
Local Educational Agency Medi-Cal Billing Option Program

Report to the Legislature

Report Period Fiscal Year 2019-20
(July 2019 through June 2020)



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EXECUTIVE SUMMARY

Schools nationwide play a critical role in providing health care services to students, particularly those requiring special education services. For many schools, federal Medicaid reimbursements are an important source of revenue for providing necessary health services to students. Under the Local Educational Agency (LEA) Medi-Cal Billing Option Program (LEA BOP), California's participating school districts and County Offices of Education are partially reimbursed by the Federal Government for health services provided to Medi-Cal enrolled students.

A report published by the United States General Accounting Office (GAO)¹ in April 2000 estimated that California ranked in the bottom quartile, with respect to the average claim per Medicaid-eligible child, of states with school-based Medicaid programs. Senate Bill (SB) 231 (Ortiz, Chapter 655, Statutes of 2001) was signed into law in October 2001, to reduce the gap in per child recovery for Medicaid school-based reimbursement among California and the three states receiving the most per child from the Federal Government. The mandates of SB 231 were amended by Assembly Bill (AB) 1540 (Committee on Health, Chapter 298, Statutes of 2009) and by AB 2608 (Bonilla, Chapter 755, Statutes of 2012). Welfare & Institutions (W&I) Code Section 14115.8 requires the California Department of Health Care Services (DHCS) to amend California's Medicaid State Plan with the goal of enhancing Medi-Cal services provided at school sites and access by students to those services. This report contains information on California's school-based Medicaid reimbursement program and covers the timeframe of fiscal year (FY) 2019-20.

Since SB 231 was chaptered into law, federal oversight of school-based programs by the Centers for Medicare and Medicaid Services (CMS) and its audit agency, the Office of the Inspector General (OIG), has increased. OIG audits of Medicaid school-based programs in 30 states have identified over a billion dollars in federal disallowances for services provided in schools. These reports were part of a series in a multi-state initiative to review costs claimed for Medicaid school-based services.

The OIG continues to audit school-based programs, and in recent years, has shifted their focus to validating state Random Moment Time Surveys (RMTS). Recent significant OIG audit findings have involved not complying with Federal statistical sampling requirements, cost allocation plan deficiencies and the lack of documentation to support moments coded as direct medical services.

¹ [GAO Report page; https://www.gao.gov/assets/230/228961.pdf](https://www.gao.gov/assets/230/228961.pdf); the General Accounting Office is now known as the Government Accountability Office (GAO).

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This shift in the OIG's focus to reviewing the statistical validity of the RMTS is notable, as California's LEA BOP is currently in the process of implementing RMTS as part of the direct medical service reimbursement methodology. The OIG's current work plan indicates that they expect to issue a report in 2021 on whether states claimed Medicaid costs that were supported and allocated on the basis of random moment sampling systems that deviated from acceptable statistical sampling practices (report number W-00-17-31467). In addition, the OIG's active work plan includes a review of Medicaid school-based costs claimed related to consultants that are paid a contingency fee based on federal funds reimbursed to the state (report number W-00-18-31529). This report, expected in 2021, will include a multi-state review to determine whether consultants developed school-based Medicaid rates based on unsupported time studies and unallowable costs.

California's LEA BOP reimbursement more than doubled since its authorization under SB 231 due to LEA Program expansion, increased participation, and claiming of covered Medi-Cal services by qualified practitioners. However, since 2015-16, the LEA BOP reimbursement has declined due to several factors, including suspension of claiming for Targeted Case Management, a requirement for a health service practitioner to order, refer or prescribe treatment services, and the delay in approval of State Plan Amendment (SPA) 15-021, which created anxiety about how costs would be reconciled back to July 1, 2015. The following table identifies LEA BOP Medi-Cal fee-for-service (FFS) interim reimbursement trends by fiscal year in California.

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LEA BOP Trends FY 2000-01 to FY 2018-19

Fiscal Year	Number of Participating LEA Providers	Total Medi-Cal Reimbursement ⁽¹⁾	Percentage Change from FY 2000-01
FY 2000-01	436	\$59.6 million	N/A
FY 2001-02	449	\$67.9 million	14%
FY 2002-03	459	\$92.2 million	55%
FY 2003-04	469	\$90.9 million	53%
FY 2004-05 ⁽²⁾	461	\$63.9 million	7%
FY 2005-06 ⁽²⁾	470	\$63.6 million	7%
FY 2006-07 ⁽³⁾	461	\$69.5 million	17%
FY 2007-08 ⁽³⁾	472	\$81.2 million	36%
FY 2008-09 ⁽³⁾⁽⁴⁾	479	\$109.9 million	84%
FY 2009-10 ⁽³⁾⁽⁴⁾	484	\$130.4 million	119%
FY 2010-11 ⁽³⁾⁽⁴⁾	497	\$147.8 million	148%
FY 2011-12 ⁽³⁾	519	\$137.9 million	132%
FY 2012-13 ⁽³⁾	531	\$145.6 million	144%
FY 2013-14 ⁽³⁾	535	\$148.7 million	150%
FY 2014-15 ⁽³⁾	536	\$149.5 million	151%
FY 2015-16 ⁽³⁾⁽⁵⁾	537	\$143.9 million	142%
FY 2016-17 ⁽³⁾⁽⁵⁾	538	\$131.6 million	121%
FY 2017-18 ⁽³⁾⁽⁵⁾	539	\$133.7 million	124%
FY 2018-19 ⁽³⁾⁽⁵⁾	537	\$124.2 million	108%

Notes:

(1) Total Medi-Cal reimbursement amounts are rounded.

(2) Total Medi-Cal reimbursement was significantly impacted by the Free Care policy implemented by CMS that stated Medicaid payment was not allowed for services that were available without charge to the beneficiary or community at large.

(3) Total interim Medi-Cal reimbursement is based on date of service and updated to reflect paid claims after implementation of Erroneous Payment Corrections (EPCs) for LEA services, correcting previous claims processing errors that were incorrectly paid and denied.

(4) Total Medi-Cal reimbursement also reflects increased Federal Medical Assistance Percentage (FMAP) through the American Recovery and Reinvestment Act (ARRA) of 2009. The increased FMAP was effective October 2008 through June 2011.

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(5) Total Medi-Cal reimbursement for FY 2015-16 through FY 2018-19 reflects the suspension of reimbursement for Targeted Case Management (TCM) services, effective 7/1/2015, until a new rate methodology is approved by CMS.

After a lengthy review process by CMS, the first SPA prepared as a result of SB 231 was approved in March 2005 and implemented on July 1, 2006 with an effective date of April 1, 2003. SPA 03-024 increased both treatment and assessment reimbursement rates for a majority of LEA BOP services provided to California's Medi-Cal enrolled children in a school-based setting. Since this SPA's implementation in FY 2006-07, LEA BOP interim reimbursement has increased approximately 79 percent.

In September 2015, DHCS submitted SPA 15-021 to CMS to expand the LEA BOP. After a lengthy review process, SPA 15-021 was approved by CMS in late April 2020. The SPA allows for several new practitioner types, as well as incorporates new covered assessment and treatment services in the LEA BOP. In addition, the SPA includes a RMTS component to the LEA BOP reimbursement methodology that will capture the amount of time spent providing direct health services by qualified health practitioners. Finally, SPA 15-021 will remove the 24 services in a 12-month period limitation, which previously applied to Medi-Cal general education students receiving LEA BOP covered services. DHCS will implement SPA 15-021 in FY 2020-21.

DHCS considers collaboration with its LEA stakeholders an important aspect of the LEA BOP's success. For instance, in the 2019-20 program year, DHCS participated in the Medi-Cal for Students Workgroup. The Medi-Cal for Students Workgroup was established by SB 75 (Committee on Budget and Fiscal Review, Chapter 51, Statutes of 2019) for the purpose of reviewing and evaluating the access and coordination of Medi-Cal for students in California. SB 75 required the California State Departments of Education and Health Care Services to form the Workgroup, which is tasked with identifying program requirements and support services needed to improve coordination and expansion of access to available federal funds through the LEA BOP, the School-based Medi-Cal Administrative Activities (SMAA) Program, and the medically necessary federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits.

As part of the Workgroup's Steering Committee, DHCS participated in a single-day in-person meeting in February 2020 and a two-day virtual meeting in May 2020. The Workgroup conducted activities, including stakeholder surveys, interviews, and a national scan/comparative analysis in order to evaluate the access and coordination of Medi-Cal for students in California. The Workgroup used the information to prepare and submit a Progress Report to the Legislature and Department of Finance (due October 1, 2020). The Progress Report includes a detailed timeline for the implementation of the Workgroup activities, information on the structure of the workgroups, frequency of

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meetings, and other relevant information.² The final report to the Legislature is due in October 2021.

