# Local Educational Agency Medi-Cal Billing Option Program

## Report to the Legislature

Report Period June 2013 through June 2015

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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 (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 reauthorized in Assembly Bill (AB) 1540 (Chapter 298, Statutes of 2009) and in AB 2608 (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 between June 2013 to June 2015.

Since SB 231 was originally 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 twenty-seven states have identified millions of dollars in federal disallowances for services provided in schools. During the June 2013 to June 2015, time period, the OIG issued three school-based audits in three other states. In previous years, the OIG work plan specifically identified Medicaid school-based services as a targeted area for compliance review; the OIG work plan for fiscal year 2015 identifies that OIG will review states to determine whether claimed Medicaid costs that were supported and allocated on the basis of random moment sampling systems deviated from acceptable statistical sampling practices. In prior OIG reviews of school-based administrative claims, OIG found significant unallowable payments when payments were based on random moment sampling systems. OIG will most likely continue to review Medicaid payments for school-based services in selected states to determine whether the costs claimed are reasonable.

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

The table below identifies LEA Medi-Cal fee-for-service (FFS) reimbursement trends by State Fiscal Year (SFY). The LEA program reimbursement has more than doubled in the past nine years and has grown by almost 144 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.

| Fiscal Year | Number of LEA Providers | Total Medi-Cal Reimbursement | Percentage Change from SFY 2000-01 |
|---|---|---|---|
| SFY 2000-01 | 436 | $59.6 million | N/A |
| SFY 2001-02 | 449 | $67.9 million | 14% |
| SFY 2002-03 | 459 | $92.2 million | 55% |
| SFY 2003-04 | 469 | $90.9 million | 53% |
| SFY 2004-05 (1) | 461 | $63.9 million | 7% |
| SFY 2005-06 (1) | 470 | $63.6 million | 7% |
| SFY 2006-07 (2) | 461 | $69.5 million | 17% |
| SFY 2007-08 (2) | 472 | $81.2 million | 36% |
| SFY 2008-09 (2)(3) | 479 | $109.9 million | 84% |
| SFY 2009-10 (2)(3) | 484 | $130.4 million | 119% |
| SFY 2010-11 (2)(3) | 497 | $147.8 million | 148% |
| SFY 2011-12 (2) | 519 | $137.9 million | 132% |
| SFY 2012-13 (2) | 531 | $145.6 million | 144% |

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 Erroneous Payment Corrections (EPCs) were implemented for LEA services to correct previous claims processing errors that were incorrectly paid and denied. This amount includes claims paid at the "basic rate" and the increased reimbursement LEAs received due to the rate inflator.
(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.

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 SFY 2006-07, LEA reimbursement has increased nearly 110 percent.

The LEA Ad-Hoc Workgroup Advisory Committee (LEA Advisory Workgroup), originally organized in early 2001 as a small group of representative program stakeholders, is now comprised of a large group of LEA program and fiscal staff. In August 2014, this group was expanded to include any interested LEA stakeholder that wanted to participate. DHCS's goal in expanding the LEA Advisory Workgroup is to foster increased collaboration and build partnerships with the LEA provider community. In the new open-invitation format, there are approximately 30 to 50 LEA program stakeholders present at meetings, in addition to representatives from DHCS, the California Department of Education (CDE), and Navigant Consulting. The LEA Advisory Workgroup assists DHCS in identifying barriers for both existing and potential LEA providers, providing LEA perspective and feedback on important issues, and has resulted in recommendations for new services and improvements to the LEA program. LEA Advisory Workgroup meetings are currently conducted every other month in Sacramento. Operational bottlenecks continue to be addressed and improved based on feedback from the LEA Advisory Workgroup members. In addition, the LEA Advisory Workgroup continues to suggest and recommend enhancements to the LEA program website and other communication venues in order to improve LEA provider communication and address relevant provider issues. The LEA Advisory Workgroup also conducts breakout sessions to brainstorm challenges and barriers in smaller groups and utilize the expertise of members to provide guidance to DHCS and suggest planning and potential solutions/recommendations.

During this reporting period, DHCS has continued its work to identify and resolve program barriers, expand the services provided to Medi-Cal students and enhance communication to LEA stakeholders. DHCS has accomplished many goals between June 2013 and June 2015, including developing a SPA that proposes a Random Moment Time Survey (RMTS) reimbursement methodology component for LEA providers. DHCS has spent considerable time conducting RMTS research, reviewing other state school-based services programs and interviewing LEA stakeholders regarding a potential new RMTS methodology for California's LEA program. DHCS also researched telehealth practices within schools and nationally in health industries in preparation for increasing service access for Medi-Cal students that will utilize the telehealth service modality. DHCS also identified state and federal regulations related to many new service practitioners, including physical therapy, occupational therapy and speech therapy assistants, to define scope of practice, practitioner qualifications and supervision requirements.

DHCS has used this information to develop SPA 15-021, which will be submitted to CMS by September, 2015. The SPA proposes to add new assessment and treatment services and new practitioner types to the LEA program. In addition, the SPA proposes a RMTS methodology to capture the amount of time spent providing direct medical services by qualified health practitioners that bill in the LEA program. Finally, the SPA proposes to implement the recent guidance issued in a December 2014 CMS letter to State Medicaid Directors (SMD-14-006) to allow Medicaid reimbursement for covered services under the approved state plan to Medicaid beneficiaries regardless of whether there is any charge for the service to the beneficiary or the community at large. This recent guidance reflects a significant departure from CMS' prior *Free Care Principle*, under which Medicaid funds could not be used to pay for services that are available without charge to anyone in the community. The goal of the new CMS guidance is to facilitate and improve access to quality healthcare services and improve the health of communities.

In addition to the significant effort required to prepare and submit SPA 15-021 to CMS, DHCS' staff continued to support LEA program growth in many ways, including:

- Assisting its fiscal intermediary (FI) with streamlining claims payments;
- Identifying and resolving technical claims processing issues and system changes;
- Revising the LEA portion of the Medi-Cal Provider Manual (LEA Provider Manual);
- Conducting a September 2013 annual LEA program training session and an April 2014 documentation training session;
- Implementing annual rate inflation adjustments for SFYs 2011-12, 2012-13 and 2013-14;
- Issuing the Annual Accounting of Funds Reports for SFYs 2012-13 and 2013-14 related to contractor costs and audit-related costs and reimbursing over-collected withholds;
- Developing a Transportation Regulations package and formally submitting the package to DHCS' Office of Regulations;
- Issuing additional resources and guidance to LEA providers, including the Transportation Billing Guide, the LEA Onboarding Handbook, Frequently Asked Questions (FAQs), and Policy and Procedure Letters (PPLs);
- Developing a site visit technical assistance plan and related documents to assist LEAs in need of support regarding the LEA program; 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, on-going relationship between DHCS and the many officials of school districts, COEs, CDE, and professional associations representing LEA services who have participated in the LEA Advisory Workgroup. 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 successfully implement the SPA.

## I. INTRODUCTION

Within the LEA program, California's school districts and COEs are partially reimbursed by the federal government for certain health services provided to Medi-Cal eligible students. A report published by the GAO 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 programs[2]. SB 231 (Chapter 655, Statutes of 2001) was signed into law in October 2001, and reauthorized in AB 1540 (Chapter 298, Statutes of 2009), and in AB 2608 (Chapter 755, Statutes of 2012), to reduce the estimated gap in per child Medicaid school-based reimbursements among California and the three states receiving the most per child from the Federal Government.

SB 231 added Welfare and Institutions (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 precluded 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[3];
- Consult regularly with CDE, representatives of urban, rural, large and small school districts and COEs, Local Education Consortiums (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;

[2] United States GAO, Medicaid in Schools, Improper Payments Demand Improvements in Health Care Financing Administration Oversight, April 2000.

[3] AB 430 (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. The rate study was completed in 2003.

- 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. The annual report requirements and corresponding sections in this report are summarized in Table 1 on the following page.

## Table 1: Annual Legislative Report Requirements

| Report Section | Report Requirements |
|---|---|
| III | • An annual comparison of school-based Medicaid systems in comparable states.<br>• 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.<br>• 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.<br>• A listing of all school-based services, activities, and providers[4] 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 state legislative 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. |

[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.

## II. BACKGROUND

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

School-based health services reimbursed by the LEA program are primarily provided to students with disabilities receiving special education services through an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP). For several of these IEP/IFSP children, additional services, many of them health-related, are necessary to assist them in attaining their educational goals. The LEA program also provides reimbursement for health services, such as nursing care, rendered to general education students, as long as the LEA can satisfy the stringent Free Care and Other Health Coverage (OHC) requirements[5]. (SPA 15-021 proposes to come into alignment with the Federal Government's recent guidance on the *Free Care Principle* to allow reimbursement for all approved services regardless of whether they are offered at no cost to students.)

The Patient Protection and Affordable Care Act of 2010 expands Medicaid eligibility by extending health care coverage and medical services to the low-income population, including children and adults. Each participating state establishes a state Medicaid plan that outlines eligibility standards, provider requirements, payment methods, and benefit packages. States must submit SPAs for CMS approval to make modifications to their existing Medicaid programs, including adding new services, adding or changing qualified rendering practitioners or updating the reimbursement rate methodology.

Medicaid is financed jointly by the states and the Federal Government. In California, LEAs fund the state share of Medicaid expenditures through a Certified Public Expenditure (CPE) program. Federal financial participation (FFP) funds for Medicaid program expenditures are available for two types of services: medical assistance (referred to as "health 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

[5] As of May 2015, the LEA Medi-Cal Billing Option Program's current 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 the care is not considered free, allowing Medi-Cal to be billed. These methods include all of the following: Establish a fee for each service provided; Collect OHC information from all those served (Medi-Cal and non-Medi-Cal); and Bill other responsible third party insurers. If these three conditions cannot be satisfied, the care is considered free care and cannot be billed to Medi-Cal.

- 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. Between October 2001 and June 2014, twenty-five states were audited by the OIG on school-based health services. These reports were part of a series in a multi-state initiative to review costs claimed for Medicaid school-based health services. However, since June 2014, these audit reports have significantly declined in number. In SFY 2014-15, the OIG only released two additional audit reports related to school-based health services: a July 2014 report related to Pennsylvania's on-site Financial Management Review of its school-based services for SFY 2011-12, and an August 2014 report related to Kansas' Medicaid reimbursement for school-based health services for SFY 2009-10. The OIG did not release any audit reports related to school-based administrative claiming in SFY 2014-15. Reported school-based health service findings have resulted in millions of dollars in alleged overpayments to schools, largely due to:

- Insufficient documentation of services;
- Improper billing of IEP services;
- 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; and
- Lack of state-level oversight of federal guidelines.

Regardless of the OIG's decreased school-based audits, the OIG continues to focus on compliance issues surrounding school-based services.

## III. OTHER STATES' SCHOOL-BASED MEDICAID PROGRAMS

An annual survey of other states' school-based Medicaid programs was conducted to compare California's school-based programs to other states' programs. The responses obtained from the survey were supplemented by reviewing provider manuals and other sources of program information. In addition, a comparison of school-based Medicaid systems in comparable states was conducted using annual survey data.

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, Federal Fiscal Year (FFY) 2010-11, CMS. |
| Number of IDEA eligible children aged 3 to 21. | U.S. Department of Education, Office of Special Education Programs Data Accountability Center (DAC), Data Analysis System (DANS), OMB #1820-0043: "Children with Disabilities Receiving Special Education Under Part B of the Individuals with Disabilities Education Act," 2012. |
| Average salaries of instructional staff (classroom teachers, principals, supervisors, librarians, guidance and psychological personnel, and related instructional staff). | Rankings of the States 2014 and Estimates of School Statistics 2015, National Education Association (NEA), March 2015. |
| Per capita personal income. | Rankings of the States 2014 and Estimates of School Statistics 2015, NEA, 2015. |

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, four states were selected as comparable to California: New York, Illinois, Pennsylvania, and Ohio. Although four states (Texas, Florida, Georgia, and Michigan) had greater numbers of Medicaid-eligible children, they were not selected, since their cost of living measures were substantially lower than California.

Many states finance their school-based direct health service claiming programs using CPE programs, which are cost-settled on a retroactive basis. In these situations, providers must complete an annual cost report as part of the cost reconciliation process. In California, the standardized CRCS report is submitted by LEAs annually and used to compare 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 health-related reimbursable services, and the units of service, encounters and related Medi-Cal reimbursement for the appropriate fiscal year on the CRCS forms. Estimated costs are compared to Medi-Cal reimbursement to verify that each LEA provider is not paid more than the costs of providing these services, which is a requirement within CPE programs. This reconciliation results in an amount owed to or from the LEA; underpayments are paid in a lump sum to LEAs 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. The LEA program is in its seventh cost certification year; the most recent CRCS was due by November 30, 2014, for SFY 2012-13. Information regarding the CRCS that was due on November 30, 2013, for SFY 2011–12, is included in this report. In order to assist LEAs in completing the CRCS, DHCS worked with its FI to create a Quarterly Reimbursement Report that could be downloaded from the LEA program website for each LEA that received Medi-Cal reimbursement for services rendered during SFYs 2011-12. This report summarized total units and reimbursement information by quarter for each LEA service and practitioner type, and included cumulative totals for the fiscal year. LEA providers could access the cumulative figures on the report to assist them in completing the SFY 2011-12 CRCS. In 2014, privacy concerns dictated that the Quarterly Reimbursement Report was too specific, and an Annual Reimbursement Report was provided to LEAs to assist in completing the SFY 2012-13 CRCS.

DHCS is responsible for auditing the CRCS reports and calculating the final cost settlement. By 2014, DHCS completed all audits as submitted for SFY 2006-07, 2007-08, and 2008-09 CRCS reports, resulting in LEAs receiving their final reconciled overpayment/underpayment amounts for the first three CRCS reporting periods. As of April 2015, DHCS completed and issued all minimal audits of SFYs 2009-10, 2010-11 and 2011-12 CRCS reports, and was in the process of finalizing the limited and field audits for these periods. DHCS estimated that final settlement for these CRCS reports (approximately 1,465 reports for the three-year period) would take place by November 30, 2016. SFY 2012-13 CRCS reports, submitted in November 2014, are in the process of being reviewed. By April 2015, DHCS completed approximately 50 minimal audits of SFY 2012-13 reports, and expected the remaining minimal audits to be completed by Summer 2015. In addition, DHCS expected some SFY 2012-13 CRCS reports to undergo limited or field audits later in 2015 and 2016.

The four states selected as comparable to California - Illinois, Pennsylvania, New York and Ohio - finance their school-based health services programs using various approaches. The LEA-specific rates in Illinois are developed 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.

As a result of a CMS audit of Pennsylvania's school-based services program in SFYs 2010-11 and 2011-12, Pennsylvania has revised its rate setting and payment methodology. Effective July 1, 2012, Pennsylvania abandoned its former methodology, whereby LEAs were paid a LEA-specific rate, subject to a rate ceiling, for each type of service. Effective July 1, 2012, Pennsylvania LEAs must complete a cost settlement process that utilizes a RMTS to document time spent on specific activities that are required to support Medicaid claims for school health services. The Commonwealth of Pennsylvania finalized guidance for FFS claiming and cost settlement for LEAs in 2014, and conducted provider training on cost report completion. For services rendered in SFY 2013-14, LEAs were required to submit annual cost reports by December 31, 2014, and cost settlements were calculated by June 2015. This quick settlement timeline is expected to be consistent in future cost report periods.

In December 2014, New York's SPA was approved, 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 City schools will be handled

under a separate SPA, which is in the process of being submitted to CMS. Schools outside of New York City will continue to submit FFS Medicaid claims and will be reimbursed at interim rates. 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 time period. Future cost reporting periods will be on a July through June fiscal year basis, with cost report submission no later than December 31 of each year. The first cost reports under the CPE methodology for SFYs 2011-12 and 2012-13 were submitted in late 2014.

Similar to New York, Ohio's school-based program is a CPE program that utilizes a quarterly RMTS. Like California, providers submit FFS Medicaid claims and receive interim payments. The interim payments are the FFP portion of the rate, based on the lesser of the billed charge or the Medicaid maximum allowable amount for the service rendered and billed by procedure code. At the conclusion of the program year (July 1 through June 30), providers prepare cost reports documenting the actual costs of providing the allowable Medicaid services. The cost report must be submitted 18 months after the end of the cost-reporting period. Ohio has been operating under a CPE methodology the longest of all comparable states, with CMS approval of its CPE SPA in August 2008.

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

DHCS administered its eleventh state survey beginning March 2015. DHCS contacted states to obtain updates to the information provided in the 2013 survey; states that did not participate in 2013 were given the opportunity to complete the 2015 survey. Multiple follow-up contacts via phone calls and e-mail were made during Spring 2015 to states that did not respond to 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. Thirty-four of 50 states contacted returned the survey. However, three[6] of the 34 survey respondents did not provide any Medicaid reimbursement figures.

