Local Educational Agency Medi-Cal Billing Option Program

Report to the Legislature

Report Period Fiscal Year 2016-17
(July 2016 through June 2017)

Director Jennifer Kent
Department of Health Care Services

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EXECUTIVE SUMMARY

Schools nationwide play a critical role in providing health 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 Program), California's participating school districts and County Offices of Education (COEs) are partially reimbursed by the Federal Government for health services provided to Medi-Cal eligible 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 to accomplish various goals to enhance Medi-Cal services provided at school sites and access by students to those services. This report covers the timeframe of fiscal year (FY) 2016-17.

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 thirty states have identified over a billion dollars in federal disallowances for services provided in schools. Between July 2016 and June 2017, the OIG issued three school-based audits: Alabama, Michigan, and Mississippi. These audits focused mainly on technicalities related to these states' Random Moment Time Survey (RMTS) statistical sampling calculations. In addition, in Alabama and Mississippi, the OIG noted significant deficiencies in the states' Cost Allocation Plans. During FY 2016-17, the OIG's monetary findings ranged from approximately $954,000 in Michigan to over $75 million in Alabama.

School-based programs continue to be an area of focus for the OIG, with more significant findings in recent years regarding the RMTS process. Since July 2016, the OIG identified significant unallowable payments based on random moment sampling systems that deviated from acceptable standards. This is notable, as the LEA Program is currently in the process of implementing RMTS as part of the direct medical service

[1] The General Accounting Office is now known as the Government Accountability Office (GAO).

reimbursement methodology. The OIG's current work plan indicates that they will review states' cost allocation plans to determine whether claimed school-based Medicaid costs were supported and allocated using acceptable statistical sampling practices under random moment sampling systems. In addition, OIG continues to review other areas, such as ensuring that providers are qualified, costs claimed are reasonable, documentation of services is adequate and that states are using sound payment methodologies.

The following table identifies LEA Medi-Cal fee-for-service (FFS) interim reimbursement trends by FY. The LEA Program reimbursement has grown by approximately 142 percent since its authorization under SB 231, due to LEA Program expansion and increased participation and claiming of covered Medi-Cal services by qualified practitioners.

LEA Program Trends FY 2000-01 to FY 2015-16

Fiscal Year	Number of Participating LEA Providers	Total Medi-Cal Reimbursement	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 (1)	461	$63.9 million	7%
FY 2005-06 (1)	470	$63.6 million	7%
FY 2006-07 (2)	461	$69.5 million	17%
FY 2007-08 (2)	472	$81.2 million	36%
FY 2008-09 (2)(3)	479	$109.9 million	84%
FY 2009-10 (2)(3)	484	$130.4 million	119%
FY 2010-11 (2)(3)	497	$147.8 million	148%
FY 2011-12 (2)	519	$137.9 million	132%
FY 2012-13 (2)	531	$145.6 million	144%
FY 2013-14 (2)	535	$148.7 million	150%
FY 2014-15 (2)	536	$149.5 million	151%
FY 2015-16 (2)(4)	537	$143.9 million	142%

Notes:

(1) 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.

(2) Total 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.

(3) 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.

(4) Total Medi-Cal reimbursement for FY 2015-16 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 State Plan Amendment (SPA) prepared as a result of SB 231 was approved in March 2005, and systematically implemented on July 1, 2006. SPA 03-024 increased both treatment and assessment reimbursement rates for a majority of LEA services provided to California's Medi-Cal eligible children in a school-based setting. Since this SPA's implementation in FY 2006-07, LEA interim reimbursement has increased 107 percent.

In September 2015, DHCS submitted a second SPA to CMS to expand the LEA Program. SPA 15-021 proposes to add several new practitioner types, as well as incorporate new covered assessment and treatment services in the LEA Program. In addition, the SPA proposes incorporating a RMTS component to the LEA Program reimbursement methodology that will capture the amount of time spent providing direct health services by qualified health practitioners. Finally, the SPA proposes to remove the 24 services in a 12-month period limitation, which currently applies to Medi-Cal general education students receiving LEA covered services. The SPA is consistent with CMS' goal to facilitate and improve access to quality healthcare services and improve the health of communities. DHCS is excited about expanding services through SPA 15-021, and continues to work collaboratively with CMS to obtain SPA approval.

DHCS considers collaboration with its LEA stakeholders an important aspect of the LEA Program's success. DHCS routinely works with LEA stakeholders to address concerns and improve the LEA Program. The LEA 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 Program. In addition, the LEA Advisory Workgroup suggests and recommends enhancements to the LEA Program website and other communication venues, to improve LEA 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 Program. Approximately 50 to 75 LEA Program stakeholders are present at these meetings, in addition to representatives from DHCS, the California Department of Education (CDE), and Navigant Consulting, DHCS' operational consultant.

In addition to collaboration with the LEA Advisory Workgroup, DHCS works closely with a limited group of technically qualified stakeholders, known as the Implementation Advisory Group (IAG), regarding the upcoming implementation of a RMTS for LEA providers. The IAG is comprised of several representatives from small, medium and

large school districts; Local Education Consortium (LEC) and Local Governmental Agency (LGA) representatives; a representative from the California School Nurses Organization; CDE; and DHCS. Navigant Consulting, facilitates these meetings. In FY 2016-17, the IAG met monthly and provided feedback to DHCS on many subjects surrounding the incorporation of RMTS in the LEA Program. These meetings included topics such as RMTS training, communication to LEAs, cost reporting, roles and responsibilities of all parties involved in RMTS, and technical RMTS implementation concerns. The IAG continued to meet on a bi-monthly basis throughout 2017 to address the upcoming implementation of RMTS.

During this reporting period, DHCS has continued its work to identify and resolve LEA Program barriers, expand the services provided to Medi-Cal students and enhance communication to LEA stakeholders. DHCS accomplished many goals in FY 2016-17, including preparing to implement SPA 15-021 upon CMS approval. In addition to the significant effort required to respond to and discuss Requests for Additional Information (RAIs) from CMS regarding SPA 15-021, DHCS continued to support LEA Program growth in many ways, including:

- Identifying and resolving technical claims processing issues and system changes;
- Revising information in the LEA portion of the Medi-Cal Provider Manual (LEA Program Provider Manual);
- Conducting a Fall 2016 annual LEA Program training session;
- Providing technical assistance to LEAs, including answering provider questions and undertaking a LEA site visit;
- Calculating the annual rate inflation adjustment for FY 2016-17;
- Finalizing the Annual Accounting of Funds Report for FY 2014-15, providing transparency to LEAs on administrative, auditing, and contractor costs;
- Providing LEAs with guidance on how to respond to parent/guardian questions related to third party liability;
- Implementing the telehealth modality for speech-language services in FY 2016-17;
- Developing a compliance process for LEAs that fail to submit required reports in a timely manner;
- Providing additional resources and guidance to LEA providers, including Frequently Asked Questions (FAQs), and Policy and Procedure Letters (PPLs); and

- Working on Cost and Reimbursement Comparison Schedule (CRCS) form submissions, auditing issues, and policies and procedures for delinquent CRCS submissions.

The work completed during this reporting period has largely been due to the positive relationships between DHCS and the many officials of school districts, COEs, CDE, and professional associations representing LEAs. DHCS is excited about the opportunity to continue to expand school-based direct health services to Medi-Cal students under SPA 15-021, and looks forward to continued collaboration with the LEA stakeholder community to implement the pending SPA.

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 to require DHCS to amend California's Medicaid State Plan to accomplish various goals to enhance 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 Program;
- Simplify, to the extent possible, claiming processes for LEA Program billing;
- Eliminate and modify State Plan and regulatory requirements that exceed federal requirements when they are unnecessary;
- Implement recommendations from the LEA Program rate study (LEA Rate Study) to the extent feasible and appropriate[2];
- Consult regularly with CDE, representatives of urban, rural, large, and small school districts and COEs, LECs and LEAs;
- Consult with staff from Region IX of 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 Program website; and
- File an annual report with the Legislature. Table 1 on the following page includes the annual legislative report requirements.

[2] 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 Program. 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.

Table 1: Annual Legislative Report Requirements

Report Section	Report Requirements
III	• 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. 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 providers[3] 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	• The 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 COEs, the LEC, LEAs, staff from Region IX of CMS, experts from the fields of both health and education, and internal departmental staff.
V	• 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.
VI	• Identify any barriers to LEA reimbursement, including those specified by the entities named in the legislation (listed in Section IV of this table) that are not imposed by federal requirements, and describe the actions that have been and will be taken to eliminate them.

[3] In this report, "providers" refer to allowable practitioners who provide services to eligible students, and LEAs or LEA providers refer to school districts and COEs that have enrolled in the LEA Program.

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 Program provides reimbursement to LEAs for Medi-Cal eligible students with disabilities receiving health-related services authorized in a student's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP). For some IEP/IFSP children, these health-related additional services are necessary to assist them in attaining their educational goals. The LEA Program also provides limited reimbursement for health services, such as nursing care, rendered to general education students, as long as the LEA can satisfy the Free Care and Other Health Coverage (OHC) requirements[4].

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 (CPE) methodology. Federal Financial Participation (FFP) 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-eligible child's IEP or IFSP; and
- Primary and preventive health services provided to Medicaid-eligible general and special education students in schools where Free Care and OHC 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.