DHCS routinely works with LEA stakeholders to address concerns and improve the LEA BOP. The LEA BOP Advisory Workgroup is comprised of a large group of LEA stakeholders that meets every other month to discuss program issues and concerns. This group assists DHCS in identifying barriers to reimbursement for LEAs, provides LEA perspective and feedback on important issues, and recommends new services and improvements to the LEA BOP. In addition, the LEA BOP Advisory Workgroup suggests and recommends enhancements to the LEA BOP website and other communication venues to improve LEA BOP provider communication and address relevant provider issues. As part of the bi-monthly meetings, the group conducts general discussion sessions to brainstorm challenges and barriers related to a specific discussion topic. Using this forum, DHCS is able to leverage the expertise of members to suggest potential solutions and recommendations to enhance the LEA BOP. Approximately 50 to 75 LEA BOP stakeholders are present at these meetings, in addition to representatives from DHCS, the California Department of Education (CDE), and Guidehouse (formerly known as Navigant Consulting), DHCS' operational consultant. In February 2019, DHCS implemented remote participation to allow for broader stakeholder participation. DHCS now routinely provides a dial-in number and WebEx presentation to allow remote stakeholders the opportunity to listen in and hear general LEA BOP updates in the morning session.

During this reporting period, DHCS has continued its work to identify and resolve LEA BOP barriers, expand the services provided to Medi-Cal students, and enhance communication to LEA stakeholders.

DHCS accomplished many goals in FY 2019-20, including preparing to implement SPA 15-021, as well as providing continued support of LEA BOP growth in many ways, including:

- Identifying and resolving technical claims processing issues and system changes;
- Drafting revised information in the LEA BOP portion of the Medi-Cal Provider Manual (LEA BOP Provider Manual), with stakeholder input;
- Updating LEA BOP regulations;

² [MediCal for Students: https://www.medi-calforstudents.org/](https://www.medi-calforstudents.org/)

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- Providing technical assistance to LEAs, including answering provider questions sent to the LEA BOP Inbox;
- Completing inflation of reimbursement rates for FY 2020-21;
- Providing additional resources and guidance to LEA BOP providers, including publication of Policy and Procedure Letters to provide clarity on LEA BOP policy including new policies concerning telehealth and updating the LEA BOP website;
- Developing and conducting seven LEA BOP training opportunities for LEAs, including the following training topics:
 - SPA 15-021 overview
 - SPA 15-021 new services and practitioners
 - LEA BOP update for billing vendors
 - Specialized medical transportation and targeted case management
 - SPA 15-021 implementation and RMTS requirements
 - CRCS updates for FY 18-19, and
 - Telehealth;
- Completing FY 2018-19 rate inflation payment adjustments;
- Conducting an outreach campaign to inform LEAs of the benefits of participating in both school-based programs and to inform LEAs about upcoming RMTS requirements that impact participating LEA BOP providers;
- Facilitating LEA BOP Advisory Workgroup meetings and activities to provide a forum for Workgroup members to identify and discuss relevant issues and make recommendations for changes to the LEA BOP; and
- Working on Cost and Reimbursement Comparison Schedule form submissions, auditing issues, and policies and procedures for outstanding Cost and Reimbursement Comparison Schedule submissions.

The work completed during this reporting period has largely been due to the working relationships between DHCS and the many officials of school districts, County Offices of Education, CDE, and professional associations representing LEAs. DHCS looks forward to continued collaboration with the LEA stakeholder community to implement SPA 15-021.

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I. INTRODUCTION

One of the goals of SB 231 is to reduce the estimated gap in per-child Medicaid school-based reimbursements among California and the three states that receive the most per child from the Federal Government. With this goal in mind, SB 231 added W&I Code Section 14115.8 requiring DHCS to amend California's Medicaid State Plan with the goal of enhancing Medi-Cal services provided at school sites and access by students to those services. W&I Code Section 14115.8 requires DHCS to:

- Ensure that schools shall be reimbursed for all eligible school-based services that they provide that are not excluded by federal law;
- Examine methodologies for increasing school participation in the LEA BOP;
- Simplify, to the extent possible, claiming processes for LEA BOP billing;
- Eliminate and modify State Plan and regulatory requirements that exceed federal requirements when they are unnecessary;
- Implement recommendations from the LEA BOP rate study (LEA BOP Rate Study) to the extent feasible and appropriate³;
- Consult regularly with CDE, representatives of urban, rural, large, and small school districts and County Offices of Education, Local Educational Consortiums (LECs), and LEAs;
- Consult with staff from CMS, experts from the fields of both health and education, and state legislative staff;
- Undertake necessary activities to ensure that an LEA shall be reimbursed retroactively for the maximum period allowed by the Federal Government for any change that results in an increase in reimbursement to LEAs;
- Encourage improved communications with the Federal Government, CDE, and LEAs;
- Develop and update written guidelines to LEAs regarding best practices to avoid audit exceptions, as appropriate;
- Establish and maintain a user-friendly, interactive LEA BOP website; and

³ AB 430 (Cardenas, Chapter 171, Statutes of 2001) authorized LEAs to contribute to a rate study to evaluate existing rates and develop rates for new services in the LEA BOP. DHCS completed the rate study in 2003. DHCS rebased rates in FY 2010-11 using the 2003 rate study and annually updates the rates for inflation.

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- File an annual report with the Legislature. Table 1 on the following page includes the annual legislative report requirements.

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Table 1: Annual Legislative Report Requirements

Report Section	Report Requirements
III	<ul style="list-style-type: none"> • An annual comparison of other states’ school-based Medicaid programs in comparable states. • A state-by-state comparison of school-based Medicaid total and per eligible child claims and federal revenues.⁴ The comparison shall include a review of the most recent two years for which completed data is available. • A summary of DHCS activities and an explanation of how each activity contributed toward narrowing the gap between California’s per eligible student federal fund recovery and the per student recovery of the top three states. • A listing of all school-based services, activities, and providers⁵ approved for reimbursement by CMS in other state plans that are not yet approved for reimbursement in California’s state plan and the service unit rates approved for reimbursement.
IV	<ul style="list-style-type: none"> • Identification of any barriers to LEA BOP reimbursement, including those specified by the entities named in the legislation that are not imposed by federal requirements, and describe the actions that have been and will be taken to eliminate them. • Official recommendations made to DHCS by the entities named in the legislation and the action taken by DHCS regarding each recommendation. The entities are CDE, representatives of urban, rural, large and small school districts and County Offices of Education, the LEC, LEAs, staff from Region IX of CMS, experts from the fields of both health and education, and internal departmental staff.
V	<ul style="list-style-type: none"> • A one-year timetable for SPAs and other actions necessary to obtain reimbursement for the school-based services, activities, and providers approved for reimbursement by CMS in other state plans that are not yet approved for reimbursement in California’s State Plan.

⁴ For this reporting period, Medicaid-eligible data for children is not available. For the calculations contained in Table 5, DHCS used federal fiscal year 2019 Medicaid enrollment data, based on unduplicated counts of children who were enrolled in Medicaid.

⁵ In this report, “providers” refer to allowable practitioners who provide services to eligible students; “LEAs” or “LEA providers” refer to school districts, County Offices of Education, charter schools and community colleges that have enrolled in the LEA BOP.

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II. BACKGROUND

Schools play a critical role in providing health services to students, particularly those requiring special education services. Since the 1970s, the Individuals with Disabilities Education Act (IDEA) has mandated schools to provide appropriate services to all children with disabilities.

The LEA BOP provides reimbursement to LEAs for Medi-Cal-enrolled students with disabilities receiving health-related services authorized in a student's Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP). For IEP/IFSP students, these health-related additional services are necessary to assist them in attaining their educational goals. The LEA BOP also provides limited reimbursement for health services included in an Individualized Health and Support Plan (IHSP), such as nursing care, when rendered to general education students (services provided to general education students are referred to as non-IEP/IFSP services). However, if the general education student has other health coverage, the LEA must bill the student's other health coverage prior to billing Medi-Cal for non-IEP/IFSP services.

