4.b. EPSDT Other Services, continued.

4. School Based Services

School Based Services (SBS) are services that are listed in an eligible student's Individualized Education Program (IEP) that are coverable under one or more of the service categories described in Section 1905(a) of the Social Security Act, and that are necessary to correct or ameliorate defects or physical or mental illnesses or conditions discovered by an EPDST screen.

Service providers shall be licensed under the applicable State practice act or comparable licensing criteria by the State Department of Public Instruction, and shall meet applicable qualifications under 42 CFR Part 440. Identification of defects, illnesses or conditions and services necessary to correct or ameliorate them is done by practitioners qualified to make those determinations within their licensed scope of practice, either as a member of the IEP team or by a qualified practitioner outside the IEP team. Eligible individuals may obtain covered services from any person qualified to perform the services required, who undertakes to provide the services.

Covered services include physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders, performed by, or under the direction of, providers who meet the qualifications set forth at 42 CFR 440.110. Covered services also include nursing services coverable under 42 CFR §440.80, and 42 CFR §440.60 ordered by a licensed physician and performed by a registered nurse or licensed practical nurse, nursing services provided on a restorative basis under 42 CFR §440.130 (d), including services delegated in accordance with the Nurse Practice Act to individuals who have received appropriate training from a registered nurse; personal care services (as known as attendant care services) coverable and performed by individuals qualified under 42 CFR §440.167; psychological, counseling, and social work services performed by licensed practitioners within the scope of practice as defined under state law and coverable as medical or other remedial care under 42 CFR §440.60 or rehabilitative services under 42 CFR §440.130. Assessments are covered as necessary to assess or reassess the need for medical services in a child's treatment plan and must be performed by any of the above licensed practitioners within the scope of practice.

The state has established controls to prevent duplicate services and assure continuity of care when a child receives services from both SBS providers and Medicaid Health Maintenance Organizations (HMOs) or fee-for-service providers. HMOs are responsible for managing medical services for recipients receiving SBS when recipients are in HMOs. SBS and HMO providers are required to sign Memorandums of Understanding setting standards, policies and procedures to avoid duplication of services and coordinate care. Where a child served within the Medicaid fee-for-service system receives SBS, SBS providers are required to document the regular contracts between schools and community providers as appropriate for each child but at least annually. Medicaid monitors service coordination and ensures duplicate services are not provided through prior authorization.

Physical therapy can be provided by physical therapy assistants, aides, and interns under the direction of a qualified physical therapist. Occupational therapy can be provided by occupational therapy assistants, aides, and interns under the direction of a qualified occupational therapist. Speech language services for individuals with speech, hearing, and language disorders can be provided by a speech language pathology assistant and interns under the direction of a qualified speech language pathologist. Audiology can be provided by audiology assistants, interns, and interpreters under the direction of a qualified audiologist.

When services are provided under the direction of a licensed therapist, the licensed must:

- see the beneficiary at the beginning of and periodically during treatment;
- is familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts under State law;
- has continued involvement in the care provided, and reviews the need for continued services throughout the treatment;
- assume professional responsibility for the services provided under his/her direction and monitors the need for continued services;
- spend as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
- ensure that individuals working under his/her direction have contact information to permit them direct contact with the supervising therapist as necessary during the course of treatment; and
- maintain documentation supporting the supervision of services and ongoing involvement in the treatment.

4.b. EPSDT Other Services, continued.

4. School Based Services

School Based Services (SBS) are services that are listed in an eligible student's Individualized Education Program (IEP) that are coverable under one or more of the service categories described in Section 1905(a) of the Social Security Act, and that are necessary to correct or ameliorate defects or physical or mental illnesses or conditions discovered by an EPDST screen.

Service providers shall be licensed under the applicable State practice act or comparable licensing criteria by the State Department of Public Instruction, and shall meet applicable qualifications under 42 CFR Part 440. Identification of defects, illnesses or conditions and services necessary to correct or ameliorate them is done by practitioners qualified to make those determinations within their licensed scope of practice, either as a member of the IEP team or by a qualified practitioner outside the IEP team. Eligible individuals may obtain covered services from any person qualified to perform the services required, who undertakes to provide the services.

Covered services include physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders, performed by, or under the direction of, providers who meet the qualifications set forth at 42 CFR 440.110. Covered services also include nursing services coverable under 42 CFR §440.80, and 42 CFR §440.60 ordered by a licensed physician and performed by a registered nurse or licensed practical nurse, nursing services provided on a restorative basis under 42 CFR §440.130 (d), including services delegated in accordance with the Nurse Practice Act to individuals who have received appropriate training from a registered nurse; personal care services (as known as attendant care services) coverable and performed by individuals qualified under 42 CFR §440.167; psychological, counseling, and social work services performed by licensed practitioners within the scope of practice as defined under state law and coverable as medical or other remedial care under 42 CFR §440.60 or rehabilitative services under 42 CFR §440.130. Assessments are covered as necessary to assess or reassess the need for medical services in a child's treatment plan and must be performed by any of the above licensed practitioners within the scope of practice.