Table 3 (See page 21) summarizes survey results for Medicaid reimbursement (federal share) for direct claiming and administrative services for SFYs 2012-13 and 2013-14. Several states did not have finalized figures available for both SFYs. When data was provided, federal direct claiming and administrative services Medicaid reimbursement

[6] Minnesota, Tennessee, and Wyoming responded to the 2015 state survey, but did not provide Medicaid reimbursement figures, since they do not currently have a school-based health services program or an administrative claiming program.

(federal share) was divided by each state's FMAP and FFP rate, respectively, to calculate total estimated claiming dollars. These total claim reimbursement dollars were divided by the number of Medicaid-eligible children aged 6 through 20 to estimate the average claim amount per Medicaid-eligible child. Additional supportive information for Table 3 is provided in Appendices 1(a) and 1(b).

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 FFS and administrative claiming programs. For those states that operate both programs (23 states in the 2015 survey, including California), only the combined program dollars can be divided by the number of Medicaid-eligible students 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 23 states that reported having both programs, one did not report complete data for their direct claiming program and four did not report complete data for their 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-eligible child is skewed, and does not allow for a fair comparison.

In addition, the FMAPs vary among states, which also impact the average claim per Medicaid-eligible child. FMAPs ranged from 50 percent to 73.43 percent among states for FY 2012-13 and from 50 percent to 73.05 percent in FY 2013-14. Further, 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. Direct comparisons between states may be impractical given these differences among state programs, data collection timing, reporting completeness and FMAP differences.

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. Based on the most recent state survey information collected, Maryland's calculated average claim per Medicaid-eligible child was $193 in SFY 2012-13 and $271 in SFY 2013-14. Maryland's survey response indicated that they no longer have a Medicaid school-based administrative claiming program, which decreased their cost per Medicaid-eligible child from the figures reported in the 2000 GAO Report. As noted in Table 3, Vermont had the highest average SFY 2013-14 claim of $768, while California's average claim was $83, a difference of $685. California's federal Medicaid reimbursement for LEA direct billing services increased approximately two percent between SFY 2012-13 and 2013-14. However, the federal revenues from administrative activities claimed in the California School-Based Medi-Cal Administrative Activities (SMAA) program decreased substantially from $90.0 million in SFY 2012-13 to $32.5 million in SFY 2013-14.[7] This 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. During this reporting period, DHCS and CMS have worked together to develop an agreement to establish methods for documenting allowable Medicaid administrative costs, which will create a process to clear deferred SMAA claims. This agreement allowed for interim payment on deferred claims for costs incurred prior to July 2012, as well as for SFYs 2012-13 and 2013-14. The reconciliation of interim payment to actual costs will be based on a "backcasting" methodology, pending CMS' approval.

According to a CMS summary of Medicaid eligibles by age group, California had over 4.3 million Medicaid eligibles aged 6 to 20 in FFY 2011-12 (approximately 17 percent of the total U.S. school-aged Medicaid eligible population). In comparison, Vermont, with the highest average claim per Medicaid-eligible child in Table 3, had 53,852 school-aged Medicaid eligible children. As indicated in Table 3, California has the highest federal Medicaid reimbursement and total claims figures in SFY 2012-13 and SFY 2013-14. However, California's average claim per Medicaid-eligible child is substantially lower when compared to other states. Based on California's SFY 2013-14 paid claims reimbursement data, the number of actual unduplicated LEA beneficiaries who received LEA program services was 334,671 students. By utilizing the actual LEA beneficiary count and the total SFY 2013-14 direct claiming FFS reimbursement, the average reimbursement per beneficiary receiving direct claiming services in SFY 2013-14 is $444.

[7] Effective June 26, 2012, CMS implemented a deferral on California's school-based administrative claims due to non-compliance with requirements defined in the Office of Management and Budget (OMB) Circular A-87, including the time study used as a basis for developing invoices. The CMS deferral is a result of the field work conducted and based on a financial management review of school-based administrative expenditures. The SFY 2012-13 figures represent approximately 95 percent of the total interim payment on deferred claims.

A comparison of the average claim in the April 2000 GAO Report to the SFY 2013-14 average claim per Medicaid-eligible child in Table 3 shows an increase in 17 of the 30 states that reported federal reimbursement (California also experienced an increase). The average claim between these periods decreased in 11 states. Two states, Hawaii and Indiana, did not have data reported in the April 2000 GAO Report. California's average claim per Medicaid-eligible child has increased approximately 340 percent compared to the figure published in the April 2000 GAO Report. It should be noted 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 2013-14 Average Claim per Medicaid-Eligible Child[8]

| | | SFY 2012-2013 (1) | | | SFY 2013-2014 (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) |
| VERMONT | [3] | $ 22,386 | $ 39,947 | $ 742 | $ 22,782 | 41,340 | $ 768 |
| IOWA | | 49,438 | 82,963 | 395 | 55,160 | 95,218 | 453 |
| MAINE | | 23,777 | 38,001 | 362 | 24,281 | 39,449 | 376 |
| KANSAS | | 28,995 | 53,698 | 364 | 28,448 | 52,283 | 354 |
| SOUTH DAKOTA | | 9,515 | 18,575 | 304 | 10,012 | 19,776 | 324 |
| MICHIGAN | | 186,028 | 285,185 | 331 | 174,058 | 267,131 | 310 |
| MASSACHUSETTS | | 76,800 | 153,600 | 335 | 65,600 | 131,200 | 286 |
| NEW JERSEY | | 108,195 | 216,389 | 382 | 80,425 | 160,851 | 284 |
| MARYLAND | | 40,000 | 80,000 | 193 | 56,000 | 112,000 | 271 |
| PENNSYLVANIA | | 115,787 | 219,692 | 263 | 108,234 | 207,440 | 248 |
| ALABAMA | | 34,713 | 62,808 | 162 | 37,412 | 66,651 | 172 |
| ARKANSAS | [6] | 34,182 | 55,750 | 170 | 34,194 | 55,772 | 170 |
| ILLINOIS | | 163,700 | 327,400 | 253 | 105,200 | 210,400 | 163 |
| MONTANA | | 5,743 | 9,832 | 138 | 5,456 | 9,246 | 130 |
| MISSOURI | | 17,744 | 34,335 | 77 | 28,676 | 55,608 | 125 |
| VIRGINIA | | 23,814 | 47,629 | 101 | 28,198 | 56,397 | 120 |
| NEW MEXICO | | 14,531 | 24,558 | 97 | 17,393 | 29,219 | 115 |
| NEW YORK | | 50,977 | 101,953 | 71 | 73,743 | 147,486 | 102 |
| NEVADA | | 5,674 | 9,499 | 63 | 8,505 | 13,478 | 89 |
| CALIFORNIA | | 235,591 | 471,181 | 108 | 181,192 | 362,383 | 83 |
| ARIZONA | | 19,249 | 30,598 | 65 | 23,062 | 36,491 | 78 |
| OREGON | | 9,709 | 17,874 | 60 | 8,502 | 15,843 | 53 |
| WASHINGTON | | 35,109 | 70,217 | 125 | 14,056 | 28,112 | 50 |
| KENTUCKY | | 9,567 | 15,854 | 43 | 7,737 | 13,487 | 36 |
| INDIANA | | 9,115 | 15,575 | 31 | 9,574 | 16,522 | 32 |
| COLORADO | [3] | 1,807 | 3,614 | 11 | 2,862 | 5,724 | 18 |
| FLORIDA | [5] | 13,982 | 24,074 | 18 | 13,225 | 22,495 | 17 |
| ALASKA | | 1,228 | 2,457 | 40 | 361 | 722 | 12 |
| CONNECTICUT | [3] | 31,601 | 63,201 | 277 | 1,349 | 2,697 | 12 |
| HAWAII | | 641 | 1,236 | 13 | 541 | 1,044 | 11 |
| WISCONSIN | [3] | 49,096 | 86,474 | 206 | - | - | - |
| LOUISIANA | [3, 4] | 29,495 | 48,163 | 88 | - | - | - |
| RHODE ISLAND | [7] | - | - | - | - | - | - |
| WEST VIRGINIA | [7] | - | - | - | - | - | - |
| IDAHO | [7] | - | - | - | - | - | - |
| DELAWARE | [7] | - | - | - | - | - | - |
| NEBRASKA | [7] | - | - | - | - | - | - |
| UTAH | [7] | - | - | - | - | - | - |
| MINNESOTA | [4] | - | - | - | - | - | - |
| MISSISSIPPI | [7] | - | - | - | - | - | - |
| NORTH CAROLINA | [7] | - | - | - | - | - | - |
| DISTRICT OF COLUMBIA | [7] | - | - | - | - | - | - |
| OHIO | [7] | - | - | - | - | - | - |
| OKLAHOMA | [7] | - | - | - | - | - | - |
| TENNESSEE | [4] | - | - | - | - | - | - |
| WYOMING | [4] | - | - | - | - | - | - |
| GEORGIA | [7] | - | - | - | - | - | - |
| TEXAS | [7] | - | - | - | - | - | - |
| NORTH DAKOTA | [7] | - | - | - | - | - | - |
| NEW HAMPSHIRE | [7] | - | - | - | - | - | - |
| SOUTH CAROLINA | [7] | - | - | - | - | - | - |

(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 Medicaid-eligible children (ages 6-20) in Federal Fiscal Year (FFY) 2011-12. (Source: Medicaid Program Statistics, Centers for Medicare and Medicaid Services, http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/02_MSISData.asp)

(3) Total federal reimbursement for this state's health services program and/or administrative claiming program was not provided for SFY 2012-13 and/or SFY 2013-14.

(4) This state did not have a school-based Medicaid health services program or administrative claiming program in effect during SFY 2012-13 and/or SFY 2013-14.

(5) Health service figures from Florida were compiled from the Florida Agency for Healthcare Administration website where online Fee-for-Service School Certified Match Reimbursement Reports are updated quarterly. (Source: http://ahca.myflorida.com/medicaid/childhealthservices/schools/index.shtml). Administrative claiming program expenditures were not available.

(6) Health service and administrative program expenditures for Arkansas were obtained from the Arkansas Medicaid in the Schools website, MITS profiles (https://arksped.k12.ar.us/applications/sbmh/default.htm).

(7) Did not complete the state survey used to collect Medicaid reimbursement (federal share) for direct claiming and administrative services for SFYs 2012-13 and 2013-14.

[8] 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 144 percent, growing from $59.6 million in SFY 2000-01 to $145.6 million in SFY 2012-13. Most LEA services may be classified into two main categories: assessments and treatments. In addition, services can be further defined as those that are provided pursuant to an IEP or IFSP, versus those that are provided to the "general education" non-IEP/IFSP population. The following eight IEP/IFSP assessment types, representing approximately 99 percent of total assessment reimbursement in SFY 2012-13, are reimbursable in the LEA program:

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

In addition, the following six non-IEP/IFSP assessment types are covered, pursuant to strict billing guidelines for Free Care and OHC[9]:

[9] Despite CMS' relaxation of the Free Care Principle as of December 2014, the LEA Medi-Cal Billing Option Program's current policy (as of June 2015) remains limited with regard to billing services that are offered free to non-Medi-Cal recipients. SPA 15-021 must be approved before the LEA program can expand the definition of a Medi-Cal eligible LEA beneficiary, and implement new policy in this area.

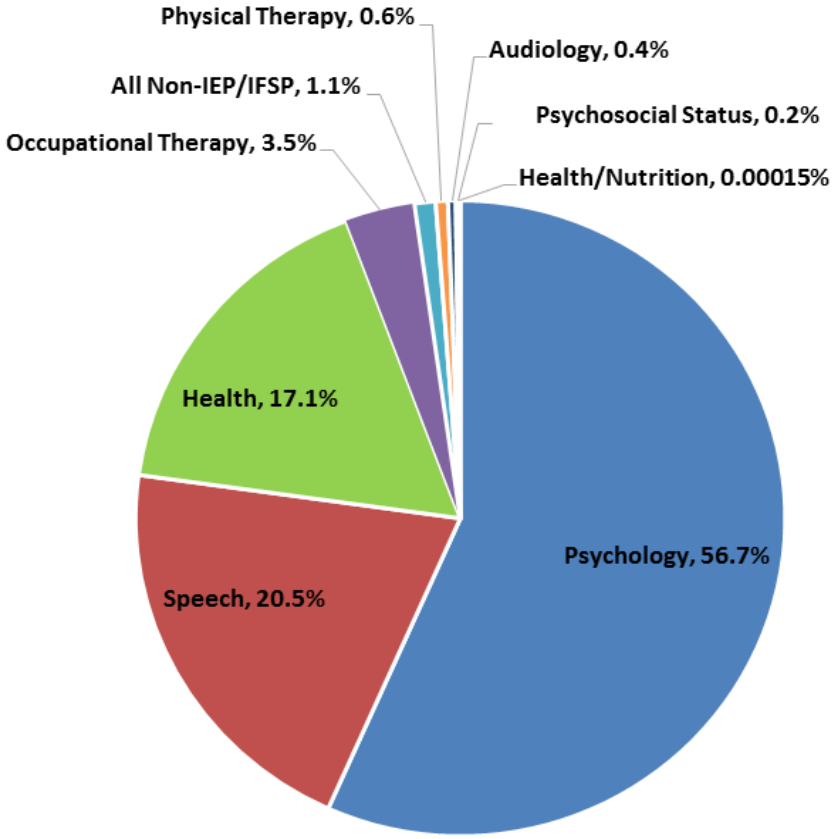
| Non- IEP/IFSP Assessment Type | Qualified Practitioners |
|---|---|
| Psychosocial Status | Licensed psychologists<br>Licensed educational psychologists<br>Credentialed school psychologists<br>Licensed clinical social workers<br>Credentialed school social workers<br>Licensed marriage and family therapists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

The majority of LEA program expenditures are attributed to treatment services, representing approximately 71 percent of SFY 2012-13 total LEA program expenditures. The following treatments may be provided to IEP/IFSP students and non-IEP/IFSP students:

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

In addition, medical transportation/mileage and Targeted Case Management (TCM) services are classified as treatment services; however, TCM is only a covered service for the IEP/IFSP student population. Currently, LEA medical transportation is allowable for students with an IEP/IFSP and must be provided in a litter van or wheelchair van. In SFY 2012-13, IEP/IFSP transportation and mileage accounted for 99.9 percent of all LEA transportation reimbursement. SPA 15-021 expands the mode of LEA medical transportation to include "specially-adapted vehicles," in addition to litter vans and wheelchair vans. However, SPA 15-021 limits transportation services to students that require medical transportation pursuant to an IEP/IFSP.

**Figure 1: Total LEA Assessment Reimbursement by Assessment Type, SFY 2012-13**

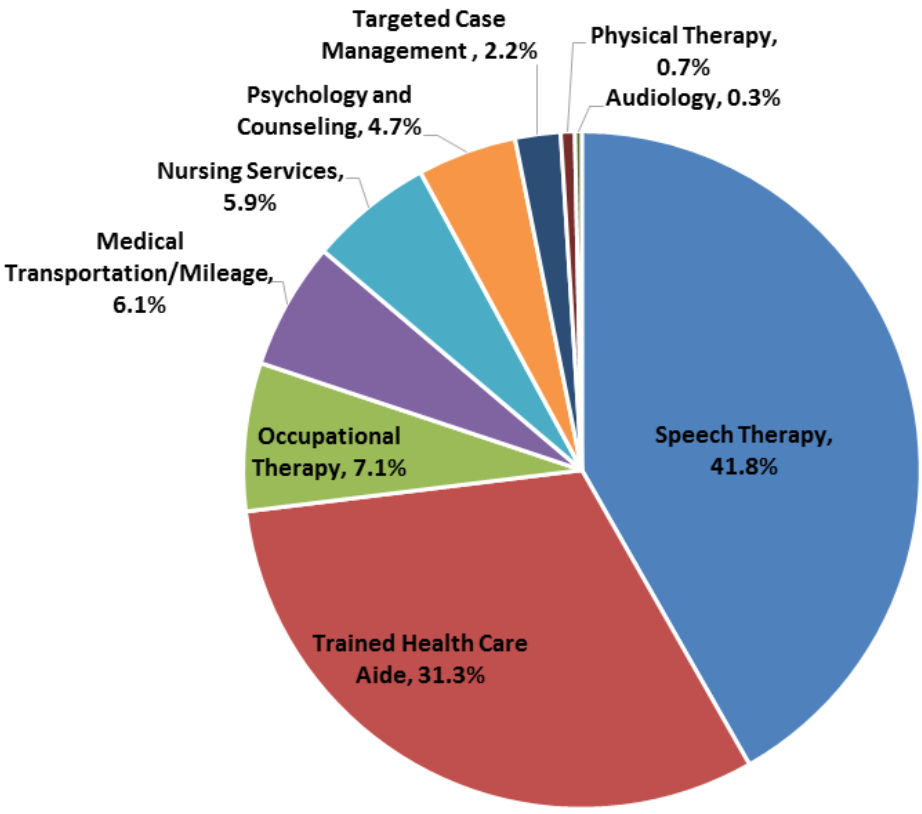



Note: Total LEA assessment service reimbursement for SFY 2012-13 was $32.96 million.

