
Local Educational Agency Medi-Cal Billing Option Program

Report to the Legislature

Report Period Fiscal Year 2017-18
(July 2017 through June 2018)



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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) 2017-18.

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. These reports were part of a series in a multi-state initiative to review costs claimed for Medicaid school-based services. Between July 2017 and June 2018, the OIG issued two school-based audits: New Jersey and Texas. These audits focused mainly on technicalities related to these states' Random Moment Time Survey (RMTS) statistical sampling calculations. In addition, the OIG noted issues with coding and an inadequate reimbursement methodology in New Jersey, and insufficient direct service moment coding documentation and inadequate oversight in Texas. The OIG also noted New Jersey's contractor changed employees' time study responses to indicate that their activities were directly related to providing Medicaid services when the responses indicated the activities were unrelated. During FY 2017-18, the OIG's monetary findings related to school-based audits were approximately \$19 million in Texas and \$300 million in New Jersey.

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

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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 2017, 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 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. Additions to the OIG's active work plan include reviewing whether Medicaid payments for targeted case management services are allowable and reviewing whether consultants develop school-based Medicaid rates based on unsupported time studies and unallowable costs.

The following table identifies LEA Medi-Cal fee-for-service (FFS) interim reimbursement trends by FY. The LEA Program reimbursement has grown by approximately 121 percent since its authorization under SB 231, due to LEA Program expansion, increased participation, and claiming of covered Medi-Cal services by qualified practitioners.

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LEA Program Trends FY 2000-01 to FY 2016-17

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%
FY 2016-17 ⁽²⁾⁽⁴⁾	538	\$131.6 million	121%

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 and FY 2016-17 reflects the suspension of reimbursement for Targeted Case Management (TCM) services, effective 7/1/2015, until a new rate methodology is approved by CMS.

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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 almost 90 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 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. DHCS plans to explore options for remote participation in future meetings, to allow for broader stakeholder participation.

In addition to collaboration with the LEA Advisory Workgroup, DHCS works closely with a limited group of technically qualified stakeholders, known as the Implementation

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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 2017-18, the IAG met three times between July and December 2017 and provided feedback to DHCS on many subjects surrounding the incorporation of RMTS in the LEA Program. These meetings focused mainly on upcoming training sessions that will be provided upon SPA 15-021 implementation. The IAG's final in-person meeting took place in December 2017, although DHCS continues to solicit IAG feedback on SPA 15-021 related topics when necessary.

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 2017-18, 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 2017 RMTS Outreach Informational webinar session;
- Providing technical assistance to LEAs, including answering provider questions;
- Implementing the annual rate inflation adjustment for FY 2016-17;
- Finalizing the Annual Accounting of Funds Report for FY 2015-16, providing transparency to LEAs on administrative, auditing, and contractor costs;
- Providing LEAs with clarification and publishing updates on Specialized Medical Transportation;
- Preparing a modified Explanation of Benefits (EOB) information letter specific to the LEA Program and posting the informational letter regarding Medi-Cal and Private Health Insurance on the LEA website;
- Providing additional resources and guidance to LEA providers, including updated Frequently Asked Questions (FAQs), Policy and Procedure Letters (PPLs), and updating the LEA Program website;

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- Developing an Ordering, Referring or Prescribing (ORP) practitioner guide and FAQs; 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 looks forward to continued collaboration with the LEA stakeholder community to implement the pending SPA.

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I. INTRODUCTION

One of the goals of SB 231 is to reduce the estimated gap in per-child Medicaid school-based reimbursements among California and the three states that receive the most per child from the Federal Government. With this goal in mind, SB 231 added W&I Code Section 14115.8 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 appropriate²;
- 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.

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Table 1: Annual Legislative Report Requirements

Report Section	Report Requirements
III	<ul style="list-style-type: none"> • An annual comparison of other states’ school-based Medicaid programs in comparable states. • A state-by-state comparison of school-based Medicaid total and per eligible child claims and federal revenues³. 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 providers⁴ approved for reimbursement by CMS in other state plans that are not yet approved for reimbursement in California’s state plan and the service unit rates approved for reimbursement.
IV	<ul style="list-style-type: none"> • Identification of any barriers to LEA reimbursement, including those specified by the entities named in the legislation, that are not imposed by federal requirements, and describe the actions that have been and will be taken to eliminate them. • Official recommendations made to DHCS by the entities named in the legislation and the action taken by DHCS regarding each recommendation. The entities are CDE, representatives of urban, rural, large and small school districts and COEs, the LEC, LEAs, staff from Region IX of CMS, experts from the fields of both health and education, and internal departmental staff.
V	<ul style="list-style-type: none"> • A one-year timetable for SPAs and other actions necessary to obtain reimbursement for the school-based services, activities, and providers approved for reimbursement by CMS in other state plans that are not yet approved for reimbursement in California’s State Plan.

