
Local Educational Agency Medi-Cal Billing Option Program

Report to the Legislature, May 2013*

*2014 Information Related to Regulations and State Plan Amendments has also been included.



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LOCAL EDUCATIONAL AGENCY MEDI-CAL BILLING OPTION PROGRAM

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 school districts and County Offices of Education (COEs) are 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 231 (SB 231), Chapter 655, Statutes of 2001, was signed into law in October 2001, and added Section 14115.8 to the Welfare and Institutions (W&I) Code to reduce the gap in per child recovery for Medicaid school-based reimbursements between California and the three states recovering the most per child from the federal government. SB 231 was reauthorized in Assembly Bill 1540 (AB 1540), Chapter 298, Statutes of 2009, in October 2009 and in Assembly Bill 2608 (AB 2608), Chapter 755, Statutes of 2012, in September 2012.

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.

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-five states have identified millions of dollars in federal disallowances for services provided in schools. The OIG work plan for fiscal year 2013 specifically identified Medicaid school-based services as a targeted area for compliance review. OIG will continue to review Medicaid payments for school-based services in selected states to determine whether the health service costs claimed are reasonable. In addition to compliance issues regarding inaccurate, inadequate or missing service documentation that resulted in significant unallowable payments identified by the OIG, "Free Care" and "Other Health Coverage" (OHC) requirements mandated by CMS during the summer of 2003 continue to impact the ability of schools to bill for health services that are provided to Medi-Cal eligible students². As of the date of publication of this report, CMS issued guidance to the State Medicaid Directors on December 15, 2014, withdrawing its prior guidance on the free care policy.

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

² On December 15, 2014, CMS issued a letter to the State Medicaid Director providing guidance on Medicaid payment for services covered under a state's Medicaid plan to an eligible Medicaid beneficiary that are available without charge to the beneficiary and to the community at large, or "free care". Free care, or services provided without charge, are services for which there is no beneficiary liability or third party liability. OHC is another insurance program that is or may be liable to pay all or part of the costs for medical assistance for Medicaid-covered services. Under Medicaid law and regulations, Medicaid will pay for health care only after a beneficiary's other health care coverage has been exhausted.

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DHCS will evaluate the impact of this new policy on Medi-Cal programs including the LEA Medi-Cal Billing Option Program.

The American Recovery and Reinvestment Act (ARRA) of 2009, as referenced on page 11, approved Federal Medical Assistance Percentage (FMAP) increases to all states and territories, effective October 2008 through June 2011. Increased FMAP rates helped to generate increased reimbursement for California's LEAs during Fiscal Year (FY) 2010-11. Effective SFY 2011-12, the FMAP for California returned to 50 percent. In accordance with California's State Plan Amendment (SPA) 03-024, DHCS implemented enhanced reimbursement rates in 2012 which increased reimbursements. Per the State Plan, DHCS will continue to annually adjust rates to be retroactive to the appropriate fiscal year.

LEA Medi-Cal reimbursement trends by State Fiscal Year are presented in the table below. The LEA Program reimbursement has more than doubled in the past six years and has grown by almost 150 percent since its authorization under SB 231, due to increased LEA 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 ⁽³⁾	461	\$63.9 million	7%
SFY 2005-06 ⁽³⁾	470	\$63.6 million	7%
SFY 2006-07 ⁽¹⁾	461	\$69.5 million	17%
SFY 2007-08 ⁽¹⁾	472	\$81.2 million	36%
SFY 2008-09 ⁽¹⁾⁽²⁾	479	\$109.9 million	84%
SFY 2009-10 ⁽¹⁾⁽²⁾	484	\$130.4 million	119%
SFY 2010-11 ⁽¹⁾⁽²⁾	497	\$147.8 million	148%

Notes:

⁽¹⁾ 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.

⁽²⁾ Total Medi-Cal reimbursement also reflects increased FMAP through the ARRA. The increased FMAP was effective October 2008 through June 2011.

