

## SIFTING THROUGH THE MEDICAID MAZE FOR THERAPY SERVICES IN SCHOOLS

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## PRESENTER BIOS

**Laurie Alban Havens, M.A.** CCC-SLP has served as Director, Private Health Plans and Medicaid Advocacy at the American Speech-Language-Hearing Association (ASHA) for the past six years. With advanced degrees in speech-language pathology and health care administration, she has services as a compliance officer, reimbursement consultant, skilled nursing facility administrator, and as a speech-language pathologist. She is ex officio to ASHA's Medicaid Committee and facilitator of ASHA's State Advocate for Reimbursement (STAR) network, representatives from each state who address Medicaid issues.

**Lou Malerba** is a retired speech-language pathologist who has practiced in a variety of school-based settings on Long Island before accepting a position as a Director of Special Education and ultimately Assistant Superintendent for Special Education. He currently serves on ASHA's School Finance Committee (SFC) and as the SFC representative to ASHA's Medicaid Committee. He has held positions on the executive boards of New York State Speech Language Hearing Association (NYSSLHA) and Long Island Speech Language Hearing Association (LISHA) as well as the Council for Advancement and Support of Education (CASE) in eastern Suffolk County, New York.

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## DISCLOSURE

- Neither Laurie nor Lou has received any financial compensation for this presentation.
- Both are members of ASHA and represent committees in that organization

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## LEARNING OUTCOMES

- Reinforce the importance of the School Medicaid Program
- List ways that the school Medicaid program provides needed services and support to children in schools
- Describe the unique challenges associated with Medicaid-covered treatment for school-based providers

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## WHO WE ARE - ASHA SCHOOL FINANCE COMMITTEE MISSION

We make recommendations to and work with National Office staff to: (a) develop strategies and initiatives to ensure appropriate coverage and reimbursement for audiology and speech-language pathology services to children in schools; (b) help ASHA members better identify and understand the complex and multiple funding processes involved in school-based services from federal, state, and local perspectives; (c) assure that the strategic finance needs and interests of both ASHA member audiologists and speech-language pathologists in school-based settings be considered and represented in the Association's annual public policy agenda; and (d) make referrals to other ASHA committees and boards for input, consideration, or action as appropriate on school finance issues of concern to ASHA members that relate to practice, research, academics, and credentialing activities of the Association.

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## WHO WE ARE - ASHA MEDICAID COMMITTEE'S MISSION

- To address speech-language pathology and audiology coverage and payment issues within the Medicaid system. Advocacy efforts, member education and needed strategies are implemented to ensure audiology and speech-language services and devices are provided through the federal Medicaid program and incorporated in each state plan including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) programs. The Medicaid Committee also monitors and informs stakeholders relative to on-going implementation of Affordable Care Act requirements (for example, the Essential Health Benefits).

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## AGENDA

- You know the mantra – you see one state, you see one state – but wait there's more, you see one district, you see one district
- A few of the basics
- We have a list of challenges, but what are yours?
- A few facts so we're on the same page
- Review our challenges – add yours
- Suggest strategies

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## STATISTICS



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## MEDICAID IN SCHOOLS

- Section 1903 (c) of Section 411 of the Medicaid Catastrophic Coverage Act:
  - amended allows Medicaid coverage of health related services to children under Individuals with Disabilities Education Act (IDEA).
- Section 1903(a) of the Social Security Act:
  - requires Medicaid to pay for covered services in an Individual Education Program (IEP)

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### SCHOOL-BASED SERVICES

- Centers for Medicare and Medicaid Services (CMS) recognizes school providers, as long as all Medicaid requirements for the provision and reimbursement of Medicaid services are followed
- Medicaid qualified provider
- IEP or Individual Family Service Plan (IFSP) included services are covered

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### MEDICAID/SCHOOL-BASED SERVICE

- Some states have changed the requirements so that a physician's signature is needed for billing Medicaid in the schools (vs. the IEP serving as statement of Medical Necessity)
- Overlap of school provided vs. private provider of services

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### MEDICAL NECESSITY

- Authority to function autonomously within the scope of practice of a human services profession is signified when members of that profession:
  - are a point of entry for services that fall within its scope of practice;
  - select the appropriate candidates for those services;
  - determine appropriate diagnostic methodology and suitable approaches to and throughout the duration of treatment;
  - effect referrals for services to be provided by other speech-language pathologists and audiologists as well as by members of other professions

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### MEDICAL NECESSITY

- The determination made on a case-by-case basis, taking into account the particular needs of the child.
- States are permitted (but not required) to set parameters that apply to the determination of medical necessity in individual cases, but those parameters **may not contradict or be more restrictive than** the federal statutory requirement.