The above Figure 1 depicts each assessment type as a percentage of total assessment reimbursement for SFY 2012-13. As demonstrated in Figure 1, approximately 94 percent of assessment reimbursement ($31 million) is attributable to three IEP/IFSP assessment types: psychological, speech-language and health assessments. The majority of all LEA assessment reimbursement ($18.7 million) is attributable to psychological assessments, representing approximately 92,086 claims. Psychological assessments, provided by licensed psychologists, licensed educational psychologists and credentialed school psychologists, have the highest interim reimbursement rates among assessment types.[10] While 56 percent of assessment reimbursement is attributed to psychological assessments, over a third of total assessment reimbursement is attributed to speech-language and health assessments, representing 20.5 percent and 17.1 percent of assessment reimbursement, respectively. The remaining five assessment types, including all non-IEP/IFSP assessments, account for approximately six percent of total assessment reimbursement in SFY 2012-13.

[10] Psychological assessments were reimbursed at $480.44 for initial/triennial assessments and $160.15 for annual and amended assessments in SFY 2012-13.

**Figure 2: Total IEP/IFSP LEA Treatment Reimbursement by Treatment Type, SFY 2012-13**

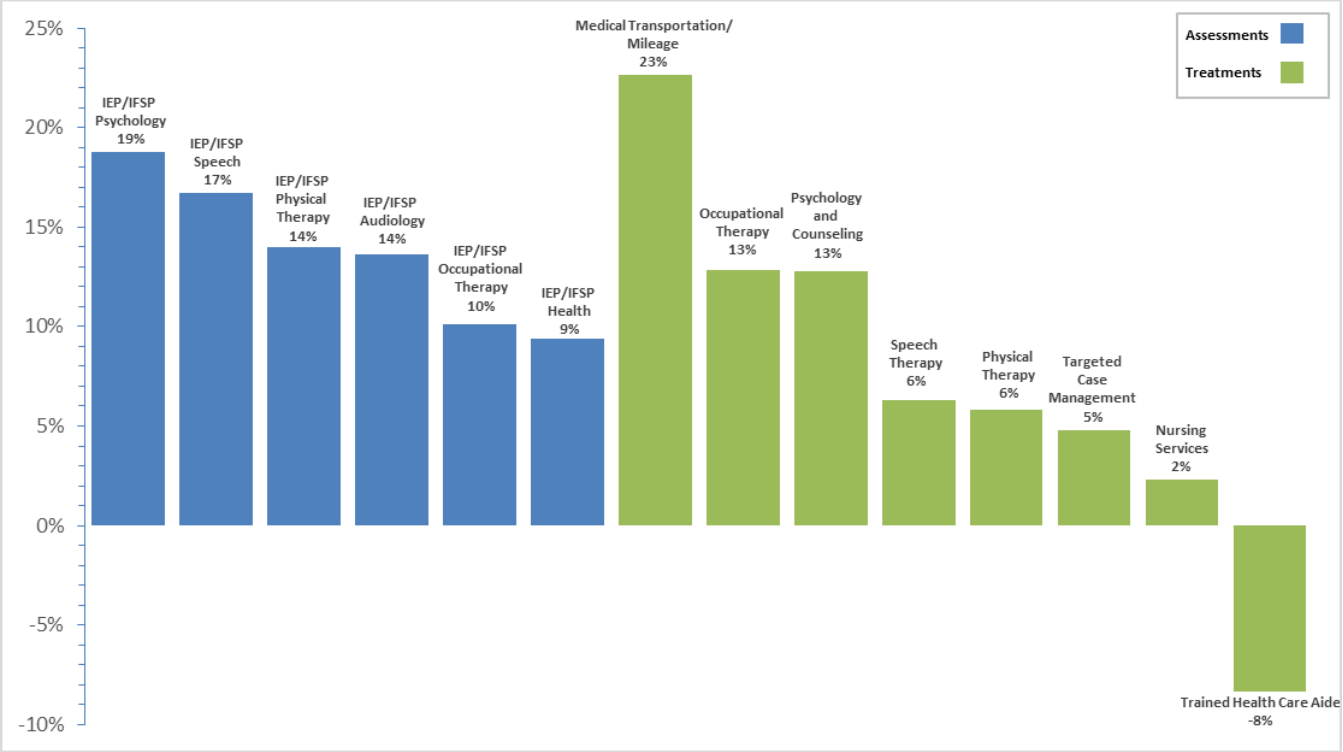



Note: Total LEA IEP/IFSP treatment, transportation/mileage and TCM service reimbursement for SFY 2012-13 was $111.7 million. Less than one percent of total treatment and transportation/mileage reimbursement is attributable to non-IEP/IFSP services.

Figure 2, above, demonstrates each IEP/IFSP treatment type as a percentage of total treatment reimbursement for SFY 2012-13. Approximately 73 percent of treatment service reimbursement is attributed to speech therapy and trained health care aide (THCA) services. Speech therapy treatment services ($46.6 million) account for approximately 42 percent of total IEP/IFSP treatment service reimbursement and approximately 61 percent of total IEP/IFSP treatment service claims. In the LEA program, speech-therapy treatment may be conducted in an individual or group setting. In SFY 2012-13, approximately 75 percent of speech-therapy treatment expenditures were attributable to group speech therapy treatment. THCA treatment services accounted for 31 percent of total IEP/IFSP treatment service reimbursement in SFY 2012-13 and approximately 14 percent of total treatment claims.

THCAs must be trained in the administration of specialized physical health care, 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. The remaining seven treatment service types account for the remaining 27 percent of IEP/IFSP treatment service reimbursement and 25 percent of claims in SFY 2012-13.

**Figure 3: Percentage Change In Reimbursement By Service Type, SFY 2011-12 Versus SFY 2012-13**




Notes: Services with a total reimbursement amount of less than $75,000 in SFY 2012-13 were excluded from the above chart. This includes two assessments: (1) IEP/IFSP psychosocial status assessments, which experienced a 206 percent increase in reimbursement between SFY 2011-12 and 2012-13, from approximately $24,000 to $72,000, and (2) health/nutrition assessments, which experienced a decline of 95 percent between SFY 2011-12 and 2012-13 from approximately $1,000 to $48 in total reimbursement, respectively. Non-IEP/IFSP assessments were also excluded from Figure 3 due to the immateriality of the expenditure amounts (approximately $346,000 in SFY 2012-13). Audiology treatment services did not experience a change in reimbursement between SFYs 2011-12 and 2012-13.

As demonstrated in the above Figure 3, most of the LEA services experienced an increase in reimbursement between SFY 2011-12 and SFY 2012-13. Total reimbursement for LEA assessments and treatment services increased, respectively, by 16 percent and three percent between SFY 2011-12 and SFY 2012-13. Reimbursement percentage increases vary from two percent for nursing treatment services to 23 percent for Medical Transportation/Mileage treatment services.

As illustrated in Figure 3, THCA services experienced a decrease in reimbursement between SFY 2011-12 and SFY 2012-13 of eight percent. In recent years, DHCS has clarified policy regarding what services are billable as THCA services. For example, in April 2014, DHCS conducted a provider training session on documentation requirements. In this training,

DHCS clarified that Personal Care Services are not considered specialized physical health care, and any time spent undressing/dressing, toileting, or performing personal hygiene of a Medi-Cal student should not be counted toward THCA billable minutes. In addition, this training clarified the requirements for THCA continuous billing in the LEA program. DHCS has also disseminated information in the LEA Advisory Workgroup and through FAQs posted on the LEA program website. Reimbursement for THCA services has decreased approximately $9 million over the SFY 2010-11 to 2012-13 period.

Numerous DHCS activities during this reporting period have contributed to the increase in school-based health services reimbursement since the passage of SB 231. These include the following activities between June 2013 and June 2015:

- **Rate Inflators**
  As mandated in SPA 03-024, DHCS is required to annually adjust LEA reimbursement rates for assessment and treatment services using the Implicit Price Deflator, which is published by the U.S. Department of Commerce.

  In May 2013, DHCS submitted the SFY 2012-13 inflated reimbursement rate table to its FI for implementation in the claims processing system. In August 2013, DHCS updated the claims processing system with the new rates. The EPC to reprocess claims with dates of service in SFY 2012-13 occurred in July 2014.

  In May 2014, DHCS submitted the SFY 2013-14 inflated reimbursement rate table to its FI for implementation. DHCS reprocessed SFY 2013-14 claims, via an EPC, in May 2015.

  In April 2015, DHCS submitted the SFY 2014-15 inflated reimbursement rate table to its FI for implementation. DHCS expects that the new rates will be implemented in Summer 2015. Until the inflated rates are implemented, LEAs will continue receiving SFY 2013-14 reimbursement rates. Another EPC will be required to reprocess claims with dates of service in SFY 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 2013, DHCS finalized the methodology to determine the fair share of withholds from each LEA, resulting in a proportionate collection of withholds across all participating LEA providers. In

October 2014, DHCS reimbursed the over-collected withholds for SFYs 2011-12 and 2012-13. DHCS did not collect any under-collected withholds for these periods, and will offset the amount due to the State from the SFY 2013-14 Annual Accounting of Funds. In May 2014, DHCS posted the SFY 2012-13 Annual Accounting of Funds report on the LEA program website. In March 2015, DHCS posted the SFY 2013-14 Annual Accounting of Funds report on the LEA program website.

- **Expanding Delivery of Service to Include "Model 4"**

  Effective July 1, 2013, DHCS notified LEAs that Model 4, a model of service delivery defined by CMS that allows LEAs to use a mix of employed and contracted practitioners, was an acceptable form of service delivery for the LEA program. As of July 2013, LEAs may use Model 4 to provide some services directly and contract out entire service types without directly employing a single practitioner in a service category. Under Model 4, the LEA may only bill Medi-Cal for services provided by the contracted qualified practitioner when the contractor has voluntarily assigned their right to bill Medi-Cal to the LEA.

- **Erroneous Claims Processing Issues**

  From August 1, 2012 through October 17, 2012, LEA claims billed with current procedural terminology (CPT) code T1017 were erroneously processed and denied as Every Woman Counts Program claims. In June 2013, DHCS instructed its FI to implement an EPC to correctly pay these inadvertently denied claims.

  For claims with dates of service between July 1, 2012 and July 30, 2014, DHCS identified a claims processing issue causing LEA claims for CPT-4 code 92507 to pay at an erroneous rate. In March 2015, DHCS instructed its FI to implement an EPC to correctly pay these claims.

- **Redefining the IEP/IFSP Initial/Triennial/Annual Assessment Utilization Controls**

  Prior to June 2013, the IEP/IFSP Assessment utilization controls were tied together and unnecessarily limited reimbursement of certain assessment claims. Effective for dates of service on or after July 1, 2009, an LEA may be reimbursed for an IEP initial or triennial assessment as long as no IEP initial or triennial assessment was reimbursed during the same SFY. The reimbursement is not contingent upon whether the LEA was reimbursed for an annual assessment during the same SFY. Similarly, reimbursement to an LEA for an IEP or IFSP annual assessment is not contingent upon whether the LEA was reimbursed for an initial or triennial

assessment during the same SFY or whether the LEA was reimbursed for an annual assessment during the prior SFY. In June 2013, DHCS instructed its FI to implement an EPC to correctly pay the denied claims under the new policy.

- **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. Meetings are held every other month and provide a forum for LEA Advisory Workgroup members to identify relevant issues and make recommendations for changes to the LEA program. The emphasis of the meeting is to suggest various goals and activities aimed at expanding and enhancing the Medi-Cal services provided on school sites and access by students to these services, while increasing federal reimbursement to LEAs for the cost of providing these services. The LEA Advisory Workgroup has been instrumental in identifying claims processing issues, assisting with LEA program training, and providing input on the operational aspects of LEA program policies within the school-based setting for specific LEA services, which has resulted in improvements to the LEA program. The LEA Advisory Workgroup members break into smaller groups to brainstorm challenges and barriers; utilize participants' combined expertise to provide guidance to DHCS, and suggest solutions to LEA issues.

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. California's program reimburses some services that are not covered in other state's programs (for example, TCM services). However, there are some services that are allowable in other state programs, which are not currently reimbursable in California's LEA program. In order to gather information on these services and qualified practitioners, we have 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. These services 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;
- Specialized transportation services beyond transportation in a wheelchair van or litter van; and
- Telehealth

Detailed information, including descriptions, qualified practitioners, and rates for additional services provided in other state programs are located in Appendix 2.

The addition of many of these benefits will be accomplished if CMS approves SPA 15-021, which DHCS will submit to CMS in September 2015. If approved, SPA 15-021 will add 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, psychological services provided by a registered associate clinical social worker or registered marriage and family therapist intern, respiratory therapy services, speech-language services provided by a speech-language pathology assistant, and specialized transportation services beyond transportation provided in a wheelchair van or litter van, among other benefits. In addition, DHCS is in the process of adding the telehealth modality for speech-language services performed via telemedicine and expects implementation in SFY 2016-17.

## 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. Recommendations related to new services and practitioners that have not been added to the State Plan or included in a proposed SPA are noted in Section V.

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

| **Recommendation I:** Update the *LEA program Provider Manual* to improve the organization and content of the policy information, as necessary. | |
|---|---|
| **Action Taken/To Be Taken SFY 2013-2014** | **Action Taken/To Be Taken SFY 2014-2015** |
| • DHCS continued to update the *LEA Program Provider Manual* throughout 2013, to provide clarity on LEA policy. 2013 *LEA Program Provider Manual* updates and revisions included Provider Participation Agreement (PPA), Annual Report (AR), CRCS, trained health care aides, patient confidentiality requirements and the medical necessity definition.<br>• DHCS updated the Models of Service Delivery to include clarification for Models 2 and 4, stating that LEAs must enter the National Provider Identifier of the contracted medical professional or agency rendering the LEA services in the designated field of the claim form.<br>• DHCS updated the TCM Labor Survey annual due date.<br>• In December 2013, DHCS posted an updated searchable *LEA Program Provider Manual in* a PDF version. The searchable PDF version allows stakeholders to quickly search for information in the manual by only typing in key words or phrases. | • DHCS continued to update the *LEA Program Provider Manual*, including updating the searchable PDF version as needed.<br>• In August 2015, DHCS published an update in the *LEA Program Provider Manual* adding clarification to the "Documentation and Records Retention Requirements" section.<br>• DHCS began working to update sections of the *LEA Program Provider Manual* to include information regarding program compliance, OHC and Free Care. |

| **Recommendation II:** Update and maintain the LEA program website, including development of LEA reimbursement reports and enrollment trends. | |
|---|---|
| **Action Taken/To Be Taken SFY 2013-2014** | **Action Taken/To Be Taken SFY 2014-2015** |
| • In 2012, DHCS worked with its FI, to determine the feasibility of providing quarterly reimbursement reports to assist LEAs to track reimbursement by procedure code/modifier combinations. In 2014, privacy concerns dictated that quarterly reimbursement reports were too specific and annual reimbursement reports would be provided to LEAs instead.<br>• In Fall 2013, DHCS posted updated claims information on the LEA program website including Medi-Cal Reimbursement by LEA provider for SFY 2011-12 Medi-Cal Reimbursement by Service Type, and Enrollment Trend Analysis.<br>• In Summer 2014, DHCS worked with its FI to produce the SFY 2012-13 *Annual Reimbursement Report*, which was posted on the LEA program website CRCS page, and allows LEAs to access and download reimbursement information online.<br>• LEA program website maintenance activities included posting the following documents: LEA Advisory Workgroup meeting minutes; PPA/AR forms; CRCS forms; CRCS submission and deadline requirements; TCM Labor Survey; LEA FAQs; current reimbursement rate charts including inflation increases; LEA program training announcements and presentation materials; LEA paid claims data summaries, and other LEA policy clarification. | • In Fall 2014, DHCS posted updated claims information on the LEA program website including Medi-Cal Reimbursement by LEA provider for SFY 2012-13 Medi-Cal Reimbursement by Service Type, and Enrollment Trend Analysis.<br>• In Summer 2015, DHCS worked with its FI to produce the SFY 2013-14 *Annual Reimbursement Report*, which was posted on the LEA program website CRCS page, and allows LEAs to access and download reimbursement information online.<br>• LEA program website maintenance activities included posting the following documents: LEA Advisory Workgroup meeting minutes; PPA/AR forms; CRCS forms; CRCS submission and deadline requirements; TCM Labor Survey; LEA FAQs; current reimbursement rate charts including inflation increases; LEA program training announcements and presentation materials; LEA paid claims data summaries for SFY 2013-14; LEA Internal Administrative Functions Chart; RMTS page that includes Implementation Advisory Group (IAG) meeting minutes and a stakeholder feedback tool; *LEA Onboarding Handbook*; *Transportation Claiming Guide*; other LEA policy clarification, and relevant LEA EPC letters. |