Since the passage of SB 231, federal oversight by CMS and the OIG has increased at the national level. Over the past fifteen years, reported school-based health service OIG findings have resulted in over a billion dollars in alleged overpayments to schools, largely due to the following:

- Insufficient documentation of services;
- Improper billing of IEP services;

[4] For this legislative report period, the LEA Program's policy on Free Care states that Medi-Cal will not reimburse LEA providers for services provided to Medi-Cal recipients if the same services are offered for free to non-Medi-Cal recipients. LEA providers must use specific methods to ensure that services billed to Medi-Cal are not offered for free to non-Medi-Cal recipients.

- Claims submitted for services provided by unqualified personnel;
- Inadequate referral and/or prescription for applicable services;
- Violation of Free Care requirements;
- Insufficient rate-setting methodologies;
- Non-compliance with respective State Plans;
- Inadequate and/or incorrect policy manuals;
- Inadequate third-party program administrators;
- Lack of state-level oversight of federal guidelines; and
- Non-compliant random moment sampling systems.

Between October 2001 and June 2016, the OIG published over 60 audits on school-based services, representing work in 27 states. These reports were part of a series in a multi-state initiative to review costs claimed for Medicaid school-based services.

Between July 2016 and June 2017, the OIG published three audit reports on school-based services for the states of Alabama, Michigan, and Mississippi. An OIG finding in all three recent audit reports was that the state was unable to substantiate its RMTS sample or used an invalid sample calculation to claim reimbursement for the reviewed timeframe. The OIG also identified several other issues in these three states, including cost allocation plan deficiencies, problems with RMTS participant lists, or issues surrounding coding of moments. The total federal disallowance found by the OIG for the three states audited during this reporting period amounted to approximately $97.4 million.

The OIG continues to focus on compliance issues surrounding school-based services, especially concerning the statistical validity of the random moment sampling methodology used to calculate school-based costs. The recent OIG findings surrounding statistical sampling issues provide timely guidance for California as RMTS is rolled out in the LEA Program.

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 from the survey with publicly available information by reviewing provider manuals and other sources of program information.

School-Based Medicaid Systems in Comparable States

Table 2 describes the four factors considered to identify states comparable to California.

Table 2: Factors Considered in Selecting Comparable States

Factor	Source of Information
Number of Medicaid-eligible children aged 6 to 20.	Medicaid Program Statistics, California Children's Health Insurance Program Reports & Evaluations, Annual Enrollment Reports, Federal Fiscal Year (FFY) 2015-16, CMS.
Number of IDEA eligible children aged 3 to 21.	U.S. Department of Education, Data Collections, Part B: Child Count and Educational Environments dataset, 2015.
Average salaries of instructional staff (classroom teachers, principals, supervisors, librarians, guidance and psychological personnel, and related instructional staff).	Rankings of the States 2016 and Estimates of School Statistics 2017, National Education Association (NEA), May 2017.
Per capita personal income.	Rankings of the States 2016 and Estimates of School Statistics 2017, NEA, May 2017.

The number of Medicaid-eligible 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-eligible children aged 6 through 20 were identified. Each of these states was ranked from highest to lowest based on each of the four factors. From this analysis, DHCS identified four states as comparable to California: Illinois, New York, Pennsylvania, and Texas. Although two states (Florida and Ohio) had a higher count of Medicaid-eligible beneficiaries, DHCS did not select these as comparable to California, since their cost of living measures were substantially lower than California.

Many states finance their school-based direct health service claiming programs utilizing CPEs, 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 CRCS, 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 services, the units of service, encounters, and related Medi-Cal reimbursement for the appropriate fiscal year on the CRCS forms. The CRCS compares estimated costs to Medi-Cal interim reimbursement to ensure that DHCS is not reimbursing each LEA provider more or less than the costs of providing these services, a requirement when utilizing CPEs. This reconciliation results in an amount owed to or from the LEA; DHCS reimburses underpayments to LEAs in a lump sum, while overpayments are withheld from future LEA claims reimbursement.

As part of the cost reconciliation process, the LEA providers certify that the public funds expended for the provision of LEA services are eligible for FFP. As of this reporting period, the LEA Program is in its tenth cost certification year. DHCS worked with its Fiscal Intermediary (FI) to create a downloadable Annual Reimbursement Report for each LEA that received Medi-Cal reimbursement for services rendered during FY 2014-15, to assist LEAs in completing the CRCS that was due November 30, 2016. This report summarized total units and reimbursement information for each LEA service and practitioner type. LEA providers could access the report on the LEA Program website to assist them in completing the FY 2014-15 CRCS.

DHCS is responsible for auditing the CRCS reports and calculating the final cost settlement. The Financial Audits Branch (FAB) of DHCS has completed all audits for FYs 2006-07 through 2010-11 CRCS reports, resulting in LEAs receiving their final reconciled overpayment/underpayment amounts for the first five CRCS reporting

periods. In addition, DHCS has completed final reconciliation for all but one LEA audit for FY 2011-12. DHCS is currently auditing FYs 2012-13, 2013-14 and 2014-15 CRCS reports, submitted in November 2014, 2015 and 2016, respectively.

The four states selected as comparable to California finance their school-based health services programs using various approaches. Illinois has both an administrative and a direct service claiming program. Illinois develops the LEA-specific rates for the direct service-claiming program based on each provider's actual costs on an annual basis. LEAs must submit their cost information by completing an electronic cost calculation form for each service provided during the fiscal year. After LEAs submit their electronic cost calculation forms for the fiscal year, Illinois reviews the information and processes adjustments using the cost-based computed rates to re-price all claims with dates of service during the fiscal year. Illinois does not currently use an RMTS process to cost-settle school-based direct service claims.

In 2012, Pennsylvania established a new payment methodology based on cost for both direct services and administrative claiming. Pennsylvania LEAs must complete a cost settlement process that utilizes a statewide RMTS to document time spent on specific activities that are required to support Medicaid claims for school health services. The Commonwealth of Pennsylvania uses the results of the cost report review/audit to develop LEA-specific interim rates that are annually adjusted using prior costs. Starting in FY 2015-16, all LEAs receive adjustments to their rates on an annual basis, based on the prior year cost settlement. For example, Pennsylvania adjusted rates for dates of service covering FY 2015-16 using the results of the FY 2013-14 cost-settlement process.[5]

Texas has operated an approved administrative claiming program since 1995. In 2007, Texas implemented a RMTS methodology for school-based direct service claims. Similar to Pennsylvania, Texas uses the RMTS to conduct a cost settlement at the end of each fiscal year. Districts participating in Texas's direct health service claiming program, known as the School Health and Related Services (SHARS) Program, are reimbursed on an interim basis using district-specific interim rates and costs are settled using an annual SHARS Cost Report.

In December 2014, CMS approved New York's SPA, requiring New York schools (outside of New York City) that receive Medicaid payments for health services provided on or after October 1, 2011, to operate under the CPE methodology. This SPA is effective only for schools outside the New York City school district; New York will

[5] The fiscal year for all states but four ends on June 30: Alabama and Michigan (ends September 30), New York (ends March 31), and Texas (ends August 31).

address New York City schools in a separate SPA. Schools outside of New York City will continue FFS Medicaid claiming and will receive interim payments that are subject to cost settlement. However, New York now initiates a cost settlement process after each school district, county, and qualifying school entity has participated in a quarterly RMTS and completed an annual cost report. The first cost reporting period was for the October 1, 2011 – June 30, 2012 period. Future cost reporting periods will be on a July through June fiscal year basis, with a cost report due no later than December 31 of each year. LEAs submitted the first cost reports under the CPE methodology for FYs 2011-12 and 2012-13 in late 2014, and resubmitted the cost reports again in January 2016 to reflect new state and federal directives regarding the calculations of the IEP and the Health Related Tuition Percentages ratios for these school years. CMS approved New York's school-based SPA on an interim basis, for dates of service between October 1, 2011 and June 30, 2016. On November 30, 2016, CMS approved SPA 16-0020, which revised the IEP eligibility ratio formula for school-based health services and extended the sunset date to June 30, 2017.

New York does not currently operate a Medicaid school-based administrative claiming program. In December 2016, New York submitted SPA 17-0001 to CMS that proposed to expand behavioral health services to Medicaid-eligible children through the Early and Periodic Screening Diagnostic and Treatment (EPSDT) benefit as of July 1, 2018. The SPA, which was a collaborative effort among the Office of Mental Health, Office of Alcoholism and Substance Abuse Services, Office of Children and Family Services and the Department of Health, covers six services that will be available to any Medicaid-eligible child. These services include: crisis intervention, community psychiatric supports and treatment (CPST), psychosocial rehabilitation (PSR), family peer support services, a non-physician licensed behavioral health practitioner, and youth peer support and training. New York's SPA, approved in November 2017, with an effective date of July 1, 2018, stemmed from a multi-year initiative to redesign the children's Medicaid service system in New York with services provided across a broad range of community-based settings (newly added services are not reimbursable in an institutional setting). New York submitted a SPA in September 2017 to increase fee rates. CMS approved this SPA in November 2017 to coincide with the previous SPAs expanding health services.

