# **Medicaid 101 Module 4: For LEA Clinical Leadership**

## **Title Slide 1: Medicaid 101: For LEA Clinical Leadership**

Welcome to the Medicaid one oh one [101] training series developed in partnership between MassHealth and the University of Massachusetts Medical School. This module is designed for Local Education Agency or L-E-A clinical leadership.

## **Slide 2: Distributed April 2021**

This training was distributed in April of twenty twenty-one [2021] and was accurate at the time of distribution. As always, Local Education Agencies are responsible for reviewing information on the School-Based Medicaid Program website, found at mass dot gov slash MassHealth slash schools [https://www.mass.gov/masshealth/schools], to determine whether subsequent guidance has superseded any content shared here. MassHealth plans to update these trainings periodically as needed.

## **Slide 3: Introduction to Medicaid 101 Training Series**

So, the Medicaid one oh one [101] training series is really designed to provide basic essentials to understanding the School-Based Medicaid Program. I’ll probably refer to that as S-B-M-P throughout the training. Some modules are broadly designed for a general audience. Other modules are very targeted to the learning needs of a specific audience.

I’m not going to go through and read what all the modules are, but, you know, they’re for your reference. There might be other modules in the series that are of interest to you, so think about making sure you check it out when it is posted on the website.

## **Slide 4: Introduction to Medicaid 101 Training Series**

And this is just the remainder of the modules in the series. The total of the nine modules are shown here.

## **Slide 5: Training Agenda**

So, here is today’s training agenda. Please note we’ve sort of written and designed this module assuming that you’ve already reviewed the introductory module to the Medicaid one oh one [101] series. I think most people attending today have done so. So, this agenda really builds upon that background knowledge, but if you did not access the introductory module, don’t worry. I think everything here is at a sufficient level that you will be able to follow and understand just fine. But, of course, we’ll answer questions if helpful as well. So, our agenda:

* We’re going to cover the training objectives,
* Talk about your contribution to your L-E-A’s Medicaid team,
* Explain the Clinical Leadership role,
* Provide an overview of Direct Services Claiming requirements,
* Discuss how clinical leadership applies to:
  + Medicaid compliance,
  + The Medicaid billing process,
  + And staff training.
* Review some next training steps,
* And we’ll provide you with some contact information and other resources.

## **Slide 6: Training Objectives**

So, by the conclusion of this training, we hope that you will:

* Understand the components of the Direct Services reimbursement program.
* Understand why involvement from clinical leadership is important to the success of the program.
* And take away ideas about focused areas for clinical leaders to maybe review current practices and processes, evaluate opportunities where your L-E-A can improve.

So, just to note that, you know, this training is at that introductory one oh one [101] level for the most part. That was the design. So, participants are going to get an overall description of concepts and processes in trying to help you build foundational knowledge, but the training is not going to provide all the details that clinical staff and leadership need to know about the Direct Service program requirements. So, you’re definitely going to want to plan to review additional resources and training opportunities. We’ll introduce those towards the end of the training.

## **Slide 7: Your Contribution to your LEA’s Medicaid Team**

So, as a clinical leader, your contribution to your L-E-A’s Medicaid team is extremely important. Successful participation in the S-B-M-P requires coordination and collaboration among people in a wide variety of roles responsible for managing these key pieces of the Medicaid program.

Your role as a clinical leader is key to the success of your Medicaid team, particularly relative to the Direct Service reimbursement portion of the S-B-M-P. This module is going to touch on all the areas where clinical leadership involvement in the program can really make a difference, and there are other modules in this training series designed for all of these other roles on the Medicaid team. So, if there are other roles and other pieces of interest to you, certainly access some of those other modules as well.

## **Slide 8: Clinical Leadership Role**

So, the Clinical Leadership role for L-E-As who participate in the Direct Medical Services reimbursement portion of the S-B-M-P program, identifying clinical leaders really is a key to success to ensure that all requirements for reimbursement are met and that opportunities for reimbursement are recognized and pursued.

Clinical Leadership will be a key to successful participation in the Medicaid program, particularly in the following areas:

* Compliance with Medicaid program requirements,
* Providing valuable Clinical perspective and support for the Medicaid billing process,
* Staff training - particularly clinical training for L-E-A procedures around documentation of plans of care and service delivery to be consistent with clinical standards of practice,
* And integrating clinical perspectives and best practices within an educational landscape and competing priorities.