<table>
<tr><th colspan="2">Recommendation II (cont.):<br>Update and maintain the LEA program website, including development of LEA reimbursement reports and enrollment trends.</th></tr>
<tr><th>Action Taken/To Be Taken<br>SFY 2013-2014</th><th>Action Taken/To Be Taken<br>SFY 2014-2015</th></tr>
<tr><td><ul><li>DHCS posted Data Use Agreement Attachment F, regarding custodianship agreement, and relevant LEA EPC letters.</li></ul></td><td></td></tr>
<tr><th colspan="2">Recommendation III:<br>Provide LEA program trainings and resources to the LEA provider community.</th></tr>
<tr><th>Action Taken/To Be Taken<br>SFY 2013-2014</th><th>Action Taken/To Be Taken<br>SFY 2014-2015</th></tr>
<tr><td><ul><li>DHCS conducted an annual LEA program policy training webinar in September 2013. This training provided new LEAs and new personnel with general information on the LEA program, including program resources; participation requirements; general program updates; audit and medical review requirements and updates; LEA reimbursable services; LEA provider billing requirements; LEA program statistics, and upcoming work. In addition, the training emphasized updates to LEA policy or procedure that include: revisions to medical transportation requirements, contracted LEA practitioners as outlined in billing model number 4, and notification that DHCS is the governing agency and that LEAs are responsible for contacting DHCS for policy and procedure questions rather than the billing vendor. The webinar was recorded and the webinar training presentation slides are available on the LEA program website. DHCS also responded to the FAQs that were generated from the training.</li></ul></td><td><ul><li>DHCS developed the Transportation Claiming Guide, which provides helpful information and resources for billing for transportation under the LEA program. DHCS received input from LEA stakeholders, CDE, and researched other state's school transportation policies that are consistent with CMS requirements. The Transportation Claiming Guide was published and posted on the LEA program website in July 2014.</li><li>DHCS, along with the collaboration of the LEA stakeholders, developed the Internal Administrative Functions Chart, which illustrates the various functions that are integral to administering the LEA program. The chart was posted to the LEA program website in December 2014. DHCS conducted a breakout session at the Advisory Workgroup meeting to receive input and feedback from the LEA stakeholders and CDE, to design the LEA Onboarding Handbook in order to provide guidance to LEAs participating in the LEA program. The LEA Onboarding Handbook was published and posted on the LEA website in December 2014.</li></ul></td></tr>
</table>

| **Recommendation III (cont.):** Provide LEA program trainings and resources to the LEA provider community. | |
|---|---|
| **Action Taken/To Be Taken SFY 2013-2014** | **Action Taken/To Be Taken SFY 2014-2015** |
| • DHCS conducted a documentation training webinar in April 2014. This training provided LEAs an overview of the legal and regulatory documentation requirements, proper LEA documentation requirements, and an examination of the documentation that auditors review. DHCS also responded to the FAQs that were generated from the training.<br>• DHCS provided a sample of documentation for LEAs to review and a sample of a denied documentation. | • DHCS continued to work on the Fall 2015 Annual Program training for LEAs. DHCS received input from the LEA stakeholders regarding topics for the training during a breakout session at an Advisory Workgroup Meeting.<br>• DHCS began developing a toolbox and a self-audit checklist in order to provide user-friendly resources for LEAs that may assist schools administer the LEA program effectively and promote LEA program compliance. |
| **Recommendation IV:** Update the LEA program models of service delivery. | |
| **Action Taken/To Be Taken SFY 2013-2014** | **Action Taken/To Be Taken SFY 2014-2015** |
| • In July 2013, PPL 13-006 was published notifying LEAs participating in the LEA program that Model 4 Service Delivery has been included as an additional option to Models 1, 2, and 3 as described in the Medicaid and School Health Technical Assistance Guide issued by CMS, and effective July 1, 2013, Model 4 may be used when billing for LEA services. Model 4 allows LEAs to use a mix of employed and contracted practitioners to provide LEA reimbursable services. LEAs may provide some services directly and contract out entire service types without directly employing a single practitioner in a service category. The LEA program Provider Manual was updated accordingly. | • LEAs utilized the Model 4 service delivery option to meet their business needs. It allows flexibility in the delivery of medically necessary services. |

| **Recommendation V:**<br>Communicate policy issues with LEA providers and stakeholders. | |
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| **Action Taken/To Be Taken<br>SFY 2013-2014** | **Action Taken/To Be Taken<br>SFY 2014-2015** |
| • DHCS prepares LEA Advisory Workgroup meeting minutes, containing information discussed during the bi-monthly meetings. The meeting minutes are posted on the LEA program website.<br>• DHCS worked with CDE to include a CDE representative in the Advisory Workgroup meetings. DHCS utilized CDE's e-mail distribution to SELPAs to increase dissemination of program information to LEA providers.<br>• DHCS utilizes PPLs as a formal notification process to disseminate guidance, information and instruction to the LEAs participating in the LEA program. On July 1, 2013, DHCS posted PPL 13-006 regarding Contracted Practitioners, and on September 13, 2013, DHCS posted PPL 13-011 regarding Freedom of Choice of Qualified Medical Providers Including TCM Providers on the LEA program Website. | • In August 2014, DHCS opened the LEA Advisory Workgroup meeting up to all LEAs participating in the LEA program. The bi-monthly meeting structure continues to focus on status updates as well-as breakout groups directed to LEA issues of concern.<br>• In August 2014, the DHCS/LEA co-chair sub-committee was dissolved, and special sub-groups are now formed, as needed, from the LEA Advisory Workgroup. A PPL sub-workgroup was formed from the LEA Advisory Workgroup comprised of LEA representatives that will review PPLs prior to publication.<br>• DHCS continues to prepare LEA Advisory Workgroup meeting minutes, containing information discussed during the bi-monthly meetings. The meeting minutes are posted on the LEA program website. |

| **Recommendation V (cont.):** Communicate policy issues with LEA providers and stakeholders. | |
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| **Action Taken/To Be Taken SFY 2013-2014** | **Action Taken/To Be Taken SFY 2014-2015** |
| • DHCS disseminated information to LEA providers via the LEA program website, including FAQs, and sent e-blasts as needed to inform stakeholders of program requirements and deadlines, program updates and other policy information. | • DHCS is currently in the process of writing/issuing the following PPLs, and once published, LEAs will be notified and the PPLs will be posted on the LEA program website:<br>o Certification Statement for Participating LEAs Receiving No LEA Medi-Cal Billing Option Reimbursement During a Fiscal Year;<br>o Compliance Process for LEAs that Do Not Submit the Provider Participation Agreement and the Annual Report by the Mandated Due Date;<br>o Compliance Process for LEAs that Do Not Submit the Cost and Reimbursement Comparison Schedule by the Mandated Due Date;<br>o Implementation of the Evergreen Provider Participation Agreement in the LEA Billing Option Program;<br>o Notification of Approved California SPA 12-009 TCM Services and the June 30, 2015, Sunset of the Current Reimbursement Methodology;<br>o Implementation of Telehealth for Speech Therapy Services in the LEA Billing Option Program; and<br>o Elimination of CPT Code 92506; and Implementation of New CPT Codes. |

| **Recommendation V (cont.):** Communicate policy issues with LEA providers and stakeholders. | |
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| **Action Taken/To Be Taken SFY 2013-2014** | **Action Taken/To Be Taken SFY 2014-2015** |
| | • In March 2015, DHCS began to regularly post the RMTS IAG meeting minutes on the LEA program website.<br>• DHCS continues to utilize CDE's e-mail distribution to SELPAs to increase dissemination of program information to LEA providers, and will continue to utilize this channel to further communicate with LEAs. |
| **Recommendation VI:** Update the statewide LEA provider contact list. | |
| **Action Taken/To Be Taken SFY 2013-2014** | **Action Taken/To Be Taken SFY 2014-2015** |
| • The statewide master LEA provider contact list was reviewed and updated with e-mail addresses and contact names from the LEA program webinar trainings, the PPA/AR, and LEA Contact Information Form. This list was continuously updated and maintained by DHCS with new contact information. | • The statewide master LEA provider contact list will continue to be updated with e-mail addresses and contact names from the LEA program webinar trainings, the PPA/AR, and LEA Contact Information Form.<br>• In Spring 2015, using the updated contact information from the LEA provider contact list, DHCS updated its Listserv e-mail list, which it uses to send out important program related notices (e-blasts) to its stakeholders. This e-mail address list will be continuously updated as new contact information becomes available. |

| **Recommendation VII:**<br>Provide Technical Assistance to the LEA provider community. | |
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| **Action Taken/To Be Taken<br>SFY 2013-2014** | **Action Taken/To Be Taken<br>SFY 2014-2015** |
| • DHCS developed an integrity plan in order to provide technical assistance to the LEA community. DHCS provides personal technical assistance to individual LEAs who are new, requesting help or are non-compliant. The integrity plan helps strengthen LEA compliance with State and federal laws.<br>Site Visit Compliance Materials were reviewed by the LEA Advisory Workgroup.<br>• DHCS conducted five general LEA site visits to provide technical assistance and strengthen program compliance.<br>• DHCS conducted two site visits to observe psychological services delivered via telehealth in order to the view the possibility of implementing telehealth for the delivery of mental telehealth services into the LEA Medi-Cal Billing Option Program.<br>• DHCS will continue to provide technical assistance to LEAs through site visit reviews in SFY 2014-15. | • DHCS implemented site visit reviews in SFY 2014-15 and continues to work with the LEA Advisory Workgroup to update and modify site visit protocols.<br>• DHCS conducted two site visits to the LEAs who requested technical assistance.<br>• DHCS provided support in order for the LEAs to be compliant with the participation requirements of the LEA Medi-Cal Billing Option Program.<br>• DHCS will continue to provide technical assistance in SFY 2015-16. |

| **Recommendation VIII:**<br>Conduct meetings with DHCS and LEA providers regarding audit procedures. | |
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| **Action Taken/To Be Taken<br>SFY 2013-2014** | **Action Taken/To Be Taken<br>SFY 2014-2015** |
| • In SFY 2013-14, DHCS worked with LEAs to explain, refine and answer any questions regarding the CRCS reconciliation and audit processes. DHCS addressed reported issues regarding the overpayment/ underpayment process and provided status updates regarding the CRCS, audit procedures and the review process.<br>• In May 2014, DHCS provided an overview to the LEAs of the CRCS acceptance process.<br>• In May 2014, DHCS reported to the LEAs that they completed minimal reviews of most of the SFYs 2009-10, 2010-11 and 2011-12 CRCS submissions, and have begun several limited scope reviews and field audits. | • In SFY 2014-15, DHCS continued to work with LEAs to explain, refine and answer any questions regarding the CRCS reconciliation and audits processes. DHCS addressed reported issues regarding the overpayment/underpayment process and provided status updates regarding the CRCS, audit procedures and the review process.<br>• In August 2014, DHCS reminded LEAs that audits are posted online and are accessible to the LEAs.<br>• In October 2014, DHCS gave a brief overview to LEAs of their role to review the filed CRCS documents on an annual basis. DHCS personnel noted that in the past they have mainly reconciled payment data to the CRCS worksheets, with occasional minimal reviews and field audits. Moving forward, additional limited and field audits will be conducted on CRCS reports. DHCS discussed various audit and review procedures.<br>• In December 2014, DHCS provided an overview to the LEAs of the CRCS acceptance process.<br>• For SFY 2012-13, DHCS informed the LEA Advisory Workgroup during the April 2015 stakeholder meeting that approximately 50 minimal audits had been completed during SFY 2014-15; the remaining minimal audits would be completed by Summer 2015. |

| **Recommendation VIII (cont.):**<br>Conduct meetings with DHCS and LEA providers regarding audit procedures. | |
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| **Action Taken/To Be Taken<br>SFY 2013-2014** | **Action Taken/To Be Taken<br>SFY 2014-2015** |
| | • In December 2014, DHCS addressed questions regarding audit disallowances for THCA claims. Workgroup members spoke of examples where claims were disallowed for observation time. DHCS noted that they audit to regulations, PPLs and provider manuals that were in place at the time of the service. DHCS requested that workgroup members submit comments on specific THCA audit issues if they would like further explanation.<br>• In February 2015, DHCS informed LEAs of their process of notifying the LEAs when audits are completed, depending on the scope of the audit.<br>• In April 2015, DHCS provided a review to LEAs of the three types of audits: minimal, limited and field. LEAs noted concerns with the lack of a process to inform LEAs that the audit has been completed. DHCS made internal changes to their process to resolve this issue.<br>• In April 2015, DHCS gave a brief overview of the CRCS audits in process for SFYs 2009-10, 2010-11, and 2011-12. For these three fiscal years, all minimal audits have been issued; limited and field audits were then being finalized. |

| **Recommendation IX:**<br>Update CRCS (Annual Cost Report) instructions and CRCS forms. | |
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| **Action Taken/To Be Taken<br>SFY 2013-2014** | **Action Taken/To Be Taken<br>SFY 2014-2015** |
| • In September 2013, DHCS updated and posted the CRCS report form for SFY 2011-12. Additionally, DHCS posted a document that contained a CRCS form sample, instructions and information on its website. The due date for submission of the CRCS was November 30, 2013.<br>• The CRCS form was slightly revised from the prior year, to accommodate one federal matching percentage (compared to three distinct federal matching percentages in the SFY 2010-11 CRCS report). | • In September 2014, DHCS updated and posted the CRCS report form for SFY 2012-13. The due date for submission of the CRCS was November 30, 2014.<br>• In April 2015, DHCS began researching a way to simplify the CRCS reporting requirement for LEAs with zero interim reimbursement. Instead of having LEAs submit the entire report (populated with zeros), DHCS wanted to implement a one-page certification for these LEAs, who are mostly new providers. |
| **Recommendation X:**<br>Determine and enforce a compliance process for LEAs that did not timely submit CRCS forms. | |
| **Action Taken/To Be Taken<br>SFY 2013-2014** | **Action Taken/To Be Taken<br>SFY 2014-2015** |
| • In SFY 2013-14, DHCS implemented penalty policies for LEAs that are non-compliant with CRCS submission requirements, starting with SFY 2009-10 CRCS submissions. DHCS implemented an initial 20 percent withhold penalty on claims payments, and ultimately LEA program termination, for those LEAs that did not submit mandatory annual CRCS forms.<br>• In August 2013, DHCS identified LEAs that have not submitted CRCS reports for SFY 2006-07 and 2007-08, but received reimbursement for LEA claims. LEAs were sent a 15-day notification letter notifying them that DHCS will recoup 100 percent of paid claims and offset all future claims until all past due CRCS reports are submitted. | • In SFY 2014-15, DHCS enforced a penalty process for non-submission of the CRCS by implementing a 100 percent withhold on payment for delinquent CRCS reports. LEA providers were issued a warning letter prior to withhold initiation, and allowed a grace period in which to submit delinquent reports.<br>• In October 2014, DHCS sent e-mail notifications to LEAs with delinquent CRCS reports for SFYs 2009-10, 2010-11, or 2011-12, that they are on 100 percent withhold until delinquent reports are submitted. |

| **Recommendation (cont.) X:** Determine and enforce a compliance process for LEAs that did not timely submit CRCS forms. | |
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| **Action Taken/To Be Taken SFY 2013-2014** | **Action Taken/To Be Taken SFY 2014-2015** |
| • In December 2013, DHCS worked with those LEAs that did not timely submit the SFY 2011-12 CRCS report.<br>• In Spring 2014, DHCS began sending letters to non-compliant LEAs for non-submission of the CRCS.<br>• In May 2014, DHCS discussed the deadlines for submitting the CRCS and advised the LEAs that A&I works with non-compliant providers before they are placed on withhold.<br>• In May 2014 DHCS implemented a 100 percent withhold on payment for delinquent CRCS reports for SFYs 2009-10, 2010-11, and 2011-12. LEA providers are issued a warning letter prior to withhold initiation and allowed a grace period in which to submit delinquent reports. | • The SFY 2012-13 CRCS was due by November 30, 2014, but providers were granted until year-end before non-compliant LEAs would be identified and sent a withhold letter. If the CRCS was not received after the withhold letter is sent, an action notice will be sent to the FI instructing it to put the LEA on 100 percent withhold.<br>• In January 2015, DHCS sent letters to LEAs instructing them to submit delinquent SFY 2012-13 CRCS reports or they would be put on 100 percent claims withhold.<br>• In February 2015, DHCS reached out to non-compliant LEAs who have not submitted past due CRCS report(s). DHCS provided the LEAs with resources and offered technical assistance in order for LEAs to become compliant.<br>• In June 2015, DHCS followed up with LEAs who have not yet submitted their SFY 2012-13 CRCS reports in order for the LEAs to submit the delinquent CRCS report.<br>• In SFY 2014-15, DHCS notified the LEAs that it was in the process of implementing a new compliance policy for the submission of the CRCS, and drafting a corresponding PPL, to be in effect for the upcoming SFY 2015-16. |