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

DHCS administered its thirteenth state survey in November 2017. DHCS contacted states to obtain claims and revenue information for FYs 2015-16 and 2016-17. Multiple follow-up calls and e-mails were conducted between November 2017 through February 2018 to states that did not respond to the survey or did not respond to all applicable questions. 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. Thirty-five of 51 states (including Washington, D.C.) completed the survey.[6,7] However, two of the 35 survey respondents did not provide any Medicaid reimbursement figures, since they were not yet final at the time of the survey.[8] An additional two respondents indicated they do not currently have a school-based health services program or an administrative claiming program.[9]

Table 3 (see page 20) summarizes survey results for Medicaid reimbursement (federal share) for direct claiming and administrative services for FYs 2015-16 and 2016-17. As noted above, several states did not have finalized figures available for both FYs. For example, a state may not complete its FY 2016-17 cost settlement process until late 2018. When states provided data, 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 the number of Medicaid-eligibles to estimate the average claim amount per Medicaid-eligible child..

In April 2000, the GAO report, as referenced on page one, estimated that California ranked in the bottom quartile with respect to the average claim per Medicaid eligible 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 student among states. This is primarily due to the basic inability to split Medicaid-eligible students between direct claiming and administrative claiming programs. For those states that operate both programs (26 states in the 2017 survey, including California), only the combined program dollars can be divided by the number of Medicaid-eligibles, in order to calculate a practical result. As such, Table 3 comparisons for those dual-program states that attempt to compare direct claiming dollars per eligible student are inadvertently impacted by the inclusion of administrative claiming program dollars.

In the state survey, some states did not provide both direct claiming and administrative claiming reimbursements for various reasons. For example, out of the 26 states that have both programs, 9 states did not report complete data for their direct claiming program and/or administrative claiming program. Nine additional states reported having either a direct claiming program or an administrative claiming program, but not both

[6] Arkansas is not included in the count of 35, since they did not submit a survey response. However, DHCS used the direct and administrative claiming reimbursement data that is available online for analysis purposes.
[7] Minnesota and Vermont are not included in the count of 35. However, DHCS used the states' respective FY 2015-2016 reimbursement data, collected in the 2016 DHCS state survey, for analysis purposes (DHCS notified these states that they would use the prior year data for analysis purposes).
[8] North Carolina and Ohio responded to the state survey, but did not provide Medicaid reimbursement figures.
[9] Tennessee and Wyoming responded to the survey and indicated they do not currently have a school-based health services program or an administrative claiming program.

programs. Without complete direct claiming and administrative claiming reimbursement information, the ranking of the average claim per Medicaid-eligible child is skewed, and does not allow for a fair comparison.

In addition, due to lack of complete reimbursement data from states, there are several other reasons that direct comparisons among states make it difficult to draw sound conclusions on the following Table 3.

- FMAPs 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 74.17 percent among states for FY 2015-16, and from 50 percent to 74.63 percent in FY 2016-17.
- Covered services 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 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 CPE 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-eligible child, due to the length of time that individual states have to conduct their audit or review of LEA provider costs. For example, California's direct claiming program is not required to complete cost settlement until more than four years after the close of the fiscal year in which interim payments were made to LEAs. Of the 26 states that reported having both programs, only six states were able to provide final reimbursement figures for both direct claiming and administrative services for both FY 2015-16 and FY 2016-17.

In the April 2000 GAO Report, Maryland had the highest average claim per Medicaid-eligible child of $818, while California's average claim was $19, a difference of $799. Maryland responded to the 2017 DHCS survey and its average claim was $76 for FY 2015-16 and $73 for FY 2016-2017. However, Maryland reported it does not have an administrative claiming program, which contributes to the decrease from their total cost per Medicaid-eligible child figures originally reported in the 2000 GAO Report.

As illustrated in Table 3, the District of Columbia had the highest FY 2015-16 average claim of $1,001, while California's average claim was $359. California's average claim per Medicaid-eligible child in FY 2015-16 has increased nearly 1,800 percent compared to the $19 figure published in the April 2000 GAO Report.

Although California's average claim per Medicaid-eligible child has significantly increased since the 2000 GAO Report, this benchmark alone does not represent an accurate measurement of California's school-based programs. The federal revenues from administrative activities claimed in the California School-Based Medi-Cal Administrative Activities (SMAA) Program have continued to climb over the last several years. SMAA reimbursement was $32.5 million in FY 2013-14, then increased to $90 million in FY 2014-15, and up again to $136 million in FY 2015-16. This increase was the result of a settlement agreement reached between DHCS and CMS on October 14, 2014, that created a sliding scale reimbursement percentage for interim payments based on the total claim amount for all deferred claims. This agreement allowed for an interim payment on deferred claims for costs incurred prior to July 2012, as well as for FYs 2012-13, 2013-14 and quarters one and two of FY 2014-15.[10] The reconciliation of interim payment to actual costs was based on a "backcasting" methodology, which was approved by CMS on October 28, 2015. As of FY 2015-16, DHCS no longer used the worker log methodology to calculate reimbursement, and instead, payments are now based on results from the RMTS.

According to the CMS Medicaid & CHIP Enrollment Report, California had approximately 1.5 million individuals determined eligible for Medicaid in FFY 2015-16, representing approximately seven percent of the total U.S. Medicaid eligible population.[11] In comparison, Washington, D.C., with the highest average claim per Medicaid-eligible in Table 3, had approximately 89,500 Medicaid eligible individuals. As indicated in Table 3, California has the second highest federal Medicaid reimbursement and total claims figures in FY 2015-16 (Texas reported the highest figures). California ranks 15th for average claim per Medicaid-eligible child in FY 2015-16, when compared

[10] Effective June 26, 2012, CMS implemented a deferral on California's School-Based Administrative Activities program for all claims submitted for reimbursement beginning with the quarter ending in December 2011, (inclusive of periods of service from FYs 2009-10 through 2013-14 and FY 2014-15 quarter one and two) due to non-compliance with requirements defined in 45 Code of Federal Regulation (CFR) Part 75, including the worker log time study used as a basis for developing invoices. The CMS deferral is a result of field work conducted and based on a financial management review of school-based administrative expenditures. The FY 2012-13 figures represent approximately 95 percent of the total interim payment on deferred claims. Beginning with FY 2014-15, Q3 and Q4 expenditures ($72.9 million) are based on RMTS.

[11] Centers for Medicare & Medicaid Services, Medicaid & CHIP Enrollment Data. https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-methodology/index.html. In previous years, CMS provided Medicaid eligible data for ages 6 to 20, but that data is not currently available. CMS changed the way they report eligible children recently which is why the figure is lower for California than the previous report.

to other states. However, using California's FY 2015-16 direct service paid claims reimbursement data and the number of actual unduplicated LEA beneficiaries who received LEA Program services (approximately 349,000 students), the total average FY 2015-16 direct service claim per Medicaid-eligible child was just over $412.

A comparison of the average claim in the April 2000 GAO Report to the average claim per Medicaid-eligible child in Table 3 shows an increase in 25 of the 34 states that reported federal reimbursement in FY 2015-16, and an increase in 18 of the 29 states that reported federal reimbursement in FY 2016-17. The average claim between these periods decreased in 9 states for FY 2015-16 and 11 states for FY 2016-17. Two states, Hawaii and Indiana, did not have data reported in the April 2000 GAO Report. As stated earlier, California's average claim per Medicaid-eligible child of $358 in FY 2016-17 has increased almost 1,800 percent compared to the figure published in the April 2000 GAO Report. 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.

Table 3: Medicaid Reimbursement and Claims by State, Ranked by 2016-17 Average Claim per Medicaid-Eligible Child

		SFY 2015-2016 [1]			SFY 2016-2017 [1]		
State		Federal Medicaid Reimbursement (000's)	Total Claims (000's)	Average Claim Per Medicaid-Eligible Child [2]	Federal Medicaid Reimbursement (000's)	Total Claims (000's)	Average Claim Per Medicaid-Eligible Child [2]
DISTRICT OF COLUMBIA	4	$ 62,749	$ 89,642	$ 1,001	$ 72,916	$ 104,165	$ 1,164
NEW HAMPSHIRE	4	29,271	58,542	812	30,595	61,189	849
IDAHO	4	39,860	55,951	921	36,718	51,347	846
NEW JERSEY	3	96,200	192,400	781	84,100	168,200	683
MONTANA		22,364	35,234	457	23,864	37,812	490
MISSOURI		31,962	61,781	509	30,547	58,519	482
COLORADO		42,576	84,083	345	54,422	108,804	446
ILLINOIS		149,190	294,790	403	152,654	300,083	410
CALIFORNIA	11	280,325	560,650	359	280,234	560,467	358
MINNESOTA	9	93,169	186,337	673	48,624	97,247	351
NEBRASKA	3	9,546	19,092	211	16,127	31,754	351
MICHIGAN		179,455	276,033	314	192,684	296,696	337
VIRGINIA		36,832	73,664	339	36,396	72,792	335
MASSACHUSETTS	6	88,600	177,200	386	58,800	117,600	256
IOWA	4, 7	57,288	104,331	234	61,975	109,227	245
ALABAMA		42,968	75,663	220	42,819	75,553	219
KANSAS	3, 7	30,655	56,924	617	9,683	19,366	210
CONNECTICUT		21,742	43,484	229	18,719	37,438	197
PENNSYLVANIA		68,831	134,184	178	63,791	124,638	165
NEW MEXICO		43,009	66,352	186	36,526	57,046	160
FLORIDA		113,857	221,773	101	119,990	234,086	106
ALASKA	4	1,358	2,717	47	2,928	5,856	102
NEW YORK	4	88,319	176,639	104	64,377	128,754	76
MARYLAND	4	20,614	41,227	76	19,979	39,957	73
WASHINGTON		16,157	32,313	63	18,716	37,433	73
INDIANA		12,966	21,900	43	16,130	27,078	54
OREGON		11,447	21,197	58	10,333	19,208	52
ARIZONA	7	26,357	40,489	43	27,706	42,760	45
OKLAHOMA	4	500	819	2	303	506	1
VERMONT	5, 10	27,327	50,699	997	-	-	-
ARKANSAS	8	44,230	72,069	787	-	-	-
TEXAS	3	643,962	1,130,994	784	-	-	-
WISCONSIN	3	80,419	142,311	587	-	-	-
LOUISIANA	3, 4	21,617	34,749	78	-	-	-
DELAWARE	5	-	-	-	-	-	-
GEORGIA	5	-	-	-	-	-	-
HAWAII	5	-	-	-	-	-	-
KENTUCKY	5	-	-	-	-	-	-
MAINE	5	-	-	-	-	-	-
MISSISSIPPI	5	-	-	-	-	-	-
NEVADA	5	-	-	-	-	-	-
NORTH CAROLINA	3	-	-	-	-	-	-
NORTH DAKOTA	5	-	-	-	-	-	-
OHIO	3	-	-	-	-	-	-
RHODE ISLAND	5	-	-	-	-	-	-
SOUTH CAROLINA	5	-	-	-	-	-	-
SOUTH DAKOTA	5	-	-	-	-	-	-
TENNESSEE	4	-	-	-	-	-	-
UTAH	5	-	-	-	-	-	-
WEST VIRGINIA	5	-	-	-	-	-	-
WYOMING	4	-	-	-	-	-	-

