# School Health Services Program Overview

The Department of Health Care Policy and Financing

2008 Fall Training



### Program History & Background

- Established in Colorado in 1997 through SB 97-101
- Allows public school districts, Boards of Cooperative Educational Services (BOCES), & K-12 institutions to receive Medicaid funds for amounts spent providing health services to Medicaideligible students



### **Partnerships**

- Department of Health Care Policy & Financing (The Department)
- Colorado Department of Education (CDE)
- Centers for Medicare and Medicaid Services (CMS)
- School Health Services (SHS) Program Providers



### The Department

- Lead Medicaid state agency
- Contracts with CMS through State Plan
- Develops program processes
- Contracts with provider districts/BOCES
- Medicaid client eligibility
- Federal & State reporting
- Claims processing through ACS, Inc. (fiscal agent)
- Provides technical assistance



# Colorado Department of Education (CDE)

- Technical assistance & evaluation of Local Service Plans (LSP)
- Coordinates MESH Program Review
- Annual reporting of program to Department
- Manages Medicaid Extended School Health (MESH)
   Listserv



# Centers for Medicare and Medicaid Services (CMS)

- Provides funding for the SHS program through the certification of public expenditures
- Implements national Medicaid program, fiscal policies, and procedures
- Implements, interprets, and applies specific laws, regulations, and policies
- Directs, coordinates, and monitors program integrity efforts and activities by States



# School Health Services (SHS) Program Providers

- Conduct community health assessment
- Develop Local Service Plan (LSP)
- Contract with State for Medicaid funds
- Follow program procedures and guidelines
- Provide additional health services with reimbursed funds as specified in LSP



## Clients Served by Program

#### Students who are:

- Enrolled in Medicaid
- Enrolled in a participating school district
- Under the age of 21
- Disabled or medically at risk and receiving services according to an Individualized Education Program or an Individualized Family Service Plan



## Steps to Provider Participation

- Local Service Plan
- Care Coordination Plan
- Contract as Medicaid Provider with the Department
- Completion of the Provider Application for claims billing
- Receipt of a Provider Billing Number



## Eligible Services

- Physician & Nursing Services
- Personal Care Services
- Psychological, Counseling, and Social Work Services
- Orientation, Mobility, and Vision Services



## Eligible Services - continued

- Speech, Language, and Hearing Services
- Occupational Therapy Services
- Physical Therapy Services
- Specialized Transportation
- Targeted Case Management



### Medically Necessary Service

Will, or is reasonably expected to, prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering or the physical, mental, cognitive, or developmental effects of an illness, injury, or disability; and for which there is no other equally effective or substantially less costly course of treatment suitable for the client's needs



### Place of Service

### Services may be performed:

- In the school
- At the client's home
- At another site in the community



# Individual Provider Qualifications

#### Qualified Health Care Professional

 Must be registered, certified, or licensed by the Department of Regulatory Agencies (DORA) as a health care professional and act within the profession's scope of practice

### In the absence of state regulations

 Must be registered or certified by the relevant national professional health organization and must be allowed to practice if qualified per state law



# Individual Provider Qualifications

### Qualified Personnel

 Meet State Education Agency-recognized certification, licensing, registration, or other comparable requirements of the profession in which they practice



# Individual Provider Qualifications

Providers or contractors operating in Colorado schools must meet federal provider qualifications as outlined in 42 Code of Federal Regulations (42 CFR 440)



### Claims Submission

- Covered entities who transmit any health information electronically must use a National Provider Identifier (NPI)
- Paper claims do not require an NPI, but do require the Colorado Medicaid provider number
- Electronically mandated claims submitted on paper are processed, denied, and marked with the message "Electronic Filing Required"



### Paper Claims Submission

# The following claims will be processed for payment on paper:

- Claims from providers who consistently submit five
  (5) claims or fewer per month
- Claims that, by policy, require attachments
- Reconsideration claims