⁽³⁾ 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 beneficiaries.

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After a lengthy review process by CMS, the first 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. DHCS, and its fiscal intermediary, collaborated during SFYs 2006-07, 2007-08 and 2008-09 to correct system errors that resulted after SPA implementation and DHCS continues to work with its current fiscal intermediary (Xerox), to resolve minor technical coding issues in the claims processing system.

The LEA Ad-Hoc Workgroup Advisory Committee (LEA Advisory Workgroup) was originally organized in early 2001. Regular LEA Advisory Workgroup meetings, currently conducted every other month, assist to identify barriers for both existing and potential LEA providers, provide LEA perspective and feedback, and have resulted in recommendations for new services and improvements to the LEA Program. 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.

During 2012, DHCS conducted research, reviewed other state school-based services programs and interviewed other state Medicaid personnel regarding potential new services for California's LEA Program. DHCS also researched telehealth practices within schools and nationally in health industries. In addition, DHCS identified state and federal regulations related to physical therapy, occupational therapy, speech therapy and audiology assistants and aides to define scope of practice, practitioner qualifications and supervision requirements. DHCS submitted SPA 12-009 to update the Targeted Case Management template per CMS requirements. Additional SPAs may be developed and submitted to CMS in the future to continue expanding and improving the LEA Billing Program.

Throughout 2012, DHCS continued to assist its fiscal intermediary with streamlining claims payments; identifying and resolving technical claims processing issues and system changes, and revising the LEA portion of the Medi-Cal Provider Manual (LEA Provider Manual). During 2012, DHCS developed audit protocols; conducted an annual LEA Program training session; audited the first two LEA Cost and Reimbursement Comparison Schedule (CRCS) form submissions from SFYs 2006-07 and 2007-08, and implemented the SFY 2009-10 CRCS resubmission and SFY 2010-11 CRCS form submission and intake process. DHCS continues to develop relevant training based on the needs of the LEA Program.

The work completed in 2012 was largely due to the positive and on-going relationship between DHCS and the many officials of school districts and COEs, the California Department of Education (CDE) and professional associations representing LEA services who have participated in the LEA Advisory Workgroup.

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I. INTRODUCTION

SB 231, Chapter 655, Statutes of 2001, Section 14115.8, requires 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. SB 231 requires DHCS to:

- Amend the Medicaid State Plan with respect to the LEA Program to ensure that schools are 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 appropriate³;
- Consult regularly with CDE, representatives of urban, rural, large and small school districts and COEs, the Local Education Consortium (LEC) and LEAs;
- Consult with CMS, experts from the fields of both health and education, and state legislative staff;
- Undertake necessary activities to ensure that LEAs are reimbursed retroactively for the maximum period allowed by the federal government;
- Encourage improved communications with the federal government, the CDE, and LEAs;
- Develop and update written guidelines to LEAs regarding best practices to avoid audit exceptions, as needed;
- Establish and maintain an LEA friendly interactive 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.

³ Assembly Bill 430 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.

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Table 1: Annual Legislative Report Requirements

Report Section	Report Requirements
III	<ul style="list-style-type: none"> • An annual comparison of school-based Medicaid systems in comparable states. • A state-by-state comparison of school-based Medicaid total and per eligible child claims and federal revenues. The comparison shall include a review of the most recent two years for which completed data is available. • A summary of Department activities and an explanation of how each activity contributed toward narrowing the gap between California’s per eligible student federal fund recovery and the per student recovery of the top three states. • A listing of all school-based services, activities, and providers⁴ approved for reimbursement by CMS in other LEA state plans that are not yet approved for reimbursement in California’s state plan and the service unit rates approved for reimbursement.
IV	<ul style="list-style-type: none"> • 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, CMS staff, experts from the fields of both health and education, and state legislative staff.
V	<ul style="list-style-type: none"> • A one-year timetable for SPAs and other actions necessary to obtain reimbursement for the school-based services, activities, and providers approved for reimbursement by CMS in other state plans that are not yet approved for reimbursement in California’s State Plan.
VI	<ul style="list-style-type: none"> • 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.