(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 individuals determined eligible for Medicaid in Federal Fiscal Year (FFY) 2015-16 and 2016-17. The Medicaid and Statistical Information System (MSIS) no longer provides data by age through the Centers for Medicare and Medicaid Services (CMS). (Source: CMS, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/monthly-reports/index.html)

(3) Total federal reimbursement for this state's health services program and/or administrative claiming program was not provided for SFY 2015-16 and/or SFY 2016-17.

(4) This state did not have a school-based Medicaid health services program and/or administrative claiming program in effect during SFY 2015-16 and/or SFY 2016-17.

(5) Did not complete survey used to collect Medicaid reimbursement (federal share) for direct claiming and administrative services for SFYs 2015-16 and 2016-17.

(6) FFY 2012 Medicaid Eligible data used as Massachusetts data was not available for FFYs 2013-2016.

(7) FFY 2015 Medicaid Eligible data used as complete data was not available for FFY 2016.

(8) Health service and administrative program expenditures for Arkansas for FY 2016 were obtained from the Arkansas Medicaid in the Schools website (Source: MITS profiles, https://arksped.k12.ar.us/applications/sbmh/documents/profiles/2016_Medicaid_Profiles.pdf). FY 2017 data not available at the time of this report.

(9) SFY 2015/16 Administrative Claiming program reimbursement amount is from the DHCS 2016 survey results.

(10) SFY 2015/16 Direct Claiming program reimbursement amount is from the DHCS 2016 survey results.

(11) SFY 2016/17 Health and Administrative figures are estimated amounts and subject to change.

Note: Additional supportive information for Table 3 is provided in Appendices 1(a) and 1(b).

Summary of Departmental Activities

Since the passage of SB 231, Medi-Cal reimbursement in the LEA Program has increased by over 140 percent, growing from $59.6 million in FY 2000-01 to $143.9 million in FY 2015-16. DHCS classifies LEA services into two main categories: assessments and treatments. In addition, services are defined as those that are provided pursuant to an IEP or IFSP (commonly referred to as "IEP/IFSP services"), versus those that are provided to the "general education", or non-IEP/IFSP population. The following eight IEP/IFSP assessment types, representing approximately 99 percent of total assessment reimbursement in FY 2015-16, are reimbursable in the LEA Program:

IEP/IFSP Assessment Type	Qualified Practitioners
Psychological	Licensed psychologists Licensed educational psychologists Credentialed school psychologists
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 Program covers the following six non-IEP/IFSP assessment types, pursuant to strict billing guidelines for Free Care and OHC[12]:

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
Health Education and Anticipatory Guidance	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

[12] Despite CMS' relaxation of the Free Care Principle as of December 2014, the LEA Program's current policy (as of December 2017) remains limited with regard to billing services that are also offered free of charge to non-Medi-Cal recipients. CMS must approve SPA 15-021 before the LEA Program can expand the definition of a Medi-Cal eligible LEA beneficiary, and implement new policy in this area.

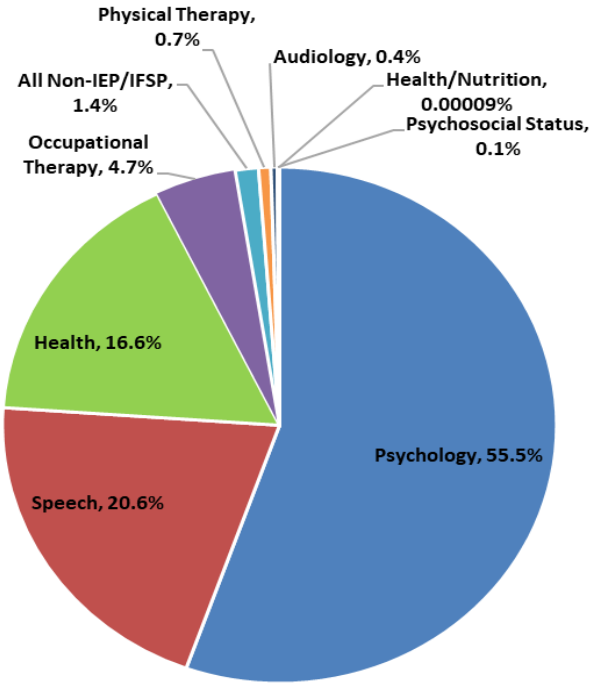
The majority of LEA Program expenditures are comprised of treatment services; representing approximately 68 percent of FY 2015-16 total LEA Program interim reimbursement. The LEA Program covers the following medically necessary treatment services for all Medi-Cal eligible students:

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

In addition, the LEA Program covers medical transportation/mileage services for Medi-Cal students with an IEP/IFSP, when LEAs can meet all of 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 eligible beneficiary's disability.
- The need for LEA covered health services and LEA covered specialized medical transportation services is documented in the student's IEP/IFSP.
- LEAs maintain a transportation trip log that includes the mileage, origination point and destination point for each student, student's full name, and date of transportation.
- School attendance records are able to verify that the student was in school and received an approved LEA Program covered medical service (other than LEA medical transportation) on the date the transportation was provided.
- 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 Program.

Figure 1: Total LEA Assessment Reimbursement by Assessment Type, FY 2015-16



Note: Total LEA assessment service reimbursement for FY 2015-16 was $45.87 million.

The above Figure 1 depicts each assessment type as a percentage of total assessment reimbursement for FY 2015-16. As demonstrated in Figure 1, approximately 93 percent of assessment reimbursement ($42.5 million) is attributable to three IEP/IFSP assessment types: psychological, speech-language and health assessments.

- The majority of all LEA assessment reimbursement ($25.4 million) is attributable to psychological assessments provided to students with an IEP or IFSP, representing 56 percent of total assessment reimbursement and approximately 119,000 claims. Psychological assessments, provided by licensed psychologists, licensed educational psychologists, or credentialed school psychologists, have the highest interim reimbursement rates among assessment types.[13]

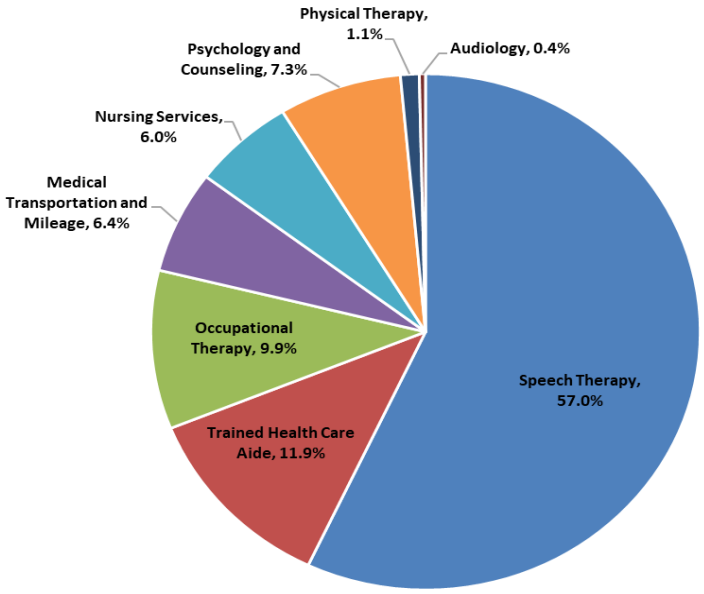
- Speech-language assessments, provided by qualified Speech Language Pathologists, represent 20.6 percent of assessment reimbursement in FY 2015-16.

[13] In FY 2015-16, the maximum allowable rate for psychological assessments was $489.90 for initial/triennial assessments and $163.30 for annual and amended assessments.