Medicaid is financed jointly by the states and the federal government. In California, LEAs fund the state share of Medicaid expenditures utilizing a Certified Public Expenditure methodology. Federal Financial Participation funds for Medicaid expenditures are available for two types of services: medical assistance (referred to as "health services" or "direct services" in this report) and administrative activities. School-based health services reimbursable under Medicaid are:

- Health services specified in a Medicaid-enrolled child's IEP or IFSP; and
- Primary and preventive health services provided to Medicaid-eligible general and special education students in schools where other health coverage requirements are met pursuant to Section 1902(a)(17)(B) of the Social Security Act and 42 Code of Federal Regulations, Sections 433.138 and 433.139.

The Centers for Medicare and Medicaid Services (CMS) approved State Plan Amendment 15-021 on April 27, 2020. Claiming for the following new services added to the LEA BOP under SPA 15-021 is expected in FY 2020-21:

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New Covered LEA BOP Services	
Service Type	Service
Assessment Services	EPSDT screening services, such as routine vision and hearing screenings
Treatment Services	Activities of Daily Living (ADL) Assistance Group Occupational Therapy Group Physical Therapy
Treatment and Assessment Services	Nutritional Services Orientation and Mobility Respiratory Therapy
Case Management	Targeted Case Management (TCM) services

Claiming for the following new SPA 15-021 practitioners is expected in FY 2020-21:

New Qualified Rendering Practitioners
Associate Marriage and Family Therapists
Licensed Occupational Therapy Assistants
Licensed Physical Therapist Assistants
Licensed Physician Assistants
Licensed Respiratory Therapists
Licensed Speech-Language Pathology Assistants
Orientation and Mobility Specialists
Registered Associate Clinical Social Workers
Registered Dieticians

DHCS classifies reimbursable LEA BOP services into two main categories: assessments and treatments. Furthermore, services are classified by the population of students served – either IEP/IFSP services provided to special education students, or non-IEP/IFSP services provided to general education students. The following information illustrates the services reimbursed under LEA BOP.

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Assessment Services

The following eight IEP/IFSP assessment types, representing approximately 99 percent of total assessment reimbursement in FY 2018-19, are reimbursable in the LEA BOP:

IEP/IFSP Assessment Type	Qualified Practitioners
Psychological	Licensed psychologists Licensed educational psychologists Credentialed school psychologists
Psychological/Psychosocial Status	Licensed clinical social workers Credentialed school social workers Licensed marriage and family therapists Credentialed school counselors
Health	Registered credentialed school nurse
Health/Nutrition	Licensed physician/psychiatrist
Audiological	Licensed audiologists
Speech-Language	Licensed speech-language pathologists Credentialed speech-language pathologists
Physical Therapy	Licensed physical therapists
Occupational Therapy	Registered occupational therapists

In addition, the LEA BOP covers the following six non-IEP/IFSP assessment types, representing approximately one percent of total assessment reimbursement in FY 2018-19:

Non-IEP/IFSP Assessment Type	Qualified Practitioners
Psychosocial Status	Licensed psychologists Licensed educational psychologists Credentialed school psychologists Licensed clinical social workers Credentialed school social workers Licensed marriage and family therapists Credentialed school counselors
Health/Nutrition	Licensed physician/psychiatrist Registered credentialed school nurse

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Non-IEP/IFSP Assessment Type	Qualified Practitioners
Health Education and Anticipatory Guidance ⁶	Licensed psychologists Licensed educational psychologists Credentialed school psychologists Licensed clinical social workers Credentialed school social workers Licensed marriage and family therapists Credentialed school counselors
Hearing	Licensed physician/psychiatrist Licensed speech-language pathologists Credentialed speech-language pathologists Licensed audiologists Credentialed audiologist Registered school audiometrist
Vision	Licensed physician/psychiatrist Registered credentialed school nurses Licensed optometrists
Developmental	Licensed physical therapists Registered occupational therapists Licensed speech-language pathologists Credentialed speech-language pathologists

Treatment Services

The majority of LEA BOP expenditures are comprised of treatment services. The following treatment services for Medi-Cal-eligible students represent approximately 62 percent of FY 2018-19 total LEA BOP interim reimbursement.

- Physical Therapy;
- Occupational Therapy;
- Individual and Group Speech Therapy;
- Audiology;
- Individual and Group Psychology and Counseling;
- Nursing Services; and
- School Health Aide Services.

⁶ Anticipatory guidance includes information about the benefits of healthy lifestyles and practices that promote injury and disease prevention.

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Specialized Medical Transportation Services

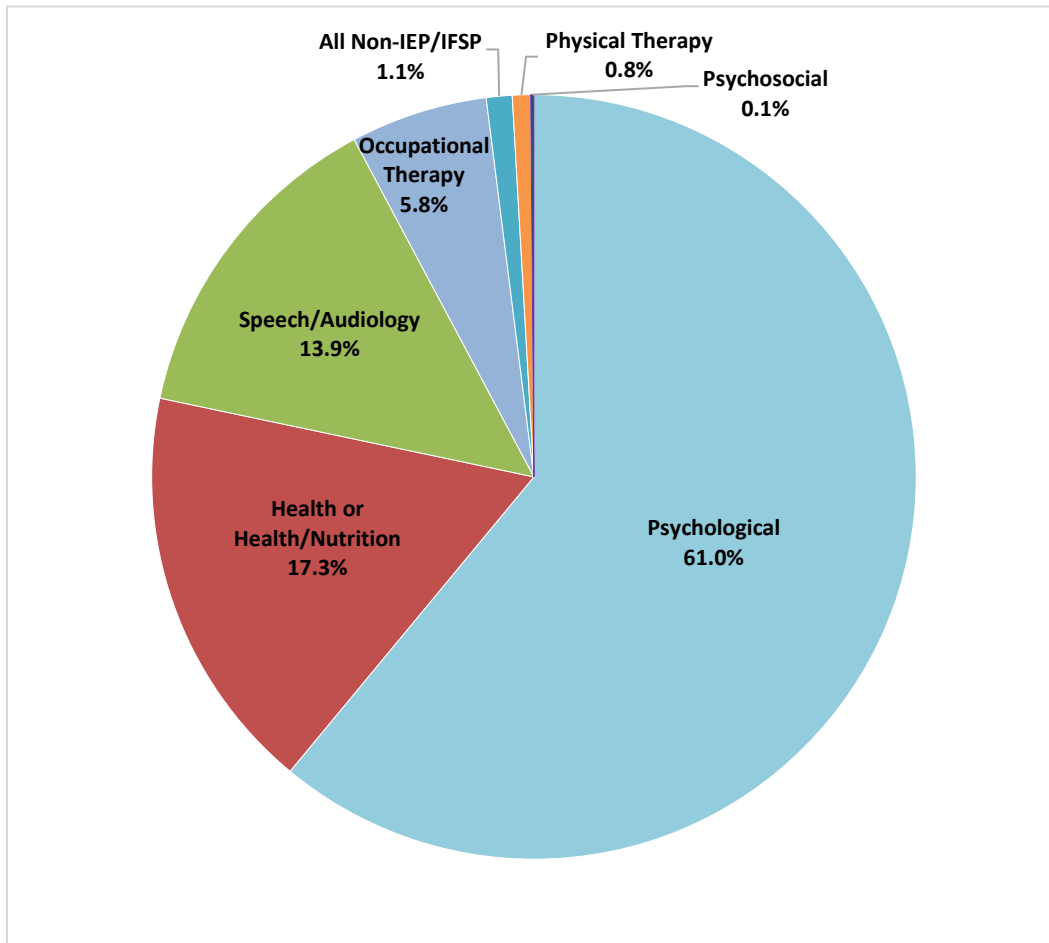
In addition to assessment and treatment services, the LEA BOP covers specialized medical transportation services and associated mileage for Medi-Cal students with transportation included in their IEP/IFSP. Transportation services which represent approximately four percent of total FY 2018-19 LEA BOP interim reimbursement, are billable when LEAs can meet the following requirements:

- LEAs provide transportation in a specially adapted vehicle or vehicle that contains specialized equipment, including but not limited to lifts, ramps, or restraints, to accommodate the LEA BOP eligible beneficiary's disability;
- The need for LEA BOP covered health services and LEA BOP covered specialized medical transportation services is documented in the student's IEP/IFSP;
- LEAs maintain a transportation trip log that includes the mileage, origination and destination point for each student, student's full name, and date of transportation;
- School attendance records can verify that the student was in school and received an approved LEA BOP covered medical service (other than LEA BOP medical transportation) on the date the transportation was provided; and
- The covered service (received on the same day that the student received transportation services) meets all the necessary standards to be billed through the LEA BOP.