³ For this reporting period, Medicaid-eligible data for children is not available. For the calculations contained in Table 4, DHCS used Medicaid-enrolled data for children.

⁴ 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.

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II. BACKGROUND

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

The LEA 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 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 if the LEA can satisfy the Free Care and Other Health Coverage (OHC) requirements⁵.

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.

DHCS classifies LEA services into two main categories: assessments and treatments. The following eight IEP/IFSP assessment types, representing approximately 98 percent of total assessment reimbursement in FY 2016-17, are reimbursable in the LEA Program:

⁵ 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.

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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, representing approximately two percent of total assessment reimbursement in FY 2016-17, pursuant to strict billing guidelines for Free Care and OHC⁶:

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

⁶ 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.

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Non-IEP/IFSP Assessment Type	Qualified Practitioners
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

The majority of LEA Program expenditures are comprised of treatment services; representing approximately 64 percent of FY 2016-17 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. Transportation services, which represent

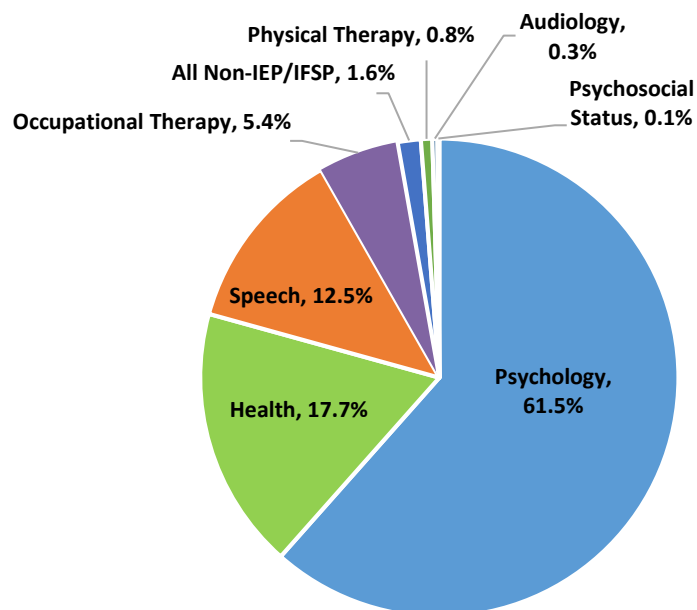
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approximately three percent of total FY 2016-17 LEA Program interim reimbursement, are billable when LEAs can meet the following requirements:

- LEAs provide transportation in a specially adapted vehicle or vehicle that contains specialized equipment, including but not limited to lifts, ramps, or restraints, to accommodate the LEA 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 and destination point for each student, student's full name, and date of transportation.
- School attendance records can verify that the student was in school and received an approved LEA 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.

The following figures illustrate the breakdown of covered assessment and treatment services for FY 2016-17.

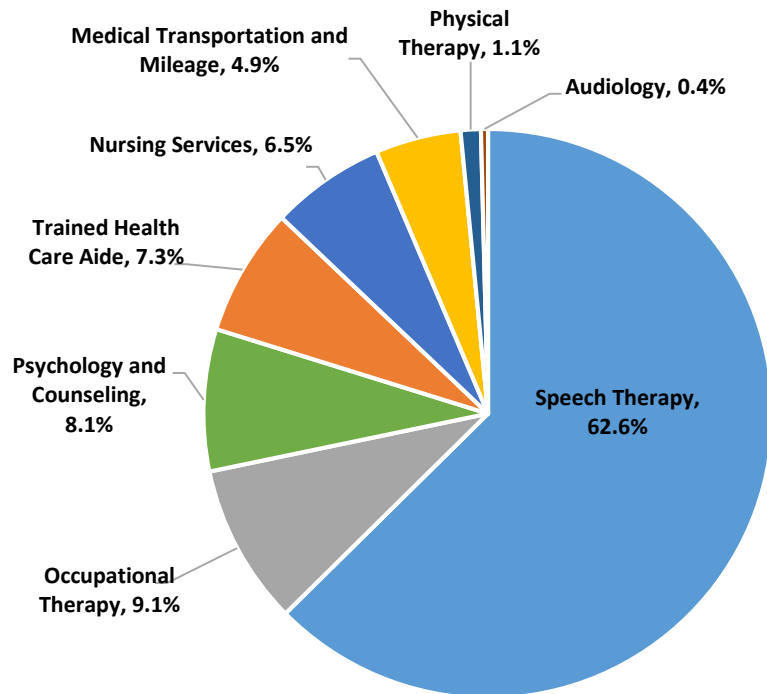
Figure 1: Total LEA Assessment Reimbursement by Assessment Type, FY 2016-17



Note: Total LEA assessment service reimbursement for FY 2016-17 was \$42.6 million.

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Figure 2: Total IEP/IFSP LEA Treatment Reimbursement by Treatment Type, FY 2016-17



Note: Total LEA IEP/IFSP treatment and transportation/mileage service reimbursement for FY 2016-17 was approximately \$88 million. Less than one percent of total treatment reimbursement is attributable to non-IEP/IFSP services.