- The third largest type of assessment service in the LEA Program is IEP/IFSP health assessments, provided by registered credentialed school nurses. Health assessments represent approximately 17 percent of assessment reimbursement in FY 2015-16.

The remaining five assessment types, including all non-IEP/IFSP assessments, account for approximately seven percent of total assessment reimbursement in FY 2015-16.

Figure 2: Total IEP/IFSP LEA Treatment Reimbursement by Treatment Type, FY 2015-16



Note: Total LEA IEP/IFSP treatment and transportation/mileage service reimbursement for FY 2015-16 was $97.27 million. Less than one percent of total treatment and transportation/mileage reimbursement is attributable to non-IEP/IFSP services.

Figure 2 above demonstrates each IEP/IFSP treatment type as a percentage of total treatment reimbursement for FY 2015-16. Speech therapy and school health aide services account for the large majority of IEP/IFSP treatment reimbursement, representing almost 69 percent of total IEP/IFSP treatment reimbursement in FY 2015-16.

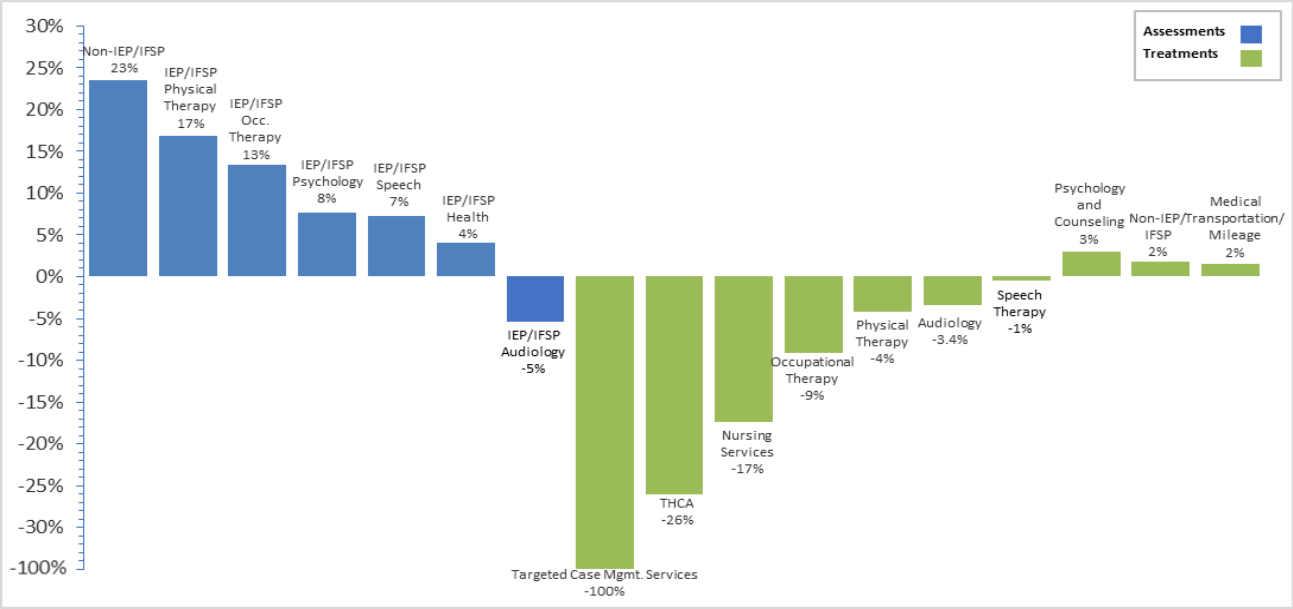
- A majority of treatment service reimbursement is attributable to speech therapy services provided by speech-language pathologists. Speech therapy treatment

services ($55.5 million) account for approximately 57 percent of total IEP/IFSP treatment service reimbursement and approximately 69 percent of total IEP/IFSP treatment service claims. In the LEA Program, speech-therapy treatment is reimbursable in an individual or group setting. In FY 2015-16, approximately 76 percent of speech-therapy treatment expenditures were attributable to group speech therapy treatment. During this reporting period, DHCS implemented telehealth as an acceptable mode of service delivery for IEP/IFSP speech therapy treatment services.

- School health aide treatment services provided by Trained Health Care Aides (THCAs) accounted for 12 percent of total IEP/IFSP treatment service reimbursement in FY 2015-16 and approximately 6 percent of total treatment claims. THCAs are required to have training in the administration of specialized physical health care services, such as gastric tube feeding, suctioning, oxygen administration, and catheterization, and may render LEA services only if supervised by a licensed physician or surgeon, a registered credentialed school nurse or a certified public health nurse. Services billed by THCAs do not include activities of daily living (ADLs), such as toileting, feeding and mobility assistance. SPA 15-021 proposes to include ADL assistance activities as a covered service, since THCAs do render these services to Medi-Cal students in schools.

The remaining seven treatment service types account for the remaining 31 percent of IEP/IFSP treatment service reimbursement and 24 percent of claims in FY 2015-16.

Figure 3: Percentage Change in Reimbursement by Service Type, FY 2014-15 Versus FY 2015-16



Notes: Services with a total reimbursement amount of less than $80,000 in FY 2015-16 are excluded from the above chart. This includes two assessments: (1) IEP/IFSP psychosocial status assessments, which experienced a 28 percent decrease in reimbursement between FY 2014-15 and 2015-16, from approximately $79,000 to $57,000, and (2) health/nutrition assessments, which experienced a decrease of 33 percent between FY 2014-15 and 2015-16 from approximately $59 to $39 in total reimbursement, respectively.

As demonstrated in the above Figure 3, the majority of the LEA assessment services experienced an increase in reimbursement between FY 2014-15 and FY 2015-16. LEAs received approximately $3.1 million more in assessment reimbursement in FY 2015-16 than the previous year, representing a 7 percent increase in reimbursement for assessments. Reimbursement for one assessment type, audiology, decreased approximately $10,000 (5 percent) from just over $181,000 in FY 2014-15 to approximately $171,500 in FY 2015-16. Audiology assessments account for less than half of one percent of interim assessment reimbursement in FY 2015-16.

Overall, approximately 1,000 less Medi-Cal eligible students received LEA direct health services in FY 2015-16 than in FY 2014-15. In addition to the decrease in beneficiaries, several types of LEA treatment services experienced a decrease in reimbursement over this time period. LEAs received approximately $8.7 million less in treatment reimbursement in FY 2015-16 as compared to the prior year, representing an 8 percent decrease in reimbursement for treatment services.

As illustrated above in Figure 3, seven treatment services accounted for the decline in treatment service reimbursement between FYs 2014-15 and 2015-16. The three services with the largest declines were TCM services, school health aide treatment services provided by THCAs, and nursing services. Review of the three services that accounted for nearly the entire 8 percent decline in treatment reimbursement follow:

- Per an agreement with CMS via SPA 12-009, DHCS suspended LEA TCM services as of July 1, 2016. DHCS submitted SPA 12-009 to CMS on January 29, 2015, and CMS approved the SPA on April 10, 2015. Policy published in PPL 15-061 instructed LEAs that TCM services provided on or after July 1, 2015, would cease and restart once CMS approved a new reimbursement methodology for TCM services in the pending SPA 16-001. DHCS informed LEAs that as of the July 1, 2015 sunset date, TCM claims would no longer be reimbursed. Once CMS approves SPA 16-001, LEAs may begin claiming for TCM services under a new reimbursement methodology. TCM services represented approximately $2.4 million in reimbursement in FY 2014-15. The $2.4 million accounts for a quarter of the decline in LEA treatment service reimbursement between FYs 2014-15 and 2015-16.

- School health aide services continues to experience the largest decrease in reimbursement, representing a 26 percent decline in reimbursement year over year. This decline coincides with a decrease in the number of LEAs reimbursed for school health aide services, from 274 LEAs in FY 2014-15 to 257 LEAs the following fiscal year. Of the 231 LEAs that received reimbursement for school health aide services in both years, 132 providers realized a decrease in reimbursement in the most recent period because they billed approximately 1.2 million fewer units than the prior year, resulting in over $5 million less in total school health aide reimbursement in FY 2015-16. The remaining 99 LEAs increased billing for school health aide services by approximately 335,000 units between the two periods, adding approximately $1.4 million to this service category's total in FY 2015-16. Forty-three LEAs that received reimbursement for their THCAs in FY 2014-15 did not bill for these practitioners in FY 2015-16.

- Nursing treatment service reimbursement, comprised of services provided by Registered Nurses (RNs) and Licensed Vocational Nurses (LVNs) decreased 17 percent in FY 2015-16. LEAs billed approximately 202,000 fewer nursing units in FY 2015-16 compared to the prior year, leading to a decrease in reimbursement of $1.2 million. Reimbursement for nursing treatment services provided by RNs decreased by approximately 43,000 units, resulting in a reimbursement decrease of $434,000, and reimbursement for services provided

by LVNs decreased by approximately 160,000 units, resulting in a reimbursement decrease of $794,000.

DHCS continues to provide guidance to LEAs regarding what services are billable to Medi-Cal. For example, in a Fall 2016 training to LEAs, DHCS discussed updates to the LEA provider manual, including discussion on Free Care policy, telehealth services, and acceptable documentation, resulting in a sample nursing treatment log being posted to the LEA Program website. In addition, DHCS updates LEAs on common audit findings during the annual training sessions. These factors may also contribute to the decline in interim program treatment reimbursement between FYs 2014-15 and 2015-16.

