

March 3, 2010 Topical Conference Call
Provider Credentials,

“How to Keep Credentials
Uncomplicated”.

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● PARTICIPATION

Based on the survey prior to the call, we have 24 states participating. This would include representatives from Medicaid Agencies, State Education Agencies, Local Education Agencies (LEA's), Consulting / Billing Agencies, Advocacy or Professional Organizations, State treasury Dept. and a Member of the National School Psychologist Organization.

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●PURPOSE

The purpose of this of this call is not to advise states or LEA's about what specific Credentialing Requirements apply in individual states, rather, it is a discussion on sharing of information to provide an understanding about the importance of how credential requirements must be part of the systems employed by LEA's. It is imperative to recognize that every state Medicaid program sets forth provider participation requirements and these may vary from state to state.

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Have you ever thought about?

- *What do the centers for Medicare and Medicaid Services (CMS) really require for provider credential services?
- *How do /don't Medicaid and Special Education credential requirements intersect?
 - *How do IDEA's highly qualified requirements intersect with Medicaid credential requirements? What if IDEA is higher? What if Medicaid is higher?
 - *Every state Medicaid programs sets forth provider participation requirements and each state is different.
- *If the Medicaid credential requirements in a state are a barrier to billing for schools, how can / should they proceed to effectively make changes in their state? Can **Early Periodic Screening, Diagnosis and Treatment (EPSDT)** be a route to use?

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Our Honored Guest Speaker

Caroline Brown

Caroline Brown is a Partner, out of the Washington DC office of Covington & Burling LLP. She is a *Magna Cum Laude* graduate of Harvard Law School and currently practices in the areas of Federal / State programs – Health Care and Litigation. She counsels state and local health and welfare agencies, consulting firms and health care providers on federal rules and policies governing Medicaid as well as other federally funded programs such as State Children’s Health Insurance Programs, Temporary Assistance to Needy Families, Child Support and Paternity Establishment, Title IV- E Foster Care and Adoption Assistance, and Food Stamps. Ms. Brown regularly represents clients in federal and state courts including Medicaid and other federal – state programs, employee benefits and constitutional cases. Ms. Brown has handled administrative cases within the U.S. Department of Health and Human Services before administrative hearing officers, the Departmental Appeals Board (DAB) and the Provider Reimbursement Review Board (PRRB).

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Medicaid Credentialing In Schools

Caroline M. Brown

Covington & Burling LLP

March 3, 2010

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What is Credentialing?

- Credentialing is the process used to evaluate the qualifications and credentials of health care providers by (1) standard setting; (2) collecting information and documentation to determine if those standards have been met; and (3) validating the information submitted.

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Caroline: The basic question about credentials is what are they? There are three aspects.

Credentialing in Medicaid

- The standards are established by (1) federal Medicaid regulation; (2) state Medicaid rules; and (3) state licensing boards.
- The information gathering and verification is conducted by the State (or its fiscal agent) for individually-enrolled providers or by a delivery system, such as a managed care entity or a school district, that submits claims for services provided by individual providers.

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Caroline: Takes into account there are federal and state requirements and so it can get confusing. Standards are set by the feds and states give the specific parameters.

No Credentials Are Necessary for Administrative Claiming

- There are no credentials required for claiming for the costs of activities such as outreach, facilitating eligibility determination, program planning and coordination, training, and referral, coordination and monitoring of services.
- Although federal regulations provide that administrative activities performed by “skilled professional medical personnel” (SPMPs) are reimbursable at a 75% (rather than 50%) match rate, in 2002 CMS took the position that professional training and expertise is not necessary for these activities in the school context and that it would not pay the enhanced match for SPMP administrative activities in schools.

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Caroline: MAC (Medicaid Administrative Claiming) has no specific federal credential requirements. Federal regulations do provide SPMP (skilled professional- medical professional) gets 75% FFP (federal financial participation) as opposed to normal MAC 50%. In 2002, CMS (Centers for Medicare and Medicaid Services) took a position that no SPMP is required in schools to conduct MAC activities. Credentials used to be important to MAC in schools but not since 2002.