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III. OTHER STATES' SCHOOL-BASED MEDICAID PROGRAMS

Each year, DHCS conducts a survey of other states' school-based Medicaid programs to compare California's school-based programs to other states' programs. DHCS supplements the responses obtained 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-enrolled children. ⁷	Medicaid Program Statistics, Medicaid & Children's Health Insurance Program Enrollment Data, Annual Enrollment Reports, 2017.
Number of IDEA eligible children aged 3 to 21.	U.S. Department of Education, Data Collections, Part B: Child Count and Educational Environments dataset, 2016.
Average salaries of instructional staff (classroom teachers, principals, supervisors, librarians, guidance and psychological personnel, and related instructional staff).	Rankings of the States 2017 and Estimates of School Statistics 2018, National Education Association (NEA), April 2018.
Per capita personal income.	Bureau of Economic Analysis, Personal Income Summary, 2016 - 2017.

⁷ For this reporting period, Medicaid-eligible data for children is not available. DHCS used Medicaid-enrolled data for the FY 2017-2018 Legislative Report.

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The number of Medicaid-enrolled and IDEA-eligible children provides a measure of the number of students that qualify for Medicaid school-based services. The average salaries of instructional staff and per-capita personal income provide a comparison of the cost of living among states. The ten states with the greatest number of Medicaid-enrolled children were identified. Each of these states was ranked from highest to lowest based on each of the four factors. From this analysis, DHCS identified four states as comparable to California: Illinois, New York, Pennsylvania, and Texas. Although three states (Florida, Georgia and Ohio) had a higher count of Medicaid-enrolled children, DHCS did not select these as comparable to California, since their cost of living measures were substantially lower than California. The following table compares California’s school-based program to the four states selected as comparable to California for this reporting period.

Table 3: Direct Service Claiming in California versus Comparable States

Covered Service	CA	IL	NY	PA	TX
Assessments/Screenings					
IEP/IFSP	X	X	X	X	X
Non-IEP/IFSP	X	Not Covered			
Treatments					
Assistive Devices				X	
Audiology	X	X		X	X
Physician Services	X	X		X	X
Psychology and Counseling	X	X	X	X	X
Speech Therapy	X	X	X	X	X
Medical Equipment/Supplies		X			
Nursing Services	X	X	X	X	X
Occupational Therapy	X	X	X	X	X
Orientation & Mobility				X	
Personal Care				X	X
Physical Therapy	X	X	X	X	X
School Health Aide Services	X	X			
Transportation	X	X	X	X	X

Many states, including those identified above, finance their school-based direct health service claiming programs utilizing 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

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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 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.

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

DHCS administered its fourteenth state survey in August 2018. DHCS contacted states to obtain claims and revenue information for FYs 2015-16, 2016-17, and 2017-18. Multiple follow-up calls and e-mails were conducted between October and November 2018 to states that did not respond to or complete the survey. Some states indicated that they were unable to complete the survey on a timely basis due to a variety of reasons, such as unconfirmed reimbursement totals, internal data request issues, and timing problems; several states did not respond to multiple follow-ups. Twenty-nine of 51 states (including Washington, D.C.) completed the survey.⁸ However, of the 29 respondents, four states that currently have a school-based health services program and an administrative claiming program did not provide both health services program and administrative claiming program reimbursement figures for FY 2017-18, since figures were not yet final at the time of the survey.⁹ One respondent indicated they do not currently have a school-based health services program or an administrative claiming program.¹⁰ The following Table 4 provides a complete list of survey respondents:

⁸ Arkansas is not included in the count of 29, since they did not submit a survey response, but data was collected for Arkansas through publicly available information on its State website. DHCS used Arkansas' direct and administrative claiming reimbursement data available online for analysis purposes.

⁹ Kansas, Virginia, West Virginia and Wisconsin responded to the state survey but did not provide Medicaid reimbursement figures for FY 2017-18.

¹⁰ Wyoming responded to the survey and indicated they do not currently have a school-based health services program or an administrative claiming program.

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Table 4: Summary of States that Completed 2018 DHCS Survey