Numerous DHCS activities occurred during this reporting period that have affected school-based health services reimbursement. These include the following activities between July 2016 and June 2017:

- **Rate Inflators**
  As mandated in SPA 03-024, DHCS is annually required to adjust LEA reimbursement rates for assessment and treatment services using the Implicit Price Deflator, published by the U.S. Department of Commerce. During this reporting period, the Implicit Price Deflator showed that there was a decline of 0.18 percent in the index, representing deflation, or a decrease in the general price level of goods and services in FY 2015-16. Since the index was nearly flat over the impacted time period, DHCS requested and received approval from CMS to maintain the FY 2014-15 rates as the effective rates for FY 2015-16, rather than decrease the rates paid to LEA providers.

- **Technical Assistance Site Visits to LEAs**

  In FY 2014-15, DHCS began offering technical assistance site visits to LEAs requesting support on various aspects of the program, including content and submission of required program documents, such as the cost report or provider participation agreement; clarification of program policies and Medicaid billing requirements; and discussing LEA provider questions on specific areas, such as enrollment or other health coverage. In FY 2016-17, DHCS completed one site visit and identified additional LEAs that could use technical assistance, such as providers that are delinquent in submitting their cost report or other required documents. DHCS continues to promote and schedule site visits with LEAs upon request. LEAs may request a site visit, which may be conducted in-person or via telephone, using the site visit request form on the LEA Program website.

- **FY 2014-15 Annual Accounting of Funds and Payment of Over-Collected Withholds**

  W&I Code Section 14132.06(k) requires DHCS to provide an annual accounting of all funds collected by DHCS from LEA Medi-Cal payments and expended by the LEA Program and make it publicly available to LEAs. In April 2017, DHCS finalized and posted the FY 2014-15 Annual Accounting of Funds Summary report on the LEA Program website (https://www.dhcs.ca.gov/provgovpart/Documents/ACLSS/LEA%20BOP/LEA%20Claims%20Processing/14-15_FairShareReportSummary.pdf). Shortly thereafter, DHCS instructed its FI to initiate the payment and collection of funds. The FI completed implementation in November 2017.

- **Elimination of Code 92506 and Related Erroneous Claims Processing Issues**

  Effective July 1, 2016, DHCS eliminated CPT Code 92506 and implemented four new replacement CPT codes (92521, 92522, 92523 and 92524) for Speech-Language Assessments. Also, effective July 1, 2016, audiological assessments previously billed using CPT code 92506 should be billed using CPT code 92557. The FI completed implementation of the five replacement codes in October 2016. DHCS published updates to the LEA Provider Manual in September 2016.

  - During implementation of "Termination of Speech Language Pathology (SLP) CPT Code 92506; Implementation of CPT Codes 92521-24 and 92557", LEAs reported erroneous claims denials. The system and denied claims have been fixed and reprocessed as of September 2017.

- **EPC Adjustment for Claims for Preventative Medicine Counseling Code 99401**

  Some claims for CPT Code 99401 were erroneously paid, affecting claims for dates of service from May 26, 2015 through May 23, 2016. DHCS had its FI adjust the affected claims and adjustments began appearing on Remittance Advice Details (RADs) on October 27, 2016.

- **Provider Participation Agreements (PPA)**

  For FY 2016-17, DHCS amended the PPA to include two exhibits: (1) the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Business Associate Addendum (BAA); and (2) Data File Description. All LEAs must abide by the terms listed in the BAA. The purpose of the BAA is to guard the privacy and security of protected health information, and to comply with certain standards and requirements of HIPAA regulations. The Data File Description illustrates the LEA

tape match record layout output. For FY 2016-17, DHCS also published an amended PPA to allow California Community College Districts, California State University campuses, and University of California campuses to enroll in the LEA Program. The PPAs and Data File Description are publicly available.

- **Reimbursement of Withholds**

  Beginning February 14, 2017, the FI began issuing LEAs an adjustment of LEA claims due to under- and over-collection on LEA withholds. LEAs were notified of these adjustments using RAD 728 (Payment to Provider of an Amount Resulting from Other Than a Cost Settlement) for the reimbursement to LEAs of over-collected withholds, and RAD 720 (Amount Withheld as a Result of Provider Debt Other Than Cost Settlement or Claims Overpayment) to offset money owed back to DHCS for under-collected withholds.

- **Third Party Liability Recoupment**

  On July 1, 2016, DHCS published PPL 16-012 clarifying the Department's third party liability recoupment requirements. PPL 16-012 outlines DHCS' statutory policy of pursuing liable third parties, typically commercial health insurers, for services provided to Medi-Cal beneficiaries. DHCS's Third Party Liability Recovery Division (TPLRD) resumed OHC recovery efforts on August 1, 2016. As a result of the recoupment process, at times the commercial insurance carriers issued an Explanation Of Benefits (EOB) statement to the parent/guardian of the insured student. In some instances, the EOBs created confusion among parents/guardians who feared their insurance carrier was billing them personally for the services their student was receiving through the LEA Program. Stakeholders reported that the EOBs had caused some parents/guardians to rescind their consent for LEAs to bill Medi-Cal for direct medical services.

  In November 2016, DHCS sent an online survey to LEAs participating in the LEA Advisory Workgroup to determine the effect the recoupment process may be having on LEA Program claiming and participation. After the initial survey received low participation, DHCS resent the online survey to all enrolled LEAs to determine whether the TPLRD recoupment process was affecting LEA reimbursements. The survey period ended in mid-January 2017. Approximately 120 LEAs responded to the survey, which found that there were very few incidents where parents/guardians rescinded consent to bill for services. Even though the survey results did not indicate that the EOBs were creating a widespread problem for LEA Program billing, the LEAs requested that DHCS produce a one-page 'TPLRD Fact Sheet' for parents and guardians, and to post the sheet on the DHCS website for LEAs to access and provide as a handout to

parents. DHCS produced the 'TPLRD Fact Sheet' for posting on its website and issued follow-up guidance on June 1, 2017 to LEAs via e-blast communication. In the e-blast, DHCS also recommended its publication: *Medi-Cal - What It Means To You*, (Section 12: *Private Health Insurance and Medi-Cal)* as a resource to explain TPLRD and OHC requirements to parents/guardians.

- **Other Health Coverage**

  DHCS included the updated Free Care policy for the LEA Program in the Billing and Reimbursement Overview section (*loc ed bil*) of the LEA Provider Manual. Additionally, DHCS included updated policy with regard to the TPLRD recoupment requirement and OHC denials of claims in *loc ed bil*. The policy indicates that if the LEA does not receive a response from the OHC carrier within 45 days of the LEA's billing date, the LEA may bill Medi-Cal without a formal denial letter being issued by the carrier. A copy of the completed and dated insurance claim form must accompany the Medi-Cal claim. The LEA must state "45-day response delay" on the billing claim form in order for the claim to adjudicate without the OHC denial information.

- **Implementation of Telehealth Services**

  DHCS implemented telehealth as an acceptable modality for speech-language assessment and treatment services in the LEA Program, effective July 1, 2016. At this point, the telehealth service modality is billable for students with speech services included in their IEP or IFSP. DHCS published telehealth-related updates in the LEA Provider Manual in September 2016.

- **LEA Advisory Workgroup**

  Members of the LEA Advisory Workgroup represent large, medium, and small school districts, COEs, professional associations representing LEA services, DHCS, and CDE. DHCS continues to hold meetings every other month, providing a forum for LEA Advisory Workgroup members to identify and discuss relevant issues and make recommendations for changes to the LEA Program. 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 Advisory Workgroup has been instrumental in improving the LEA Program.

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

California's LEA Program 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 Program. To gather information on these services and qualified practitioners, DHCS has relied on numerous sources, including responses from the state survey, updated reviews of relevant provider manuals and Medicaid state plans, and interviews with other state Medicaid program personnel. Other state school-based services not currently reimbursable in the LEA Program 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;
- Interpreter services;
- Occupational therapy services provided by an occupational therapy assistant;
- Orientation and mobility services;
- Personal care services;
- Physical therapy services provided by a physical therapy assistant;
- Respiratory therapy services;
- Services for children with speech and language disorders provided by a speech-language pathology assistant; and
- Specialized transportation services beyond transportation in a wheelchair van or litter van.

When approved, SPA 15-021 will add the following services to the LEA Program:

- Occupational therapy, physical therapy and speech-language therapy services provided by assistants;
- Orientation and mobility services;
- Support for activities of daily living;
- Respiratory therapy services; and
- Specialized transportation services beyond transportation provided in a wheelchair van or litter van.

In addition to the services listed above, SPA 15-021 proposes to reimburse for psychological services provided by a registered associate clinical social worker or associate marriage and family therapist. While most states provide reimbursement for behavioral services, dental, durable medical equipment, and interpreter services, the LEA Program does not provide reimbursements for these services since DHCS covers these services through other Medi-Cal programs. Upon approval of SPA 15-021, California will have one of the most robust school-based service programs in the nation.

IV. OFFICIAL RECOMMENDATIONS MADE TO DHCS

Recommendations and proposed LEA Program changes are made to DHCS, typically during LEA Advisory Workgroup meetings. The following table summarizes those recommendations and the action taken/to be taken regarding each recommendation.