Credentialing Is Critical For Claims for School-Based Services

- Medicaid will reimburse only pay for services described in the Medicaid statute and the state plan.
- Federal and state rules set the standards as to what credentials are needed.
- “School-based services” is not its own category of service and in general the State cannot have different credentials for schools than for its other providers.

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Caroline: Credentials are necessary and important for school based claiming. MA (Medicaid) will pay only if in federal statute and the State Plan, the feds and the state both set forth requirements. School-based services is not a separate service. School-based services is not its own category. It defines a location where services otherwise covered can be provided. So, the consequence is you can't have separate standards for school-base providers, they must be comparable to the standards for community based providers.

Components of Credentialing

- Federal definitional requirements
- State professional license
- MMIS Requirements
- Additional state requirements
- Excluded Provider List



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Caroline: The federal definition for credentials is found in the definition of the service. On top of that you must apply the state professional licensing requirements. To that, we add the MMIS (Medicaid Management Information system) required data elements the state must have on file and additional state requirements set out in the approved State Plan. Last, we exclude any providers for whom MA won't pay.

Federal Requirements

- The federal definitions of various Medicaid services often set forth requirements as to the qualifications of the individual performing the service. (42 C.F.R. Part 440).
- If the provider does not meet these qualifications, the State does not have the discretion to make the service reimbursable under Medicaid.



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Caroline: The federal requirements in the definition of services is found at 42 CFR (code of Federal Regulations) part 40. States can add to the requirements but they cannot subtract from them.

Physical Therapy

- A *qualified physical therapist* is an individual who is—(i) a graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent; and (ii) where applicable, licensed by the State.

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Caroline: Physical Therapy from the federal definition

Occupational Therapy

- A *qualified occupational therapist* is an individual who is (i) Registered by the American Occupational Therapy Association; or (ii) a graduate of a program in occupational therapy approved by the committee on Allied Health Education and Accreditation of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association.

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Caroline: Occupational Therapy from the federal definition

Speech Pathologist

- A “*speech pathologist*” is an individual who meets one of the following conditions: (i) Has a certificate of clinical competence from the American Speech and Hearing Association. (ii) Has completed the equivalent educational requirements and work experience necessary for the certificate. (iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

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Caroline: Speech language pathology (SLP) is different from PT/OT. It provides a possibility to have education and work experience and it opens the door for supervised work experience.

“Equivalency” Determinations

- States can seek equivalency rulings from their State Attorney General in instances where they believe State licensure is equivalent to ASHA certification for speech pathologists.
- The equivalency determination should be submitted to CMS, who must approve it in order for Medicaid reimbursement to be available.



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Caroline: SLP is also different because it allows an equivalency. States may ask their State AG (Attorney General) if the state’s licensure requirements are equivalent. The AG opinion is submitted to CMS who must agree it is equivalent and approve.

Audiologist

- A *qualified audiologist* means an individual who: (A) has a Certificate of Clinical Competence in Audiology granted by the American Speech-Language-Hearing Association; (B) has successfully completed a minimum of 350 clock-hours of supervised clinical practicum (or is in the process of accumulating that experience under the supervision of a qualified master or doctoral-level audiologist); performed at least 9 months of full-time audiology services under the supervision of a qualified master or doctoral-level degree in audiology, or a related field; and successfully completed a national examination in audiology (or meets State licensing requirements that meet or exceed these requirements).

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Caroline: Audiology is slightly different. It recognizes that the service can be provided under a qualified audiologist.

Nurse practitioner services

- *Nurse practitioner services* means services that are furnished by a registered professional nurse who meets a State's advanced educational and clinical practice requirements, if any, beyond the 2 to 4 years of basic nursing education required of all registered nurses.

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Caroline: Nurse Practitioner references state practice requirements. The feds do not set this, it is referred to the state.

Personal care services

- *Personal care services* means services . . . provided by an individual who is qualified to provide such services and who is not a member of the individual's family.

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Caroline: Most open ended requirement

Rehabilitative Services

- “Rehabilitative services” includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level.

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Caroline: Rehab services (option) for many school-based services fall here including mental health and behavioral services. There is a hook to this described on next slide

Medical or other remedial care

- Medical care or any other type of remedial care means any medical or remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice as defined under State law.