Count	State	Administrative Claiming Program	Direct Claiming Program	Administrative Claiming		Direct Claiming	
				Reported for FY 2016-17	Reported for FY 2017-18	Reported for FY 2016-17	Reported for FY 2017-18
1	ALABAMA	Yes	Yes	X	X	X	X
2	ALASKA	No	Yes	N/A	N/A	X	X
3	ARIZONA	Yes	Yes	X	X	X	X
4	ARKANSAS ⁽¹⁾	Yes	Yes	X	Not Reported	X	Not Reported
5	CALIFORNIA	Yes	Yes	X	X	X	X
6	COLORADO	Yes	Yes	X	X	X	X
7	CONNECTICUT	Yes	Yes	X	X	X	X
8	DISTRICT OF COLUMBIA	No	Yes	N/A	N/A	X	X
9	FLORIDA	Yes	Yes	X	X	X	X
10	IDAHO	No	Yes	N/A	N/A	X	X
11	ILLINOIS ⁽²⁾	Yes	Yes	X	X	X	X
12	INDIANA	Yes	Yes	X	Not Reported	X	X
13	IOWA	No	Yes	N/A	N/A	X	X
14	KANSAS	Yes	Yes	X	Not Reported	X	Not Reported
15	MARYLAND	No	Yes	N/A	N/A	X	X
16	MASSACHUSETTS	Yes	Yes	X	X	X	X
17	MISSOURI	Yes	Yes	X	X	X	X
18	MONTANA	Yes	Yes	X	X	X	X
19	NEW HAMPSHIRE	No	Yes	N/A	N/A	X	X
20	NEW JERSEY	Yes	Yes	X	X	X	X
21	NEW MEXICO	Yes	Yes	X	X	X	X
22	NEW YORK ⁽²⁾	No	Yes	N/A	N/A	X	X
23	OKLAHOMA	No	Yes	N/A	N/A	X	X
24	OREGON	Yes	Yes	X	X	X	X
25	RHODE ISLAND	Yes	Yes	X	X	X	X
26	VIRGINIA	Yes	Yes	X	Not Reported	X	Not Reported
27	WASHINGTON	Yes	Yes	X	X	X	X
28	WEST VIRGINIA	Yes	Yes	Not Reported	Not Reported	X	Not Reported
29	WISCONSIN	Yes	Yes	X	Not Reported	Not Reported	Not Reported
30	WYOMING	No	No	N/A	N/A	N/A	N/A
Counts		21	29	20	15	28	24

Note: (1) Arkansas did not submit a survey response, but data was collected for Arkansas through publicly available information on its State website. Only FY 2016-2017 data was available online at the time of this report.

(2) Of the four states that are considered comparable to California, only two responded to the survey (IL, NY). Illinois reported data for both programs and NY reported only for direct services, as they don't have an administrative program. Pennsylvania and Texas did not respond to the survey.

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 or Medicaid-enrolled students among states. This is primarily due to the basic inability to split Medicaid-eligible students between direct claiming and administrative claiming programs. Also, since Medicaid-eligible data for children was not available at the time of this report, DHCS used Medicaid-enrolled data for this year's state comparison, making a direct comparison to the 2000 GAO report difficult. For those respondent states that

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operate both programs (21 states, including California), only the combined program dollars can be divided by the number of Medicaid-enrolled children, in order to calculate a practical result. As such, Table 5 (page 21) comparisons for those dual-program states that attempt to compare direct claiming dollars per enrolled child are inadvertently impacted by the inclusion of administrative claiming program dollars.

In the state survey, some states did not provide both direct claiming and administrative claiming reimbursements for various reasons. For example, out of the 21 respondent states that have both programs, 6 states did not report complete data for their direct claiming program and/or administrative claiming program. Eight additional states reported having either a direct claiming program or an administrative claiming program, but not both programs. Without complete direct claiming and administrative claiming reimbursement information, the ranking of the average claim per Medicaid-enrolled child is skewed and does not allow for a fair comparison among states and to the GAO 2000 report.

In addition to 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 Table 5.

- 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 74.63 percent among states for FY 2016-17, and from 50 percent to 75.65 percent in FY 2017-18.
- 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-enrolled child, due to the length of time that individual states may 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

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the fiscal year in which interim payments were made to LEAs. Of the 21 respondent states that have both programs, including California, 15 were able to submit reimbursement figures for both direct claiming and administrative services for FY 2015-16, FY 2016-17 and FY 2017-18. However, of these 15, only 6 states were able to provide the final reimbursement figures for both direct claiming and administrative services for each of these years. Ten states indicated that either the direct claiming figures and/or the administrative figures that they reported for at least one of the years were interim payment figures that will be subject to cost-settlement before being classified as final payment amounts.

Table 5 summarizes survey results for Medicaid reimbursement (federal share) for direct claiming and administrative services for the two most recent periods, FYs 2016-17 and 2017-18. As noted above, several states did not have finalized figures available for FY 2017-18 due to timing of cost settlement. When states provided data for any or all of the three fiscal years surveyed, Medicaid direct claiming and administrative services reimbursement (federal share) was divided by each state's FMAP, to calculate total estimated claiming dollars. These figures were then divided by each state's number of Medicaid-enrolled children to estimate the average claim amount per Medicaid-enrolled child.