Table 4: Summary of Significant Recommendations Made to DHCS and Actions Taken/To Be Taken by DHCS

Recommendation	Action Taken/To Be Taken
• Update the LEA Program Provider Manual to improve the organization and content of the policy information, as necessary.	• A new section for Telehealth was added to the manual, to include the background and requirements for telehealth. • Updates were made to the manual to reflect the new CPT codes for speech and audiology services. • Additional updates were made to include more information on DHCS's OHC denial policy and the Free Care policy.
• Update and maintain the LEA Program website, including development of LEA reimbursement reports and enrollment trends.	• DHCS updated the FAQs to reflect clearer policy on documentation and record retention requirements. • DHCS also made updates to the LEA Toolbox and the Onboarding Handbook; these tools provide program guidance to LEAs.
• Provide LEA Program trainings and resources to the LEA provider community.	• DHCS conducted a program training in October of 2016. The training included several topics such as: o Refresher on program requirements and resources o Participation requirement updates o Claims Processing o SPA 15-021 and 16-001 updates o Overview of RMTS o Telehealth for Speech Therapy Services o New CPT codes for speech and audiology services. o Audits and documentation
• Update interim reimbursement rates for LEA services per the State Plan.	• DHCS started the process of updating the rates for LEA services in June 2016, but was expected to have it completed in the beginning of the next fiscal year.

Recommendation	Action Taken/To Be Taken
• Communicate policy issues with LEA providers and stakeholders.	• On July 1, 2016, DHCS published PPL16-012 clarifying the Department's third party liability recoupment requirements. • DHCS conducted a breakout session with the Advisory Workgroup to review the current FAQs for any updates, clarification, or removal. • On February 16, 2017, DHCS published PPL 17-002, which rescinded PPL 13-004, 13-014, and 16-019 Regarding Subrecipient Monitoring for County-Based Medi-Cal Administrative Activities TCM, LEA Program, and SMAA Contracts.
• Conduct meetings with DHCS and LEA providers regarding audit procedures.	• During the October 2016 training noted above, DHCS educated LEA providers on documentation requirements according to DHCS' Audits and Investigations (A&I) audit findings. • DHCS provided information on the appeals process, the different roles of each A&I branch, and information on what auditors look for during audits.
• Monitor the LEA claims processing system to ensure claims are reimbursed according to LEA Program policy, and implement EPCs as needed.	• DHCS will initiate an EPC to reprocess claims submitted by LEAs for dates of service July 1, 2016 – June 30, 2017, which will reflect the updated reimbursement rates for LEA services. • Some LEAs received erroneous payments associated with claims for CPT Code 99401 specifically for dates of service from May 26, 2015, through May 23, 2016. DHCS worked with the FI to adjust the affected claims.
• Institute a fair share withhold methodology and provide an accounting of withholds collected from LEAs.	• In April 2017, DHCS finalized and posted the FY 2014-15 Annual Accounting of Funds Summary report on the LEA Program website. Shortly thereafter, DHCS instructed its FI to initiate the payment and collection of funds. The FI completed implementation in November 2017.
• Removal and development of CPT codes.	• On October 24, 2016, LEAs were notified of the implementation of the five replacement CPT codes in the claims processing system. Instructions were provided on how to bill those claims from July 1, 2016 forward.

Recommendation	Action Taken/To Be Taken
• Review withholds applied to LEA Program claims reimbursements to determine if LEAs are being over or under withheld.	• Beginning February 14, 2017, the FI began issuing LEAs an adjustment of LEA claims due to under- and over-collection on LEA withholds. LEAs were notified of these adjustments using RAD 728 (Payment to Provider of an Amount Resulting from Other Than a Cost Settlement) for the reimbursement to LEAs of over-collected withholds, and RAD 720 (Amount Withheld as a Result of Provider Debt Other Than Cost Settlement or Claims Overpayment) to offset money owed back to DHCS for under-collected withholds.
• Update on the LEA Program on SPA 15-021 and RMTS Methodology Implementation.	• DHCS submitted SPA 15-021, which proposes new services, practitioners and a new RMTS Methodology, to CMS on September 30, 2015. It also proposes to include coverage for all individuals under the age 22 who are Medicaid eligible beneficiaries without any limitations. • DHCS received RAIs from CMS throughout the fiscal year. • DHCS continued to communicate with CMS regarding SPA 15-021 during FY 2016-17. • DHCS continued to work with the RMTS IAG throughout FY 2016-17, working on design/technical phases, identifying barriers to implementation and possible solutions. • The RMTS IAG meeting minutes for FY 2016-17 were published on the LEA website.
• SPA 16-001	• SPA 16-001 was sent to CMS in March 2016, proposing to include all Medicaid eligibles, including those with an IEP/IFSP/Individualized Health and Support Plan (IHSP), for TCM Services with an effective date of January 1, 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. • Per CMS, SPA 16-001 cannot be considered until SPA 15-021 is approved.

Recommendation	Action Taken/To Be Taken
• Discuss the new CMS policy regarding Free Care with LEA stakeholders.	• DHCS discussed with the LEAs regarding what the change in policy means for the LEAs and how it would be applied to the LEA Program. In September 2016, DHCS amended and finalized program policy to reflect the change in the rule. Many stakeholders, some of whom were not present for the preceding discussions, had questions regarding these changes. DHCS addressed those questions at the bi-monthly LEA Advisory Workgroup meetings and via email.

V. ONE-YEAR TIMETABLE FOR STATE PLAN AMENDMENTS

As of June 2017 DHCS is still working with CMS and involved in discussions regarding SPA 15-021. Below is the history and progress for the pending SPA.

As a term and condition of DHCS' resolution to the SMAA program deferral, DHCS agreed to implement a combined cost allocation methodology for the SMAA and LEA Programs. CMS required DHCS to submit a SPA no later than September 30, 2015, which included the introduction of RMTS for the LEA Program. CMS requires that the LEA Program transition to the use of RMTS as a component of the Medicaid reconciliation methodology.

In September 2015, DHCS submitted SPA 15-021 to CMS. In December 2015, DHCS received numerous RAIs from CMS regarding SPA 15-021. At the recommendation of CMS, DHCS and CMS have been working outside of the CMS required 90-day timeline to address the RAIs. Since December 2015, CMS and DHCS have engaged in a series of conference calls and written communication to address the RAIs. In December 2016, CMS asked DHCS additional questions regarding transportation services.

DHCS has informally submitted responses to all December 2015 RAIs to CMS. In many cases, both parties have informally agreed to those responses. However, DHCS continues to discuss a small number of outstanding questions with CMS, including the December 2016 questions. Once DHCS and CMS agree upon the remaining outstanding items, DHCS can re-submit the SPA and RAIs for CMS' final review.

SPA 15-021 proposes to expand access to federal Medicaid funds for LEAs, through the following three primary changes:

- Change 1: Incorporation of a RMTS as part of the cost settlement process.

New Service Providers:	**New Services:**
• Occupational and physical therapy assistants • Orientation and mobility specialists • Physician assistants • Registered associate clinical social workers • Registered dieticians • Registered marriage and family therapist interns • Respiratory care practitioners • Speech-language pathology assistants	• Nutritional (assessment and direct treatment services) • Group occupational therapy services • Orientation and mobility (assessment and direct treatment services) • Group physical therapy services • Respiratory therapy (assessment and direct treatment services)

- Change 2: Addition of new service providers and services covered under the LEA Program, including:
- Change 3: Expansion of the population covered under the LEA Program to include Medicaid beneficiaries outside of special education, including those covered by an IHSP or a "plan of care." In December 2014, CMS provided guidance to state Medicaid Directors that allows schools to bill Medicaid for "Free Care" services, or services not covered under the IDEA.[14] Since Medi-Cal beneficiaries covered under an IHSP are carved out of California's managed care contracts[15], this population will be eligible to receive services under SPA 15-021.

While DHCS and CMS are working to finalize the remaining issues, DHCS has continued to move forward with developing materials that will assist LEAs in implementing the SPA, once approved. For example, DHCS has worked on the following areas since SPA 15-021 was submitted in September 2015:

- Incorporation of the LEA Program into the current RMTS process, resulting in a revised draft of the SMAA Manual that will be published upon CMS approval;
- Drafting of new cost report forms and instructions;
- Identification of new CPT codes and modifiers that will be used to submit claims for newly covered benefits;
- Updating the LEA Program Provider Manual in anticipation of SPA approval; and
- Developing training materials that will be presented to stakeholders upon SPA approval.

[14] State Medicaid Director Letter 14-006, Medicaid Payment for Services Provided without Charge (Free Care). Available online: https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf
[15] California DHCS, COHS Boilerplate Contract. Available online: http://www.dhcs.ca.gov/provgovpart/Documents/COHSBoilerplate032014.pdf

DHCS has made consistent progress in developing implementation materials for LEAs that will be available once CMS approves SPA 15-021. Table 5 below addresses the timetable for proposed SPA 15-021.