| **Recommendation XI:**<br>Update and process the PPA and AR annually, and provide assistance and guidance to LEA providers regarding those reports. | |
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| **Action Taken/To Be Taken<br>SFY 2013-2014** | **Action Taken/To Be Taken<br>SFY 2014-2015** |
| • In SFY 2013-14, DHCS provided updates regarding the collection of the PPA/AR and common errors made by the LEAs when submitting the documents.<br>• In August 2013, DHCS updated and posted the AR for the SFY 2012-13 for LEAs to submit by October 10, 2013. The PPA remained the same from the prior year and was only to be submitted by new LEAs.<br>• In August 2013, DHCS discussed with its stakeholders the simplified amount LEAs should report in the AR for budgeted salaries, benefits and administrative costs of employees who provide health services and activities covered by the LEA program.<br>• Following the posting of the documents online in August 2013, DHCS reviewed and processed the PPA and AR submissions throughout the year and sent e-mails to LEAs notifying them if they have been accepted or require corrections. | • In SFY 2014-15, DHCS continued to provide updates regarding the collection of the PPA/AR and common errors made by the LEAs when submitting the documents.<br>• In October 2014, DHCS updated and posted the AR for SFY 2012-13 for LEAs to submit by the extended deadline of November 30, 2014. The PPA remained the same from the prior year and was only to be submitted by new LEAs.<br>• In October 2014, DHCS reviewed and processed the submitted PPAs and ARs and sent notifications to LEAs if the reports have been accepted or require corrections.<br>• In October 2014, DHCS discussed the new Data Universal Numbering System (DUNS) number requirement on the LEA Medi-Cal Provider Information Enrollment Sheet of the AR. The DUNS number is a unique nine-digit identification number provided by Dun & Bradstreet and must be provided to DHCS by entities receiving federal funds.<br>• In February 2015, DHCS notified the LEAs that the PPA and AR will be updated for the upcoming fiscal year, making them more user-friendly and allowing for electronic signatures for both documents.<br>• In Spring 2015, DHCS moved forward with implementing the 'evergreen' PPA, which would no longer have an expiration date or predetermined effective period. It would remain effective until terminated by either party, and would not need to be renewed every three years by the LEAs. |

| **Recommendation XII:**<br>Identify non-compliant LEAs that have not submitted the annual PPA/AR. | |
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| **Action Taken/To Be Taken<br>SFY 2013-2014** | **Action Taken/To Be Taken<br>SFY 2014-2015** |
| • DHCS identified and reviewed all PPA/AR submissions and contacted LEAs if information was incomplete, missing and/or incorrect. In addition, DHCS created and maintained a tracking system of LEAs that did not submit a PPA/AR as required, and contacted non-compliant LEAs to provide technical assistance to ensure that they properly complete and submit their PPA/ARs as required. As part of normal DHCS business process, the LEA Medi-Cal Billing Option Program annually reviews all PPA/AR submissions and contacts non-compliant LEAs to offer assistance to bring them into compliance.<br>• In December 2013, DHCS began issuing suspension letters to LEAs that have not timely submitted their PPAs and ARs, and coordinating implementation of the suspension process to be effective SFY 2014-15. | • DHCS identified and reviewed all PPA/AR submissions and contacted LEAs if the information was incomplete, missing and/or incorrect. DHCS provided technical assistance to these LEAs to ensure that they properly complete and submit their PPA/AR as required.<br>• In SFY 2014-15, DHCS notified the LEAs that DHCS was in the process of implementing new compliance policy for the submission of the PPA and AR, and drafting a corresponding PPL, to be in effect for the upcoming SFY 2015-16. |

| **Recommendation XIII:**<br>Update interim reimbursement rates for LEA services per the State Plan. | |
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| **Action Taken/To Be Taken<br>SFY 2013-2014** | **Action Taken/To Be Taken<br>SFY 2014-2015** |
| • DHCS is required to annually adjust LEA reimbursement rates for assessments and treatment services using the Implicit Price Deflator, which is published by the U.S. Department of Commerce.<br><br>• In May 2013, DHCS inflated the SFY 2011-12 interim reimbursement rates to calculate the SFY 2012-13 interim reimbursement rates, and instructed the FI to apply the inflation adjustment to the SFY 2012-13 rate table, which was completed August 2013.<br><br>• In October 2013, an EPC was initiated to reprocess claims with dates of service in SFY 2012-13 based on the updated rates; the EPC was implemented in July 2014.<br><br>• In 2013, rate rebasing was put on hold, pending discussions on RMTS. | • In May 2014, DHCS inflated SFY 2012-13 interim reimbursement rates to calculate the SFY 2013-14 interim reimbursement rates, and instructed the FI to apply the inflation adjustment to the SFY 2013-14 rate table; this was completed July 2014.<br><br>• In July 2014, an EPC was initiated to reprocess claims with dates of service in SFY 2013-14 based on the updated rates; the EPC was implemented in May 2015.<br><br>• DHCS determined that rate rebasing was no longer necessary because the LEA program interim reimbursement rates are inflated annually. This policy change was proposed in SPA 15-021. |

| **Recommendation XIV:** Monitor the LEA claims processing system to ensure claims are reimbursed according to LEA program policy, and implement EPCs and System Development Notices (SDN), as needed. | |
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| **Action Taken/To Be Taken SFY 2013-2014** | **Action Taken/To Be Taken SFY 2014-2015** |
| • EPC for Resubmission of LEA Claims Denied as Every Woman Counts (EWC): From August 1, 2012, through October 17, 2012, LEA claims billed with the Healthcare Common Procedure Coding System code T1017 were erroneously processed and denied as EWC program claims. The FI resubmitted the affected claims and adjustments began appearing June 13, 2013.<br>• EPC for Resubmission of Denied LEA Claims for Assessments: Reimbursement to a LEA for an IEP or IFSP annual assessment is not contingent upon whether the LEA was reimbursed for an initial or triennial assessment during the same FY or whether the LEA was reimbursed for an annual assessment during the prior FY. Claims billed by LEA providers for dates of service from July 1, 2009 - June 30, 2010, for various codes that were erroneously denied. The FI resubmitted the affected claims and adjustments began appearing June 13, 2013.<br>• SDN 14-002: DHCS determined that an additional withhold was erroneously being applied to cost settlements, reimbursements for withhold over-collections, and electronic health record payments. In August 2014, DHCS approved the FI to implement SDN 14-002, which will exempt cost settlements, over-collected withhold reimbursements, and electronic health record incentive payments from withholds. | • EPC for Adjustment of LEA Claims for CPT code A0425: DHCS identified a claims processing issue causing LEA claims for this code to be erroneously denied. The error was corrected by the FI in May 2015, and DHCS is awaiting a subsequent EPC implementation to reprocess affected claims.<br>• EPC for Adjustment of LEA Claims for CPT Code 92507: DHCS identified a claims processing issue causing LEA claims for this code to pay at an erroneous rate, affecting claims with dates of service from July 1, 2012, through July 30, 2014. The issue was resolved and adjustments began appearing March 12, 2015.<br>• DHCS will monitor SDN 14-002 and expects full implementation of this SDN to be completed in Fall 2015. |

| **Recommendation XV:**<br>Institute a fair share withhold methodology and provide an accounting of withholds collected from LEAs. | |
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| **Action Taken/To Be Taken<br>SFY 2013-2014** | **Action Taken/To Be Taken<br>SFY 2014-2015** |
| • Per AB 2608, effective for SFY 2013-14, DHCS is required 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 2012, DHCS began working on developing methodology to collect the fair share of withholds from each LEA, resulting in a proportionate collection of withholds across all participating LEA providers.<br>• DHCS initiated the fair share withhold methodology, whereby any over-collection of funds is proportionally redistributed to LEAs, and on October 30, 2014, the FI began refunding those LEAs that overpaid withholds for SFYs 2011-12 and 2012-13. LEAs that underpaid for these fiscal years will be offset from the SFY 2013-14 refunds.<br>• In 2014, DHCS posted the SFY 2012-13 LEA program Annual Accounting of Funds Summary Report on the LEA program website. This report provides an accounting of all funds collected by DHCS from LEA Medi-Cal payments and how these funds are expended by the LEA program.<br>• DHCS worked on the SFY 2013-14 *LEA program Annual Accounting of Funds Summary Report* and will make it available to LEAs once completed | • LEAs that overpaid for SFY 2013-14 will receive funds once SDN 14-002 has been fully implemented, which is expected to occur in 2015. Implementation of SDN 14-002 ensures that withholds will not be placed on the refunded amounts. DHCS will offset those LEAs that underpaid for SFYs 2011-12 and 2012-13 from the SFY 2013-14 refunds.<br>• In 2015, DHCS posted the SFY 2013-14 *LEA program Annual Accounting of Funds Summary Report* on the LEA program website.<br>• DHCS continues to work on the SFY 2014-15 *LEA program Annual Accounting of Funds Summary Report* and will make it available to LEAs, once completed.<br>• DHCS continues to work with its FI to develop more efficient streamlined reports that identify the amount of withholds collected by each LEA. |

| **Recommendation XVI:**<br>Review withholds applied to LEA program claims reimbursements to determine if LEAs are being over or under withheld. | |
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| **Action Taken/To Be Taken<br>SFY 2013-2014** | **Action Taken/To Be Taken<br>SFY 2014-2015** |
| • The annual amount of the 2.5 percent withhold was not to exceed $1.5 million and the annual amount of the one percent withhold was not to exceed $650,000. These withholds were subtracted from the total reimbursement amount on the Medi-Cal Remittance Advice Detail (RAD). The 2.5 percent and one percent withholds were tracked and turned off when they reached their caps. As specified in AB 2608, DHCS will implement proportionate withholds to all LEAs receiving Medi-Cal reimbursement through the LEA program so that no one LEA loses a disproportionate share of its federal Medicaid payments.<br>• Effective with SFY 2013-14, DHCS established a single withhold of 2.5 percent that would run year-round and not be turned on and off, to replace the 2.5 percent and A&I one percent withholds that were tracked and turned off when capped. This single 2.5 percent withhold is in addition to the one percent administrative withhold, and it ensures that all LEAs are paying withholds year-round.<br>• DHCS will monitor and track the withhold amounts and will work with its FI to adjust the withhold percentage, if necessary, due to excessive over or under collections. | • In SFY 2014-15, DHCS continued to run the single year-round withhold of 2.5 percent, in addition to the one percent administrative withhold. DHCS evaluated the total withhold amounts and determined that the 2.5 percent withhold percentage should be reduced.<br>• DHCS is researching with the FI on how to implement a reduction in the single year-round withhold percentage. The FI suggested that SDN 14-002 be fully implemented before requesting the withhold percentage reduction.<br>• Once SDN 14-002 is fully implemented, which is expected to be in Fall 2015, DHCS will initiate the request for a withhold reduction with the FI. |

| **Recommendation XVII:**<br>Implement Telehealth as a modality for the provision of existing LEA program reimbursable services. | |
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| **Action Taken/To Be Taken<br>SFY 2013-2014** | **Action Taken/To Be Taken<br>SFY 2014-2015** |
| • In October 2011, AB 415 (Chapter 547, Statutes of 2011) defined telehealth as the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. AB 415 allows DHCS to reimburse providers for Medi-Cal covered services that are appropriately provided through telehealth consultations. In addition, Medi-Cal does not require providers to document a barrier to a face-to-face visit or restrict the types of settings and locations of services at originating and distant site. Providers are no longer required to obtain written consent before telehealth services are rendered. Providers can now obtain and document verbal consent.<br>• DHCS researched school-based and general Medicaid telemedicine and telehealth standards to determine how telemedicine can be implemented in the LEA program. This included inter-departmental research as well as subject matter expert and stakeholder input, including research with the LEA Advisory Workgroup and other LEAs to define services, practitioners, and supervision and documentation requirements. | • DHCS researched school-based and general Medicaid telemedicine and telehealth standards to determine how telemedicine can be implemented in the LEA program. Research includes: conducting speech-language services via telehealth, licensure requirements, the feasibility of including the facility fee and transmission costs as reimbursable expenses, and whether to change W&I Code to allow telehealth claiming by practitioners according to the State Plan requirements for Speech Language Pathologists.<br>• In order to expand school-based health services in California, DHCS will add LEA procedure code/modifier combinations for speech-language assessment and treatment services conducted via telehealth. The effective date of this policy will be July 1, 2016. For services rendered via telehealth, practitioners will add the GT modifier ("Service Rendered via Interactive Audio and Telecommunications Systems") to the speech-language claim. The LEA Medi-Cal Billing Option Program will pay the same reimbursement rates for health services provided via telehealth as it pays for face-to-face in person speech-language services, by type of service.<br>• DHCS continued making *LEA program Provider Manual* updates regarding telehealth. This includes a new Telehealth section, and a revised Speech Therapy section, to include speech language services conducted via telehealth as reimbursable services. |

<table>
<tr><th colspan="2">Recommendation XVII (cont.):<br>Implement Telehealth as a modality for the provision of existing LEA program reimbursable services.</th></tr>
<tr><th>Action Taken/To Be Taken<br>SFY 2013-2014</th><th>Action Taken/To Be Taken<br>SFY 2014-2015</th></tr>
<tr><td><ul><li>DHCS researched conducting speech-language services via telehealth, including licensure requirements, and continued its work on an implementation plan to allow for reimbursement for speech-language telehealth services.</li><li>DHCS initiated LEA program Provider Manual updates to include speech language pathology services conducted via telehealth, originating site facility fee, and transmission fee as reimbursable services.</li><li>Moving forward, the LEA rate table will be updated, and utilization controls will be established and implemented into the claims processing system.</li></ul></td><td><ul><li>DHCS continued its work on an implementation plan for reimbursement for speech-language telehealth services, including updating the LEA rate table to include telehealth for speech language services, and establishing the appropriate utilization controls.</li><li>DHCS began writing a PPL to inform stakeholders that telehealth will be implemented in the LEA program on July 1, 2016, and will submit it to the PPL sub-workgroup for their input.</li></ul></td></tr>
<tr><th colspan="2">Recommendation XVIII:<br>Removal and development of CPT codes.</th></tr>
<tr><th>Action Taken/To Be Taken<br>SFY 2013-2014</th><th>Action Taken/To Be Taken<br>SFY 2014-2015</th></tr>
<tr><td><ul><li>Effective January 1, 2014, CMS deleted CPT code 92506 and replaced it with four new codes (92521 – 92524). The four new codes are components of the original code for speech-language assessments and will provide additional detail on the type of speech-language evaluation provided to beneficiaries. Per the CMS Manual System Pub 100-04 Medicare Claims Processing, Change Request 8539, DHCS shall comply with the mandatory requirements to delete CPT code 92506 and replace it with four new CPT codes. Prior to this change, the LEA program utilized CPT code 92506 for both speech-language and audiology assessments.</li></ul></td><td><ul><li>DHCS researched the removal of CPT code 92506, and the implementation of the new CPT codes, with the appropriate stakeholders: California Speech Language and Hearing Association, American Speech-Language-Hearing Association, LEA Advisory Workgroup, various DHCS Divisions, and CMS.</li><li>DHCS will transition to the four new codes for speech-language assessments. For audiology assessments, the LEA program has identified a new code (92557) as a replacement code. Reimbursements will be based on current Medi-Cal rates. The effective date of this policy will be July 1, 2016.</li></ul></td></tr>
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| **Recommendation XVIII (cont.):** Removal and development of CPT codes. | |
|---|---|
| • DHCS initiated discussions with LEA stakeholders and various DHCS divisions to determine how best to implement the removal of CPT code 92506.<br>• Moving forward, DHCS will ensure the proper transition into the new CPT codes in order to conform to CMS and American Medical Association nation-wide standards. DHCS will provide guidance, information, and technical assistance to increase stakeholder awareness for claiming under the new CPT codes. The LEA rate table will be updated, and utilization controls will be established and implemented into the claims processing system. | • DHCS initiated *LEA program Provider Manual* updates to include the CPT code changes.<br>• DHCS initiated an implementation plan for the CPT code changes, including updating the LEA rate table to include the new CPT codes, and establishing the appropriate utilization controls.<br>• DHCS began writing a PPL to inform stakeholders that the CPT code changes will be implemented in the LEA program effective July 1, 2016, and plans to submit it to the PPL sub-workgroup for their input. |
| **Recommendation XIX:** Transportation Regulations: Update the LEA transportation services section of the State regulations to be compliant with AB 2608. | |
| **Action Taken/To Be Taken SFY 2013-2014** | **Action Taken/To Be Taken SFY 2014-2015** |
| • In April 2013, DHCS shared the final draft of the proposed LEA Specialized Medical Transportation regulations DHCS 12-015 language with the LEA Advisory Workgroup Co-Chairs, and with CDE's Special Education Division staff, for their review and feedback. DHCS received edits and comments that were incorporated in the proposed language.<br>• In December 2013, DHCS conducted a breakout session on transportation. The goal was to identify perceived or real barriers to LEA transportation/mileage billing and determine how these issues can be addressed to increase LEA transportation reimbursement. Barriers identified included: | • In June 2014, DHCS received one minor edit to the draft and included a scenario for multiple trips to service providers.<br>• In July 2014, the LEA program *Transportation Claiming Guide* was posted on the LEA program website. The purpose of the *Transportation Claiming Guide* is to provide instruction and clarification with respect to LEA Medi-Cal Billing Option Transportation claiming.<br>• In September 2014, DHCS internally distributed DHCS 12-015 LEA Specialized Medical Transportation regulations package in an effort to provide timely information on regulation proposals under development within DHCS. |