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Caroline: It's hard to have a covered service if the state does not have a license for the practitioner.

State's Responsibilities in Medicaid

- Ensure that providers are qualified to render specific services under the Medicaid program by screening applicants for State license and certification, by Specialty Board certification if appropriate, and by visit to the provider by a review team if necessary.
- Review enrolled providers on a continuing basis to ensure that they continue to meet provider eligibility requirements.

Source: State Medicaid Manual sec. 11320.

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Caroline: It is the state's responsibility. States are obligated to assure if a claim for services is paid that the individual meets all the qualifications of the feds and the state.

State Processes and Requirements

- States are allowed to determine how they will credential their Medicaid providers. These requirements may be stringent in one State, but less stringent in another.
- States have discretion to impose or implement additional requirements or processes to determine if providers are, or continue to be, eligible for participation in the program.

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Caroline: Varies.....there is state to state decision to impose the requirements.

Required Elements for Medicaid Management Information System

- Name
- Address
- Previously Assigned Medicaid Provider Number
- Payment Mailing Address
- Group Name
- Group Address
- Group Number
- Type of Provider
- Type of Practice Organization
- Employer Identification Number
- Social Security Number
- Medicare Provider Identification Number

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Caroline: There is nothing magic in addition to the credentials and the license.

Other Types of State Requirements

- Particular degree (e.g., M.S.W.) or work experience with a particular population
- External validation of license or qualifying course work
- Bonding
- Background checks
- Fingerprinting
- On-site visits

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Caroline: Other

Exclusion Rules

- Sections 1128 and 1156 of the Social Security Act bar certain individuals and entities from participating in a federal health program, including Medicaid
- Bases for exclusion include convictions for program-related fraud and patient abuse, licensing board actions and default on Health Education Assistance Loans.



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Caroline: OIG (Office of Inspector General) exclusion rules apply. The Social Security Administration (SSA) rules for exclusion conditions that include: program fraud, patient abuse, etc.

Consequences of Exclusion

- Medicaid will not pay for any item or service furnished, ordered, or prescribed by an excluded individual or entity, including
 - all methods of reimbursement
 - payment for administrative and management services that are a necessary component of providing items and services to Medicaid recipients
 - payment to cover an excluded individual's salary, expenses or fringe benefits, regardless of whether he or she provides direct patient care, when those payments are reported on a cost report or are otherwise payable by the Medicaid.
- In addition, civil monetary penalties may be imposed against Medicaid providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid recipients.

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Caroline: If an individual provider is “excluded” their costs can’t be included in the cost report. It’s important to check this list.

How to Check for Exclusion

- All excluded individuals and entities are listed on the OIG's website at <http://oig.hhs.gov/fraud/exclusions.asp>
- The web site has information in both on-line searchable and downloadable formats, and it is updated on a regular basis. The OIG web site sorts the exclusion of individuals and entities by: (1) the legal basis for the exclusion, (2) the types of individuals and entities that have been excluded, and (3) the State where the excluded individual resided at the time they were excluded or the State where the entity was doing business.
- CMS recommends that providers search the website monthly.

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Caroline: The list of excluded providers is updated monthly.

Need for Recredentialing

- No set schedule is established by federal regulation, but many states require re-credentialing at least every three years



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Caroline: There is no federally set time frame to re-check credentials. It is up to the state licensing requirements, State Plan, etc.

Any Questions?



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Q. Why does Medicaid have different requirements in obtaining parental authorization than Special Ed?

A. This is a consent question. There is no federal Medicaid requirement. A state Medicaid program may have a requirement, but it is not likely to go beyond the federal requirements.

Q. If other states are paying for services provided by certified speech language pathology assistants – and / or what might CMS's view be on this? Also, are S/L therapists required to have their CCC's (Certificate of Clinical competence)?

A. If they don't have their CCC's or equivalency and have not completed the education / supervision requirement they can't be reimbursed. States may have different standards.

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Q. (1) In NY State, certain school professionals, such as certified school psychologists are not licensed professionals and therefore can't provide services outside of the school setting. We are having issues in our State Plan Amendment regarding this and I am wondering if any other states have resolved this issue in their SPA and what the outcome was?