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II. BACKGROUND

Schools play a critical role in providing health services to students, particularly those requiring special education services. Since the 1970s, 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 Free Care and OHC requirements.

Medicaid provides health care coverage and medical services to low-income children, pregnant women, families, persons with disabilities, and elderly citizens. Each state establishes a state Medicaid plan that outlines eligibility standards, provider requirements, payment methods, and benefit packages. Generally, 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.

For the most part, Medicaid is financed jointly by the states and the federal government. In school-based programs, LEAs fund the state share of Medicaid expenditures through a Certified Public Expenditure (CPE) process. 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
- 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. In SFY 2012-13, the OIG released three audit reports related to school-based health services in Arizona, Maine and New Hampshire. Twenty-five states have had audit reports issued on school-based health services since October 2001. These reports were part of a series in a multi-state initiative to review costs claimed for Medicaid school-based health services.

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Reported school-based health service findings have resulted in millions of dollars in alleged overpayments to schools, which include:

- 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.

The OIG continues to focus on compliance issues surrounding school-based services.

As part of the ARRA of 2009, the federal government approved FMAP increases to all states and territories. Effective October 2008, the California FMAP increased from 50 percent to 61.59 percent, providing increased federal match funding for the LEA Program. In SFY 2010-11, the ARRA FMAP increases were gradually lowered from 61.59 percent to 58.77 percent and 56.88 percent in the second and third quarters of the federal fiscal year, respectively. Since the LEA Program is a local-federal match program, the extended enhanced FMAP resulted in additional funding for LEA providers in California through the end of SFY 2010-11. Effective SFY 2011-12, the California FMAP rate returned to 50 percent, where it currently remains.

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.

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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) 2009-10, 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," 2011.
Average salaries of instructional staff (classroom teachers, principals, supervisors, librarians, guidance and psychological personnel, and related instructional staff)	Rankings of the States 2012 and Estimates of School Statistics 2013, National Education Association (NEA), December 2012
Per capita personal income	Rankings of the States 2012 and Estimates of School Statistics 2013, NEA, December 2012

The number of Medicaid-eligible and IDEA eligible children provide 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 and used to compare the interim Medi-Cal reimbursements 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

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the units of service, encounters and related Medi-Cal reimbursement for the appropriate fiscal year on the CRCS forms. Actual costs are compared to Medi-Cal reimbursement to ensure 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 reimbursement claims. As part of the cost reconciliation, the LEA providers certify that the public funds expended for the provision of LEA services are eligible for FFP. SFY 2010-11 marked the fifth cost certification year. In order to assist LEAs in completing the Medi-Cal cost report, DHCS worked with its fiscal intermediary to create an Interim Reimbursement and Units of Service (IRUS) Report in October 2012 for all LEAs that received Medi-Cal reimbursement for services during SFY 2010-11. This report summarized total units and reimbursement information by LEA service and practitioner type and was made available to providers on the LEA Program website.

In 2012, DHCS finished auditing SFY 2006-07 and 2007-08 CRCS reports, resulting in LEAs receiving their final reconciled overpayment/underpayment amounts for the first two CRCS reporting periods. DHCS is currently in the process of reviewing the SFY 2008-09 through SFY 2011-12 CRCS submissions.

The four states selected as comparable to California (Illinois, Pennsylvania, New York and Ohio) finance their school-based health services programs using various approaches.

In contrast to California's LEA Program that is administered using a CPE Program, in Illinois, each LEA submits cost data by completing an electronic cost calculation form for each health service it provided during the school year (data includes number of employees, hours worked, and salaries and benefits). The Illinois Department of Health and Family Services (HFS) reviews the cost information and then re-prices claims paid with dates of service during the corresponding fiscal year. For example, LEAs submit cost information for the 2012-13 school year and the claims with dates of service for FY 2012-13 are re-priced and paid based on the 'actual cost' of those services. All claim adjustments are performed retroactively by HFS.