| Recommendation XIX (cont.): Transportation Regulations: Update the LEA transportation services section of the State regulations to be compliant with AB 2608. | |
|---|---|
| **Action Taken/To Be Taken SFY 2013-2014** | **Action Taken/To Be Taken SFY 2014-2015** |
| the labor intensive documentation requirements; manual process to ensure the student attended school, received transportation and another reimbursable LEA program service the same day; cost/benefit of billing transportation; and lack of odometer readings documented for pick-up and drop-off. The LEA Advisory Workgroup discussed the options for LEAs to bill transportation services for one-way trips only; and/or for one-way trips with mileage.<br>• DHCS continued to research and edit existing language to the Transportation regulations.<br>• In February 2014, DHCS provided an update on the Transportation regulations package being submitted to DHCS' Office of Regulations for review. DHCS also discussed the billing documentation requirements for transportation services. DHCS indicated that work was pending on a school-based Transportation Handbook to be released after approval of the Transportation regulations. In addition, DHCS adopted many of the LEA Advisory Workgroup's suggestions noted on December 4, 2013, regarding transportation. Suggestions included clarifying the CMS guidelines for school-based transportation services, specific requirements for documentation, and various scenarios for transportation claiming.<br>• In May 2014, DHCS shared the draft *LEA Transportation Claiming Guide* with stakeholders to provide feedback by June 16, 2014. | • In October 2014, DHCS estimated a 10 percent annual growth rate for LEA transportation claiming based on passage of AB 2608 and implementation of the LEA Specialized Transportation regulations package.<br>• In February 2015, DHCS forwarded the LEA Specialized Medical Transportation Regulations package to the Department of Finance (DOF) for review and approval.<br>• In April 2015, DOF requested CDE to sign off on the LEA Specialized Medical Transportation Regulations package, and on April 15, 2015, CDE submitted their completed review. |

| **Recommendation XX:**<br>Implementation of International Classification of Diseases, 10th Revision (ICD-10). | |
|---|---|
| **Action Taken/To Be Taken<br>SFY 2013-2014** | **Action Taken/To Be Taken<br>SFY 2014-2015** |
| • ICD-10 is a Health Insurance Portability and Accountability Act (HIPAA) mandated diagnosis and procedure coding system and is a revision of the ICD-9 system, which physicians and other providers use to code all diagnoses, symptoms, and procedures recorded in hospitals and physician practices. All providers covered by HIPAA must transition to ICD-10.<br>• In 2013, DHCS informed stakeholders that the ICD-9 code sets used to report medical diagnoses and inpatient procedures would be replaced by ICD-10 code sets, with an implementation date of October 1, 2014, and guidance would be forthcoming. | • In 2014, the ICD-10 implementation date was extended, and DHCS informed stakeholders that the new implementation date was October 1, 2015.<br>• DHCS participated in the Non-FI Business Process Remediation Project by submitting monthly ICD-10 implementation status reports.<br>• DHCS informed LEAs that effective September 22, 2014, paper UB-04 claims submitted to Medi-Cal will require an ICD indicator "9" in the *Diagnosis Code* field (Box 66).<br>• In April 2015, DHCS provided LEAs with ICD-10 updates and resources, and provided a presentation on ICD-10 requirements and tips for mapping between ICD-9 and ICD-10.<br>• In May 2015, DHCS sent an e-blast to LEAs and stakeholders, including an update on ICD-10 implementation and links to numerous ICD-10 resources.<br>• DHCS initiated production of a General Equivalency Mappings tool which is a crosswalk summary of the 20 most frequently billed ICD-9 codes in the LEA Medi-Cal Billing Option Program and their associated ICD-10 codes.<br>• DHCS will include a section on ICD-10 implementation in the Fall 2015 LEA Provider Training Webinar. |

| **Recommendation XXI:**<br>Update on the LEA program RMTS Methodology Implementation. | |
|---|---|
| **Action Taken/To Be Taken<br>SFY 2013-2014** | **Action Taken/To Be Taken<br>SFY 2014-2015** |
| • In October 2013, Los Angeles Unified School District (LAUSD) presented their RMTS to DHCS staff. The presentation included, among other topics, background information containing the approval of the LAUSD Implementation Plan in October 2010, by CMS, and the implementation of the RMTS methodology in January 2011. In addition, the presentation outlined three phases of RMTS operations: Pre-Quarter, During the Quarter, and Post-Quarter. Each phase contained a set of specific tasks, quality controls and monitoring, and audit document requirements.<br>• In March 2014, DHCS conducted preliminary research to gather additional information regarding RMTS and how it would apply to the LEA Medi-Cal Billing Option Program. The RMTS process is a federally approved technique for statistically valid sampling of randomly selected moments assigned to randomly selected participants. The purpose of RMTS is to measure the work effort of the entire group of approved participants involved in a school district's Medicaid and health related programs by sampling and analyzing the work efforts of a randomly selected cross sectional group. | • During the month of July 2014, DHCS continued to research other states using a RMTS methodology to support their Medicaid reimbursement process for school-bases services. The research identified the following states: Arizona, Colorado, Kentucky, New York, Pennsylvania, and Texas. Most states contracted with a vendor to implement the RMTS. All states required RMTS as part of the annual reconciliation process, and most states had at least two cost pools; one for direct services and the other for administrative activities.<br>• In October 2014, DHCS agreed to have Navigant Consulting Inc. (NCI), facilitate the LEA RMTS IAG meetings. NCI developed the RMTS Assessment that provided a third party neutral forum to allow stakeholders to individually communicate their interests and issues with respect to the development of an effective and efficient RMTS workgroup.<br>• In November 2014, DHCS issued a letter to the LEA Medi-Cal Billing Option Program Stakeholders regarding the formation of the RMTS IAG with an attached RMTS Assessment Survey to identify the RMTS technical knowledge needed for the RMTS IAG members. The goal was to recruit technically knowledgeable stakeholders to provide advice on the design of the RMTS implementation. |

| **Recommendation XXI (cont.):** Update on the LEA program RMTS Methodology Implementation. | |
|---|---|
| **Action Taken/To Be Taken SFY 2013-2014** | **Action Taken/To Be Taken SFY 2014-2015** |
| • In May 2014, DHCS reported to the LEA Advisory Workgroup, that DHCS was implementing SMAA RMTS and then rolling in the LEA direct services RMTS at a later date. The workgroup members noted that they would like to be a part of the RMTS discussions to note distinct differences in the LEA program vs. the SMAA program. DHCS committed to including LEA representatives in a future committee that would be formed to discuss RMTS.<br><br>On June 2, 2014, members of the LEA Advisory Workgroup submitted a report to DHCS regarding integrating the LEA Medi-Cal Billing Option Program into a RMTS Methodology. The report mainly expressed concerns about implementing RMTS into the LEA Medi-Cal Billing Option Program. The report outlined the following:<br>o Several SMAA Activity Codes need to be edited and realigned to capture all claimable direct services activity;<br>o CMS Free Care policy states Medicaid reimbursement is not allowable for care to students without charge when no third party insurance is billed;<br>o Cost Pool Considerations for contracted personnel and universe composition;<br>o Billing and Cost Reimbursement;<br>o SPA, and<br>o Potential Costs to Districts | • The RMTS Assessment survey was distributed to 89 LEAs and 49 responded. Additional interviews were scheduled to determine the knowledge level, experience, and interest. In February 2015, DHCS approved the list of 17 participants for the RMTS IAG that included 7-LEAs, 3-LECs, 3-DHCS, 2-NCI, 1-CDE, and 1-Local Educational Agency (LGA). The first RMTS IAG meeting was held on February 25, 2015.<br><br>• In March 2015, DHCS posted the RMTS Webpage to provide updates on the design and development of the RMTS for the LEA Medi-Cal Billing Option Program; to provide links to the RMTS IAG Meeting Summaries; and to provide a tool for stakeholder feedback regarding RMTS implementation issues.<br><br>• In May 2015, DHCS issued an e-blast to the LEA stakeholders to comment on the issue of TCM services related to the LEA Medi-Cal Billing Option Program RMTS. The IAG members recommended that LEAs interested in receiving reimbursement for future TCM services select billing for this service through the SMAA program or the LEA Medi-Cal Billing Option Program, but not through both programs, to ensure no duplication of services between the two programs. |

| **Recommendation XXI (cont.):** Update on the LEA program RMTS Methodology Implementation. | |
|---|---|
| **Action Taken/To Be Taken SFY 2013-2014** | **Action Taken/To Be Taken SFY 2014-2015** |
| • On June 18, 2014, DHCS responded to the concerns expressed by the LEA Advisory Workgroup Members with the opportunity to lead the process and to work collaboratively with CDE and other stakeholders on preparatory steps for the implementation of RMTS in the LEA program. | • In June 2015, DHCS provided a summary update to the IAG members on the draft SPA 15-021 LEA Services and RMTS. The updates included:<br>o Public Comment period began June 26, 2015.<br>o Public Comment Period ended August 10, 2015.<br>o SPA 15-021 to be submitted by September 30, 2015.<br>o SPA 15-021 effective date July 1, 2015.<br>o Adds new assessments, treatments, and practitioners.<br>o Adds RMTS methodology for capture time spent providing direct medical services. |

| **Recommendation XXII:**<br>Discuss the new CMS policy regarding Free Care with LEA stakeholders. | |
|---|---|
| **Action Taken/To Be Taken<br>SFY 2013-2014** | **Action Taken/To Be Taken<br>SFY 2014-2015** |
| • In SFY 2013-14, the CMS guided 'free care' policy restricted reimbursement of services not specified in a student's IEP/IFSP if those same services were offered to non-Medi-Cal students without charge to the students or the community at large.<br><br>For non-IEP/IFSP services provided to Medi-Cal eligible students to be reimbursable, the LEA provided had to (1) establish a fee for each service that is available; (2) ascertain whether every student served by the provider has any third party benefits; and (3) bill other responsible third party insurers.<br><br>The LEA had to request and collect OHC information from all students served, obtain a 100 percent response rate, and bill third party insurers first prior to billing Medi-Cal.<br><br>Also, LEA services that were not authorized in a student's IEP/IFSP were limited to a maximum of 24 services per 12-month period. | • In December 2014, LEAs were informed via e-blast that CMS issued a letter to clarify ambiguities concerning Medicaid payment for services provided without charge ("free care").<br><br>• In February 2015, DHCS and LEAs discussed the December 2014, CMS Letter regarding changes to the Free Care policy, and developed a list of questions that would be forwarded to the National Alliance for Medicaid in Education Organization.<br><br>• In June 2015, DHCS researched how the new CMS guidance will affect Medi-Cal programs, including the LEA Medi-Cal Billing Option Program. |

## V. ONE-YEAR TIMETABLE FOR STATE PLAN AMENDMENTS

The first SPA after enactment of SB 231 was originally submitted to CMS in June 2003, re-submitted in December 2004, and finally approved in March 2005. In October 2010, CMS issued a State Medicaid Director letter, which revised the SPA review process and outlined the new procedures for SPA processing to create efficiency. In December 2011, CMS approved California's speech-language equivalency SPA 05-010.

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 Medi-Cal Billing Option programs. CMS required DHCS to submit a SPA no later than September 30, 2015, that included the introduction of a RMTS for the LEA Medi-Cal Billing Option Program. CMS requires that the LEA program transition to the use of a RMTS as a component of the Medicaid reconciliation methodology.

DHCS spent considerable time in 2014 preparing for the upcoming LEA RMTS process, including interviewing stakeholders to develop an IAG, a small group of technically qualified stakeholders that work in a collaborative environment with DHCS on RMTS implementation issues. The purpose of the RMTS IAG is to approach technical RMTS issues from differing LEA perspectives, and to provide LEA Medi-Cal Billing Option Program RMTS recommendations to DHCS. The IAG, which began meeting in February 2015, and continues to meet monthly, is comprised of representatives from DHCS, CDE, Navigant Consulting, and the LEA provider community, including representatives from two LECs and one LGA. The IAG continues to work on the design and development of the LEA RMTS, and addresses LEA provider concerns and questions through a public stakeholder feedback tool that is available on the LEA program website.

In addition to adding RMTS to the LEA program, SPA 15-021 also includes several benefits that are expected to significantly contribute to overall Program growth. If approved, SPA 15-021 will add the following new claimable services and allowable practitioners to the LEA program:

- New Assessments
    - Respiratory Therapy Assessments
    - Orientation and Mobility Assessments
- New Treatments
    - Personal Care Services
    - Respiratory Therapy Services
    - Orientation and Mobility Services

- New Practitioners
  - Personal Care Assistant
  - Speech-Language Pathology Assistant
  - Licensed Physical Therapy Assistant
  - Licensed Occupational Therapy Assistant
  - Orientation and Mobility Specialist
  - Licensed Respiratory Therapist
  - Registered Marriage and Family Therapist Intern
  - Registered Associate Clinical Social Worker

SPA 15-021 also removes the limitation of 24 services in a twelve-month period for non-IEP/IFSP Medi-Cal eligible individuals, and expands the beneficiary definition to include all Medi-Cal eligible individuals under age 22, regardless of whether they have an IEP or IFSP. This change will incorporate CMS' December 2014 Free Care guidance, wherein CMS stated that Medicaid payment is allowed for any covered services for Medicaid-eligible beneficiaries when delivered by Medicaid-qualified providers. CMS' prior *Free Care Principle* prohibited Medicaid payment for services that were available without charge to anyone in the community.

**Table 5: Timetable for Proposed State Plan Amendments**

| Service Description | Submission Date |
|---|---|
| SPA 15-021:<br>• Adds RMTS methodology to capture the amount of time spent providing direct medical services by qualified health professionals that bill in the LEA program<br>• 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"<br>• Includes new assessment and treatment services<br>• Includes new qualified rendering practitioners<br>• Includes a specialized medical transportation reimbursement methodology<br>• Removes the requirement to rebase rates a minimum of every three years | • September 30, 2015 |

## VI. BARRIERS TO REIMBURSEMENT

Barriers to reimbursement continue to be identified and acted upon through discussions with LEA Advisory Workgroup members. Table 6 describes the barriers to reimbursement identified by the LEA Advisory Workgroup between June 2013 and June 2015, as well as the actions that have been and will be taken by DHCS to remove those barriers.

**Table 6: Barriers to Reimbursement**

| Barriers | Actions Taken /To Be Taken |
|---|---|
| • Certain health and mental health services and services provided by assistants are provided by LEAs but are not currently reimbursable in the LEA program. | • During this reporting period, DHCS compiled research from state and federal regulations to define the qualifications, supervision requirements, and scope of practice for Occupational Therapy, Physical Therapy, Speech Therapy and/or Audiology assistants and aides. In addition, DHCS researched other states school-based programs and identified states that reimburse for assistants and aides.<br>• DHCS will include the following practitioner types in SPA 15-021: Personal Care Assistant, Speech-Language Pathology Assistant, Licensed Physical Therapy Assistant, Licensed Occupational Therapy Assistant, Orientation and Mobility Specialist, Licensed Respiratory Therapist, Registered Marriage and Family Therapist Intern, and Registered Associate Clinical Social Worker. The addition of these qualified rendering practitioners to the LEA program will expand the scope of reimbursable services for LEAs in California. |

| Barriers | Actions Taken /To Be Taken |
|---|---|
| • Recent CMS guidance on Free Care has not been implemented in the LEA Medi-Cal Billing Option 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.<br>• The LEA Advisory Workgroup is eager to take advantage of the new CMS guidance, and has asked DHCS to formalize policy in this area. 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. 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. |

| Barriers | Actions Taken /To Be Taken |
|---|---|
| • Implement telehealth as a modality for the provision of existing LEA reimbursable services. | • In October 2011, AB 415 (Chapter 547, Statutes of 2011) was chaptered and defined telehealth as the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. AB 415 allows DHCS to reimburse providers for Medi-Cal covered services that are appropriately provided through telehealth consultations. In addition, Medi-Cal does not require providers to document a barrier to a face-to-face visit or restrict the types of settings and locations of services at originating and distant site. Providers are no longer required to obtain written consent before telehealth services are rendered. Providers can now obtain and document verbal consent.<br>• In 2012, DHCS researched school-based and general Medicaid telemedicine and telehealth standards to determine how telemedicine can be implemented in the LEA program. DHCS also participated in telehealth workgroup meetings to determine how to implement standards for non-face-to-face LEA services. In addition, DHCS conducted a telehealth survey to identify LEA provider interest and the feasibility of providing school-based services via telehealth. DHCS also researched other state's school-based provider manuals and conducted conference calls to identify and discuss with other states that allow school-based telehealth services.<br>• DHCS continues to work on the implementation plan to allow for reimbursement for speech-language telehealth services. Among other items, DHCS has revised the LEA Provider Manual with respect to telemedicine, has worked to develop a telehealth rate table and corresponding utilization controls for the claims processing system, and has drafted a PPL regarding speech therapy services provided via telemedicine. DHCS expects to implement reimbursement for LEA speech-language telehealth services in SFY 2016-17. |

