quarterly Medicaid Cost Reports are generally due 45 days from the end of the quarter.
- They are prepared electronically in the PCG website. Certification of Public Expenditures (CPE forms) are completed electronically in the system, too.
- MAC Invoices are sent to DHHR quarterly for payment.

Annual vs Quarterly

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Differences between the Annual and Quarterly Reports

Annual Medicaid Cost Report

- Costs associated with direct medical services and specialized transportation only
- Accrual accounting
- Cost report tied directly to the interim revenue that an LEA receives through Medicaid billing for SBHS services.

Quarterly Financials

- Costs associated with Medicaid Administrative Claiming (MAC)
- Includes direct service staff, support staff, and administrative staff
- Cash Accounting
- Cost report provides a revenue stream IN ADDITION to funding for provision of direct medical services

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Differences between the Annual and Quarterly Settlement Process

Annual Medicaid Settlement Process

- No invoices – the annual cost settlements are paid through the fee-for-service claiming system
- Results in a Direct Medicaid Services Claim

Quarterly Settlement Process

- Invoices initialed and emailed to DHHR and paid through the Auditor's Office
- Results in a Medicaid Administrative Claim (MAC)

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Medicaid Legislation

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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 decides 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

- While there may be some county boards that desire to stop participating in the Medicaid program altogether, based on the allowable Medicaid costs from past cost settlements, it is unlikely that a county would be able to show that there was no net cost benefit to the county as a whole. In addition, the statute requires that the billing process must "detract from the educational program," which would be difficult to argue for certain Medicaid-eligible services.
- A more likely scenario is that county boards of education will look at specific Medicaid services which could be argued to detract from the educational program, such as Targeted Case Management and Personal Care, to see if there is a net cost benefit for those services.

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Current Status of Payments

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FY22 Annual Cost Report & Quarterly MAC Payments

- FY22: Annual cost settlement paid in June for a statewide total of $22,942,686 (payments posted on/around June 28th)

- Quarterly MAC payments
  - July – Sept 2021 – PAID in April 2023
  - Oct – Dec 2021 – PAID in December 2022
  - Jan – Mar 2022 – PAID in April 2023
  - Apr – June 2022 – Scheduled to be paid in July 2023

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FY23 Quarterly Cost Reports

- July – Sept 2022 – Certified, CPE forms should be ready in August
- Oct – Dec 2022 – CPE forms collected in June
- Jan – Mar 2023 – Certified, going through desk reviews now
- Apr – June 2023 – With counties to be certified now – DUE Aug 18th

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FY24 Calendar

- Quarterly Financial Submission Dates (Tentative)
  - July – Sept 2023 – Opens: Oct 2, 2023; Closes: Nov 10, 2023
  - Oct – Dec 2023 – Opens: Jan 2, 2024; Closes: Feb 9, 2024
  - Jan – Mar 2024 – Opens: Apr 1, 2024; Closes: May 10, 2024
  - Apr – June 2024 – Opens: July 1, 2024; Closes: Aug 9, 2024

- RMTS Staff Pool List/Calendar Certification Dates
  - Oct – Dec 2023 – Opens: July 31, 2023; Closes: Sept 1, 2023
  - Jan – Mar 2024 – Opens: Oct 30, 2023; Closes: Dec 1, 2023
  - Apr – June 2024 – Opens: Jan 29, 2024; Closes: Mar 1, 2024

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Medicaid Deadlines

- **It is very important to meet the Medicaid deadlines!**

- **Consequences include:**

  - **County being left out of a quarterly claim because they didn't certify the quarterly financials before the deadline**

  - **County must pay back money received for interim payments because they don't submit the annual cost settlement on time**

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One Last Note….

- PCG plans to enable Multi-Factor Authentication (MFA) on/around Aug 22, 2023
  - They will send a user guide about MFA to all claiming system users
  - Will NOT impact RMTS participants responding to moments

Thank You!

Lori.Elliott@k12.wv.us

304-558-6300, ext. 1