As a result of a CMS audit of Pennsylvania's school-based services program in SFY 2010-11 and 2011-12, Pennsylvania revised its rate setting and payment methodology. Effective July 1, 2012, Pennsylvania abandoned its former methodology, whereby LEAs were paid an 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 Random Moment Time Study (RMTS) to document time spent on specific activities that are required to support Medicaid claims for school health services. The Commonwealth of Pennsylvania is in the process of finalizing guidance for Fee-For-Service (FFS) claiming and cost settlement for LEAs. Additional changes to Pennsylvania's Program include a requirement for practitioners to electronically complete log sheets to document their activities, and a restriction on billing time spent developing IEPs, which was previously a reimbursable service.

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Effective SFY 2011-2012, New York schools that receive Medicaid payments for health services provided on and after October 1, 2011, are required to operate under the CPE methodology. Schools continue to submit FFS Medicaid claims and are reimbursed at interim rates. New York will initiate a cost settlement process after each school district, county and qualifying school entity has completed a quarterly RMTS and 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. Beginning September 2012, New York required all billing providers to register for payment via Electronic Funds Transfer (EFT) and utilize electronic remittances in an effort to achieve cost savings by eliminating the production, processing and mailing of paper.

Similar to New York, Ohio's school-based program is a CPE program that utilizes a quarterly RMTS. Like California, Ohio providers submit FFS Medicaid claims and receive interim payments. The interim payments are the federal financial participation 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.

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

DHCS administered the tenth state survey beginning January 2013. DHCS contacted states to obtain updates to the information provided in the 2011 survey; states that did not participate in 2011 were given the opportunity to complete the 2012 survey. Follow-up contact was made 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, program transition and overhaul, and internal data request issues; several states did not respond to multiple follow-ups. 42 of 50 states (and Washington, D.C.) contacted returned the survey, however, nine⁶ of those survey respondents did not provide Medicaid reimbursement figures. Two states (Tennessee and Wyoming) confirmed they do not currently have a school-based health services program. Table 3 summarizes survey results for Medicaid reimbursement (federal share) for health and administrative services for SFY 2010-11 and 2011-12. Several states did not have finalized figures available for both SFYs. When data was provided, federal Medicaid reimbursement was divided by each state's FFP rate to estimate total claim dollars. Based on the federal changes in FMAP rates throughout SFY 2010-11, DHCS used the Quarter 2 FFP for each individual state to estimate total claim dollars. Total claim 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).

⁶ Arkansas, Georgia, Kansas, New Hampshire, New York, North Dakota, South Carolina, South Dakota and Texas did not respond to the survey.

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It is important to note that the original GAO report, as referenced on page one, and DHCS surveying results cannot definitively compare direct billing option program dollars spent per Medicaid-eligible student among states. This is due to the inherent inability to split Medicaid-eligible students between direct claiming FFS and administrative claiming programs. For those states that operate both programs, only the combined program dollars can be divided by the number of Medicaid-eligible students. As such, Table 3 comparisons for those states (including California) that attempt to compare direct billing service dollars per eligible student are inadvertently impacted by the inclusion of administrative claiming program dollars. In addition, the FMAPs vary between states, which impact the average claim per Medicaid-eligible child. FMAPs range from 58.77 percent to 82.03 percent in FY 2010-11 and from 50 percent to 74.18 percent in FY 2011-12. Any state ranking interpretations made within these tables should consider this important caveat.

