

Wayne RESA Medicaid Annual Quality Assurance Plan July 2025 – June 2026

School-Services Program (SSP) – Part I

Policy:

The Direct Service Claiming (DSC) and Caring 4 Students (C4S) programs will collectively be identified as Michigan's School Services Program (SSP). SSP is federally and state-funded, therefore, the Centers for Medicare and Medicaid Services (CMS) and the Michigan Department of Health and Human Services (MDHHS) audit ISDs and LEAs to confirm that claimed Medicaid costs and billed services are allowable, correct, and appropriate.

Wayne RESA must keep a written Quality Assurance Plan on file because Local Education Agencies (school districts and academies) request Medicaid reimbursements under the Intermediate School Districts (ISDs) National Provider Identification (NPI) number. The quality assurance plan is used to establish and maintain a process for monitoring and evaluating the quality and documentation of covered services, and the impact of Medicaid enrollment on the school environment.

An acceptable quality assurance plan must address each of the following quality assurance standards:

- A. Covered services are medically necessary, as determined and documented through appropriate and objective testing, evaluation, and diagnosis.
- B. Medical Plans of Care (POC) identify the condition, disability, or reason for treatment, frequency, duration, goals and objectives of the services provided in the school setting.
- C. A monitoring program exists to ensure that services are appropriate, effective, and delivered in a cost-effective manner consistent with the reduction of physical or mental disabilities and assisting the beneficiary to benefit from education services.
- D. Billings are reviewed for accuracy.
- E. Staff qualifications meet current license, certification, supervision, and program requirements.
- F. Established coordination and collaboration exist to develop POCs with all other providers (i.e., Public Health, MDHHS, Community Mental Health Services Programs (CMHSPs), Medicaid Health Plans (MHPs), Hearing Centers, Outpatient Hospitals)
- G. Parent/guardian and beneficiary participation exist outside of the POC team process in evaluating the impact of the SSP on the educational setting, service quality, and outcomes.

WCRESA Plan:

- A. Covered services are medically necessary, as determined and documented through appropriate and objective testing, evaluation, and diagnosis.**

The Michigan Administrative Rules for Special Education (MARSE), the Multi-Tiered System of Support (MTSS), and the Safe and Healthy Schools Framework require observations and evaluations to help school providers identify when students have disabilities or chronic conditions that benefit from medically necessary direct service support during the school day. For certain school support services, MDHHS has policies that say that schools can only bill Medicaid when medical necessity is also determined by a physician or a qualified healthcare provider's written order, prescription, referral, or authorization.

Wayne RESA runs reports for services that require orders, prescriptions, and referrals. The Medicaid authorization for services and the C4S Plan of Care have a place for tracking authorizations. The billing application confirms ordering, prescribing, and referring NPIs during the claim's generation process.

- B. The POC identifies the condition, disability, or reason for treatment, frequency, duration, goals and objectives of the services provided in the school setting.**

For compliance, Wayne RESA's MISTAR Q forms have built-in POC validation rules to ensure medical care plans always include written goals and objectives. When the plan lists service support during the school day, the service support must be listed with the delivery method, frequency, and duration.

- When the plan is the student's IEPT/IFSP/NPSP, MISTAR's Authorization for Medicaid Services Form must also be completed, signed, titled, and dated by a Medicaid-qualified provider.
- When the plan is the student's C4SP, the qualified provider's signature and authorization for Medicaid services are included in the plan.

When C4S plans and Medicaid authorizations are validated, the forms can be finalized for electronic and wet signatures. Signed forms can be archived for documentation purposes. Wayne RESA's Medicaid Reimbursement Office uses a random service audits to demonstrate POC compliance throughout the school year.

Process for obtaining Orders, Prescriptions, Referrals, and Authorizations:

Nursing Orders: Per public health code and Medicaid rules, school nursing services are medically necessary when the student's personal physician, physician assistant, nurse practitioner, or clinical nurse specialist orders them, and when the nursing interventions (goals and objectives) are listed in the student's Individualized Healthcare Plan (IHP).

Each school year, the Medicaid reimbursement office reminds schools and nurses that family orders and IHPs are required for SSP Medicaid billing. When Wayne RESA's Medicaid Department obtains orders from the district/academy, they will be loaded in MISTAR for Medicaid billing.