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When services are provided under the direction of a licensed therapist, the licensed must:

- see the beneficiary at the beginning of and periodically during treatment;
- is familiar with the treatment plan as recommended by the referring physician or other licensed practitioner of the healing arts under State law;
- has continued involvement in the care provided, and reviews the need for continued services throughout the treatment;
- assume professional responsibility for the services provided under his/her direction and monitors the need for continued services;
- spend as much time as necessary directly supervising services to ensure beneficiaries are receiving services in a safe and efficient manner in accordance with accepted standards of practice;
- ensure that individuals working under his/her direction have contact information to permit them direct contact with the supervising therapist as necessary during the course of treatment; and
- maintain documentation supporting the supervision of services and ongoing involvement in the treatment.

28. Medicaid-Covered Services included in Medicaid-eligible Students' Individualized Education Programs (IEPs) Provided by Local Education Agencies

Overview

This section of the plan describes how:

1. The Department establishes rates for interim Medicaid reimbursement,
2. Local education agency (LEA) providers identify total allowable Medicaid costs, including the Federal and non-Federal share of expenditures for Medicaid-covered services provided by Medicaid-qualified providers, and
3. The Department reconciles interim payments to total allowed cost as reported on the CMS-approved cost report for direct medical services and specialized transportation services.

This section of the plan applies only to Medicaid-covered services identified in the child's IEP.

Payment for Medicaid-Covered Services included in Medicaid-eligible Students' IEPs Provided by LEAs

LEA providers shall be reimbursed on an interim basis and those payments shall retrospectively be reconciled to cost. Sections A and B cover the interim payment process. Sections C through F cover the process for certification and reconciliation.

Interim Payment for Covered Services Provided by LEA Providers

A. Before July2007, statewide rates will be set on an interim basis using the July 2004 school year's reimbursement updated for inflation at a rate not to exceed the qualified economic offer (QEO) annual rate. In negotiating teacher's contracts, the QEO identifies the minimum offer required by state statute that a local school district may make to avoid binding arbitration on salaries and fringe benefits.

B. After July 2007, LEA specific rates will be set on an interim basis using the LEA's most recent cost information updated to the current year for inflation at a rate not to exceed the QEO.

Identification of Total Allowed Cost

C. LEA providers are required to report annually total allowed cost, including the Federal and non-Federal share of expenditures using a CMS-approved cost report. The following steps will be used to determine cost:

1. The provider will identify cost to be included in the direct medical services cost pool.

   The pool of cost will consist of compensation to practitioners and some additional cost for clinical materials and supplies. Practitioners are licensed medical providers and other qualified providers doing delegated medical tasks under the school-based services section Attachment 3.1-A Supplement 1 and 3.1-B Supplement 1 of the Wisconsin Medicaid State Plan. Only those practitioners who are expected to deliver hands-on services to clients and who are expected to generate a service unit documented through the medical record may be included in the direct services cost pool. The cost of supervisors, program coordinators, special education teachers, administrators and other personnel are included in the cost pool only to the extent they are qualified providers and are expected to provide hands-on care. The LEA will identify individually the practitioners eligible for inclusion in the direct services cost pool. Their compensation data will be reported by individual on the CMS-approved cost report and will reflect offsetting amounts to the extent required by law for all other sources of revenue.

   Only Medicaid qualified providers that are the direct practitioners may be included in the direct services cost pool. The following practitioners must meet the requirements of 42 CFR §440.110 to report their costs: physical therapist, occupational therapist, speech language pathologist, audiologist, and aides providing medical services under the direction of the physical therapist, occupational therapist, speech-language pathologist, and audiologist. Providers of personal care services (also known as attendant care services) must meet the requirements of 42 CFR §440.167 to report their costs. Providers of psychological, counseling, and social work services must meet the requirements of 42 CFR §440.60 or 42 CFR §440.130 to report their costs. Providers of nursing services must meet the requirements of 42 CFR §440.80 and 42 CFR §440.60 or 42 CFR §440.130 (d) to report their costs.

   The Department shall specify the method for identifying these costs using the CMS-approved cost report which employs the use of data derived from the Wisconsin Uniform Financial Accounting Requirements (WUFAR), the Special Education Fiscal Report project codes and other data classifications maintained by the Department of Public Instruction (DPI). These costs shall be identified in compliance with the scope of cost that CMS has approved. DHS allows districts to report compensation data by individual and requires an offsetting adjustment for other revenue sources of revenue. However, DHS assures that the beginning balances tie to the WUFAR.

2. The provider/LEA will identify the amount of cost in the direct services cost pool that may be attributed to the provision of medical services.

   To allocate this cost, the provider multiplies the applicable statewide direct medical services time study percentage by the total direct medical services cost pool amount. The source of the direct medical services time study percentage(s) is the Medicaid Administrative Claiming Time Study for Schools (MACS), which is hereby referred to as the Medicaid Administrative Claiming Time Study for Schools (MACS). The State will supply the time study percentage(s) for direct medical services to providers. The use of this CMS-approved time study assures that no more than 100 percent of time is captured for Medicaid administrative activities and direct medical services and that the time study is statistically valid.