The following Figures 1 and 2 illustrate the breakdown of covered assessment and treatment services for FY 2018-19.

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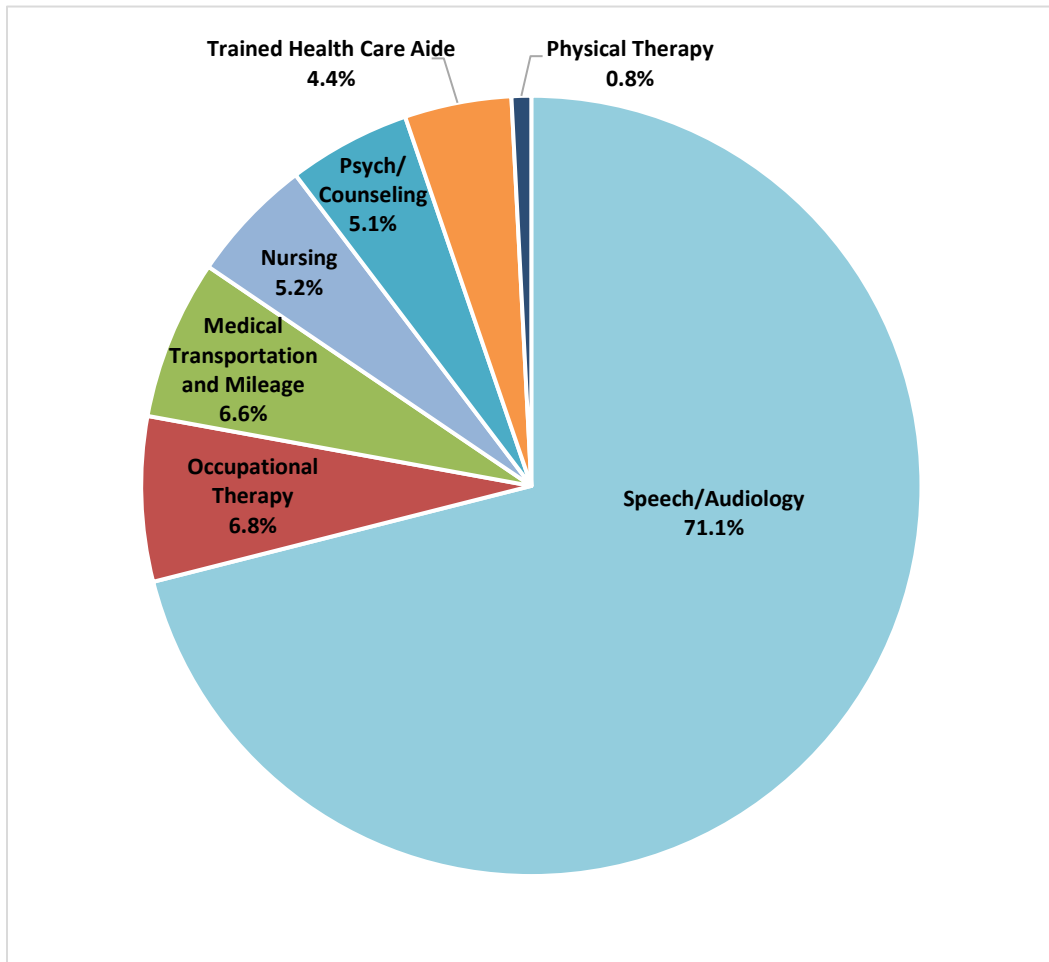
Figure 1: Total LEA Assessment Reimbursement by Type, FY 2018-19



Note: Total LEA assessment reimbursement for FY 2018-19 was \$46.6 million.

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Figure 2: Total IEP/IFSP LEA Treatment Reimbursement by Type, FY 2018-19



Note: Total LEA IEP/IFSP treatment and transportation/mileage service reimbursement for FY 2018-19 was approximately \$76.3 million. Less than one percent of total treatment reimbursement is attributable to non-IEP/IFSP services.

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III. OTHER STATES' SCHOOL-BASED MEDICAID PROGRAMS

Each year, DHCS conducts a survey of other states' school-based Medicaid programs to compare California's school-based programs to other states' programs. DHCS supplements the responses obtained through the survey with publicly available information by reviewing provider manuals and other sources of program information.

School-Based Medicaid Systems in Comparable States

To narrow the list of comparable states, DHCS identifies states that are similar to California using four factors. Table 2 describes the four factors considered and the information source.

Table 2: Factors Considered in Selecting Comparable States

Factor	Source of Information
Number of Medicaid-enrolled children.	Medicaid Program Statistics, Medicaid & Children's Health Insurance Program Enrollment Data, Annual Enrollment Reports, 2019.
Number of IDEA-eligible children aged 3 to 21.	U.S. Department of Education, Data Collections, Part B: Child Count and Educational Environments dataset, 2018.
Average salaries of instructional staff (classroom teachers, principals, supervisors, librarians, guidance and psychological personnel, and related instructional staff).	Rankings of the States 2018 and Estimates of School Statistics 2019, National Education Association (NEA), June 2020.
Per capita personal income.	Bureau of Economic Analysis, Personal Income Summary, 2019.

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The number of Medicaid-enrolled and IDEA-eligible children provides a measure of the number of students that qualify for Medicaid school-based services. The average salaries of instructional staff and per-capita personal income provide a comparison of the cost of living among states. The ten states with the greatest number of Medicaid-enrolled children were identified. Each of these states was ranked from highest to lowest based on the previous four factors. From this analysis, DHCS identified four states as comparable to California: Illinois, New York, Pennsylvania, and Texas. Tables 3a and 3b compare California’s school-based program to the four states selected as comparable to California for this reporting period. These four states were also identified in DHCS’ comparable state analysis for the previous reporting period (Fiscal Year 2018-19).

Table 3a: Direct Service Claiming in California versus Comparable States – Assessments/Screenings

Covered Service	CA	IL	NY	PA	TX
IEP/IFSP	X	X	X	X	X
Non-IEP/IFSP ⁷	X	Not Currently Covered	Not Currently Covered	Not Currently Covered	Not Currently Covered

⁷ Several states are broadening the school health services that can be covered under Medicaid to include services outside of those authorized under provisions of IDEA (termed “non-IEP/IFSP” services in this report). Many states, including some of the comparable states, are currently undergoing discussions regarding the potential expansion to direct service claiming.

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Table 3b: Direct Service Claiming in California versus Comparable States – Treatments (Pursuant to an IEP/IFSP)

Covered Service	CA	IL	NY	PA	TX
Assistive Devices				X	
Audiology	X	X		X	X
Physician Services	X	X		X	X
Psychology and Counseling	X	X	X	X	X
Speech Therapy	X	X	X	X	X
Medical Equipment/Supplies		X			
Nursing Services	X	X	X	X	X
Occupational Therapy	X	X	X	X	X
Orientation & Mobility	X			X	
Personal Care	X ⁸			X	X
Physical Therapy	X	X	X	X	X
Respiratory Care	X				
School Health Aide Services	X	X			
Transportation	X	X	X	X	X

Many states, including those identified above, finance their school-based direct health service claiming programs utilizing Certified Public Expenditures, which are cost-settled on a retroactive basis. Under this reimbursement methodology, providers must complete an annual cost report as part of the cost reconciliation process. In California, the LEAs annually submit the Cost and Reimbursement Comparison Schedule, which compares the interim Medi-Cal reimbursement received throughout the fiscal year to the estimated Medi-Cal costs to provide the health services. LEAs report the actual costs and annual hours worked for all qualified practitioners who provide and bill for LEA BOP services, the units of service, encounters, and related Medi-Cal reimbursement for the appropriate fiscal year on the Cost and Reimbursement Comparison Schedule forms. The Cost and Reimbursement Comparison Schedule compares estimated costs to Medi-Cal interim reimbursement to ensure that DHCS is not reimbursing each LEA BOP provider more than the costs of providing these services, a requirement when utilizing Certified Public Expenditures. This reconciliation results in an amount owed to or from

⁸ In the LEA Medi-Cal Billing Option Program, these services are identified as ADL Assistance Services.

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the LEA; DHCS reimburses underpayments to LEAs in a lump sum, while overpayments are withheld from future LEA BOP claims reimbursement.

