The Invisible Transformation: How Medicaid in Schools is Transitioning to a New Paradigm

October 14, 2009
3:45 – 5:15 pm
Salons E & F
Agenda

- Introductions
- Session Goals
- Understanding the New Paradigm
- Cost Based Rates
- Lessons Learned
  - The Texas Experience
  - The North Carolina Experience
  - The Illinois Experience
- Blueprint for Success
- Questions
Presenters

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Session Goals

• Contextual and practical awareness needed for managing State Medicaid Plan changes after the rescission of CMS-2287

• Lessons learned and best practices from experience of states whose Medicaid plans have been transformed

• Strategies on how Medicaid and Education officials can collaborate to manage transformation and protect stakeholders
Our Goldilocks Perspective

Our presentation addresses the differences experienced in three states:

• One state whose plan was changed under CMS direction and is a more mature program
• One state who requested plan changes and ended up with extensive changes during CMS review and is a less mature program
• One state whose program changes were initiated through mutual agreement with CMS and is in the early stages of implementation
State Experience

The goals, challenges and lessons learned from three states who are transforming their Medicaid programs

- **Texas**, the first state to transform its program into the new CMS approved paradigm,
- **North Carolina**, which is in its second year under the new paradigm
- **Illinois**, which is literally just now implementing their plan changes
How is it happening?

CMS review and approval of state plans usually has been initiated by one or more of the following events:

- Request by state to change its plan to allow for an expansion of the reimbursement of related services
- Request by state to change its time study methodology and rate setting process
- Plan revisions initiated by CMS in response to a deferral of claims or rejection of legacy methodology

Interactions with CMS affected whether state is requesting changes or directed by CMS to implement those changes.
What is the New Paradigm

• CMS’s New Paradigm is an effort to make Medicaid reimbursement in schools look more like the rest of the Medicaid world

• CMS indicated this at the 2006 NAME conference and again at the 2008 NAME conference

• CMS is applying standardization of time study and cost finding methodologies for use in rate setting, cost reconciliation and final cost settlement
CMS Hot Issues

From CMS Presentation at 2008 NAME Conference:

- Comparability
  - School services vs. Community services
- Freedom of Choice of Providers
  - School providers vs. Community providers

Source: NAME, CMS Presentation
CMS challenge is structural

We know how we got here, but why is it happening...?

- CMS is structured, organized and managed with a focus on community-based health care providers as stakeholders and constituents
- The mission of CMS is to ensure effective, up-to-date health care coverage and to promote quality care for beneficiaries

Source: CMS
CMS’ Vision

• To achieve a *transformed* and modernized health care system

• CMS will accomplish our mission by continuing to *transform* and modernize America's health care system

*Source: CMS*
Medicaid Providers Include...

- Hospitals and clinics
- Pharmacies, laboratories and imaging centers
- Skilled nursing facilities
- Physicians and other clinical providers of care who can be enrolled as Medicaid providers
- These include for profit entities, not-for-profit entities and governmental entities
CMS Stakeholders

- These stakeholders form a natural constituency for CMS
- CMS is organized to provide a wide array of regulatory and compliance monitoring activities related to assuring the integrity of the Medicaid program
- State Medicaid Agencies are single point of contact
- Historically, schools have not been a natural constituency of CMS
RMTS has wrought...

- Random Moment (RMS or RMTS) has been in use by states for decades
- State Medicaid, Social Service and other agencies support the Medicaid program in providing outreach, eligibility determinations, case management and other support
- Standard methodology for state claiming of *administrative* costs since the inception of the Medicaid program
...Uniformity and Rate Setting

- Although in use by states for decades most school based claiming programs did not use it.
- The 2003 Claiming Guide expressly identified RMTS as one of two acceptable approaches.
- RMTS replaced worker day logs for time studies.
- CMS has expressed goal of converting all school based claiming programs to RMTS.
The RMTS Paradigm

- State plans that CMS review must include RMTS
- Roughly a quarter of all states are now in some phase of transitioning to RMTS
- CMS has been transitioning every state to the same paradigm for time studies as has been in use for other agencies
- CMS is transitioning states to transform school district claiming to be generally uniform with other Medicaid providers
The RMTS Paradigm

• While RMTS has been used for decades to reimburse states for Medicaid administrative costs, it has not been applied in determining payments for services until now

• CMS’ New Paradigm requires using RMTS for schools, but inconsistencies with other providers remain

• CMS’s application of RMTS represents a new and unfamiliar approach for school providers
The RMTS Paradigm

CMS is applying RMTS to determine both administrative and direct service costs:

- Results used to calculate administrative claims
- Results used for Direct Services Cost Based Reimbursement Rate Setting
- Annual Cost Reports using uniform, time based cost principles
- Annual Reconciliation of Medicaid payments under the Direct Services program and settlement to actual costs
Direct Service Cost Calculation

• The Direct Medical Services Code is subdivided into IEP and non-IEP medical services