Physical Therapy Prescriptions: When a medical plan of care lists direct physical therapy service support during the school day, a physical therapy prescription is required. Under MARSE, “physical therapy” must be prescribed by a physician and provided by a state of Michigan licensed physical therapist under 1878 PA 368, MCL 333.1101 et seq., or a physical therapy assistant.

Each school year, the Medicaid reimbursement office reminds schools and PTs that prescriptions are required, and it is suggested that when students have a POC that lists direct Physical and Occupational Therapy services, the family’s prescription should include both services. When Wayne RESA’s Medicaid Department obtains prescriptions from the district/academy, they will be loaded in MISTAR for Medicaid billing.

Occupational Therapy and Orientation and Mobility Prescriptions: When a medical plan of care includes direct occupational therapy or orientation & mobility services, a prescription is required. It is suggested that when students have a POC that lists both direct Physical and Occupational Therapy services, the family’s prescription should include both.

Each school year, the Medicaid reimbursement office reminds schools, OTs, and O&Ms that schools must obtain prescriptions for direct OT and O&M services. When an OT or O&M prescription is not received within 30 days of the medical plan of care’s service begin date, the school should request help from Wayne RESA. When Wayne RESA’s Medicaid Department obtains a copy of the prescriptions from the district/academy/physician, they will be loaded in MISTAR for Medicaid billing.

Speech, Language, and Hearing Referrals: When a medical plan of care includes speech/language or hearing services, a referral is required. To meet the requirement, the Medicaid Reimbursement Office will obtain referrals for Medicaid-eligible speech/language and hearing LEA students. When Wayne RESA’s Medicaid Department secures copies of the physician-signed referrals, they will be loaded in MISTAR for Medicaid billing.

Personal Care Authorizations: When a medical plan of care team determines that a student has a disability or condition that limits or prevents them from performing certain daily living personal care activities by themselves, they must indicate the need for assistive personal care services in the student’s medical plan of care (IEPT/IFSP/C4SP). When the IEPT/IFSP is the medical plan of care, it must list the personal care activities in the *Authorization for Medicaid Services* form. The form must be signed, titled, and dated by a Medicaid-qualified authorizer. MISTAR forms have validation rules that ensure assistive personal care services are documented and that plans for Medicaid services are always signed, titled, and dated by a healthcare provider who is qualified to authorize them.

As a best practice, Wayne RESA’s Medicaid office regularly evaluates MISTAR Q Forms, Program Records, and Billing Application Data for up-to-date orders, prescriptions, referrals, and authorizations.

- C. A monitoring program exists to ensure that services are appropriate, effective, and delivered in a cost-effective manner consistent with the reduction of physical or mental disabilities and assisting the beneficiary to benefit from education services.**

School programs (MARSE, MTSS, Safe and Healthy Schools) regularly monitor the appropriateness and effectiveness of the services they deliver during the school day using measurable goals and objectives that help them reduce or ameliorate behavioral, medical, or mental health service needs during the school day.

As a best practice, Wayne RESA's Medicaid office regularly evaluates MISTAR Q Forms, Program Records, and Billing Application Data for up-to-date orders, prescriptions, referrals, and authorizations.

D. Billings are reviewed for accuracy.

Billing accuracy begins with the Wayne County District/Academy MISTAR Service Tracker billing application. Only District/Academy Direct Service, Designated Case Management, and Personal Care quarterly Staff Pool List staff have the MISTAR Q faculty certifications that allow them to submit Medicaid billings.

Before LEA Direct Service, Case Management, and Personal Care staff are assigned permissions for MISTAR Service Tracker, they must complete Wayne RESA's Medicaid policy and billing training. The training packet includes the provider's specific tip sheet, Service Tracker guide, case manager activity examples, personal care service definitions, personal care service logs, specialized transportation driver logs, and newsletters.

MISTAR Service Tracker includes a "staff editor" module for Medicaid faculty certifications based on Medicaid policy. The provider/faculty certifications comply with provider-specific procedure code service times, group size, daily notes, and monthly summaries requirements. When the student receives specialized transportation trips on the same day as a behavioral, medical, or mental health service, Service Tracker generates Medicaid-reimbursable specialized transportation claims.