State-by-State Comparison of School-Based Medicaid Claims and Federal Revenues

DHCS administered its 16th state survey in October 2020. DHCS contacted states to obtain claims and revenue information for FYs 2018-19 and 2019-20. Multiple follow-up calls and e-mails were conducted between October and December 2020 to states that did not respond to or complete the survey. Some states indicated that they were unable to complete the survey on a timely basis due to a variety of reasons, such as unconfirmed reimbursement totals, internal data request issues, and timing problems; several states did not respond to multiple follow-ups. Twenty-four of 51 states (including Washington, D.C.) completed the survey.⁹ However, of the 24 respondents, three states that currently administer both a school-based health services program and an administrative claiming program did not provide both reimbursement figures for FY 2019-20, since figures were not yet final at the time of the survey.¹⁰ One state (New York) that administers a school-based health services program, but not an administrative claiming program, did provide health services program reimbursement figures for FY 2018-19 but did not have figures available for FY 2019-20. One state (Maine) that administers a school-based health services program, but not an administrative claiming program, did not have health services program reimbursement figures available for FY 2018-19 or FY 2019-20. The following Table 4 provides a complete list of survey respondents.

⁹ DHCS also included Arkansas and Wyoming as part of the state-by-state comparison. Arkansas is not considered a respondent and is not included in the count of 24, since they did not submit a survey response, but data was collected for Arkansas through publicly available information on its state website. DHCS used Arkansas' direct and administrative claiming reimbursement data available online for analysis purposes. Wyoming is also not included in the count of 24, since they did not submit a survey response, but DHCS confirmed they do not have a direct and administrative claiming reimbursement program at the time of the survey.

¹⁰ Kansas, Texas, and Vermont responded to the state survey but did not provide reimbursement figures for FY 2019-20.

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Table 4: Summary of States that Completed 2020 DHCS Survey

Count	State	Administrative Claiming Program	Direct Claiming Program	Administrative Claiming		Direct Claiming	
				Reported for FY 2018-19	Reported for FY 2019-20	Reported for FY 2018-19	Reported for FY 2019-20
1	ALASKA	No	Yes	N/A	N/A	X	X
2	ARIZONA	Yes	Yes	X	X	X	X
3	ARKANSAS ⁽¹⁾	Yes	Yes	X	Not Reported	X	Not Reported
4	CALIFORNIA	Yes	Yes	X	X	X	X
5	CONNECTICUT	Yes	Yes	X	X	X	X
6	DISTRICT OF COLUMBIA	No	Yes	N/A	N/A	X	X
7	INDIANA	Yes	Yes	X	X	X	X
8	IOWA	No	Yes	N/A	N/A	X	X
9	KANSAS	Yes	Yes	X	X	Not Reported	Not Reported
10	MAINE	No	Yes	N/A	N/A	Not Reported	Not Reported
11	MARYLAND	No	Yes	N/A	N/A	X	X
12	MASSACHUSETTS	Yes	Yes	X	X	X	X
13	MINNESOTA	No	Yes	N/A	N/A	X	X
14	MISSOURI	Yes	Yes	X	X	X	X
15	NEW MEXICO	Yes	Yes	X	X	X	X
16	NEW YORK ⁽²⁾	No	Yes	N/A	N/A	X	Not Reported
17	NORTH CAROLINA	Yes	Yes	Not Reported	Not Reported	Not Reported	Not Reported
18	OKLAHOMA	No	Yes	N/A	N/A	X	X
19	RHODE ISLAND	Yes	Yes	X	X	X	X
20	TEXAS ⁽²⁾	Yes	Yes	X	X	X	Not Reported
21	VERMONT	Yes	Yes	Not Reported	Not Reported	X	X
22	VIRGINIA	Yes	Yes	X	X	X	X
23	WASHINGTON	Yes	Yes	X	X	X	X
24	WEST VIRGINIA	Yes	Yes	X	Not Reported	X	Not Reported
25	WISCONSIN	Yes	Yes	X	Not Reported	Not Reported	Not Reported
26	WYOMING ⁽³⁾	No	No	N/A	N/A	N/A	N/A
Counts		17	25	15	12	21	17

Notes:

(1) Arkansas did not submit a survey response, but DHCS collected data for Arkansas through publicly available information on its State website. Only FY 2018-19 Arkansas data was available online at the time of this report.

(2) Of the four states that are considered comparable to California, two responded to the survey (New York and Texas). New York reported data only for direct services, as they do not have an administrative program. Texas reported direct services and administrative program data, but direct claiming data was not available for FY 2019-2020. Illinois and Pennsylvania did not respond to the survey.

(3) Wyoming did not submit a survey response, but DHCS confirmed that Wyoming does not have an administrative or direct program.

In April 2000, the GAO report (referenced on page two), estimated that California ranked in the bottom quartile with respect to the average claim per Medicaid enrolled child. It is important to note that the GAO report and DHCS surveying results cannot definitively compare direct claiming program dollars spent per Medicaid-eligible or Medicaid-enrolled students among states. This is primarily due to the basic inability to split Medicaid-eligible students between direct claiming and administrative claiming programs. Also, since Medicaid-eligible data for children was not available at the time of this report for all states, DHCS used Medicaid-enrolled data for this year's state

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comparison, making a direct comparison to the 2000 GAO report difficult. For those respondent states that operate both programs (16 states, including California), only the combined program dollars can be divided by the number of Medicaid-enrolled children, in order to calculate a practical result. As such, Table 5 (page 23) comparisons for those dual-program states that attempt to compare direct claiming dollars per enrolled child are inadvertently impacted by the inclusion of administrative claiming program dollars.

Furthermore, in the state survey, some states did not provide both direct claiming and administrative claiming reimbursements for various reasons. For example, out of the 16 respondent states that administer both programs and provided reimbursement data, five states did not report complete data for their direct claiming program and/or administrative claiming program. Eight additional states reported having either a direct claiming program or an administrative claiming program, but not both programs. Without complete direct claiming and administrative claiming reimbursement information, the ranking of the average claim per Medicaid-enrolled child is skewed and does not allow for a fair comparison among states and to the GAO 2000 report.

In addition to a lack of complete program reimbursement data from states, there are several other reasons that direct comparisons among states make it difficult to draw sound conclusions from Table 5.

- Federal Medical Assistance Percentages (FMAP) vary among states: DHCS calculates each state's total estimated claiming expenditures (federal share) by dividing the reported direct and administrative Medicaid reimbursement by the state's FMAP. The differences in state FMAP influence the average claim per Medicaid-eligible child. FMAPs ranged from 50 percent to 76.39 percent in FY 2018-19 and from 50 percent to 76.98 percent in FY 2019-20.¹¹
- Covered services and covered qualified practitioners differ from state to state: The cost of school-based service providers can range from expenditures for physicians to non-skilled health aide workers. Depending on which services states cover and the associated cost of the rendering practitioners, direct

¹¹ On March 18, 2020, the President signed into law H.R. 6021, the Families First Coronavirus Response Act (FFCRA) (Pub. L. 116-127). Section 6008 of the FFCRA provides a temporary 6.2 percentage point increase to each qualifying state's FMAP under section 1905(b) of the Social Security Act (the Act) effective beginning January 1, 2020 and extending through the last day of the calendar quarter in which the public health emergency declared by the Secretary of Health and Human Services for COVID-19, including any extensions, terminates. The FMAP increases have not been considered in the analysis.

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claiming figures will vary among states, particularly those with a cost settlement reimbursement methodology.

- Timing of finalized reimbursement information: As more states move to a Certified Public Expenditure reimbursement methodology (where interim payments are compared to actual costs and result in an end-of-year cost settlement), interim reimbursement diverges from what is eventually paid to school-based providers. The timing of this state survey does not align with the availability of final state cost settlement figures used in the analysis of the average claim per Medicaid-enrolled child, due to the length of time that individual states may conduct their audit or review of LEA BOP provider costs. For example, California's direct claiming program is not required to complete the cost settlement process until more than four years after the close of the fiscal year in which interim payments were made to LEAs.

Of the 16 respondent states that have both programs, including California, ten were able to submit reimbursement figures for both direct claiming and administrative services for FY 2018-19 and FY 2019-20. However, of these ten, only two states were able to provide the final reimbursement figures for both direct claiming and administrative services for each of these years.

Table 5 summarizes survey results for Medicaid reimbursement (federal share) for direct claiming and administrative services for the two most recent periods, FYs 2018-19 and 2019-20. Several states did not have finalized figures available for FY 2019-20 due to timing of cost settlement. When states provided data for both of the fiscal years surveyed, Medicaid direct claiming and administrative services reimbursement (federal share) was divided by each state's FMAP to calculate total estimated claiming dollars. These figures were then divided by each state's number of Medicaid-enrolled children to estimate the average claim amount per Medicaid-enrolled child.