(2) Barriers to actually bill for behavioral / mental health / psych services makes this an off limits area or extremely limited area to bill Medicaid.

(3) School Psychologists in many states are now ineligible to provide school based Medicaid services due to CMS requirements. This is severely impacting services to children in some areas. What can be done to align CMS requirements with State Education Agency (SEA) requirements for the provision of services?

(4) Please consider discussing the essence of the amendment to the Social Security Act (SSA) that allows schools to receive Medicaid

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reimbursement for Individualized Education Plans (IEP) services, and acknowledge that the structure of the Special Ed world is legitimate and can be built upon, NOT dismissed. Specifically: a) the premise that Medicaid recognizes state have the right to regulate health care professionals – in our state (NY), there are two state level entities who do this – the licensing boards, nursing, speech, psychologists, OT, PT, etc. AND the state board of education, that has been licensing / certifying professionals who have completed educational, experiential and clinical requirements to work with children in our public schools. The CMS and our state Medicaid agency will not recognize those professional as equivalent speech, psychologists, consultants with post masters education, unless the attorney general say's they are equivalent.

A. It is up to the state to establish qualifications for providers. For mental health and other re-hab services the state can't have different qualifications for schools and they can't reimburse for different services in and out of the schools.

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Jane Reagan, MI: If there are no credential requirements for MAC , why does CMS allow only certain folks who can participate?

Caroline: I am not aware of certain credential requirements for MAC. Sometimes the time study and costs bleed the two together because of how the time study is conducted.

Jane: I will try to pull my state MAC specifics for credentials because some staff can't be in the time study.

Caroline: Sometimes there is criteria established about who should be in because they are the most likely to be engaged in that type of activity.

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Unknown Name : Schools are loosing because they can't bill school mental health services. How can we work with CMS?

Caroline: My experience in a couple of states is that the Medicaid agency has qualifications in place for the community and can't have non-comparable standards in schools. School based service is only a place of service not a separate category. This is the biggest (credential) barrier for schools in billing. CMS does not have much flexibility unless school based services were to have it's own category or allowed distinction based on location. These are very fundamental changes. Equivalency is only available for speech – language pathologists.

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Unknown Person: In Oklahoma there is a way the professional license of the school Psychologist allows equivalency based on federal rules like the speech – language pathologists. There is a waiver states can apply for if they have staff shortages.

Caroline: I am not aware of any type of waiver for this.

Unknown Person: There are federal requirements for school psychologists and they have a Masters plus additional training and education and some have a doctorate. Sounds like the re-hab option is a system that could allow this scope of practice so it depends on how the state makes up the requirements. There are parts of this comment that are missing due to problems with the audio on the telephone. Our appologies.

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Unknown person: For OT and PT, is there a prescription required ?

Caroline: Under federal regulations both require a physicians prescription. Under the re-hab option, is also included a “practitioner of the healing arts”. Therefore, when a state permits, it can be okay for OT / PT to self refer.

Unknown person: With the MAC discussion, are we confusing job classification with credentials?

Caroline: Yes, the requirements lay out who can be in the study.

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Caroline: Lets talk briefly about EPSDT (Early Periodic Diagnosis and Treatment). It's a provision of Medicaid we mentioned earlier that requires a Medicaid Agency must provide medically necessary services to children.

- It broadens the obligation but does not change qualifications of providers. Only the scope is broadened, qualifications stay the same.

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Rena: Where does Orientation and Mobility Specialist fit in licensure requirements?

Caroline: I have not heard of requirements for that.

Jane Reagan, *Sharing a Comment*. Michigan allows payments for Orientation and Mobility services under these billing codes, 97533, 97535, G9041, G9042 and v2799. There is a national credentialing body, Academy for Certification of Vision Rehabilitation and Education Professionals. At the local level, our school districts are responsible to assure all staff have credentials and to conduct self audits. Michigan does not license speech-language pathologists, but requires them to have their CCC's or they have to be working under someone with their CCC's. Some have Masters and other additional training. School Psych's are licensed. Our state level standards meet or exceed federal standards.

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