To review for accuracy, Wayne RESA Medicaid Reimbursement Office regularly runs reports that check the validity of all billed and unbilled encounters (see "Additional Reviews" below)

E. Staff qualifications meet current license, certification, and program requirements.

Information regarding staff qualifications is communicated using PCGUS Staff Pool List trainings, Click 2 Learn videos, Wayne RESA Medicaid Office staff trainings, and tip sheets.

Every quarter, LEA Special Education and Business Office staff verify the qualifications for the SSP pool. They match the billing provider's credentials to the appropriate MISTAR Service Tracker faculty code. Each faculty code has rules regarding Medicaid billing. They also ensure that supervising clinicians submit a copy of their documented proof of supervision to their district's Medicaid office.

To meet SSP staff qualification rules, Wayne RESA's Medicaid Reimbursement Office regularly takes steps to verify that SSP staff are set up with the appropriate faculty code credentials for staff pool lists and MISTAR Q Service Tracker.

F. Established coordination and collaboration exist to develop POCS with all other providers (i.e., Public Health, MDHHS, Community Mental Health Services Programs (CMHSPs), Medicaid Health Plans (MHPs), Hearing Centers, and Outpatient Hospitals)

Wayne RESA LEAs are responsible for coordinating student services with outside agencies.

The C4S plan of care that Wayne RESA LEAs use has a dedicated space for service coordination. When coordination is necessary, they must list the other service providers' information directly in the student's care plan.

If the student's IEPT/IFSP does not include coordination of services, Wayne RESA's Special Education department can assist LEA providers in coordinating services with various agencies.

G. Parent/guardian and student participation exists outside of the POC team process in evaluating the impact of the SSP on the educational setting, service quality, and outcomes.

The parental and student feedback on the SSP is monitored through case management. The SSP monitor has access to parent/guardian satisfaction through treatment and progress notes of case manager activities that discuss all health-related services. Because parents of Early On students help LEAs develop family service plans, participate in family training, and direct support services, they are always knowledgeable regarding service quality and outcomes. Additionally, each card marking, parents/guardians receive updates on both academic and health-related services that the student is receiving in school.

Wayne RESA's Medicaid webpage and MISTAR plan of care application include the Medicaid Annual Notification and One-Time Consent to Bill participation forms. Because the annual notification form explains the SSP program and the parent rights regarding Medicaid billing, it is always given to parents of students receiving either DSC or C4S services. The parental consent forms are also given to parents to obtain their approval for LEAs to bill Medicaid for their services. Most districts/academies seek parental consent at the POC meeting.

Wayne RESA has two processes for the One-Time Consent to Bill Medicaid requirement.

- The DSC program school staff will complete the *Medicaid One-Time Consent to Bill* form when they complete other Special Education (REED, MET, IEPT, and IFSP) forms.
- The C4S program school staff will complete the One-Time Consent when they complete the C4S Plan of Care.

If consent is not received at the POC meeting, it may be sought via a letter sent to parents by the district on their letterhead.

Parent responses to the consent are logged by the district into the MISTAR student data system. Parent refusals must be tracked in the MISTAR SIS system, and they will cause any services entered for the student to be filtered out of the claim submissions.

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Additional Reviews

Annual Record Review for the Direct Service Claiming Billing Component:

Each year, the Medicaid Reimbursement Department conducts an internal records review of Medicaid billings to identify accuracy and compliance with state-approved claims. The current parameters for the reviews of the Direct Service Claiming billing component are as follows:

- One student from each district or Public-School Academy (PSA) for whom at least one medical service has been reported is selected at random
- Service logs for three months of the current school year are printed for each practitioner
- A letter is sent to each district's/PSA's Special Education office requesting documentation of the services rendered
- The documentation request includes:
 - The student's POC that covers the quarter in review
 - The MET(s), POC(s) evaluations, and goals and objectives related to the selected quarter
 - Clinician notes that pertain to all services submitted for the quarter
 - Prescriptions/referrals/authorizations as necessary
 - Student attendance records for the quarter
 - Parental consent for Medicaid billing
 - Authorization for Medicaid Services form
 - Personal Care Authorization, if applicable
 - Monthly Personal Care Activity Log, if applicable
 - Transportation logs, if applicable
 - Staff certifications/licenses
 - Documentation of "under the direction of" and/or "supervision of" limited licensed staff
- The documentation is then reviewed by the Medicaid Reimbursement Office as follows:
 - The student had an active POC in place for the dates of service
 - POC identifies the medically necessary services to be provided and the service frequency, duration, goals, diagnosis, and objectives
 - The number of services rendered was within the frequencies/durations prescribed on the POC
 - Services rendered were prescribed on the POC (or were inherent in the program for center-based services)
 - The student was in attendance on all dates for which direct services were billed per the student attendance report
 - MET and/or REED are within the last 3 years and covered services are medically necessary, as determined and documented through appropriate and objective testing, evaluation, and diagnosis
 - Parental consent for Medicaid billing was obtained and filled out correctly
 - Authorization for Medicaid Services form completed and signed by an authorized provider

- Personal Care Authorization and Monthly Activity logs are filled out, signed, dated, and services provided match the service recorded on the log
 - Transportation logs are signed and dated by the bus driver/bus aide
 - Prescriptions/referrals/authorizations were obtained for the reported services, and they include all required information such as the doctor's NPI, signature, credentials, diagnosis/condition, date, and student demographics.
 - Clinician notes provided sufficient documentation to support the selected procedure code(s) and supervision where required
 - Staff qualifications meet current license, certification, and program requirements
 - The corresponding Documentation of "under the direction of" and/or "supervision of" limited licensed staff was filled out correctly and signed
- Exceptions are noted and reported to district Special Education Directors/Supervisors. Exceptions are resolved via corrective action or claim cancellations/voids, depending upon the severity of the issue. "Systematic issues" are addressed in the Medicaid Messenger newsletter, training sessions, and/or written communications with district Special Education Directors/Supervisors and applicable staff.

Annual Record Review for the Caring 4 Students Billing Component:

Each year, the Medicaid Reimbursement Department conducts an internal records review of Medicaid billings to identify accuracy and compliance with state-approved claims. The current parameters for the review of the Caring for Students billing component are as follows:

- One student from each district/PSA for whom at least one mental/behavioral/medical health service has been reported is selected at random
- Service logs for one quarter of the current school year are printed for each practitioner
- A letter is sent to each district's/PSA's Special Education office and/or C4S district/PSA identified contact, requesting documentation of the services rendered
- The documentation request includes:
 - The student's POC that covers the quarter in review
 - Clinician notes that pertain to all services submitted for the quarter
 - Prescriptions/referrals/authorizations as necessary
 - Student attendance records for the quarter
 - Parental consent for Medicaid billing
 - Authorization for Medicaid Services form
 - Personal Care Authorization, if applicable
 - Monthly Personal Care Activity Log, if applicable
 - Staff certifications/licenses
 - Documentation of "under the direction of" and/or "supervision of" limited licensed staff
- The documentation is then reviewed by the Medicaid Reimbursement Office as follows:
 - The student had an active POC in place for the dates of service
 - The student was in attendance on all dates for which direct services were billed
 - Services rendered were prescribed on the POC

- The number of services rendered was within the frequencies/durations prescribed on the POC
 - Prescriptions/referrals/authorizations were obtained for the reported services, if needed
 - Parental consent for Medicaid billing was obtained and filled out correctly
 - Authorization for Medicaid Services form completed and signed by an authorized provider
 - Personal Care Authorization and Monthly Activity logs are filled out, signed, dated, and services provided match (if applicable)
 - Clinician notes provided sufficient documentation to support the selected procedure code(s) and supervision where required
 - Staff met Medicaid qualifications to provide billed services
 - The corresponding Documentation of “under the direction of” and/or “supervision of” limited licensed staff was filled out and signed
- Exceptions are noted and reported to district Special Education Directors/Supervisors and/or C4S district/PSA identified contact. Exceptions are resolved via corrective action or claim cancellations/voids, depending upon the severity of the issue. “Systematic issues” are addressed in the Medicaid Messenger newsletter, training sessions, and/or written communications with district Special Education Directors/Supervisors and applicable staff.

Annual Notes Review:

To monitor compliance with the quality controls outlined above, Wayne RESA reviews clinician notes on an annual basis.