| Barriers | Actions Taken /To Be Taken |
|---|---|
| • Claims processing issues have been identified and have resulted in LEA 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 to alter the system design to ensure LEA claims were processing properly prior to implementation of system changes.<br>• As of July 2012, some LEA TCM claims were denied with RAD Code 033 (recipient is not eligible for the special program billed and/or restricted services billed). This issue was due to a system update implemented by another Medi-Cal Program (Every Woman Counts Cancer Detection). An Operating Instructions Letter (OIL) amendment was implemented in October 2012, to exempt LEA providers from the original OIL. An EPC reprocessed denied TCM claims in June 2013.<br>• For claims with dates of service between July 1, 2012 and June 30, 2014, DHCS identified a claims processing issue causing LEA claims for CPT-4 code 92507 with modifiers GN and TM to pay at an erroneous rate. In March 2015, DHCS instructed its FI to implement an EPC to correctly pay these claims. |
| • Withholds are being incorrectly applied to cost settlements, incentive payments and over-collected withhold reimbursement amounts. | • LEA claims are proportionately reduced to fund administrative activities, auditor positions and AB 2608 activities.<br>• Prior to July 2015, LEA payments relating to cost settlement, electronic health record incentive payments, and over-collected withhold reimbursements were inappropriately discounted by the withhold amounts.<br>• In 2014 and 2015, DHCS worked with its FI to implement SDN 14002, whereby certain reimbursements would be exempt from the withhold process. DHCS continues to work with its FI to ensure that this SDN was implemented properly, and to identify the erroneously paid cost settlement, incentive payment, and over-collected withhold reimbursement amounts prior to the SDN implementation date. |

| Barriers | Actions Taken /To Be Taken |
|---|---|
| • Update the LEA transportation services section of the State regulations to be compliant with AB 2608. | • In September 2012, AB 2608 (Chapter 755, Statutes of 2012) was chaptered to allow LEA medical transportation services to be provided in a litter van or wheelchair van for Medi-Cal eligible students who are not confined to a wheelchair or in a prone or supine position.<br>• In January 2013, DHCS issued PPL 13-001 and provided guidance regarding LEA medical transportation services based on AB 2608. DHCS clarified that effective January 1, 2013, LEA medical transportation services must still be provided in a litter van or wheelchair van in order to be reimbursable under the LEA program; however, the following exceptions have been made: 1) LEA beneficiaries transported in a litter van are no longer required to be transported in a prone or supine position, because they are incapable of sitting for the period of time needed to be transported; 2) LEA beneficiaries transported in a litter van and whose medical or physical condition does not require the use of a gurney are no longer required to be secured to a gurney by restraining belts while being loaded, unloaded and transported; 3) LEA beneficiaries transported in a wheelchair van are no longer required to be transported in a wheelchair or assisted to and from the residence, vehicle and place of treatment because of a disabling physical or mental limitation; and 4) LEA beneficiaries transported in a wheelchair van and whose medical or physical condition does not require the use of a wheelchair are no longer required to be secured to wheelchairs while being loaded, unloaded or transported. This update has also been reflected in the LEA Provider Manual.<br>• In 2014, DHCS developed a proposed regulation package related to transportation updates mandated in AB 2608. This package includes revisions to existing State regulations that are required to implement AB 2608, as well as expand LEA medical transportation services to include specialized medical transportation services. DHCS submitted the final proposed regulations package to Office of Regulations in December 2014. DHCS expects the public comment period to take place in Fall 2015. |

| Barriers | Actions Taken /To Be Taken |
|---|---|
| • Revise state regulations to be no more restrictive than federal requirements. | • Once SPA 15-021 is approved, 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. |
| • Review the LEA program models of service delivery. | • The CMS Medicaid Technical Assistance Guide outlines four models of service delivery for direct medical services. After review, DHCS will now allow LEA providers to utilize Model 4. Model 4 allows LEAs to use a mix of employed and contracted practitioners to provide LEA reimbursable services. LEAs may provide some services directly and contract out entire service types without directly employing a single practitioner in a service category. Under Model 4, the LEA may only bill for services provided by the contracted qualified practitioner when the contracted practitioner voluntarily reassigns their right to bill Medi-Cal for services. In order for LEAs to bill Medi-Cal for LEA services provided by a contracted practitioner, LEAs must now enter the NPI of the contracted medical professional or agency actually rendering the LEA service on the claim.<br>• In July 2013, DHCS published PPL 13-006 on this subject and updated the LEA Provider Manual accordingly.<br>• This expanded model of service delivery is expected to reduce a significant barrier to LEA reimbursement in both rural and urban settings, especially for California charter schools participating in the LEA program. |

| Barriers | Actions Taken /To Be Taken |
|---|---|
| • LEAs are providing a wide array of behavioral services but are not reimbursed for certain services through the LEA program. | • In July 2014, CMS released guidance regarding the coverage of services to children with autism spectrum disorder (ASD). CMS provided states with several possible approaches under the federal Medicaid program for providing services to children with ASD, and indicated that states are required to provide coverage of the EPSDT benefit for any Medicaid covered service that is determined to be medically necessary to correct or ameliorate any physical or behavioral conditions.<br>• On September 15, 2014, DHCS issued All Plan Letter 14-011, which provided an interim policy for the provision of behavioral health treatment coverage for children with ASD. This All Plan Letter stated that Medi-Cal Managed Care Plans are responsible for the provision of EPSDT services for Medi-Cal beneficiaries 0 to 21 years of age, including those who have special health care needs.<br>• On September 30, 2014, DHCS submitted SPA 14-026 to CMS, adding Behavioral Health Treatment (BHT) services as a Medi-Cal benefit to treat or address ASD. This SPA will add medically necessary BHT services for Medi-Cal beneficiaries age 0 to 21, under the EPSDT benefit.<br>• In May 2015, DHCS issued a BHT Transition Plan, which discusses the transition of services between California's Regional Centers and the Managed Care Plans. The BHT Transition Plan indicates that DHCS will issue final guidance in the form of a revised All Plan Letter to managed care plans once the SPA and 1915(b) Medi-Cal Specialty Mental Health Waiver amendments have been approved by CMS. |

| Barriers | Actions Taken /To Be Taken |
|---|---|
| • Program administration at the LEA level varies significantly among LEAs. | • In early 2014, the LEA Advisory Workgroup identified a wide variation of LEA program administration models, depending on the local LEA coordinator's experience, job classification and familiarity with the LEA program. These variations can impact LEAs' abilities to understand program rules and requirements, and can impact the continuity and quality of information in the LEA provider community.<br>• In 2014, the LEA Advisory Workgroup worked to clearly define "best practices" for LEA program administration by developing an LEA program Administrative Functions Chart. This chart illustrates some key functions that are integral to administering the LEA Medi-Cal Billing Option Program, and provides guidance as to what type of personnel at the local level may be responsible for participating in each key function. This chart is intended to assist LEAs in organizing their program, while acknowledging that responsibilities and titles may differ among LEAs. DHCS and the LEA Advisory Workgroup believe that this chart clarifies terms, explains relationships and provides "best practices" to LEA providers. The chart is posted on the LEA program website. |

## VII. APPENDICES

Appendix 1 – Medicaid Reimbursement and Claims by State

Appendix 2 – Other State's School-Based Services and Providers

**Appendix 1(a): Medicaid Reimbursement And Claims By State**
**Ranked By Average Claim Per Medicaid-Eligible Child, State Fiscal Year (SFY) 2012-2013**

| | | SFY 2012-13 | | | | | |
|---|---|---|---|---|---|---|---|
| | | Federal Reimbursement (Federal Share) | | | Calculated Claim Dollars | | |
| State | FMAP[1] | Health (000's) | Administrative (000's) | Total (000's) | Health (000's)[2] | Administrative (000's)[3] | Total (000's) |
| VERMONT [4] | 56.04% | $ 22,386 | $ - | $ 22,386 | $ 39,947 | $ - | $ 39,947 |
| IOWA [6] | 59.59% | 49,438 | - | 49,438 | 82,963 | - | 82,963 |
| NEW JERSEY | 50.00% | 96,200 | 11,995 | 108,195 | 192,400 | 23,989 | 216,389 |
| KANSAS | 56.51% | 18,630 | 10,365 | 28,995 | 32,968 | 20,729 | 53,698 |
| MAINE [6] | 62.57% | 23,777 | - | 23,777 | 38,001 | - | 38,001 |
| MASSACHUSETTS | 50.00% | 52,300 | 24,500 | 76,800 | 104,600 | 49,000 | 153,600 |
| MICHIGAN | 66.39% | 175,943 | 10,085 | 186,028 | 265,014 | 20,171 | 285,185 |
| SOUTH DAKOTA | 56.19% | 2,063 | 7,452 | 9,515 | 3,672 | 14,904 | 18,575 |
| CONNECTICUT | 50.00% | 26,052 | 5,549 | 31,601 | 52,104 | 11,098 | 63,201 |
| PENNSYLVANIA | 54.28% | 75,344 | 40,442 | 115,787 | 138,807 | 80,885 | 219,692 |
| ILLINOIS | 50.00% | 113,600 | 50,100 | 163,700 | 227,200 | 100,200 | 327,400 |
| WISCONSIN | 59.74% | 35,936 | 13,160 | 49,096 | 60,153 | 26,320 | 86,474 |
| MARYLAND [6] | 50.00% | 40,000 | - | 40,000 | 80,000 | - | 80,000 |
| ARKANSAS [9] | 70.17% | 21,941 | 12,241 | 34,182 | 31,269 | 24,481 | 55,750 |
| ALABAMA | 68.53% | 12,237 | 22,476 | 34,713 | 17,856 | 44,953 | 62,808 |
| MONTANA | 66.00% | 3,410 | 2,332 | 5,743 | 5,167 | 4,665 | 9,832 |
| WASHINGTON | 50.00% | 2,934 | 32,175 | 35,109 | 5,867 | 64,350 | 70,217 |
| CALIFORNIA | 50.00% | 145,582 | 90,009 | 235,591 | 291,164 | 180,017 | 471,181 |
| VIRGINIA | 50.00% | 19,266 | 4,548 | 23,814 | 38,533 | 9,096 | 47,629 |
| NEW MEXICO | 69.07% | 8,157 | 6,374 | 14,531 | 11,810 | 12,748 | 24,558 |
| LOUISIANA [6] | 61.24% | 29,495 | - | 29,495 | 48,163 | - | 48,163 |
| MISSOURI | 61.37% | 3,112 | 14,632 | 17,744 | 5,071 | 29,264 | 34,335 |
| NEW YORK [6] | 50.00% | 50,977 | - | 50,977 | 101,953 | - | 101,953 |
| ARIZONA | 65.68% | 16,546 | 2,703 | 19,249 | 25,191 | 5,406 | 30,598 |
| NEVADA [6] | 59.74% | 5,674 | - | 5,674 | 9,499 | - | 9,499 |
| OREGON | 62.44% | 3,872 | 5,836 | 9,709 | 6,202 | 11,673 | 17,874 |
| KENTUCKY | 70.55% | 5,632 | 3,936 | 9,567 | 7,983 | 7,871 | 15,854 |
| ALASKA [6] | 50.00% | 1,228 | - | 1,228 | 2,457 | - | 2,457 |
| INDIANA | 67.16% | 5,195 | 3,920 | 9,115 | 7,736 | 7,840 | 15,575 |
| FLORIDA [8] | 58.08% | 13,982 | - | 13,982 | 24,074 | - | 24,074 |
| HAWAII [6] | 51.86% | 641 | - | 641 | 1,236 | - | 1,236 |
| COLORADO [5] | 50.00% | - | 1,807 | 1,807 | - | 3,614 | 3,614 |
| RHODE ISLAND [10] | 51.26% | - | - | - | - | - | - |
| WEST VIRGINIA [10] | 72.04% | - | - | - | - | - | - |
| IDAHO [10] | 71.00% | - | - | - | - | - | - |
| DELAWARE [10] | 55.67% | - | - | - | - | - | - |
| NEBRASKA [10] | 55.76% | - | - | - | - | - | - |
| UTAH [10] | 69.61% | - | - | - | - | - | - |
| MINNESOTA [7] | 50.00% | - | - | - | - | - | - |
| MISSISSIPPI [10] | 73.43% | - | - | - | - | - | - |
| NORTH CAROLINA [10] | 65.51% | - | - | - | - | - | - |
| DISTRICT OF COLUMBIA [10] | 70.00% | - | - | - | - | - | - |
| OHIO [10] | 63.58% | - | - | - | - | - | - |
| OKLAHOMA [10] | 64.00% | - | - | - | - | - | - |
| TENNESSEE [7] | 66.13% | - | - | - | - | - | - |
| WYOMING [7] | 50.00% | - | - | - | - | - | - |
| GEORGIA [10] | 65.56% | - | - | - | - | - | - |
| TEXAS [10] | 59.30% | - | - | - | - | - | - |
| NORTH DAKOTA [10] | 52.27% | - | - | - | - | - | - |
| NEW HAMPSHIRE [10] | 50.00% | - | - | - | - | - | - |
| SOUTH CAROLINA [10] | 70.43% | - | - | - | - | - | - |

(1) The Federal Medical Assistance Percentage (FMAP) for each state was obtained from the Federal Register, published on November 30, 2011.

(2) Calculated as Medicaid reimbursement (federal share) divided by each state's FMAP.

(3) Calculated as Medicaid reimbursement (federal share) divided by 50%.

(4) Total federal reimbursement for this state's health services program and/or administrative claiming program was not provided for SFY 2012-13.

(5) This state reported on the survey that they did not have a fee-for-service school-based Medicaid health services program in effect during SFY 2012-13.

(6) This state reported on the survey that they did not have an administrative claiming program in effect during SFY 2012-13.

(7) This state did not have either a school-based Medicaid health services program or administrative claiming program in effect during SFY 2012-13 and/or SFY 2013-14.

(8) Health service figures from Florida were compiled from the Florida Agency for Healthcare Administration website where online Fee-for-Service School Certified Match Reimbursement Reports are updated quarterly. (Source: http://ahca.myflorida.com/medicaid/childhealthservices/schools/index.shtml). Administrative claiming program expenditures were not available.

(9) Health service and administrative program expenditures for Arkansas were obtained from the Arkansas Medicaid in the Schools website, MITS profiles (https://arksped.k12.ar.us/applications/sbmh/default.htm).

(10) Did not complete the state survey used to collect Medicaid reimbursement (federal share) for direct claiming and administrative services for SFYs 2012-13 and 2013-14.

**Appendix 1(b): Medicaid Reimbursement And Claims By State**
**Ranked By Average Claims Per Medicaid-Eligible Child, State Fiscal Year (SFY) 2013-2014**