As illustrated in Table 5, Vermont had the highest FY 2018-19 and FY 2019-20 average claim of \$798 and \$747, respectively. California's average claim was \$116 and \$107 for these two periods.¹² However, using California's direct service paid claims reimbursement data and the number of actual unduplicated LEA BOP beneficiaries who received LEA BOP services (approximately 328,000 students for FY 2018-19 and

¹² California's direct health service claiming figure for FY 2019-20 includes reimbursement paid to LEAs as of December 2020. LEAs have until July 2021 to submit claims for services rendered in FY 2019-20, which results in an understated cost per child figure for that year.

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276,000 students for FY 2019-20), the total average direct service claim per Medicaid-enrolled student was approximately \$379 for FY 2018-19 and \$340 for FY 2019-20.

It is important to note that these survey results do not generally reflect any past, current, or expected adjustments due to prior or on-going OIG or CMS investigations or audits in any state. The direct claiming figures for California are based on interim payments and do not include any audit adjustments made by DHCS.

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**Table 5: Medicaid Reimbursement and Claims by State,
Ranked by 2019-20 Average Claim per Medicaid-Enrolled Child**

State	SFY 2018-2019 ⁽¹⁾			SFY 2019-2020 ⁽¹⁾		
	Federal Medicaid Reimbursement (000's)	Total Claims (000's)	Average Claim Per Medicaid- Enrolled Child ⁽²⁾	Federal Medicaid Reimbursement (000's)	Total Claims (000's)	Average Claim Per Medicaid- Enrolled Child ⁽²⁾
VERMONT	³ \$ 30,449	\$ 56,533	\$ 798	\$ 28,526	\$ 52,963	\$ 747
DISTRICT OF COLUMBIA	^{4,8} 31,923	45,604	560	33,424	47,749	587
RHODE ISLAND	29,047	55,803	512	26,167	50,400	462
IOWA	⁴ 70,743	115,593	342	52,349	85,538	253
MASSACHUSETTS	⁸ 94,605	189,210	352	65,746	131,491	244
MARYLAND	⁴ 53,594	107,187	195	46,686	93,371	170
ARIZONA	⁸ 58,259	87,108	101	66,233	100,832	117
NEW MEXICO	⁸ 47,607	72,331	182	26,602	46,415	117
MINNESOTA	^{4,8} 49,513	99,027	152	37,100	74,200	114
CALIFORNIA	⁸ 261,692	523,384	116	242,825	485,651	107
MISSOURI	⁸ 28,276	53,830	91	32,921	63,222	107
KANSAS	³ 13,239	26,479	108	12,224	24,448	99
CONNECTICUT	⁸ 24,966	49,932	138	16,791	33,583	93
VIRGINIA	⁸ 40,966	81,931	120	20,561	41,122	60
INDIANA	21,165	35,647	53	22,595	39,082	59
ALASKA	⁴ 1,878	3,756	36	1,132	2,264	22
WASHINGTON	⁸ 5,480	10,960	13	3,595	7,189	9
TEXAS	^{3,8} 741,525	1,222,846	362	11,133	22,265	7
OKLAHOMA	⁴ 2,152	3,260	6	1,902	2,881	6
NEW HAMPSHIRE	^{5,7} 26,380	52,760	592	-	-	-
NEW YORK	^{3,4} 378,489	756,978	365	-	-	-
WEST VIRGINIA	³ 29,033	41,010	179	-	-	-
ARKANSAS	^{3,6} 43,335	69,377	169	-	-	-
MONTANA	^{5,7} 9,652	16,786	118	-	-	-
OREGON	^{5,7} 21,676	40,812	104	-	-	-
WISCONSIN	³ 19,128	38,256	76	-	-	-
DID NOT RESPOND	⁹ -	-	-	-	-	-

(1) Amounts for health and administrative services are included in federal Medicaid reimbursement and total claims. Federal payment disallowances resulting from completed or on-going Office of Inspector General audits may not be reflected in these amounts.

(2) Calculated as total claims divided by the number of children enrolled for Medicaid in Federal Fiscal Year (FFY) 2019-20.
(Source: CMS, <https://www.medicaid.gov/chip/downloads/fy-2019-childrens-enrollment-report.pdf>)

(3) Total federal reimbursement for this state's health services program and/or administrative claiming program was not provided for SFY 2018-19 and/or SFY 2019-20.

(4) This state did not have a school-based Medicaid health services program and/or administrative claiming program in effect during SFY 2018-19 and/or SFY 2019-20.

(5) Did not complete DHCS 2020 survey used to collect Medicaid reimbursement (federal share) for direct claiming and administrative services for SFYs 2018-19 and 2019-20.

(6) Health services program and administrative claiming program expenditures for Arkansas for SFY 2018-19 were obtained from the Arkansas Medicaid in the Schools website (Source: MITS profiles, https://arksped.k12.ar.us/applications/sbmb/documents/profiles/2018_Medicaid_Profiles.pdf). SFY 2019-20 data not available at the time of this report.

(7) SFY 2018-19 health services program and/or administrative claiming program reimbursement amount is from the DHCS 2019 survey results.

(8) SFY 2019-20 health services program and/or administrative claiming program figures are estimated amounts and subject to change.

(9) The following states had no survey data from either DHCS's 2019 or 2020 surveys and, therefore, are not pictured:
Alabama, Colorado, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Kentucky, Louisiana, Maine, Michigan, Mississippi, Nebraska, Nevada, New Jersey, North Carolina, North Dakota, Ohio, Pennsylvania, South Carolina, South Dakota, Tennessee, Utah, and Wyoming. Wyoming does not have a school-based Medicaid health services or administrative claiming program.

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The following Table 6 compares state survey respondents that only administer a direct service claiming program and provided reimbursement data. Since the impact of administrative claiming dollars are eliminated in Table 6, the calculation allows for a more accurate representation of how the LEA BOP compares to other state direct claiming programs. However, it should be noted that although Table 6 figures are limited to direct service expenditures, the number of Medicaid-enrolled children used as the denominator in this calculation is not necessarily representative of the actual beneficiary count for these state programs, which likely results in an understated cost per child amount.

Table 6: State Survey Respondents that only have a Direct Claiming Program, Ranked by FY 2018-19 Average Claim per Medicaid-Enrolled Child

State	Average Direct Service Claim per Medicaid-Enrolled Child	
	FY 2018-19	FY 2019-20
DISTRICT OF COLUMBIA	\$560	\$587
CALIFORNIA	\$379	\$340
NEW YORK	\$365	N/A
IOWA	\$342	\$253
MARYLAND	\$195	\$170
MINNESOTA	\$152	\$114
ALASKA	\$36	\$22
OKLAHOMA	\$6	\$6

Note: Although California operates both Administrative and Direct Claiming Programs, a direct-claiming reimbursement per child figure may be calculated based on the total interim LEA BOP direct service reimbursement and the actual LEA BOP beneficiary count for the respective fiscal year. The LEA BOP actual average direct service claim per Medicaid beneficiary was approximately \$379 for FY 2018-19 and \$340 for FY 2019-20.

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Summary of Departmental Activities

Numerous DHCS activities occurred during this reporting period that have affected school-based health services reimbursement. These include the following activities between July 2019 and June 2020:

- **AB 3192 LEA Medi-Cal Billing Option – Program Guide**

AB 3192 (O' Donnell, Chapter 658, Statutes of 2018) requires DHCS, in consultation with the LEA BOP Ad Hoc Workgroup, to issue and regularly maintain a Program Guide for the LEA BOP. The Program Guide contains fiscal and programmatic compliance information regarding processes, documentation and guidance necessary for the proper submission of claims and auditing of LEAs. The Program Guide also contains state plan amendments, policy and procedure letters, provider manuals and other types of instructional materials. DHCS published and distributed the initial Program Guide to LEAs in early 2020.

- **Cost and Reimbursement Comparison Schedule (CRCS) – Submission Process**

DHCS amended the annual submission requirements for the CRCS to indicate LEA BOP providers no longer need to submit duplicate scanned versions of all worksheets of the CRCS that were originally completed using the Excel template. Instead, LEA BOP providers must submit the Excel version of the completed CRCS form (all worksheets), and only the scanned LEA certification page of the CRCS, signed by the LEA's authorized representative. DHCS notified LEAs in Policy and Procedure Letter (PPL) 19-019 and updated the CRCS instruction document for the FY 2017-18 submission to reflect this policy change.