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### MEDICAL NECESSITY

- In states where health care is delivered to enrolled children through managed care organizations (MCOs), the MCOs must make medical necessity determinations according to parameters set by the state, or according to the federal statutory requirements if the state has not adopted its own parameters.
- National Academy of State Health Policy– fed/state definitions per EPSDT/Medicaid <http://www.nashp.org/medical-necessity/>

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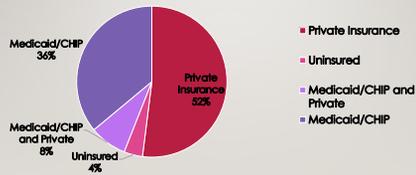
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### 44% OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS HAVE MEDICAID OR OTHER PUBLIC INSURANCE



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### IMPORTANCE OF SCHOOL MEDICAID PROGRAMS

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- Importance of billing and funding positions
- Making up the gap for IDEA and budgets
- Provides for technology (real-time billing, reduction in paperwork, connection with technology)
- Need for streamlining of information between districts as well as across states
- Timely access to care

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### IMPORTANCE OF SCHOOL MEDICAID PROGRAMS

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- Population of Medicaid recipients: Monetary access to services limited – knowledge of advocacy is limited – schools can help advocacy efforts/access to care
- Impacts on workload/caseload
- Medicaid money received from billing can be used for people, staffing, equipment
- Reduction of caseload= better care for students

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### IMPACT OF LOSING FUNDING FOR STUDENTS

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- Fewer or underqualified professionals
- Under-identified or unidentified students
- Reduced or eliminated non-mandated areas of general education
- Less or uneven progress
- Less support for mental health
- Less support to fund other expenses
  - Ex. feeding, AAC, HA/HATI/ALD Equipment

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### IMPACT ON PROFESSIONALS

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- Cuts to positions resulting in increase to caseload
- Eliminated resources
  - Technology
  - Materials
  - Staff development
- Job satisfaction

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### PARENT DISSATISFACTION

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- Concerns about progress or lack thereof
- Quality of service provision
- Highly qualified providers
- Due process
- Financial impact\*

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### JUMPING IN – WHAT ARE THE CHALLENGES

- Telepractice
- Managed Care
- Prior Authorization
- Parental Consent
- Overlap of schools/private
- Qualified Provider
- Supervision/Clinical Fellow
- Referrals
- Documentation
- Paperwork/administrative tasks
- What other challenges are you facing?

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### MEDICAID REIMBURSEMENT FOR TELEPRACTICE FOR SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY

- ★ In the future
- In New York/DC
- In New York/DC only
- ▲ In New York/DC and other states
- In New York/DC and other states
- Medical only, no non-Medicaid patients
- Medicaid only, no non-Medicaid patients
- Limited reimbursement for Medicaid patients only
- Not covered




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### MANAGED CARE ORGANIZATIONS (MCOs)

- More states are moving to the managed care model, in which the state Medicaid agency contracts with a plan to provide all the health care services that an enrollee needs.
- The plan then makes its own rules for what services are approved, and often caps the number of allowed sessions.
- Caveat – Not all MCOs operate the same way

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### PRIOR AUTHORIZATION (PA)

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- Providers must get approval before beginning treatment, and often the approval is for a limited period of time or number of sessions, requiring providers to obtain re-authorization to continue treatment beyond the limit.
- The unique challenge in the school is that you have to provide services in accordance with the IEP, regardless of Medicaid's requirements and potential stop/start/delay in funding awaiting authorization

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### PARENTAL CONSENT

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- Show of hands –
  - How many need parental consent once?
  - How many need consent more often?
  - Once a year?
  - Every six months?
  - Do you have to get the consent or does someone else obtain this?

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### OVERLAP SCHOOLS/PRIVATE

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- Coordination of treatment between school-provided and private treatment
- States billing private insurance prior to billing Medicaid

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### DOUBLE DIPPING?

- Susie, age 7 is seen in school once a week for 30 minutes a week in a group of four to address multiple speech and language problems. Her family is Medicaid eligible and her services are billed to Medicaid. Her physician along with her family have concerns about her overall functioning because of her multiple problems and refers her to a private provider. The SLP identifies specific areas that would be best addressed in an individual setting that would augment the services that she is receiving in school. She provides treatment and also bills Medicaid.

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### QUESTIONS

- Is this double dipping into the Medicaid system?
- What documentation does the clinician need to provide to justify treatment?
- How could services provided to the child be most beneficial?

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### PAPERWORK

- School districts often require additional paperwork for Medicaid students.
- In some cases providers must enter information twice to meet the unique payer and administrative requirements.
- Also, many districts require providers to complete Medicaid paperwork for *all* students on their caseload, even though not all are Medicaid-eligible.
- What's the fix? Ideally, more districts will use software that captures IEP and Medicaid information at the same time.