3. The indirect cost is determined through use of the cognizant agency unrestricted indirect cost rate.

   One plus the cognizant agency's unrestricted indirect cost rate assigned to each LEA provider is multiplied by total direct medical services cost as determined under the previous step. If a provider does not have an unrestricted indirect cost rate, the provider does not have any Medicaid-allowable indirect costs associated with direct medical services.

4. Medicaid's portion of total direct services cost will be calculated.

   The results of the previous step are multiplied by the ratio of the total number of IEP students receiving medical services and eligible for Medicaid to the total number of IEP students receiving medical services. One IEP ratio is applied to cost for all practitioner types.

Methodology for Determining Specialized Transportation Cost

D. Transportation is reimbursed only on days when a covered Medicaid service was provided pursuant to an IEP and only if specialized transportation is listed as a service in the IEP.

Each LEA provider shall report to the Department, on an annual basis, the total allowed costs incurred for Specialized Transportation services using the following steps.

1. Each LEA will use the CMS-approved cost report to accumulate annually direct cost, which will which will include some personnel cost, contracting cost, and specialized transportation vehicle depreciation, fuel, insurance, and repairs and servicing costs necessary for the provision of school-based IEP transportation services.

2. Total specialized transportation cost will be determined by multiplying cost identified under Step 1 by one plus the cognizant agency's unrestricted indirect expenditure (cost) rate. If a provider does not have an unrestricted indirect cost rate, the provider does not have any Medicaid-allowable indirect costs associated with specialized transportation services.

3. Medicaid's portion of specialized transportation cost will be identified by multiplying the results of Step 2 by the ratio of the total number of one-way Medicaid specialized transportation trips pursuant to the IEP over all one-way specialized transportation trips that were provided. The provider is responsible to maintaining one-way trip documentation.

E. Cost Reconciliation and Cost Settlement

Each LEA provider shall be required to do all of the following activities:

1. Each LEA provider must complete annually the CMS-approved cost report for direct medical services and specialized transportation. It will contain total cost incurred to provide Medicaid-covered services to Medicaid beneficiaries, including the Federal and non-Federal share of incurred cost. This cost report will be filed with the Department by March 31, 2007 for 2005-2006 state fiscal year, and the December 31 following the end of the state fiscal year for all future years. The Department will inform the provider of whether there has been an over- or underpayment.

2. The LEA provider is required to keep, maintain and have readily retrievable financial records that fully identify or support its allowable costs eligible for FFP in accordance with Federal and Wisconsin Medicaid records requirements. The LEA provider is also required to participate in statewide time studies conducted by the Department.

3. The LEA provider shall paid at cost. Using the reconciled cost as reported on the CMS-approved cost report, any settlement amount will be identified. LEA providers shall be required to reimburse overpayments of interim payments. If the interim payments underpay an LEA provider, the Department will reimburse the provider up to its cost. All costs will be settled no later than 24 months after the close of the applicable state fiscal year. The State cannot adjust its interim rates prospectively to account for overpayment. The provider will be required to refund any overpayment within the 24-month timeframe. Similarly, the State must reimburse providers, within 24 months of the end of the applicable state fiscal year, separately when there has been an underpayment.

4. Special Rule for Cost Reconciliation and Cost Settlement

   Applicable to the Fiscal Year July 2005-June 2006

   For the fiscal year July 2005 - June 2006 only, cost reconciliation will be performed in accordance with a methodology submitted by the Department and approved by CMS.

F. Department's Responsibilities

1. The Department shall assure that it utilizes the CMS-approved scope of cost as reflected in the CMS-approved cost report. For costs that were reported using invoices instead of object codes, the State will assure by 7/1/07 all cost be reported using object codes. The changes in coding will be made in consultation with CMS. The Department shall review future changes in the DPI WUFAR and Special Education Fiscal Report project codes and other data and procedures as they occur to assure that costs included in cost reports are consistent with CMS-approved cost categories. Whenever there is a change in the object codes used in the cost report, the State will seek approval from CMS. This action may or may not result in the required submission of a state plan amendment. The Department shall conduct time studies that meet CMS guidelines for approved Administrative Claiming Time Studies to determine that percentage of time that school staff spend on activities related to the provision of Medicaid allowable medical services.

2. All cost will be settled no later than 24 months after the close of the applicable school year. The State cannot adjust its interim rates prospectively to account for overpayment. The provider will be required to refund any overpayment separately within the 24-month timeframe. Similarly, the State must reimburse providers, within 24 months of the end of the applicable state fiscal year, separately when there has been an underpayment.

3. As part of the financial oversight responsibilities, the Department shall develop review procedures for the certified expenditures that include procedures for assessment of risk that expenditures and other information submitted by the LEAs is incorrect. The financial oversight of all LEA providers shall include reviewing the allowable costs in accordance with the scope of cost approved by CMS. The scope of allowed cost approved by CMS was adjusted for services provided on or after 7/1/2009.

   If the Department becomes aware of potential instances of fraud, misuse, or abuse, it shall perform timely audits and investigations to identify and take the necessary actions to remedy and resolve the problems.