The most successful school districts, in terms of their Medicaid reimbursement program, have a clinical leader or leaders who translate Medicaid requirements, implement the detailed procedures and processes that the clinical staff will follow.

## **Slide 9: SBMP Reimbursement Streams**

Just a quick overview of the S-B-M-P reimbursement streams.

The diagram illustrates the two streams, one for Administrative Activity Claiming and one for Direct Services Claiming. L-E-As may choose to participate in one or both reimbursement streams; however, R-M-T-S participation is required for either one.

## **Slide 10: Clinical Leadership Role**

Clinical leaders are challenged to pull together all these pieces to reach your organization’s full potential in terms of your Medicaid reimbursement program.

As we can see in this diagram, clinical leaders are involved in a variety of different processes that support the S-B-M-P program.

You’re providing oversight and guidance for clinical staff in establishing procedures, training and managing their time. You’re working for your students to ensure the educational needs and requirements are met, as well as health-care needs and requirements while keeping in mind requirements that come from fur-pah [FERPA], I-D-E-A and other sources. As a clinical leader in terms of Medicaid requirements, you’re overseeing documentation standards and compliance with the S-B-M-P program requirements. And, whether you yourself are a part of your L-E-A’s administration or not, as a clinical leader your leadership of these clinical processes directly impacts reimbursement, and you may also be part of the process of identifying allowable costs related to health-care services and things like that.

## **Slide 11: What is Direct Service Claiming (DSC)?**

So, what is Direct Service Claiming?

* The Direct Service Claiming program, that revenue stream of the S-B-M-P program, is the mechanism through which L-E-As seek federal reimbursement for a portion of the costs of providing direct services.
* The S-B-M-P covers direct medical services provided in the school-setting including speech, occupational, physical therapy, psychological counseling, skilled nursing, audiology services, personal care services, and A-B-A therapy services when the Medicaid claiming requirements are met.
* The S-B-M-P program provides reimbursement for the provision of these Medicaid covered services that I just mentioned when the service meets Medicaid’s definition of medical necessity and all other program requirements, whether services are pursuant to an I-E-P, or not. This expansion of the program to include reimbursement for services that are not pursuant to an I-E-P went into effect July first of twenty nineteen [2019].
* L-E-As submit interim claims for covered services provided to eligible MassHealth-enrolled members through MassHealth’s Medicaid Management Information System, M-M-I-S. That’s the MassHealth claim processing system.
* Providers must submit interim claims for all services for which they seek reimbursement in the annual Direct Services Cost Report.

## **Slide 12: Medicaid-Covered Direct Services**

* The services listed here are the MassHealth covered services within the scope of the S-B-M-P. So:
  + A-B-A
  + Audiology
  + Dental Screenings
  + Medical Nutritional Services
  + The Mandated Health or Behavioral Health Screenings
  + Occupational Therapy
  + Personal Care
  + Physical Therapy
  + Medical Evaluations
  + Psychological Counseling
  + Skilled Nursing
  + Speech and Language Therapy, and
  + Vision Services
* All of these services listed are covered, regardless of whether they’re part of a child’s I-E-P, when all other requirements are met.
* And the go-to document about covered services and qualified practitioners is called the L-E-A Covered Services and Qualified Practitioners document. It’s on that S-B-M-P website.

## **Slide 13: Reimbursable Services Requirements**

So, reimbursable services requirements:

* If a covered service is delivered, we just went through the sort of the list of all the covered services, the following requirements must be met to be considered a reimbursable service. So, for example, occupational therapy is a covered service, but in order for an L-E-A to be reimbursed for an occupational therapy service provided to a student, these requirements must be met:
  1. So, the practitioner has R-M-T-S Direct Service pool participation requirements, that actually only applies to in-district services, not out-of-district.
  2. Practitioners have license qualifications.
  3. The service must meet Medicaid’s definition of medical necessity.
  4. Services must be authorized.
  5. And services must be appropriately documented.
* L-E-As must ensure that each of these five requirements is met before an interim claim is submitted to M-M-I-S for adjudication and payment.
* The L-E-A must maintain, and produce upon request, documentation of compliance with these requirements for each reimbursable service. So, there is a six-year record retention period, and failure to produce any documentation related to these requirements in the event of an audit could result potentially in recoupment.
* And then just a note to always remember that the understanding of these requirements and guidelines around the program apply when participants are answering an R-M-T-S moment as well. So, if at the time of the selected or sampled moment, the participant, your staff member, was providing a reimbursable Medicaid service, they need to understand the reimbursable services requirements so they can appropriately answer that R-M-T-S moment and respond that they were in compliance with program guidelines.