- **CRCS – Compliance Process**

In January 2020, DHCS notified LEAs in PPL 20-003 of the compliance process for LEA BOP providers participating in the LEA BOP that have failed to submit the CRCS to DHCS for past reporting periods. The notification indicated that participating LEA BOP providers that did not submit CRCS reports for past reporting periods covering fiscal years 2009-10 through 2015-16 will receive a written notice from DHCS within 30 calendar days of the publication of PPL 20-003. The written notice informs the non-compliant LEA BOP providers that they must immediately submit all past due CRCS reports to DHCS, or return all interim payments made to the LEA BOP provider during the applicable reporting periods, within 30 calendar days of the date of the written notice.

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- **Elimination of Current Procedural Terminology (CPT) Codes 96150, 96151, 96152, and 96153, related to Psychology/Counseling and Health/Nutrition Services**

Effective January 1, 2020, CPT codes 96150, 96151, 96152, and 96153, used to bill psychology/counseling and health/nutrition services, were eliminated and replaced with new CPT codes. The new CPT replacement codes– 96156, 96158, 96159, 96164, and 96165 – were effective for dates of service beginning January 1, 2020. DHCS issued PPL 19-033 in December 2019 with guidance to stakeholders on the code changes. DHCS updated the LEA BOP Provider Manual to reflect the new replacement CPT codes and modifiers. This issue did not impact interim reimbursement to LEAs.

- **SPA 19-0009 (Vision Services)**

DHCS formally submitted SPA 19-0009 to CMS on March 20, 2019. The SPA will provide additional comprehensive vision services to Medi-Cal eligible students in the LEA BOP. The proposed retroactive effective date is January 1, 2019. On July 25, 2019, following discussions between CMS and DHCS, both parties agreed that SPA 19-0009 will remain “off the clock” until SPA 15-021 is implemented.

- **SPA 19-0010 (Credentialing Requirements)**

As of July 1, 2019, DHCS withdrew SPA 19-0010 from formal submission for federal review. The SPA was intended to remove references to licensing, credentialing and supervision requirements for the LEA BOP, based on guidance from CMS that DHCS could restructure how school-based services are written into the State Plan. Based on this guidance from CMS, DHCS will instead work with CMS to implement the changes contained in SPA 19-0010 through SPA 19-0009 or a future SPA.

- **Payment Adjustment for FY 2018-19 Rate Inflation**

DHCS initiated Erroneous Payment Correction (EPC) 51900 to reprocess claims paid with dates of service on or after July 1, 2018 through March 25, 2019. Operating Instruction Letter (OIL) 362-18 was completed on March 3, 2020, with a payout amount of approximately \$1.3 million. This action increased interim reimbursement provided to LEAs.

- **FY 2019-20 LEA BOP Reimbursement Rate Rebasing**

In FY 2018-19, DHCS completed a rebasing of the LEA BOP reimbursement rates, using the latest available as-submitted cost report data (FY 2015-16 CRCS

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reports). Expenditures considered in rebasing included LEA employee salaries, benefits and other costs, as well as contractor costs. A cost per hour was calculated per practitioner type, these costs were then arrayed, and the median cost per hour was identified. The median cost was then applied to a historical time study, using the established rate development methodology, to arrive at the new rates used for all LEA BOP providers. DHCS posted rebased rates for FY 2019-20 on its LEA BOP website. Overall, the rebased rates resulted in increased interim reimbursement provided to LEAs.

- **Exempting LEA BOP Procedure Codes from Managed Care Edits**

In April 2019, the fiscal intermediary (FI) exempted all LEA BOP CPT codes from other health coverage edits in the claims processing system. Following that, in May 2019, DHCS approved an EPC for installation which resulted in a payout of approximately \$4,400 related to newly implemented CPT code 96130 that was impacted by the other health coverage edits. As part of the table update for CPT code 96130, it was also discovered that newly implemented CPT codes 97163, 97164, 97167 and 97168 were also erroneously impacted by other health coverage edits. DHCS initiated EPC 51961 in FY 2019-20 to pay these erroneously denied claims. EPC 51961 was completed in January 2020 and the payout amount was approximately \$1.1 million.

- **LEA Provider Outreach**

Prior to the approval of SPA 15-021, DHCS initiated an outreach campaign to inform LEAs about upcoming RMTS requirements that will impact participating LEA BOP providers. Specifically, the outreach was targeted at LEAs that only participate in one of the two school-based programs in California. On July 1, 2020, the LEA BOP will fold into the existing School Based Medi-Cal Administrative Activities (SMAA) RMTS process. The DHCS outreach campaign was initially focused on informing LEAs that currently do not participate in RMTS through the SMAA program, since those LEAs are more likely to be unaware of the upcoming RMTS requirement. DHCS informed LEAs that in order to continue LEA BOP participation as of July 1, 2020, they must contract with a Local Educational Consortium (LEC) or Local Governmental Agency (LGA) in their region to participate in RMTS. As part of the outreach, DHCS also informed LEAs of the benefits of participating in both school-based programs.

DHCS also conducted a call campaign to reach out to the LEAs that participated in the SMAA Program, but not the LEA BOP. As a result of this outreach, DHCS enrolled or processed applications for seven new LEAs. During the outreach

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efforts, DHCS identified that staff transitions at the district level between coordinators often results in a loss of contact between the LEA BOP staff and participating LEAs. Therefore, DHCS will be working with stakeholders to develop a LEA BOP Coordinator Transition Plan. Several stakeholders have volunteered to be part of this workgroup and DHCS looks forward to this collaborative effort, which will begin after SPA 15-021 is implemented.

- **LEA BOP Advisory Workgroup**

Members of the LEA BOP Advisory Workgroup represent large, medium, and small school districts, County Offices of Education, professional associations representing LEA services, DHCS, and CDE. DHCS holds meetings every other month, providing a forum for LEA BOP Advisory Workgroup members to identify and discuss relevant issues and make recommendations for changes to the LEA BOP. The emphasis of the meeting is to complete various goals and activities aimed at expanding and enhancing the Medi-Cal services provided on school sites and access by students to these services, by increasing federal reimbursement to LEAs for the cost of providing these services. The LEA BOP Advisory Workgroup, which met six times during FY 2019-20, has been instrumental in improving the LEA BOP. Due to the Governor's Executive Order N-33-20 that proclaimed a State of Emergency as a result of COVID-19, the April 2020 and June 2020 LEA BOP Advisory Workgroup meetings were hosted virtually via WebEx. DHCS will continue offering virtual meetings in FY 2020-21.

School-Based Services, Activities, and Providers Reimbursed in Other States

California's LEA BOP provides many of the same "core" services that exist in other states' school-based programs. Although California's school-based services program is quite robust, there are some services that are allowable in other state programs that are not currently reimbursable in California's LEA BOP. Other state school-based services not currently reimbursable in the LEA BOP include:

- Behavioral services provided by a behavioral aide, certified behavioral analyst, certified associate behavioral analyst, or intern;
- Dental assessment and health education provided by a licensed dental hygienist;
- Durable medical equipment and assistive technology devices; and
- Interpreter services.

The above services were not included in SPA 15-021, since reimbursement is available to LEAs through other Medi-Cal programs. For example, Medi-Cal dental covered

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services include dental screenings, x-rays, prophylaxis (cleanings), fluoride treatments, and other medically necessary services. However, with the approval of SPA 15-021, the following services are now available for reimbursement through the LEA BOP:

- Occupational therapy and physical therapy provided by licensed assistants;
- Speech-language therapy services provided by registered assistants;
- Orientation and mobility services;
- Assistance with activities of daily living;
- Respiratory therapy services; and
- EPSDT screening services.

In addition to the services listed above, SPA 15-021 also includes reimbursement for psychological services provided by a registered associate clinical social worker or associate marriage and family therapist. With the approval of SPA 15-021, California has one of the most robust school-based service programs in the nation.

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IV. BARRIERS TO REIMBURSEMENT AND OFFICIAL RECOMMENDATIONS MADE TO DHCS

Barriers to reimbursement and recommendations regarding proposed LEA BOP changes are identified during LEA BOP Advisory Workgroup (AWG) meetings. Table 7 summarizes barriers identified by the AWG and the action taken/to be taken regarding each barrier.