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### QUALIFIED PROVIDERS

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- Holding state licensure does not guarantee ability to bill for Medicaid clients.
- Providers must often apply to the Medicaid agency; in some states, however, the LEA has a provider number and individual SLPs can bill under that number.
- Requirements may vary depending on educational level.
- What's the fix? Providers should check the definition of who is a qualified provider in their specific setting, usually through the state Medicaid agency.

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### SUPERVISION/SIGNING OFF

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- Who is able to provide service determines who bills?
- What does signing off mean?
- Adequate time to supervise/review documentation?

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### REFERRALS

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- Is the IEP team's referral adequate
- Is physician referral needed – recent issues in Ohio and Illinois
- Illinois – Clinicians can refer for each other, but can't refer and treat the same child
- Ohio – Received clarification about who is a "licensed practitioner of the healing arts"

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## SPECIFIC RULES

- Each state defines how it will administer its Medicaid program, and each plan determines the policy for implementation. These policies form the framework for local education agencies (LEAs)
- The multiple levels of information-sharing may result in misinterpretation or misunderstanding of the rules. For instance, the state may say that SLPs are qualified "licensed health care professionals," but the district may recognize only physicians.
- Some LEAs add extra rules to comply with other district-specific requirements. The challenge is to make sure that all LEA directives meet the requirements of the state plan.
- What's the fix? Review the state plan. It is ultimately your responsibility to obtain this.

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## DOCUMENTATION

- Documentation of services and sessions is a challenge for all providers, regardless of setting.
- What's the fix?
  - Use the available resources to make sure your documentation reflects medical necessity and other requirements.
  - Where possible, work with other health care professionals in the district to develop streamlined documentation

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## CODING

- Providers use two sets of codes. The first—Current Procedural Terminology (CPT, © American Medical Association) indicate procedures. Most Medicaid agencies use the codes, though some have developed their own coding requirements.
  - If the LEA requires the codes, the provider—or other personnel—must include that number in the record and/or billing sheet.
- The second code set is the International Classification of Diseases-Clinical Modification (ICD-10-CM), which indicates diagnoses. The physician or team may assign the code, within their scope of practice.
- Who is assigning codes?

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## PAPERWORK/ADMIN TASKS

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- Other responsibilities like
  - Obtaining consent
  - Coordinating with private treatment
  - Billing for everyone whether they are currently on caseload or not

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## BURDEN

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- Some LEAs choose not to apply for Medicaid reimbursement because of the multiple tasks that are required:
  - obtaining parent consent,
  - dealing with administrator directives,
  - adjusting to electronic health record, and/or
  - data entry.
- However, because of their need for funding, more districts are deciding to bite the bullet and apply for reimbursement for Medicaid-eligible students.
- What's the fix? Just make sure you are aware of—and comply with—the specific requirements

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## THE FUTURE

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- The future of Medicaid is uncertain. National health plan proposals under consideration include cuts in Medicaid, and how those cuts could affect service delivery models is unknown.
- What's the fix?
  - Keep informed about changes.
  - Find out how the decisions will affect the services provided in your state.
  - Look for opportunities to provide input and recommendations by serving on committees that include providers in the stakeholder group.
  - Continue to document treatment outcomes that demonstrate the value of the services you provide.

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## FUNDING ALTERNATIVES – PER CAPITA CAP/BLOCK GRANTS

- Medicaid funding helps support critical early childhood and education services, including home visiting programs, development services that help ensure school readiness, special education services in public schools, school-based health care services, and even school nurses.
- Most children in Medicaid, and many of those with special health care needs, are in what are considered “mandatory” categories – those with incomes below the poverty line and those receiving Supplemental Security Income (SSI). Children with disabilities can be found in both of those categories. These children all receive the mandatory EPSDT benefit. States will have to continue providing these services to these children, although the strong likelihood is that they would slash payments to pediatricians, children’s hospitals and others that serve them.

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## RESOURCES

- National Association of State Health Plans (NASHP) EPSDT Resources**  
<http://www.nashp.org/epsdt/resources-improve-medicad-children-and-adolescents>
- Medical Necessity by State: <http://www.nashp.org/medical-necessity/>
- Kaiser Family Foundation (KFF)**
- Getting into Gear for 2014: Shifting New Medicaid Eligibility and Enrollment Policies into Drive <http://kff.org/medicaid/report/getting-into-gear-for-2014-shifting-new-medicad-eligibility-and-enrollment-policies-into-drive/>
  - Medicaid and CHIP eligibility <http://kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-children-at-application-effective-january-1-2014/>
  - Medicaid Quiz <http://kff.org/quiz/medicaid-quiz>

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