• Examples of non-IEP services include:
  – First aid
  – Medication administration

• An IEP Medicaid ratio is applied to the IEP Direct Medical Service code results to determine the amount of costs attributable to Medicaid covered services provided pursuant to IDEA
## Direct Medical Services Calculation

<table>
<thead>
<tr>
<th>Cost Category</th>
<th>Employee Salary</th>
<th>Other Costs</th>
<th>Federal Funds and Other Reductions</th>
<th>Net Direct Costs (less reductions &amp; Federal Funds)</th>
<th>Indirect Costs</th>
<th>Net Direct Costs plus Indirect Costs</th>
<th>Application of Direct Medical Percentage</th>
<th>Applicatio of IEP Ratio</th>
<th>Medicaid Allowable Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calculation</td>
<td>(A)</td>
<td>(B)</td>
<td>(C)</td>
<td>(D)</td>
<td>(E)</td>
<td>(F)</td>
<td>(G)</td>
<td>(H)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>A + B - C</td>
<td>D * UICR %</td>
<td>D + E</td>
<td>F * Direct Medical %</td>
<td>G * IEP Ratio</td>
<td></td>
</tr>
<tr>
<td>Audiology &amp; Hearing</td>
<td>$19,407</td>
<td>$28</td>
<td>$ -</td>
<td>$19,435</td>
<td>$1,300</td>
<td>$20,735</td>
<td>$11,207</td>
<td>$6,453</td>
<td>$6,453</td>
</tr>
<tr>
<td>Counseling Services</td>
<td>$1,962</td>
<td>-$</td>
<td>$ -</td>
<td>$1,962</td>
<td>$131</td>
<td>$2,093</td>
<td>$1,131</td>
<td>$651</td>
<td>$651</td>
</tr>
<tr>
<td>Nursing Services</td>
<td>$72,774</td>
<td>$4,168</td>
<td>$12,769</td>
<td>$64,173</td>
<td>$4,293</td>
<td>$68,466</td>
<td>$37,006</td>
<td>$21,308</td>
<td>$21,308</td>
</tr>
<tr>
<td>Total</td>
<td>$94,143</td>
<td>$4,196</td>
<td>$12,769</td>
<td>$85,570</td>
<td>$5,724</td>
<td>$91,294</td>
<td>$49,344</td>
<td>$28,412</td>
<td>$28,412</td>
</tr>
</tbody>
</table>
# Comparison of Medicaid Cost Approaches

<table>
<thead>
<tr>
<th>Medicaid Cost Approach</th>
<th>Schools</th>
<th>Other Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determination of Medicaid costs to total costs</td>
<td>IEP ratio and Time Study Results applied to costs</td>
<td>Ratio of Cost to Charges</td>
</tr>
<tr>
<td>Determination of the proportion of staff time spent on Medicaid activities</td>
<td>RMTS</td>
<td>Billing and volume data</td>
</tr>
<tr>
<td>Determination of allowable Medicaid costs</td>
<td>Costs attributable to Medicaid by applying RMTS results to cost data</td>
<td>Costs attributed to Medicaid by allocation of utilization data</td>
</tr>
</tbody>
</table>
### State Experiences: **Texas**

<table>
<thead>
<tr>
<th><strong>Change Imperative</strong></th>
<th>CMS required that no Medicaid funds could be released until a new methodology was approved. State Medicaid implemented a statewide RMTS program and transformed billing and claiming approaches for schools and other state and local agency providers</th>
</tr>
</thead>
</table>
| **The Timeline**       | Very compressed time frame for implementation:  
  • Based on CMS requirement to transition to RMTS and annual cost settlement, State Medicaid released RFP for statewide RMTS in Oct 2006 and awarded in March 2007  
  • RMTS Implemented in April-June 2007 quarter |
| **The Outcome**        | Significant CMS involvement in implementation details  
  • Requirement of 95 +/- 2% sample size  
  • Significant input into programmatic changes and district participation requirements  
  • Coordinated effort and high level involvement from State Medicaid Agency  
  • Effective use of technology  
  • Effective internal coordination |
## State Experiences: North Carolina

<table>
<thead>
<tr>
<th>Change Imperative</th>
<th>Main objective was RMTS and cost report was required by CMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Timeline</td>
<td>State Medicaid initially pursued a transition to RMTS for the administrative claim program, which ultimately required a transition to an annual cost settlement for the direct service program. RMTS implemented in October 2007.</td>
</tr>
</tbody>
</table>
| The Outcome       | • Strong commitment of Medicaid staff to SBHS program  
                      • Requirement of 95 +/- 2% sample size  
                      • Transition to RMTS was successful with 97% statewide compliance  
                      • Distribution and collection of initial cost report completed and review of cost reports by Medicaid still underway  
                      • Administrative claim program data significantly helped districts complete the majority of cost report  
                        • States should consider coordination of data sources and retrieval of data between these two programs  
                      • Coordinating data at state level minimizes reporting errors and maintains consistency across programs |
## State Experiences: **Illinois**