## **Slide 14: Interim Claiming is Required**

So, interim claiming is required. Whenever an L-E-A provides a reimbursable service, for which your L-E-A is seeking reimbursement, to an eligible MassHealth enrolled student, you must submit an interim claim!

EVERY time a qualified practitioner, who participates in the Direct Service R-M-T-S pool, if providing in-district services, provides a MassHealth covered service with the required authorization and service documentation that meets Medicaid’s definition of medical necessity, in other words, all the things that make it a reimbursable service, to a MassHealth-enrolled student, an interim claim must be submitted.

## **Slide 15: Interim Billing Submission**

So, L-E-As are expected to submit interim bills consistent with these rules below:

* So, claims are submitted in an electronic format in accordance with that’s hip-pah [HIPAA] guidelines; there is something called the eight thirty-seven pee [837P] claim format. It’s an electronic claim format for submission of health claims. Or through Direct Data Entry, which is available on the Provider Online Service Center. That is a free option any L-E-A can use to submit claims to M-M-I-S.
* L-E-As may perform the billing themselves using this Provider Online Service Center D-D-E option, or you can purchase software. There are lots of options for purchasing billing software that will generate these required eight thirty-seven pee [837P] claim files, or you can contract with a third party to perform the billing for the district.
* Interim claims must be submitted within ninety days of the date of service and must include the appropriate procedure code and a clinically appropriate I-C-D code.
* All claims are subject to audit, and L-E-As are responsible for ensuring the appropriate documentation can be produced in the event of an audit or any other request by MassHealth or a state or federal compliance agency. And, again, note, you know, failure to comply with that requirement or produce documentation upon audit, you know it is a provider contract requirement, so that would be bad.
* Although clinical leaders may not have day-to-day responsibility for whatever process your L-E-A has chosen to submit the claims to M-M-I-S, the school-based health care providers whom you lead are the primary users of any Medicaid billing system or software, or at the very least are the primary suppliers of the documentation or billing forms that are the inputs to any billing process. So, we strongly recommend that, as a clinical leader, you’re very familiar with all of the pieces of the process and how it works at your L-E-A and have a good understanding of how interim billing is done. Hopefully, you will also be able to provide input to decision-makers about the process and can contribute clinical perspective on decisions like software purchases or vendor selection.

## **Slide 16: Clinical Leadership for Medicaid Compliance**

Let’s talk about**c**linical leadership for Medicaid compliance

Clinical leaders play an important role in Medicaid program compliance, particularly in these areas. So:

* Help translating Medicaid requirements and training materials to ensure that they’re understood by your school-based practitioners.
* Monitoring clinical licensure status and ensuring that practitioners have supervision in place where required.
* Clinical training for your L-E-A’s procedures around documentation of plans of care and service delivery.
* Clinical input and perspective on the design of interfaces or processes that support Medicaid billing.
* And finally, clinical leadership are likely responsible for ensuring that the appropriate documentation can be produced in the event of an audit as we talked about earlier.

## **Slide 17: Clinical Leadership for Licensure Compliance**

So, licensure compliance.

It’s important as a clinical leader in your L-E-A to understand the licensure requirements for any participating staff. So, again, I’m going to refer you to that L-E-A Covered Services and Qualified Practitioners document that’s available on the S-B-M-P website. That’s the exact link there to the document.

* Medicaid qualified providers must follow their individual clinical licensing regulations regarding scope of practice and supervision requirements.
* So, for example, the Board of Registration of Allied Health Professionals, pursuant to state regulations found at two fifty-nine C-M-R three and five [259 CMR 3 and 5] defines the scope of clinical practice for Occupational and Physical Therapists and Assistants. The board’s guidance indicates that:
  + OTAs or PTAs may not initiate or alter a treatment program without prior evaluation and approval of the supervising occupational physical therapist.
  + OTAs and PTAs may not interpret data beyond the scope of their occupational or physical therapy assistant education.
  + But it is not a board requirement for OTAs and PTAs to have their service documentation co-signed.

So, in this presentation I’m not going to go through all of the licensing boards and all of the requirements for all of the variety of licensed practitioners working in schools, but just really, this was to illustrate that it varies. It varies by license, it varies by board, and it is the responsibility of all licensed practitioners, as well as clinical leaders, to know and understand their scope of practice and clinical practice standards.