| State | | SFY 2013-14 | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Federal Reimbursement (Federal Share) | | | | Calculated Claim Dollars | | |
| | | FMAP [1] | Health (000's) | Administrative (000's) | Total (000's) | Health (000's) [2] | Administrative (000's) [3] | Total (000's) |
| VERMONT | 4 | 55.11% | $ 22,782 | $ - | $ 22,782 | $ 41,340 | $ - | $ 41,340 |
| IOWA | 6 | 57.93% | 55,160 | - | 55,160 | 95,218 | - | 95,218 |
| MAINE | 6 | 61.55% | 24,281 | - | 24,281 | 39,449 | - | 39,449 |
| KANSAS SOUTH | | 56.91% | 19,000 | 9,448 | 28,448 | 33,386 | 18,897 | 52,283 |
| DAKOTA MICHIGAN | | 53.54% | 1,872 | 8,140 | 10,012 | 3,497 | 16,279 | 19,776 |
| MASSACHUSETTS NEW | | 66.32% | 164,549 | 9,508 | 174,058 | 248,114 | 19,016 | 267,131 |
| JERSEY | | 50.00% | 38,500 | 27,100 | 65,600 | 77,000 | 54,200 | 131,200 |
| MARYLAND | 6 | 50.00% | 68,200 | 12,225 | 80,425 | 136,400 | 24,451 | 160,851 |
| PENNSYLVANIA | | 50.00% | 56,000 | - | 56,000 | 112,000 | - | 112,000 |
| ALABAMA | | 53.52% | 68,639 | 39,596 | 108,234 | 128,249 | 79,192 | 207,440 |
| ARKANSAS | 9 | 68.12% | 15,363 | 22,049 | 37,412 | 22,553 | 44,098 | 66,651 |
| ILLINOIS | | 70.10% | 22,000 | 12,194 | 34,194 | 31,383 | 24,389 | 55,772 |
| MONTANA | | 50.00% | 52,600 | 52,600 | 105,200 | 105,200 | 105,200 | 210,400 |
| MISSOURI | | 66.33% | 3,384 | 2,072 | 5,456 | 5,102 | 4,144 | 9,246 |
| VIRGINIA NEW | | 62.03% | 4,497 | 24,179 | 28,676 | 7,250 | 48,357 | 55,608 |
| MEXICO | | 50.00% | 24,000 | 4,198 | 28,198 | 48,000 | 8,397 | 56,397 |
| NEW YORK | 6 | 69.20% | 10,031 | 7,362 | 17,393 | 14,496 | 14,723 | 29,219 |
| NEVADA | 6 | 50.00% | 73,743 | - | 73,743 | 147,486 | - | 147,486 |
| CALIFORNIA | | 63.10% | 8,505 | - | 8,505 | 13,478 | - | 13,478 |
| ARIZONA OREGON | | 50.00% | 148,721 | 32,470 | 181,192 | 297,443 | 64,940 | 362,383 |
| WASHINGTON | | 67.23% | 18,795 | 4,267 | 23,062 | 27,956 | 8,535 | 36,491 |
| KENTUCKY INDIANA | | 63.14% | 2,790 | 5,712 | 8,502 | 4,419 | 11,424 | 15,843 |
| COLORADO | 5 | 50.00% | 3,505 | 10,552 | 14,056 | 7,009 | 21,103 | 28,112 |
| FLORIDA | 8 | 69.83% | 3,500 | 4,237 | 7,737 | 5,012 | 8,475 | 13,487 |
| ALASKA | 6 | 66.92% | 5,195 | 4,379 | 9,574 | 7,763 | 8,759 | 16,522 |
| CONNECTICUT | 4 | 50.00% | - | 2,862 | 2,862 | - | 5,724 | 5,724 |
| HAWAII | 6 | 58.79% | 13,225 | - | 13,225 | 22,495 | - | 22,495 |
| WISCONSIN | 4 | 50.00% | 361 | - | 361 | 722 | - | 722 |
| LOUISIANA | 4, 6 | 50.00% | 1,349 | - | 1,349 | 2,697 | - | 2,697 |
| RHODE ISLAND | 10 | 51.85% | 541 | - | 541 | 1,044 | - | 1,044 |
| WEST VIRGINIA | 10 | 59.06% | - | - | - | - | - | - |
| IDAHO | 10 | 60.98% | - | - | - | - | - | - |
| DELAWARE | 10 | 50.11% | - | - | - | - | - | - |
| NEBRASKA | 10 | 71.09% | - | - | - | - | - | - |
| UTAH | 10 | 71.64% | - | - | - | - | - | - |
| MINNESOTA | 7 | 55.31% | - | - | - | - | - | - |
| MISSISSIPPI | 10 | 54.74% | - | - | - | - | - | - |
| NORTH CAROLINA | 10 | 70.34% | - | - | - | - | - | - |
| DISTRICT OF COLUMBIA | 10 | 50.00% | - | - | - | - | - | - |
| OHIO | 10 | 73.05% | - | - | - | - | - | - |
| OKLAHOMA | 10 | 65.78% | - | - | - | - | - | - |
| TENNESSEE | 7 | 70.00% | - | - | - | - | - | - |
| WYOMING | 7 | 63.02% | - | - | - | - | - | - |
| GEORGIA | 10 | 64.02% | - | - | - | - | - | - |
| TEXAS | 10 | 65.29% | - | - | - | - | - | - |
| NORTH DAKOTA | 10 | 50.00% | - | - | - | - | - | - |
| NEW HAMPSHIRE | 10 | 65.93% | - | - | - | - | - | - |
| SOUTH CAROLINA | 10 | 58.69% | - | - | - | - | - | - |
| | | 50.00% | - | - | - | - | - | - |
| | | 50.00% | - | - | - | - | - | - |
| | | 70.57% | - | - | - | - | - | - |

(1) The Federal Medical Assistance Percentage (FMAP) for each state was obtained from the Federal Register, published on November 30, 2012.

(2) Calculated as Medicaid reimbursement (federal share) divided by each state's FMAP.

(3) Calculated as Medicaid reimbursement (federal share) divided by 50%.

(4) Total federal reimbursement for this state's health services program and/or administrative claiming program was not provided for SFY 2013-14.

(5) This state reported on the survey that they did not have a fee-for-service school-based Medicaid health services program in effect during SFY 2013-14.

(6) This state reported on the survey that they did not have an administrative claiming program in effect during SFY 2013-14.

(7) This state did not have either a school-based Medicaid health services program or administrative claiming program in effect during SFY 2012-13 and/or SFY 2013-14.

(8) Health service figures from Florida were compiled from the Florida Agency for Healthcare Administration website where online Fee-for-Service School Certified Match Reimbursement Reports are updated quarterly. (Source: http://ahca.myflorida.com/medicaid/childhealthservices/schools/index.shtml). Administrative claiming program expenditures were not available.

(9) Health service and administrative program expenditures for Arkansas were obtained from the Arkansas Medicaid in the Schools website, MITS profiles (https://arksped.k12.ar.us/applications/sbmh/default.htm).

(10) Did not complete the state survey used to collect Medicaid reimbursement (federal share) for direct claiming and administrative services for SFYs 2012-13 and 2013-14.

## Appendix 2: Other States' School-Based Services and Practitioners

| Service | Potential Qualified Practitioner(s) | Example Rates |
|---|---|---|
| **Behavioral services provided by a behavioral aide**<br><br>Behavioral aide services prevent or correct maladaptive behavior on the part of the child. The interventions are used to change specific behaviors.<br>A behavioral plan is designed by a mental health professional and carried out by behavioral aides.<br>The plan provides a description of the behavior to be addressed and positive or negative incentives to encourage appropriate behavior. | **Mental health behavioral aide**<br><br>A paraprofessional working under the direction of a mental health professional. | **Iowa:** Based on each school district's cost of providing service.<br><br>Health and behavior intervention, per 15-minute increment: $3.39 – $10.83<br><br>Health and behavior intervention by contracted staff, per 15-minute increment: $0.36 – $9.79<br><br>Health and behavior intervention, group (2 or more) per 15-minute increment: $0.35 – $9.63<br><br>**Minnesota:** Based on school district's cost of providing service. |
| **Behavioral services provided by a certified behavioral analyst or certified associate behavioral analyst**<br><br>Behavioral services include behavioral evaluations and functional assessments, analytic interpretation of assessment results, and design and delivery of treatments and intervention methods. | **Certified behavior analyst**<br><br>A person with a bachelor's or master's degree who meets state requirements for a certified behavioral analyst. A person with a bachelor's degree must work under the supervision of a certified behavioral analyst with a master's degree.<br><br>**Certified associate behavioral analyst**<br><br>A person with a bachelor degree or higher who meets state requirements for a certified associate behavioral analyst and who works under supervision of a certified behavioral analyst with a master's degree. | **Florida:** Certified behavior analyst,<br>Individual: $8.00 per 15-minute increment<br>Group: $4.00 per 15-minute increment<br><br>Certified behavior analyst (bachelor's level),<br>Individual: $6.70 per 15-minute increment<br>Group: $3.35 per 15-minute increment<br><br>Certified associate behavior analyst,<br>Individual: $6.40 per 15-minute increment<br>Group: $3.20 per 15-minute increment |

## Appendix 2: Other States' School-Based Services and Practitioners

| Service | Potential Qualified Practitioner(s) | Example Rates |
|---|---|---|
| **Behavioral services provided by an intern**<br><br>Behavioral services include testing, assessment and evaluation that appraise cognitive, developmental, emotional, and social functioning; therapy and counseling, and crises assistance. | **Psychologist intern, Social worker intern**<br><br>A psychologist or social worker with a master's degree or higher obtaining the required work experience for licensure and working under the supervision of a qualified provider. | **Florida:** Psychologist Intern, Individual: $9.66 per 15-minute increment<br>Group: $4.95 per 15-minute increment<br><br>Social Worker/MFT/Mental Health and Guidance Counselor Interns,<br>Individual: $8.97 per 15-minute increment<br>Group: $4.25 per 15-minute increment<br><br>**Illinois:** Based on each school district's cost of providing service. |
| **Dental assessment and health education provided under Early and Periodic Screening, Diagnostic and Treatment services**<br><br>Dental assessment services include a dental oral exam using a mouth mirror and explorer to identify abnormalities, such as abscess, growth or lesion, traumatic injury and periodontal problems. Dental health education includes one-on-one teaching of awareness, prevention and education, including awareness of teeth and dental hygiene techniques. | **Licensed dentist**<br><br>A person who is a licensed dentist.<br><br>**Dental hygienist**<br><br>A person who is a licensed dental hygienist. | **Oklahoma:** Dentist: $20.35<br><br>**Delaware:** Dental hygienist:<br>0-29 minutes: $13.50<br>30-44 minutes: $27.00<br>45-59 minutes: $40.50<br>60 minutes and over: $54.00 |

## Appendix 2: Other States' School-Based Services and Practitioners

| Service | Potential Qualified Practitioner(s) | Example Rates |
|---|---|---|
| **Durable medical equipment and assistive technology devices**<br>Purchase or rental of medically necessary and appropriate assistive devices such as augmentative communication devices, crouch screen voice synthesizers, prone standers, corner chairs, wheelchairs, crutches, walkers, auditory trainers, and suctioning machines. The equipment is for the exclusive use of the child and is the property of the child. | **Not applicable** | **Illinois:** Medically necessary equipment may be claimed up to a total of $1,000 per day based on the cost of the equipment. Equipment costing more than $1000 must be obtained through a durable medical equipment provider enrolled with the department.<br>**Minnesota:** Cost-based rate**,** based on purchase price, rental costs or costs of repairs.<br>**Vermont:** Medicaid reimbursement for Durable Medical Equipment provided pursuant to an IEP will be made at the lower of the actual charge or the Medicaid fee set for the service. Medicaid will cover up to one-month rental if the device cannot be loaned. The cost of rental must be included in the price if eventually purchased. If the equipment is rented and the recipient is ineligible for Medicaid during a portion of a rental month, rental is only paid for those days the recipient is eligible. |
| **Service Plan Review**<br>Coordination and management of the activities leading up to and including the writing of the IEP or IFSP, including convening and conducting the meeting to write the IEP or IFSP. | **Case manager**<br>A person who has a bachelor's degree with a major in special education, social services, psychology, or related field; or a registered nurse. | **West Virginia:** Based on costs determined through RMTS methodology, Cost Reconciliation and Cost Settlement. |

## Appendix 2: Other States' School-Based Services and Practitioners

| Service | Potential Qualified Practitioner(s) | Example Rates |
|---|---|---|
| **Interpreter services**<br>Interpretive services rendered to a child who requires an interpreter to communicate with the professional or paraprofessional providing the child with a health-related service. Services include oral language interpretation for children with limited English proficiency or sign language interpretation for children who are deaf or hard of hearing. Services must be provided in conjunction with another Medicaid service. | **Interpreter**<br>Oral language: A person who speaks the language understood by the child and who is employed by or has a contract with the school district to provide oral language interpreter services.<br>Sign language: A person with a bachelor's degree or higher who has graduated with a valid certification from a recognized interpreters' evaluation program. | **Minnesota:** Based on each school district's cost of providing service. Services are not covered when provided in conjunction with special transportation or Personal Care Assistance services. |
| **Occupational therapy services provided by an occupational therapy assistant**<br>Services rendered to a child to develop, improve, or restore functional abilities related to self-help skills, adaptive behavior and sensory, motor, postural development, and emotional deficits that have been limited by a physical injury, illness, or other dysfunctional condition. | **Occupational therapy assistant**<br>A person who meets state requirements as an occupational therapy assistant and works under the direction of a qualified occupational therapist. | Most states do not have separate rates for occupational therapy services provided by occupational therapists versus occupational therapy assistants. The rates listed below apply only to occupational therapy assistants.<br>**Florida:** Individual: $13.58 per 15-minute increment<br>Group: $2.60 per 15-minute increment<br>**Texas:** Interim payment for individual services is based on $11.20 per 15-minute increment; Interim payment for group services is $3.74 per 15-minute increment.<br>Final settlement is based on the cost of providing services.<br>**Oklahoma:** Individual: $28.96 per 15-minute increment<br>Group: $14.77 per session |

## Appendix 2: Other States' School-Based Services and Practitioners

| Service | Potential Qualified Practitioner(s) | Example Rates |
|---|---|---|
| **Orientation and mobility services**<br><br>Evaluation and training designed to correct or alleviate movement deficiencies created by a loss or lack of vision in order to enhance the child's ability to function safely, efficiently and purposefully in a variety of environments. | **Orientation and mobility provider**<br><br>- Orientation and mobility specialist certified by the Association for the Education and Rehabilitation of the Blind and Visually Impaired; the Academy for Certification of Vision Rehabilitation and Education Professionals; or the National Blindness Professional Certification Board<br><br>- Teacher of special education with approval as teacher of the visually impaired<br><br>- Assistive technology consultant with a master's degree in special education or speech pathology<br><br>- Licensed Occupational Therapist | **Michigan:** Based on each school district's cost of providing service. Providers receive interim monthly payments based on prior year actual costs, which are reconciled on an annual basis to current year costs.<br><br>**Pennsylvania:** Based on each school district's cost of providing service from prior years, up to a maximum rate ceiling of $31.25 per 15-minute increment.<br><br>**South Carolina**: $15.41 per 15-minute increment<br><br>**Service Limitations**<br>Assessment: Up to 8 units per lifetime;<br>Re-assessment: Up to 5 units, with 3 re-assessments per year; and<br>Services: Up to 30 per week |

## Appendix 2: Other States' School-Based Services and Practitioners

| Service | Potential Qualified Practitioner(s) | Example Rates |
|---|---|---|
| **Personal care services**<br>Services and support furnished to an individual to assist in accomplishing activities of daily living (eating, toileting, grooming, dressing, bathing, transferring, mobility, and positioning); health related functions through hands-on assistance, supervision, and cuing; and redirection and intervention for behavior, including observation. | **Health aide, Personal care assistant**<br>A paraprofessional supervised by a qualified health care professional. | **Michigan:** Based on each school district's cost of providing service from prior year.<br>**Oklahoma:** $3.49 per 10-minute increment<br>**Virginia:** Based on estimated costs for services provided, maximum rate of $3.58 for individual and $1.18 for group of up to six individuals (per 15-minute increments).<br>**West Virginia:** Based on costs determined through RMTS methodology, Cost Reconciliation and Cost Settlement.<br>**Texas**: Interim payment for individual services is based on $5.74 per 15-minute increment; Interim payment for group services is $1.91 per 15-minute increment. Final settlement is based on the cost of providing services. |
| **Physical therapy services provided by a physical therapy assistant**<br>Services rendered to a child to develop, improve or restore neuromuscular or sensory-motor function, relieve pain, or control postural deviations to attain maximum performance. | **Physical therapy assistant**<br>A person who meets state requirements for a physical therapy assistant and works under the direction of a qualified physical therapist. | Most states do not have separate rates for physical therapy services provided by physical therapists versus physical therapy assistants. The rates listed below apply only to physical therapy assistants.<br>**Florida:** Individual: $13.58 per 15-minute increment<br>Group: $2.60 per 15-minute increment<br>**Texas:** Interim payment for individual services is based on $13.58 per 15-minute increment; Interim payment for group services is $6.79 per 15-minute increment. Final settlement is based on the cost of providing services.<br>**Oklahoma:** Individual: $26.79 per session<br>Group: $14.77 per session |

## Appendix 2: Other States' School-Based Services and Practitioners

| Service | Potential Qualified Practitioner(s) | Example Rates |
|---|---|---|
| **Respiratory therapy services**<br>Respiratory therapy services assist a child who has breathing or other cardiopulmonary disorders. Procedures include, but are not limited to, the assessment and therapeutic use of the following: medical gases (excluding anesthetic gases); aerosols, humidification, environmental control systems; ventilator support; and maintenance and care of natural and artificial airways. | **Licensed respiratory therapist**<br>A person who meets state requirements as a licensed respiratory therapist. | **Connecticut:** $21.50 per 15-minute increment<br>**Kentucky:** $3.50 per 15-minute increment |
| **Services for children with speech and language disorders provided by a speech-language pathology assistant**<br>Services rendered to a child to treat speech and language disorders of verbal and written language, articulation, voice, fluency, phonology, and mastication. | **Speech-language pathology assistant**<br>A person who meets state requirements for a speech-language pathology assistant and works under the direction of a qualified speech pathologist. | Most states do not have separate rates for speech therapy services provided by speech pathologists versus speech-language pathology assistants. The rates listed below apply only to speech-language pathology assistants.<br>**Florida:** Individual: $13.58 per 15-minute increment<br>Group: $2.60 per 15-minute increment<br>**Texas:** Interim payment for individual services is based on $8.57 per 15-minute increment; Interim payment for group services is $2.86 per 15-minute increment. Final settlement is based on the cost of providing services. |

## Appendix 2: Other States' School-Based Services and Practitioners

| Service | Potential Qualified Practitioner(s) | Example Rates |
|---|---|---|
| **Specialized transportation**<br>Transportation in a vehicle adapted to serve the needs of the disabled to and from school when the child receives a Medicaid-covered service in school and when transportation is specifically listed in the IEP or IFSP as a required service. Transportation from the school to a provider in the community also may be billed to Medicaid. (Reimbursable transportation is currently restricted a litter van or wheelchair van, in California's LEA Program.) | **Not Applicable** | **Michigan:** Maximum of two one-way trips per day, based on each school district's cost of providing service from prior year.<br>**New York:** School rate for a one-way trip: $7.92 – $21.69 per day, based on the county in which the school district is located<br>Pre-school rate: $14.21 – $36.50 per day, based on the county in which the school district is located.<br>* In Michigan and New York, providers may not bill separately for an attendant.<br>**Texas:** Interim rate of $4.70 per one-way trip |

**Note**: Information contained in this table is based on publicly available data as of March 2015.