As illustrated in Table 5, New Hampshire had the highest FY 2016-17 and FY 2017-18 average claim of \$607 and \$576, respectively, while California's average claim was \$93 and \$117 for these two periods. However, using California's direct service paid claims reimbursement data and the number of actual unduplicated LEA beneficiaries who received LEA Program services (approximately 325,000 students), the total average direct service claim per Medicaid-enrolled student was approximately \$412 for FY 2016-17 and \$396 for FY 2017-18. Table 6 (page 22) compares state survey respondents that only have a direct service claiming program. Since the impact of administrative claiming dollars are eliminated in Table 6, the calculation allows for a more accurate representation of how the LEA Program compares to other state direct claiming programs. However, it should be noted that although Table 6 figures are limited to direct service expenditures, the number of Medicaid-enrolled children used as the denominator in this calculation is not necessarily representative of the actual beneficiary count for these state programs, which likely results in an understated cost per child amount for the states listed in the table.

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

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Table 5: Medicaid Reimbursement and Claims by State, Ranked by 2017-18 Average Claim per Medicaid-Enrolled Child

State	SFY 2016-2017 ⁽¹⁾			SFY 2017-2018 ⁽¹⁾		
	Federal Medicaid Reimbursement (000's)	Total Claims (000's)	Average Claim Per Medicaid-Enrolled Child ⁽²⁾	Federal Medicaid Reimbursement (000's)	Total Claims (000's)	Average Claim Per Medicaid-Enrolled Child ⁽²⁾
NEW HAMPSHIRE	4 \$ 28,767	\$ 57,534	\$ 607	\$ 27,286	\$ 54,573	\$ 576
DISTRICT OF COLUMBIA	4,8 23,383	33,404	389	20,644	29,492	344
MASSACHUSETTS	8 102,500	205,000	369	93,900	187,800	338
IOWA	4 61,975	109,227	319	63,206	108,082	316
RHODE ISLAND	16,765	33,135	296	17,232	33,926	303
NEW JERSEY	8 97,503	195,006	264	108,822	217,643	294
IDAHO	4,7,8 36,718	51,347	240	38,600	54,236	253
ILLINOIS	8 163,030	320,309	223	138,342	273,981	191
MONTANA	9,232	15,493	150	10,225	17,561	170
ALABAMA	42,819	75,553	126	43,452	75,771	126
CALIFORNIA	8 224,437	448,874	93	283,636	567,273	117
NEW YORK	4,8 106,091	212,181	96	125,343	250,686	113
MISSOURI	30,547	58,519	95	33,468	63,953	103
FLORIDA	119,990	234,086	99	113,662	220,925	93
NEW MEXICO	8 42,268	65,103	155	23,141	38,320	91
MARYLAND	4 19,451	38,902	72	18,561	37,122	69
CONNECTICUT	8 19,799	39,598	113	10,598	21,196	61
ARIZONA	8 27,706	42,760	47	31,031	47,297	52
OREGON	11,240	20,595	47	11,070	20,470	46
ALASKA	4 2,928	5,856	59	2,176	4,351	44
COLORADO	8 25,378	50,740	100	9,904	19,807	39
INDIANA	3 15,804	26,415	38	11,424	17,417	25
WASHINGTON	8 8,844	17,688	22	6,853	13,706	17
OKLAHOMA	4 303	506	1	260	444	1
KANSAS	3 52,935	96,313	338	-	-	-
MICHIGAN	3,5,7 192,684	296,696	255	-	-	-
NEBRASKA	3,5,7 16,127	31,754	190	-	-	-
ARKANSAS	3,5,6 46,509	75,523	164	-	-	-
MINNESOTA	3,5,7 48,624	97,247	147	-	-	-
VIRGINIA	3 48,158	96,317	143	-	-	-
WEST VIRGINIA	3 23,368	32,546	132	-	-	-
PENNSYLVANIA	3,5,7 63,791	124,638	102	-	-	-
WISCONSIN	3 15,291	30,582	58	-	-	-
DID NOT RESPOND	9 -	-	-	-	-	-

(1) Amounts for health and administrative services are included in federal Medicaid reimbursement and total claims. Federal payment disallowances resulting from completed or on-going Office of Inspector General audits may not be reflected in these amounts.
(2) Calculated as total claims divided by the number of children enrolled for Medicaid in Federal Fiscal Year (FFY) 2016-17.
(Source: CMS, <https://www.medicaid.gov/chip/downloads/fy-2017-childrens-enrollment-report.pdf>)
(3) Total federal reimbursement for this state's health services program and/or administrative claiming program was not provided for SFY 2016-17 and/or SFY 2017-18.
(4) This state did not have a school-based Medicaid health services program and/or administrative claiming program in effect during SFY 2016-17 and/or SFY 2017-18.
(5) Did not complete DHCS 2018 survey used to collect Medicaid reimbursement (federal share) for direct claiming and administrative services for SFYs 2016-17 and 2017-18.
(6) Health services program and administrative claiming program expenditures for Arkansas for FY 2017 were obtained from the Arkansas Medicaid in the Schools website (Source: MITS profiles, https://arksped.k12.ar.us/applications/sbmbh/documents/profiles/2016_Medicaid_Profiles.pdf). FY 2018 data not available at the time of this report.
(7) SFY 2016-17 Health services program and/or administrative claiming program reimbursement amount is from the DHCS 2017 survey results.
(8) SFY 2017-18 Health services program and/or administrative claiming program figures are estimated amounts and subject to change.
(9) The following states had no survey data from either DHCS's 2017 or 2018 surveys and, therefore, are not pictured:
Delaware, Georgia, Hawaii, Kentucky, Louisiana, Maine, Mississippi, Nevada, North Carolina, North Dakota, Ohio, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont and Wyoming