## **Slide 18: Clinical Leadership Support for RMTS**

So, let’s talk about **c**linical leadership support for R-M-T-S for a minute.

So, your L-E-A’s R-M-T-S Coordinator needs support from clinical leadership to appropriately identify staff who should be included in one of the direct service pools. Only staff who meet ALL of the requirements for reimbursement under the Direct Service claiming program should be included in a Direct Service pool, and those requirements include:

* + Again, having that active clinical license for their specialty,
    - Refer to the L-E-A Covered Services and Qualified Practitioners document available on the Resource Center.
  + Providing Direct Services that meet Medicaid reimbursement requirements,
  + And your L-E-A submitting interim claims for their services.

Additional information about the details of all the reimbursement requirements related to the Direct Service Program are in the S-B-M-P Direct Service Claiming, called D-S-C, Guide, which is also available out on the Resource Center on the S-B-M-P website.

## **Slide 19: Participant Staff Pools – Direct Services**

Back on slide twelve, we reviewed the Medicaid-covered services. The qualified practitioners for whom your L-E-A can seek reimbursement related to provision of all those covered services have to participate in one of these three R-M-T-S Direct Service pools. Each staff member should be considered individually and not automatically included based on their job title or their license. Clinical leaders can be very helpful and probably should be involved in supporting your L-E-A’s R-M-T-S coordinator when making determinations about which staff members to include in the R-M-T-S and what pool is appropriate for them, whether it’s one of these Direct Service pools or whether they really should be participating for administrative reimbursement only.

## **Slide 20: Service Documentation**

So, let’s talk about service documentation.

Clinical leadership should ensure that providers document their services consistent with clinical standards of practice and develop a system for doing so.

* Service documentation substantiates that the requirements for Medicaid reimbursement were met.
* L-E-As are responsible for ensuring that practitioners complete sufficient clinical documentation for all covered services provided to students for whom the L-E-A is seeking reimbursement.
* Documentation can be completed using a paper form, chart, medical record, an electronic health record of the L-E-A’s choosing, as long as all the requirements for clinical documentation and practitioner signature or electronic signature are met.
* MassHealth does not endorse any particular clinical documentation form, process, or system. That’s up to you to determine what works best for your L-E-A and your staff.

And just a note: The service documentation is not a billing form and is not the interim claim record; it’s the clinical documentation that supports that a medically necessary, reimbursable service was provided, and it’s usually retained by the L-E-A, not submitted to MassHealth, except in the case of like an audit. It must be present, and it must be compliant prior to submitting that interim claim. So, people sometimes confuse those two terms when we’re talking about documentation standards. We’re talking about the clinical record documentation that’s retained by the L-E-A. We’re not talking about the billing form.

## **Slide 21: Medicaid Billing Process**

If we think about the Medicaid Billing process, clinical leaders are going to want to have input and provide the practitioner clinical perspective in the development and/or selection of interfaces and processes that support recordkeeping and documentation that’s required for Medicaid billing.

* Things to consider regarding service capture or documentation that supports billing are:
  + Does it work for all type of practitioners? If not, do we need to develop different processes for different types of practitioners?
  + Does it work for all types of services and settings, including evaluations, I-E-P-prescribed services, non-I-E-P services, services provided in context, telehealth services, home services, etc.?
  + Does it integrate with I-E-P service requirement data? Processes for providing progress notes? Plans of care?
  + And, how will it support needs for clinical supervision and oversight?
* When thinking about Medicaid billing, consider:
  + How it’s integrated with your service documentation processes, and
  + Does it work for all types of practitioners, services and settings?

## **Slide 22: Clinical Leadership related to Staff Training**

Clinical leadership related to staff training on Medicaid requirements.

The primary source of information for Medicaid requirements in the Direct Service Claiming program are found in the S-B-M-P Direct Service Claiming Guide, which is published on the S-B-M-P Resource Center at the address listed here.

You should review the D-S-C guide in full and are responsible for understanding the program requirements. Clinical leadership should require that all staff who provide Medicaid-covered services for which your L-E-A seeks reimbursement receive appropriate training and oversight to ensure program compliance.

Some frequently misunderstood concepts are:

* Diagnosis or I-C-D codes
* Medical necessity
* Service authorization
* And service documentation versus billing forms

These concepts are addressed in the Medicaid one oh one [101] module eight for Direct Service providers, which is a good starting point for building your L-E-A’s training program. We are going to discuss each of these things briefly in this module coming up next.

