

Medicaid Reimbursement: Ohio Case Study

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The following is a transcript of a video that appears at
<http://www.apa.org/ed/graduate/about/reimbursement/index.aspx>

Hi, I'm Dr. Kevin Arnold and I am here to talk to you about how Ohio dealt with the internship match problem, and specifically, how to fund internships using Medicaid. Being in private practice, I first learned about the internship match problem not from an academic or training perspective, but from a practice perspective when attending the ASPPB conference and heard Dr. Sharon Berry's presentation. When she described the match disparity, it occurred to me that Ohio might be able to do something to help its graduate students looking for internship site matches.

I presented the idea to OPA leadership and OPA agreed to work on the problem. They asked me to put together a proposal. That meant that I needed to review the literature, not only on the match disparity, but also on how STPAs in the past had created solutions regarding internship sites. The most prevalent solutions that STPAs had developed were consortium models that ran statewide. In addition to that, I analyzed APPIC data, and APPIC requirements for both internship sites and consortium sites. I prepared a report and a set of proposals and presented it to OPA. The OPA then asked me to create a task force that was largely populated by the members of the executive committee. It was strategic that the task force be made up mostly by executive committee members so that the task force could have access to leadership at OPA when trying to implement its work.

An initial problem was funding. Coming up with an internship site without funding is like coming up with no internship site at all. It seemed obvious to us that Medicaid funding was going to be necessary. If we were going to have adequate stipends and cover the administrative costs for any internship, whether a consortium or an individual internship site, Medicaid funding seemed obviously one of the primary solutions to the problem. It was this point when talking with leaders at OPA as well as in the medical community that I discovered what I've now come to think of as commonly believed myths. These are the types of ideas or notions that form in groups and then become believed whether true or not. And one of those myths was that Medicaid funding could not be used to pay for interns. In fact, when we were looking at this prior to 2014, it was clear that internship sites could be funded for individual doctoral level psychology interns, but that the supervision requirements were so onerous that most sites would find them impossible to fulfill in order to obtain Medicaid funding. In particular, the supervision requirements were that the supervisor met with the patient every single session.

This moved the task force away from developing the model and toward an advocacy role to change that type of rule. In working with the Ohio Psych Associations Director of Professional Affairs, we approached Medicaid. It was an opportune moment. The governor had decided to

expand Medicaid funding as part of the overall federal effort to do the very same thing across the states. The Medicaid director and office was not only committed to increasing coverage but also increasing access to services, and they offered us a chance for us to draft rules for them to consider. OPA asked that I draft these rule, and when I did, I worked on language that eventually would fit inside a broader and less time-consuming version of supervision. We suggested that direct contact with the supervisor occur at the first session and once per quarter, along with direct oversight of records and that the supervision definition change.

The rules were reshaped by the Medicaid office, although most of the changes we asked were kept. The rules were promulgated in 2013 for comment. There were very few comments if any at all, and the rules that had been drafted went into effect January of 2014. You might think that was the end of the work that we had to do. But it isn't. We then had to ensure that those rules were implemented effectively. In Ohio there is a Managed Care Organization model, where most of the Medicaid services are delivered under the MCOs. So, if the changes were going to work, we had to see that the MCOs were going to implement them effectively. My own practice is a large group in Central Ohio, so we decided to use it to test the idea of Medicaid funding for interns.

We had our staff contact Provider Relations in one of the large MCOs only to discover that the people in positions that I might refer to as push-the-pay-button positions, were unaware that interns could be reimbursed, and told us that they would deny any services codes that reflected internship services. We went back to the DPA, we went back to Medicaid. Medicaid reiterated that the rules were changed and that MCOs must follow those rules. It was at this point that the DPA then approached the director for the Medicaid MCO that we contacted. Through a series of iterations that went over perhaps as many as five months, we were able to obtain an advisory memo from the director at the MCO that we contacted which went down to the folks that pushed the pay button, that advised them that interns could be paid and that they were obliged to process those claims for payment. To quote what that director said: "My apologies for a delayed response. I believe we communicated to Bobbie [that's the DPA] that this is in fact a covered, billable service and that we have communicated this updated information to our Provider Relations reps. If you have any issue, feel free to let us know, but you should be able to bill accordingly. Thank you for bringing this to our attention. There are several new rules for our Provider Reps to be aware of and unfortunately, issues related to enhanced primary care payments made available under the Health Reform Law, and the ICD-10 change/delay has been keeping them rather busy. Hope you have a great weekend."

We tested this several times including testing it with other MCOs, and found that the change had been made. We then decided to try to set up a consortium and analyze the APPIC stipend data, but as began to work toward identifying consortium sites and survey the graduate students, it became clearer that the role of OPA might be better served by consulting to sites developing their own internships. We discovered in the course of the two years we worked on the consortium concept that several new internships in Ohio were developing. They needed help on how to complete the internship application process and how to access Medicaid funding.

A case in point is pretty useful, I think. The Ohio State Department of Psychiatry and Behavioral Health created an internship in 2014 in clinical health psychology. When they moved toward a Medicaid-funding model, the compliance office at the Ohio State University Medical Center told them that they would not be able to bill for psychology doctoral interns through Medicaid. We provided assistance over a two month period to the internship director that led to a resolution of the problem. We discovered that the main problem stemmed back to the definition of billable providers, and supervision definitions. There is a prohibition in the Ohio Medicaid rules that states that unlicensed individuals cannot be reimbursed by Medicaid; however, the rule that had been written through our work with Medicaid office stated that the work of unlicensed doctoral interns could be reimbursed. The compliance office was focusing on the prohibition rather than the exception. The prohibition states that reimbursement cannot occur under personal and direct supervision. The type of supervision we had written in for the doctoral level interns, however, was general supervision.

This may seem like a simple linguistic issue but it is not. The definition of different types of supervision inside Medicaid is a very serious matter. We worked with the internship director to educate their compliance personnel on the differences in the supervision, and pointed them to the psychology law which permits unlicensed interns to practice psychology under the supervision of a training supervisor. We helped them to define, out of the Medicaid rules at the state and federal level, that direct supervision had a different definition than general supervision, and that the psychology interns were required to receive general supervision. This formed the basis of the decision by the compliance personnel to allow Medicaid reimbursement for doctoral interns. In Ohio, that reimbursement has to be done under the name of the psychologist who is providing the supervision. There is a specific code used that indicates that the services were provided by a supervisee. Things having to do with the definition of a rendering provider and a billing provider come into play here, but are beyond what I would like to discuss today. However, when we discussed these issues with my practice's general counsel, so that we were knowledgeable and my advice was based on legal advice I had received, I learned more about the various definitional terms and how providers were referred to within the Medicaid rules than I ever imagined I would learn or know.

In the end, we were able to identify the mechanisms for the supervision to the Ohio State compliance folks and resolved the issues for the internship. In summary, your state may or may not be permitted to bill for doctoral psychology interns. If it is not, advocacy to seek that is probably a good idea. If they are, you'll need to identify any mistaken or mythical ideas about how it should go about, and seek the general supervision model as the one that defines how doctoral interns will be supervised. Thanks a lot. I've had a lot of fun working on this and I look forward to continuing my work as the task force chair, helping graduate students have an increased number of internships with adequate funding so they can complete their training and move on to being licensed psychologists.