Table 7: Summary of Barriers to Reimbursement and Official Recommendations Identified by the LEA BOP Advisory Workgroup

<p align="center">Barrier to Reimbursement and Official Recommendation Identified by the AWG</p>	<p align="center">DHCS Action</p>
<p>Provide guidance on additional topics for future claiming of services and practitioners reimbursable under SPA 15-021.</p>	<ul style="list-style-type: none"> • Developed and incorporated guidance into training materials for FY 2019-20. • Shared materials with and collected feedback from the AWG and updated materials based on AWG review. • Conducted training on various SPA topics in FY 2019-20 and will continue to provide training during implementation of SPA 15-021. • At the SPA trainings, DHCS distributed information for new services and new practitioners so that LEAs could begin preparing their systems for future claiming. • Conducted a training and posted resource materials on its LEA BOP CRCS website for the revised Cost and Reimbursement Comparison Schedule. • Developed and presented a SPA 15-021 Readiness Checklist to the AWG to facilitate a smooth program transition into FY 2020-21. • Communicated updates and requirements at AWG meetings and also through LEA E-Blasts and website updates. • Developing PPLs to release in early FY 2020-21 notifying providers of SPA 15-021 requirements.

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<p align="center">Barrier to Reimbursement and Official Recommendation Identified by the AWG</p>	<p align="center">DHCS Action</p>
<p>Provide clarification and guidance regarding documentation standards.</p>	<ul style="list-style-type: none"> • AB 3192 (2018) was chaptered, requiring DHCS, in consultation with the LEA BOP Ad Hoc Workgroup, to issue and regularly maintain a program guide for the LEA BOP by January 1, 2020. The program guide contains fiscal and programmatic compliance information for LEA BOP providers. • Continued to work with the LEA BOP Guide sub-committee, comprised of DHCS representatives and several volunteers from the AWG, to collect feedback from stakeholders regarding organization/content of the guide. • Updated and shared the Program Guide draft introduction and outline and archive log with the sub-committee for feedback. • Presented the structure and proposed content of the Program Guide to a broader audience of LEA stakeholders at AWG meetings. • Distributed a notification to LEAs via E-Blast in January 2020 regarding how to access the Program Guide. BOP • Made a copy of the Program Guide available upon request, while the document was being converted to an ADA compliant document that could be posted on the LEA BOP website.

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<p align="center">Barrier to Reimbursement and Official Recommendation Identified by the AWG</p>	<p align="center">DHCS Action</p>
<p>Provide guidance regarding upcoming RMTS implementation in the LEA BOP.</p>	<ul style="list-style-type: none"> • Continues to host, monitor and respond to LEA BOP RMTS questions from its RMTS specific e-mail account (LEA BOP RMTS e-mail address: RMTS@dhcs.ca.gov). • Shared stakeholder RMTS questions and responses with the AWG and discussed related issues and solutions. • Developed RMTS training, including training for DHCS' LEC and LGA partners, specific to RMTS coding. • Worked with the SMAA Program in the development of a school-based RMTS Guide, which will replace the RMTS information contained currently in the SMAA Manual. • Worked with the SMAA Program to develop a school-based claiming RMTS webpage, which will house all RMTS documents that are relevant to both school-based programs. • Developed an RMTS quick fact sheet to help answer common RMTS questions.
<p>Update the LEA BOP Provider Manual with new policy information, including updates related to implementation of SPA 15-021.</p>	<ul style="list-style-type: none"> • Developed updates to the LEA BOP Provider Manual sections and shared drafts with a sub-committee comprised of LEA representatives. • Incorporated sub-committee feedback and input for the suggested changes to the LEA BOP Provider Manual. • DHCS continues to process the updates and plans to publish the revised manual in FY 2020-21.
<p>Resolve LEA BOP claims processing system errors that are impacting LEA BOP reimbursement.</p>	<ul style="list-style-type: none"> • Investigated denials on behalf of LEA providers and worked with the fiscal intermediary to adjust the affected claims. • Provided updates via the LEA BOP AWG meetings to stakeholders on claims processing errors, suggested resolution, and expected timelines. • Communicated to LEAs that they should continue to submit potential claims processing errors to the LEA BOP inbox (LEA BOP inbox: LEA@dhcs.ca.gov). • Proactively working with the fiscal intermediary on SPA 15-021 system changes in an attempt to avoid programming errors upon system implementation.

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<p align="center">Barrier to Reimbursement and Official Recommendation Identified by the AWG</p>	<p align="center">DHCS Action</p>
<p>Update LEAs regarding the impact of COVID-19 on the LEA BOP.</p>	<ul style="list-style-type: none"> • Received and responded to questions and concerns from the AWG and stakeholders regarding the impact of COVID-19 as it relates to telehealth, claiming and impact on district budgeting. • Acknowledged and actively worked to address the current challenges facing students and LEAs. • Published formal communication to LEAs regarding the impact and update to the LEA BOP, including PPL 20-014, published on May 11, 2020. The PPL provided guidance on telehealth services provided during the COVID-19 national emergency. The PPL communicated that effective March 1, 2020, until the end of the national emergency, LEAs may bill for covered direct medical services provided via telehealth under the LEA BOP , except for services, such as specialized medical transportation services, that preclude a telehealth modality. • Modified its meetings and trainings to be conducted via webinar. • Hosted a webinar on June 9, 2020, to provide additional guidance on LEA BOP telehealth services during the COVID-19 national emergency. DHCS shared a link with access to the recording of the webinar via E-Blast on June 18, 2020. • Reviewed telehealth and billing for direct medical services, including updates based on CMS guidance. • DHCS continues to evaluate how the LEA BOP can implement additional billing of telehealth for covered services under the LEA BOP beyond the public health emergency. • Responded to LEA questions and updated stakeholders on telehealth-related claiming issues.

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V. ONE-YEAR TIMETABLE FOR STATE PLAN AMENDMENTS

In late April 2020, DHCS received approval of State Plan Amendment 15-021. At this point, DHCS' highest priority is the successful implementation of the many policy changes related to SPA 15-021.

DHCS submitted SPA 16-001 in March 2016, which proposes expanding the population of students eligible to receive TCM services. Under this SPA, TCM will be a covered service for Medi-Cal eligible students with an IHSP and not limited to students with an IEP/IFSP. Now that SPA 15-021 has been approved, DHCS expects that SPA 16-001 will be reviewed and approved by CMS in FY 2020-21.

In March 2019, DHCS submitted SPA 19-0009, which proposes to provide comprehensive vision services to LEA BOP Medi-Cal eligible students. SPA 19-0009 is currently inactive, pending the implementation of SPA 15-021. Once SPA 15-021 and 16-001 are implemented, DHCS will continue to pursue approval of SPA 19-0009. Tables 8a and 8b include a summary of key dates related to the pending SPAs.

Table 8a: Timetable for Proposed State Plan Amendments – State Plan Amendment 16-001 Submission

Key Date	Activity
March 29, 2016	<ul style="list-style-type: none"> • DHCS submits SPA 16-001 to CMS, which proposes to include Medicaid eligible beneficiaries with an IHSP, in addition to those with an IEP/IFSP, for TCM services with an effective date of January 2, 2016 • The reimbursement methodology for TCM services is proposed in SPA 15-021, which will allow TCM services to be reimbursed at incremental cost of a school nurse proxy rate
June 3, 2016	<ul style="list-style-type: none"> • Per CMS, SPA 16-001 cannot be considered until SPA 15-021 is approved
April 2020	<ul style="list-style-type: none"> • CMS approved SPA 15-021 • Upon approval of SPA 15-021, DHCS requested that CMS continue review of SPA 16-001 • DHCS will review and respond to CMS Requests for Additional Information (RAIs)

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Table 8b: Timetable for Proposed State Plan Amendments – State Plan Amendment 19-0009 Submission

Key Date	Activity
April 2019	<ul style="list-style-type: none"> • CMS sent informal comments/questions on reimbursement for vision services
May 2019	<ul style="list-style-type: none"> • DHCS responded to CMS comments/questions • CMS sent informal comments/questions regarding service coverage • DHCS responded to CMS comments/questions
June 2019	<ul style="list-style-type: none"> • CMS sent formal RAIs to DHCS • DHCS requested that it postpone the response to the RAI until SPA 15-021 is approved and finalized; CMS accepted this proposal, putting SPA 19-0009 formally off the clock until DHCS responds to the CMS RAIs
June 2020	<ul style="list-style-type: none"> • DHCS continues to hold on responding to CMS RAIs, due to staffing constraints related to successful implementation of SPA 15-021 • In FY 2020-21, DHCS hopes to put SPA 19-0009 back on the clock with CMS