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Table 6: State Survey Respondents that only have a Direct Claiming Program, Ranked by FY 2017-18 Average Claim per Medicaid-Enrolled Child

State	Average Direct Service Claim per Medicaid-Enrolled Child	
	FY 2016-17	FY 2017-18
NEW HAMPSHIRE	\$607	\$576
DISTRICT OF COLUMBIA	\$389	\$344
IOWA	\$319	\$316
IDAHO	\$240	\$253
NEW YORK	\$96	\$113
MARYLAND	\$72	\$69
ALASKA	\$59	\$44

Note: Although California operates both Administrative and Direct Claiming Programs, a direct-claiming reimbursement per child figure may be calculated based on the total interim LEA direct service reimbursement and the actual LEA beneficiary count for the respective fiscal year. The LEA Program actual average direct service claim per Medicaid beneficiary was approximately \$412 for FY 2016-17 and \$396 for FY 2017-18.

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Summary of Departmental Activities

Numerous DHCS activities occurred during this reporting period that have affected school-based health services reimbursement. These include the following activities between July 2017 and June 2018:

- **Rate Inflat**

As mandated in SPA 03-024, DHCS is annually required to adjust LEA reimbursement rates for assessment and treatment services. DHCS implemented the FY 2016-17 Rate Inflation on October 26, 2017. An Erroneous Payment Correction (EPC) was initiated to reprocess claims submitted by LEAs, for dates of service July 1, 2016, through June 30, 2017, using the updated reimbursement rates. This action increased interim reimbursement provided to LEAs.

- **FY 2015-16 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 May 2018, DHCS finalized and posted the FY 2015-16 Annual Accounting of Funds Summary report on the LEA Program website. Shortly thereafter, DHCS instructed its Fiscal Intermediary (FI) to initiate the payment and collection of funds. The FI will complete implementation in November 2018. This issue did not impact reimbursement to LEAs.

- **Occupational Therapy and Physical Therapy Assessment Current Procedural Terminology Codes 97001 - 97004**

Effective January 1, 2017, CMS replaced Current Procedural Terminology (CPT) codes 97001-97004, used to bill initial/triennial, annual, and amended physical therapy and occupational therapy assessments, with new replacement codes. DHCS plans to implement the code changes on July 1, 2018. Until the implementation date, CPT codes 97001-97004 will continue to be used to bill OT and PT assessments. The new CPT codes for OT and PT assessments – 97163, 97164, 97167 and 97168 – are effective for dates of service on or after July 1, 2018. DHCS issued Policy and Procedure Letter (PPL) #18-016 in May 2018 with guidance to stakeholders on the upcoming code changes. This issue did not impact interim reimbursement to LEAs.

- **Non-IEP/IFSP Medicaid Transportation and Mileage Codes**

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An Operating Instruction Letter was implemented in January 2018 that updated the claims processing system tables to require modifiers designating IEP or IFSP services for Medical Transportation and mileage procedure codes (T2003 and A0425, respectively). This update reflects DHCS policy on transportation reimbursement and was made to ensure that claims process according to policy directives provided to LEAs. DHCS updated the Transportation section of the LEA Provider Manual and issued a PPL with guidance to stakeholders on this change.

- **EPC Adjustment for Speech Assessment Claim Denials**

Some LEAs received denial code 0008 (“The provider of service is not eligible for the type of services billed”) associated with speech assessment claims billed with dates of service (DOS) on or after July 1, 2016. In June 2018, an EPC was completed to repay LEA providers for these erroneous claim denials. This action increased interim reimbursement provided to LEAs.

- **EPC Adjustment for Speech Therapy Claims Denials**

An EPC was fully implemented in October 2017, for erroneous claims denials of individual and group speech therapy treatment service claims using CPT codes 92507 and 92508. This EPC impacted claims with dates of service prior to July 1, 2016. This action increased interim reimbursement provided to LEAs.

- **EPC Adjustment for Speech and Audiology Assessment Claims Denials**

Certain claims submitted October 27, 2017, and after were denied incorrectly for CPT codes 92521, 92523 and 92557. The FI fixed the claims processing error in November 2017, and is expected to complete implementation of the EPC in FY 2018-19. This action will increase interim reimbursement provided to LEAs.