<table>
<thead>
<tr>
<th>Change Imperative</th>
<th>Illinois Medicaid voluntarily viewed a move to RMTS as beneficial in allowing for efficient oversight and monitoring of the LEA program as well as reducing the training and workload required for LEA participation under a worker day log approach</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The Timeline</strong></td>
<td>A competitive procurement was issued November 2008, award made in August 2009 for implementation of the October – December 2009 quarter. Procurement has been planned by Illinois Medicaid for many years</td>
</tr>
</tbody>
</table>
| **The Outcome**                        | Short term results are extremely positive:  
  - Prior to RMTS, 85% LEA participation and under RMTS 94% LEA participation  
  - CMS is mandating +/-2% for survey, Illinois Medicaid is continuing conversations to move to +/-5%  
  - Statewide training, live and webinar, provided and attended by just under 100% of the 940 LEAs in the State  
  - Interest level among LEA’s is very high |
Blueprint for Success

Be Prepared

• Start planning early
• Know the end game
  – Reporting requirement
• Include CMS once State knows what the State wants to accomplish
• Know the methodology
• Understand all phases of operations before roll-out
• Leverage vendor relationships
Cost Report Data Collection Process

Start-Up

Review

Collection
# Start-Up

## Clearly Define Roles and Responsibilities

<table>
<thead>
<tr>
<th>District</th>
<th>State</th>
<th>Vendor</th>
</tr>
</thead>
<tbody>
<tr>
<td>RMTS</td>
<td>Medicaid</td>
<td>RMTS</td>
</tr>
<tr>
<td>• Compile Participant List</td>
<td>• RMTS Monitoring</td>
<td>• Provide application and toolset</td>
</tr>
<tr>
<td>• Monitor Time Study Compliance</td>
<td>• Financial Monitoring</td>
<td>• Assist in compliance monitoring</td>
</tr>
<tr>
<td>Financial Reporting</td>
<td>• MAC Financials</td>
<td>• Financial Reporting</td>
</tr>
<tr>
<td>• MAC Financial Data</td>
<td>• Cost Report</td>
<td>• Collection</td>
</tr>
<tr>
<td>• Cost Report Financial Data</td>
<td>Education</td>
<td>• MAC and Cost Report Data</td>
</tr>
</tbody>
</table>

Define Other Roles
Start-Up

Communication

- Utilize Multiple Channels
  - Medicaid
  - Education
  - Vendor
  - Other Agencies or Entities

- Training
  - Live
  - Webinar

- Support
  - Hotline
  - Dedicated Staff

- Time Lines and Due Dates
  - Post online
  - Frequent emails and follow-up

- Consistency

- Role of Vendor (partner)
  - Application
  - Communication
  - Follow-up
Collection

- **Leverage the MAC Program**
  - Although the Cost Report is utilized for rate setting for Direct Services, processes and data gathered are similar to MAC
  - **Similarities**
    - Cost Report
    - Participant List
    - Contacts
    - Time Study Percentages
    - Quality Assurance
    - Training

- **Potential Conflicts with FFS Vendors**
Collection

• Electronic Entry and Submission
  – Help in the review process
• Consistency
  – Forced formatting of data
  – Required fields
  – Easy to make changes and alterations with minimal impact to districts
• Push Quality Assurance Parameters Upon Data Entry
  – Eliminate ‘silly’ mistakes and typo’s
  – Gather follow-up information up front
Review

• Electronic Review
• Data Quality Checks
  – Compare District Figures
  – Trend Analysis
• Electronic Status Tracking
• Electronic Adjustments and Modifications
  – OIG Review
  – District ‘Approval’ or ‘Denial’
• Reconciliation: Collection vs. Payout
Key Success Factors

• Plan for success--know the “end game” before you start
• Understand reasons for CMS recommendations
• Leverage experience of other states
• Avoid Medicaid vs. Education conflicts
• Work together to get Plan developed and approved
• Ensure program oversight sustainability amid budget limitations
Plan for Success

- Demonstrate to CMS that program oversight and monitoring are robust and ongoing
- Understand Medicaid cost principles to demonstrate how state method complies
- Minimize transformational disruption for LEAs
- *Keep the money flowing...*
Challenges and Opportunities

- State-Based or LEA-Based Implementation:
  - Benefits
  - Challenges
- Contradictory CMS guidance
- CMS committing to a State timeline
- Type of Plan Being Revised
- Sampling and Statistical Validity
- Cost principles of Direct Services
- Data redundancy
Reporting and Compliance

- RMTS
- Cost Reconciliation
- IDEA Compliance Data vs. Medicaid Cost Reporting Data
- How are Cost Reporting requirements for LEAs Different?
Things to Avoid

- Contradictory guidance from CMS
- Excessive involvement by CMS in toolsets used
- Duplicative processes
- Excessive sampling and compliance requirements
- Cost principles that are more restrictive than for other provider groups
- Credentialing and Certification inconsistencies
Questions?

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