The current parameters for the reviews are as follows:

- In January, RESA will select one provider type from the current staff pool list and will download all Service and Summary Notes entered to date for the September 1st – November 30th
- Notes will be reviewed for content. Exceptions are noted and reported to the appropriate local Special Education Director and staff
- Staff are allowed to clarify their note, or the service will be voided
- “Systematic issues” are addressed in the Medicaid Messenger newsletter, training sessions, and/or written communications with district Special Education Directors/Supervisors and applicable staff

Designated Case Manager (DCM)/Personal Care (PC) Cost Review:

To monitor compliance with the quality controls outlined above, Wayne RESA conducts an annual review of costs submitted for Designated Case Managers and Personal Care Aides. The current parameters for the reviews are as follows:

- Wayne RESA reviews the PC and DCM staff pool lists against reported services for the school year to verify that the PC and DCM information that will be submitted to the state for Facility Settlement cost reporting is correct
- Districts are asked to substantiate all costs submitted for staff who have not reported any services during the school year

- If necessary, LEAs will be given a deadline to submit changes to the PC and DCM costs.

Random Moment Time Study Compliance Reports:

The RESA Medicaid office monitors the Public Consulting Group Claiming System Compliance Report daily to ensure random moment time studies are completed on time. RESA will notify local districts via e-mail and phone calls to staff who have not yet completed their time study. If necessary, RESA will contact LEA Superintendents for assistance. The RESA Medicaid office will also assist PCG with contacting participants for follow-up questions regarding time study responses.

School-Services Program—Part II

Policy:

The Medicaid Provider Manual, School-Services Program Section 5.1 states:

“The financial data reported for the Direct Medical Services (salaries, benefits, purchased services, supplies, and other) must be based on actual detailed expenditure reports obtained directly from the participating ISDs’ financial Accounting system and be directly attributable to staff who are included on the staff pool lists. The financial accounting system data is applied using generally accepted governmental accounting standards and principles or applicable administrative rules. The expenditures accumulated for calculating the Direct Medical Services allowable costs are to include actual non-federal expenditures incurred during the claiming period. These allowable expenditures include such things as salaries, wages, fringe benefits, medically related supplies, purchased services, and materials.”

Caring 4 Students: The Medicaid Provider Manual, School-Services Program Section 5.1 states:

“It is the intent of this policy that the ISD, in cooperation with the local education agencies (LEAs), use both existing funding and those from this program to maintain and increase behavioral health and other health services for general education students. These increases can take place in the current or subsequent year and must supplement and not supplant existing services. It is expected that these additional services for General Education Students be provided without negatively impacting services provided to Special Education Students.”

WCRESA Plan:

Quarterly Staff Pool lists are submitted electronically by each district’s Special Education Director/Supervisor, who receives instructions for review and updates from both Wayne RESA and PCG. Before certification, Wayne RESA reviews LEA staff pool lists.

For certain periods, the Quarterly Financials will be opened for editing. On or before the due date, the LEA must complete, certify, and submit the report in the PCGUS claiming system.

Wayne RESA will review district reports as follows:

- Verify district Indirect Cost Rates
- Verify with the local district that the total reported costs are correct

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- Verify by random sample that the listed LEA staff are reporting services
- Verify Direct Service licensure

Facility Settlement:

Each year, PCG sends Wayne RESA a county-wide annual staff pool list for the cost report. Wayne RESA sends LEA-specific annual staff pool lists, training invitations, and cost report instructions to the LEA Business Office CHAMPS contacts. The training and instructions remind staff to use the staff pool list for the report. The LEAs that use the Wayne County SMART Financial Tool will also be reminded to use the system's Medicaid staff tool for the report.

Beginning on November 1st, LEAs can access and complete their Local Education Cost Report (LCR) in CHAMPS. The LEA's complete and certified report must be submitted to Wayne RESA by no later than November 30th. As LEA reports are completed, Wayne RESA confirms that annual indirect cost rates, FTEs, reported salaries, benefits, purchased services, and other costs are appropriate and correct. When all reports are received and reviewed, Wayne RESA will compile, certify, and submit its annual Facility Settlement Cost Report (FSCR) using the sub-system in the Community Health Automated Medicaid Processing System (CHAMPS) on or before December 31st for the school year that ended on June 30th of that year.