- **EPC Adjustment for FY 2016-17 Rate Inflation**

An EPC to reprocess claims with updated reimbursement rates for claims submitted by LEAs with dates of service in FY 17-18 was implemented on October 26, 2017. This action increased interim reimbursement provided to LEAs.

- **Provider Participation Agreements (PPA)**

The PPA was posted on the LEA website on July 1, 2017, and included only minor updates. DHCS issued a PPL (#17-016) in November 2017, notifying LEAs that a PPA is required for participation in the LEA Program. This issue did not impact interim reimbursement to LEAs.

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- **Reimbursement of Withholds**

Beginning November 2017, the FI began issuing LEAs an adjustment of LEA claims due to under- and over-collection on LEA withholds for FY 2014-15. 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. Most LEA providers saw an increase in reimbursement because of this action.

- **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, which met six times during FY 2017-18, 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;

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- 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.

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IV. BARRIERS TO REIMBURSEMENT AND OFFICIAL RECOMMENDATIONS MADE TO DHCS

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

Table 7: Summary of Barriers to Reimbursement and both Recommendations Made to DHCS Regarding Actions To Be Taken and Actions That Were Taken

Barrier to Reimbursement	Recommendation on Action to be Taken / Action Taken
Need for guidance on Activities of Daily Living (ADL) requirements and development of policy for future SPA 15-021 claiming.	<ul style="list-style-type: none"> • Stakeholders requested detailed guidance on covered ADL assistance services, including information on what services will not be covered under SPA 15-021. • DHCS summarized the ADLs provided in schools and proposed ADL requirements for the LEA Program, including covered services, practitioner types, supervision requirements and prescription requirements. • DHCS will consider stakeholder comments/questions provided during the AWG presentation and establish detailed policy to be included in the LEA Provider Manual. • DHCS will highlight the differences between ADLs and Instrumental Activity of Daily Living (IADLs) in the LEA Provider Manual.
Loss of parental consent to bill Medi-Cal due to lack of DHCS-sponsored information to Medi-Cal families.	<ul style="list-style-type: none"> • Stakeholders noted that parents/guardians are confused and worried that providing consent to bill Medi-Cal will impact their child's lifetime maximum health insurance benefits. • Stakeholders requested an Explanation of Benefits (EOB) informational letter, specific to the LEA Program, that can assist LEAs in explaining information to families so that LEAs don't unnecessarily lose parental consent to bill Medi-Cal. • DHCS prepared a document that is specific to the LEA Program and posted the informational letter on the LEA website for LEAs.
College participation in the LEA Program is not maximized.	<ul style="list-style-type: none"> • It was suggested that DHCS form a college subcommittee as part of the AWG so that colleges can be represented in discussions on Program policy. • DHCS established a list of college contacts to communicate with on Medi-Cal college issues.

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Barrier to Reimbursement	Recommendation on Action to be Taken / Action Taken
<p>Request from stakeholders for clearer auditing guidelines.</p>	<ul style="list-style-type: none"> • Stakeholders noted concern with policy updates being made and past provider manuals not being accessible, which could result in confusion during the audit process. LEAs wanted to ensure that the audit findings reflect policy in effect at the time of billing. • DHCS made LEAs aware that past provider manuals are archived and provided information on how to obtain archived versions. • The AWG updated the Self-Audit Checklist on the LEA website so that LEAs understand the purpose of the document. • DHCS renamed the document “Program Administration Checklist” and it is posted on the LEA website.
<p>New requirement for an Ordering, Referring or Prescribing (ORP) practitioner National Provider Identifier (NPI) on school-based claims.</p>	<ul style="list-style-type: none"> • DHCS developed a PPL and ORP Guide and posted the files on the LEA website. • DHCS developed/posted ORP FAQs on the LEA website. • DHCS will include ORP information in future general LEA Program training. • DHCS continues to answer stakeholder questions regarding the application process to become an ORP.
<p>Lack of policy guidance regarding reimbursable Mental Health Services in the LEA Program.</p>	<ul style="list-style-type: none"> • DHCS, in coordination with CDE and LEAs, provided background information and documents to the AWG. • DHCS will review stakeholder comments and concerns when developing policy related to mental health services. • Medi-Cal managed care is responsible for providing Behavioral Health Treatment to Autism Spectrum Disorder students. • This area will continue to be an area of focus in future LEA training sessions.
<p>Dissemination of Program policies and other information to the LEA provider community.</p>	<ul style="list-style-type: none"> • DHCS conducted a Random Moment Time Survey Informational Webinar in October 2017. <ul style="list-style-type: none"> ○ The webinar focused on LEAs that participate in the LEA Program but do not participate in the School Based Medi-Cal Administrative Activities (SMAA) Program. ○ The webinar provided information on the benefits to LEAs of participating in both programs. • DHCS worked with the IAG in FY 17-18 to develop and finalize future training sessions related to SPA 15-021.