### **Electronic Claims Submission**

# Instructions for completing and submitting electronic claims:

- X12N Implementation Guides for the 837P, 837I, or 837D (<a href="http://www.wpc-edi.com/hipaa">http://www.wpc-edi.com/hipaa</a>)
- Companion Guides for the 837P, 837I, or 837D (via Provider Services page found at <a href="https://www.colorado.gov/hcpf">www.colorado.gov/hcpf</a>)
- Web Portal User Guide (within the portal)



### Colorado Medicaid Web Portal

- -User connects to portal through the internet for electronic claims submissions
- -Claims are adjusted, edited and resubmitted, and voided in real time
- -Submitter receives immediate feedback
- -Claims are processed to provide weekly reports to providers
- -Provides access to reports and transactions generated from claims submitted by other methods



### Colorado Medicaid Web Portal

#### Reports & Transactions Include:

- Accept/Reject Report
- Provider Claim Report
- Health Care Claim Payments/Advice (ASC X12N 835)
- Managed Care Reports such as Primary Care Physician Rosters



# Timely Filing of Claims

- 120 days from the date of service to submit claims
- 60-day resubmission for denied/rejected claims
- A Late Bill Override Date (LBOD) and numeric delay reason code allow providers to document and submit late claims for processing

# Timely Filing of Claims

#### Valid Delay Reason Codes:

- (1) Proof of Eligibility Unknown or Unavailable
- (3) Authorization Delays
- (7) Third Party Processing Delay
- (8) Delay in Eligibility Determination
- (9) Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules
- (11) Other



# Record Keeping & Documentation

All SHS providers are required to maintain complete and legible records that show that services provided to or on behalf of the client billed under Medicaid are:

- Medically necessary
- Consistent with the diagnosis and plan of treatment for the patient's condition
- Consistent with professionally recognized standards of care

# Record Keeping & Documentation - continued

#### **Providers must:**

- Maintain auditable records that will substantiate the claim
- Make such records available to the Department or its representatives upon request
- Retained records a minimum of six (6) years

Failure to maintain supporting fiscal and clinical records may result in claim denials and recoupment of Medicaid payments



The SHS Program now uses a cost-based, provider-specific, annually reconciled and settled reimbursement methodology



# The reimbursement process is comprised of the following:

- The SHS fee-for-service (FFS) procedure code specific billing and interim rate process
- The random moment time study (RMTS)
- The cost reconciliation and cost settlement process



### Interim Payment

- Rates developed by the Department and applied to specific procedure codes will be used to reimburse providers as claims are submitted
- Rates will be developed based on cost report data received from participating providers
- Fee-for-service payments resulting from billed claims will serve as interim reimbursement until the end-offiscal-year settlement process



### Random Moment Time Study

- A Federal requirement, mandatory for all participating districts/BOCES
- Conducted on a state-wide basis each quarter, with the exception of June – August
- Results are converted to a percentage which documents the time providers are performing Medicaid-eligible services for Medicaid-eligible clients
- In order to be valid and accepted by CMS, Colorado must obtain an 85% compliance/response rate for the time study



### **Cost Reporting**

- Documents and reports district-specific costs for providing health-related services
- The district/BOCES certifies actual, incurred costs and expenditures for providing Medicaid School Health Services
- Reporting period covers July 1 though June 30 of each year



### Cost Reporting

- Cost report is due from each participating district/BOCES on or before October 31 of the year following the reporting period
- Report combines:
  - Medicaid allowable cost information
  - RMTS results
  - Indirect cost rates from CDE
  - Medicaid eligibility rates



### Cost Reconciliation & Settlement

District-specific, allowable costs from cost report are compared to interim payments made to provider during reporting period

- If interim payments exceed actual costs, the provider shall return an amount equal to the overpayment
- If actual costs of provider exceed the interim payments, the Department will pay the federal share of the difference to the provider and submit claims to CMS for reimbursement



### Cost Reconciliation & Settlement

The cost reconciliation and settlement process shall be completed no later than April 1st (9 months after the fiscal year ends)



### Program Contacts and Web Site

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