Table 5:Timetable for Proposed State Plan Amendment Number 15-021

Service Description	Submission Date
SPA 15-021: • Adds RMTS methodology to capture the amount of time spent providing approved direct medical services by qualified health professionals that bill in the LEA Program • Expands the definition of a Medi-Cal eligible beneficiary in the LEA Program to allow Medicaid reimbursement to beneficiaries regardless of whether there is any charge for the service to the beneficiary or the community at large; also known as “Free Care” • Includes new assessment and treatment services • Includes new qualified rendering practitioners • Includes a specialized medical transportation reimbursement methodology • Removes the requirement to rebase rates a minimum of every three years	• September 30, 2015
SPA 15-021 RAI • Initial RAI received from CMS • Initial RAI response to CMS • Additional RAI and responses between DHCS and CMS	 • December 10 & 14, 2015 • January 22 & 29, 2016 • March 15 to June 2017

VI. BARRIERS TO REIMBURSEMENT

The LEA Advisory Workgroup continues to play a key role in identifying barriers to reimbursement for LEA Program services. Table 6 describes the barriers to reimbursement identified by the LEA Advisory Workgroup between July 2016 and June 2017, as well as the actions DHCS has taken or plans to take to remove those barriers.

Table 6: Barriers to Reimbursement

Barriers	Actions Taken /To Be Taken
• Certain practitioner types and services were not included in the initial draft of SPA 15-021, but are among the services provided by LEAs in California.	• During this report period, DHCS met with stakeholders to discuss the qualifications for the new practitioners included in SPA 15-021. Practitioners recommended by the Advisory Workgroup included the Marriage and Family Therapist Interns and Registered Associate Clinical Social Workers; services included occupational and physical therapy, group treatment services. • DHCS met with CMS during this report period and discussed the proposed practitioners; however, CMS has not yet approved SPA 15-021 or provided official guidance on the inclusion of these practitioners. The potential addition of these qualified rendering practitioners and expansion on scope of billable services provided by occupational and physical therapists will increase reimbursement for LEAs in California.

Barriers	Actions Taken /To Be Taken
• CMS guidance on Free Care has not been implemented in the LEA Program.	• In December 2014, CMS issued a State Medicaid Director's Letter clarifying ambiguity related to its Free Care policy. The new CMS guidance allows Medicaid reimbursement for covered services under the approved state plan that are provided to Medicaid students, regardless of whether there is a charge for the service to the Medicaid beneficiary or the community at large. The new guidance does not change the OHC requirement, whereby LEAs are still required to bill legally liable third parties prior to billing Medicaid. • The LEA Advisory Workgroup has requested DHCS to formalize policy on non-IEP/IFSP services, in light of the December 2014 CMS letter. DHCS has taken initial steps to implement the CMS guidance, including expanding the definition of a Medi-Cal eligible beneficiary in SPA 15-021 to include any Medi-Cal eligible student between 0 to 21, regardless of whether or not the student has an IEP/IFSP[16]. In addition, DHCS is moving forward with research to remove the non-IEP/IFSP utilization controls in the claims processing system, in anticipation of CMS approval of SPA 15-021. • During this reporting period, DHCS worked to prepare for implementation of the CMS guidance on Free Care. However, CMS has not yet approved SPA 15-021, therefore DHCS did not provide the LEAs with approval to bill for non-IEP/IFSP services beyond the current State Plan limitation of 24 services within a 12-month period. DHCS met with stakeholders to discuss screening services provided to the general population and DHCS asked CMS about including these in SPA 15-021. Once CMS approves SPA 15-021, DHCS will issue new policy on Free Care via a PPL and incorporate the changes into the Provider Manual.

[16] SPA 15-021 proposes to cover all Medi-Cal eligible students receiving LEA services that are carved out of managed care contracts, including services provided pursuant to an IEP/IFSP or IHSP.

Barriers	Actions Taken /To Be Taken
• LEAs find the LEA Program Provider Manual incomplete for audit purposes.	• In February 2016, Advisory Workgroup Members requested that all policies under which LEAs are to be audited, be included in the provider manual, noting that some information is located in training slides or FAQs. Stakeholders also requested that DHCS create an effective date on policy publications so that documentation requirements and timing are clear to all parties. • DHCS has identified common audit findings and provided guidance to LEAs, placing information in the provider manual or PPLs, when necessary. LEA Program provider manual updates and PPLs include the publication date. In addition, DHCS sends an e-blast to all LEAs on the listserv when it publishes provider manual updates or important documents on the LEA Program website. DHCS takes into consideration any feedback received from LEAs in regards to guidance that is needed concerning the provider manual. DHCS included information in the annual LEA Program training in October 2016 so that LEAs are aware of systemic documentation concerns that result from audits. During this report period, DHCS published the Telehealth section of the LEA Program's provider manual, updated the speech and audiology billing codes, and updated the Program's policy on "Free Care" services.

Barriers	Actions Taken /To Be Taken
• Lack of LEA understanding of the audit process and required documentation	• In February 2016, stakeholders requested that DHCS offer an annual LEA Program training that walks LEAs through a "mock financial audit" process. LEAs requested that A&I use redacted documents from a real audit to show LEAs the documentation requirements expected by A&I. • Since the Medi-Cal audit plans are confidential, DHCS is limited with the type of information that they may present regarding audits of providers. However, A&I did conduct a CRCS documentation training in 2011, which is still publicly available. This training included details on the various types of audits, what to expect during an audit, and screen shots of sample documentation that could support expenditures reported on the CRCS. The FAQs for this training are also available on the A&I Financial Audit Branch LEA Program website, along with a sample "bridging" schedule that an LEA could produce to link its accounting system with reported CRCS expenditures. • In October 2016, DHCS included presentations by A&I in the annual LEA Program training. The training included common audit findings for the year, as well an overview of the audit process and documentation standards for nursing services. DHCS answered questions both during the training and posted follow-up answers on the LEA Program's website.

Barriers	Actions Taken /To Be Taken
• Claims processing issues resulted in LEA Program claims being incorrectly paid or denied.	• DHCS worked closely with its FI to resolve outstanding claims processing issues. Throughout this reporting period, DHCS monitored and researched claims processing issues and clarified LEA Program billing policies and requirements for the FI. When claims were not paying correctly, DHCS worked with the FI to alter the system design to ensure LEA Program claims were processing properly prior to implementation of system changes. National Correct Coding Initiative edits were inadvertently applied to LEA claims, resulting in the denial of preventative medicine counseling claims when more than one unit of service per day was billed for CPT code 99401. The FI corrected this error in May 2016, and the EPC was processed on October 27, 2016. • As of July 1, 2016, DHCS implemented new speech and audiology evaluation billing codes due to a national change in allowable CPT codes. In October 2016, the FI implemented the new procedure codes, which resulted in all speech claims being denied for a short period of time, for both evaluations and treatment services. The FI corrected the issue for the new evaluation codes in October 2016 and addressed denials submitted under the old CPT codes in April 2017. The erroneously denied claims will be reprocessed under multiple EPCs in the upcoming year.

Barriers	Actions Taken /To Be Taken
• State regulations have not yet been revised to be no more restrictive than federal requirements.	• Once CMS approves SPA 15-021, DHCS will propose revisions to existing State regulations that are required to implement recent LEA Program changes. The regulations will be consistent with SPA 03-024, SPA 05-010, and SPA 12-009, and SPA 15-021 requirements, existing federal law and regulations, and existing state law. • After the October 5, 2016 Advisory Workgroup Meeting, there were several subcommittees formed to provide stakeholder input on policy topics. Two subcommittees, one on documentation and one on LEA terminology, will provide DHCS feedback from an "LEA perspective" related to policy. The documentation subcommittee will review and discuss documentation standards for new and existing policies. The terminology crosswalk subcommittee will help bridge the gap between terms that may have a different definition in Education versus the Medi-Cal arena.
• Unclear policy about the prescription requirements for Occupational and Physical Therapy services.	• During the 2016 Fall Training there was a question about the requirements for occupational therapy (OT) and physical therapy (PT) services. A&I stated that the beneficiaries' primary physician must write the OT and PT prescription. In March 2017, the Documentation subcommittee, DHCS' Safety Net Financing Division, and A&I met with the Medical Board of California (MBC) to discuss whether a physician could review an OT or PT assessment report to write a prescription for these services or if they are required to be written by the beneficiaries' primary physician. The MBC stated that the LEA Program can allow a physician's prescription for treatment services to come from physicians employed by or contracted with the LEA, or the student's primary care physician. • DHCS is finalizing this policy guidance. Some stakeholders have stated that they are not billing for these services until there is formalized policy guidance from DHCS.

Barriers	Actions Taken /To Be Taken
• Parents have reported receiving Explanation of Benefits (EOB) letters for LEA Billing Option Program services.	• On July 1, 2016, DHCS published PPL 16-012, clarifying the Department's measures to ascertain and pursue TPLRD claims for services provided to Medi-Cal beneficiaries. This PPL also states that if a beneficiary has OHC through a third-party commercial payer or other responsible payer, the OHC may issue payment to DHCS for Medi-Cal LEA Program services. If the OHC pays for those services, they may issue an EOB to the parent/guardian of the Medi-Cal beneficiary. • LEAs reported to DHCS that parents were receiving EOB letters and rescinding parental consent to bill for services. DHCS sent a survey to LEAs to understand the impact of the EOB letters on LEAs. DHCS received 127 responses to the EOB survey, which showed minimal impact to the LEAs when a parent/guardian receives an EOB for LEA Program services. DHCS published an EOB 'fact sheet' to summarize what an EOB is, which LEAs can hand out to parents/guardians who receive an EOB.