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Barrier to Reimbursement	Recommendation on Action to be Taken / Action Taken
<p>LEA claims processing system errors are impacting LEA reimbursement.</p>	<ul style="list-style-type: none"> • DHCS implemented additional EPCs related to the following claims processing issues: <ul style="list-style-type: none"> ○ Adjustments for LEAs that received denial code 0008 for speech assessments and service dates after July 1, 2016; ○ Erroneous claims denials of CPT codes 92507 and 92508 for claims for dates of service prior to July 1, 2016; and ○ Claims submitted October 27, 2017 and after that were denied incorrectly for CPT codes 92521, 92523 and 92557. • DHCS continues to investigate denials on behalf of LEA providers and works with the FI to adjust the affected claims.
<p>Lack of CMS approval of SPA 15-021 and delay of the RMTS methodology implementation.</p>	<ul style="list-style-type: none"> • DHCS continues to work with CMS toward approval of SPA 15-021. During this reporting period, DHCS received extensive RAIs from CMS and worked to answer these RAIs in phases. DHCS gained “off the clock” approval from CMS on many RAIs. • DHCS maintained RMTS and SPA implementation as standing agenda items at the AWG meetings during FY 2017-18, keeping stakeholders informed of progress. • DHCS worked with the AWG sub-committees regarding forthcoming PPLs and Provider Manual updates related to SPA 15-021. • DHCS continued to work with the RMTS IAG throughout FY 2017-18, working on identifying potential implementation concerns and possible solutions and developing training materials, such as participant and coder training. <ul style="list-style-type: none"> ○ The RMTS IAG meeting minutes for FY 2017-18 were published on the LEA website. • DHCS started working with Local Educational Consortiums and Local Governmental Agencies on the RMTS implementation timeline.

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V. ONE-YEAR TIMETABLE FOR STATE PLAN AMENDMENTS

As of June 2018, DHCS is still working with CMS and involved in discussions regarding SPA 15-021. In addition, DHCS has submitted a related SPA, SPA 16-001, which will expand the population of students eligible to receive Targeted Case Management (TCM) services, when approved. Under SPA 16-001, TCM will be a covered service for all Medi-Cal eligible students, and not limited to students with an IEP/IFSP.

Table 8 includes a summary of key dates related to the pending SPAs.

Table 8: Timetable for Proposed State Plan Amendments

Communications	Key Dates
<p>SPA 15-021 submitted to CMS proposes the following:</p> <ul style="list-style-type: none"> • 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 with an effective date of July 1, 2015. • Expands the definition of a Medi-Cal eligible beneficiary in the LEA Program to allow Medicaid reimbursement 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 	<ul style="list-style-type: none"> • September 30, 2015
<p>SPA 15-021 – Initial Requests for Additional Information (RAIs)</p> <ul style="list-style-type: none"> • Initial RAIs received from CMS • Initial RAI responses to CMS (completed in phases) 	<ul style="list-style-type: none"> • December 2015 • January 2016, February 2016, March 2016, April 2016, June 2016, March 2017, October 2017

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Communications	Key Dates
<p>SPA 15-021 – Supplemental RAIs</p> <ul style="list-style-type: none"> • Additional RAIs received regarding Coverage and Managed Care • Additional RAIs received regarding transportation services • Personal Care Services questions received from CMS (Same-Page Review) • Personal Care Services responses to CMS • CMS approval of Personal Care Services responses • DHCS submits responses on Coverage and Managed Care questions 	<ul style="list-style-type: none"> • November 2016, June 2017, March 2018 • Dec. 2017, May 2018 • December 2015 • June 2016, March 2017 • June 2017 • April 2018
<ul style="list-style-type: none"> • Revised CRCS/draft instruction package provided to CMS 	<ul style="list-style-type: none"> • March 2017
<p>Edits to SMAA Manual, incorporating RMTS changes impacting SMAA and LEA Program</p> <ul style="list-style-type: none"> • Revised SMAA Manual Sections 5 and 6 sent to CMS • CMS provides questions to DHCS on draft SMAA Manual • DHCS submits feedback on new CMS time survey policy regarding prior notification and response timeline • DHCS submits responses to CMS questions, including the notification and response timeline • CMS provides draft approval of SMAA Manual, excluding the notification and response timeline 	<ul style="list-style-type: none"> • November 2017 • December 2017 • March 2018 • April 2018 and June 2018 • May 2018
<p>SPA 16-001 Submitted to CMS March 31, 2016:</p> <ul style="list-style-type: none"> • SPA 16-001 proposes 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. 	<ul style="list-style-type: none"> • March 31, 2016 • June 3, 2016

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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;
- Drafting new Policy and Procedures Letters to provide guidance to stakeholders and
- Developing training materials that will be presented to stakeholders upon SPA approval.

DHCS anticipates that the SPA will be implemented in FY 2019-20 and looks forward to working with LEAs to successfully roll-out the expanded services and practitioner types, as well as partner with LECs and LGAs in the successful implementation of RMTS in the LEA Program.