## **Slide 23: ICD Diagnosis and/or Signs and Symptoms Codes**

So, I-C-D diagnosis and/or signs and symptoms codes.

So, per hip-pah [HIPAA] requirements, all claims must include clinically appropriate I-C-D code that is supported by service documentation and explains the reason or need for a service.

* An I-C-D code does not necessarily mean that you made a formal diagnosis.
* Many I-C-D codes actually identify presenting signs and symptoms.
* L-E-As are responsible for submitting at least one clinically appropriate I-C-D code on each interim claim.
* When appropriate, an I-C-D code provided by a qualified practitioner who is not employed by the L-E-A, maybe a physician outside or maybe, you know, a nurse practitioner, if you have that kind of written documentation, written and signed from that qualified provider, of a diagnosis, then you can use that diagnosis on a claim. But you gotta maintain the source documentation of where you obtained that information from.
* Some L-E-As have worked with their billing vendor or professional coders to come up with a list of common I-C-D codes. Some professional practice organizations have public-facing and some have member-only information, guidance, lists of common I-C-D codes that apply with their practice area.
* And just as a brief reminder, A-B-A therapy is only a covered service in this program when provided to students with a documented autism spectrum disorder, the A-S-D diagnosis. So, for A-B-A therapy claims, an A-S-D code has to be on the claim.
* A really important takeaway for clinical leaders here is that the Medicaid I-C-D code requirement is within the scope of practice for school-based qualified practitioners to determine. They’re just telling us why the service was necessary.

## **Slide 24: Medical Necessity**

Medical necessity and educational necessity or needs can and do overlap.

* Medically necessary services means they have a clinical basis and may also help students achieve educational goals and access the curriculum.
* The amount, frequency, and duration of services needs to be consistent with professionally recognized standards of practice for the clinical specialty area, and
* The D-S-C guide includes clarifications in the Medical Necessity section of the guide to assist providers to understand and implement requirements.
* Medically necessary services are skilled services that require the clinical expertise of the licensed practitioner to safely and effectively address or treat underlying health-care needs of the students. This includes physical and mental and behavioral health-care needs, and we’re going to cover this more extensively in module eight for the Direct Service practitioners.

## **Slide 25: Service Authorization**

Service authorization is often plan of care or treatment plan.

* Authorization is just documentation by a qualified practitioner that demonstrates that the service is medically necessary and consistent with standards of practice.
* I-E-Ps themselves do not constitute service authorization.
* If an evaluation and treatment plan was written by a qualified practitioner, then that may be service authorization.
* We’re going to review this in depth more in Module eight, running through an example of kind of how this flows and what this looks like. The point being that the service authorization is documentation that a qualified practitioner has determined that the child, the student needs the care, there is an underlying healthcare need or issue that requires skilled interventions be provided, and they have written a treatment plan or plan of care for what those services are and that authorizes services.

## **Slide 26: Service Documentation**

Service documentation is not a billing form.

* So, MassHealth considers service documentation to be the practitioner’s clinical service delivery treatment notes. Billing forms or software that many L-E-As use to generate a claim are separate and are not service documentation. So, we often find that school-based practitioners use these terms interchangeably or think of these two things interchangeably, and they’re not. An interim claim or billing form is not service documentation.
* Service documentation must meet MassHealth’s minimum standards as outlined in the D-S-C guide, and also must comply with clinical standards of practice for the practitioner’s clinical licensing board and professional practice organization’s guidelines.
* L-E-As must maintain service documentation that supported claiming for that six-year record retention period and it must be retrievable in case of an audit.

## **Slide 27: Next Training Steps**

So, some next training steps:

Again, this is the full set of the nine modules in the Medicaid one oh one [101] training series.

## **Slide 28: Contact Information & Resources**

And, contact information, other resources referred multiple times throughout this presentation to the School-Based Medicaid Program website, so that is:

Mass dot gov slash MassHealth slash schools [https://www.mass.gov/masshealth/schools]

Almost everything you need is on that website.

If you have questions or require assistance really with anything about this program, don’t ever hesitate to reach out to the U-Mass School-Based Help Desk. Our e-mail address is school-based claiming at U-mass med dot E-D-U [SchoolBasedClaiming@umassmed.edu], and there is our eight hundred [800] number one eight hundred five three five six seven four one [1-800-535-6741]. We’re open seven thirty [7:30] in the morning until seven thirty [7:30] at night, Monday through Friday, and we’re here to help you.