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 had decreased to \$71 in SFY 2010-11 and \$80 in SFY 2011-12. Maryland's survey response indicated that they no longer have a Medicaid school-based administrative claiming program. As noted in Table 3, Vermont had the highest average SFY 2010-11 claim of \$681, while California's average claim was \$148, a difference of \$533. California's federal Medi-Cal reimbursement for LEA direct billing option program services decreased nine percent between SFY 2010-11 and 2011-12. This decrease is likely attributable to claims reimbursed at 50 percent FMAP for SFY 2011-12, as opposed to the increased ARRA FMAPs of 61.59, 58.77 and 56.88 percent for claims in SFY 2010-11. It should also be noted that there are outstanding EPCs relating to services provided in SFY 2012-13 that have yet to be implemented, which will ultimately increase total SFY 2011-12 reimbursements. In addition, the federal revenues from administrative activities claimed in the California Medi-Cal Administrative Activities (MAA) Program decreased substantially from \$129.2 million (year-to-date) in SFY 2010-11 to \$5.3 million (year-to-date) in SFY 2011-12. 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 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. As of January, 2015, CMS has released approximately 50 school claiming units from deferral, and DHCS continues to release individual invoice claims for settlement payments. The administrative claiming program has approximately \$19.3 million that has not been paid in SFY 2010-11 and approximately \$60.3 million in SFY 2011-12.

According to a CMS survey of all states Medicaid eligibles ages 6-20 in FFY 2009-10, California had over 3.4 million Medicaid eligibles aged 6 to 20 (approximately 15 percent of the total U.S. school-aged Medicaid eligible population). In comparison, Vermont had the highest average claim per Medicaid-eligible child as illustrated in Table 3. As indicated in Table 3, California has the highest federal Medicaid reimbursement and total claims figures in SFY 2010-11 and second highest in SFY 2011-12. However, due to California's large

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Medicaid eligible population used in the Table 3 rankings, California's average claim per Medicaid-eligible child is substantially lower when compared to other states. Based on California's SFY 2010-11 paid claims reimbursement data, the number of actual LEA beneficiaries who received LEA Program services was 251,270 students. By utilizing the actual LEA beneficiary count and the total SFY 2010-11 direct claiming FFS reimbursement, the average reimbursement per beneficiary receiving LEA Program services in SFY 2010-11 was \$588.

A comparison of the average claim per Medicaid-eligible child from the SFY 2010-11 versus 2011-12 as illustrated in the SFY 2010-11 Table 3 shows an increase in 23 of the 34 states that reported federal reimbursement. The average claim decreased in 10 states (including California). It should be noted that these survey results do not reflect any past, current or expected adjustments due to prior or on-going OIG or CMS investigations or audits in any state.

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Table 3: Medicaid Reimbursement and Claims by State, Ranked by 2010-11 Average Claim Per Medicaid-Eligible Child

**Table 3: Medicaid Reimbursement and Claims by State
Ranked by Average Claim Per Medicaid-Eligible Child, State Fiscal Year (SFY) 2010 - 2011**

State	SFY 2010-2011 ⁽¹⁾			SFY 2011-2012 ⁽¹⁾		
	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	\$ 24,372	\$ 36,305	\$ 681	\$ 24,248	\$ 42,112	\$ 789
RHODE ISLAND	27,398	47,024	638	26,506	51,417	698
WEST VIRGINIA	50,540	62,994	445	41,487	57,129	403
IDAHO	29,779	39,003	363	26,431	37,635	350
PENNSYLVANIA	165,975	273,740	341	-	-	-
IOWA	41,664	59,793	311	43,945	72,386	377
DELAWARE	12,060	19,594	296	-	-	-
NEBRASKA	16,762	32,044	287	19,199	37,713	338
MASSACHUSETTS	66,800	121,035	267	74,000	148,000	327
MAINE	³ 20,083	27,882	265	45,853	72,472	690
ILLINOIS	166,147	300,545	263	223,847	447,694	391
NEW JERSEY	64,500	110,496	221	-	-	-
MICHIGAN	122,264	172,271	200	113,391	175,548	204
UTAH	19,982	27,988	194	23,457	34,909	242
MINNESOTA	32,209	54,805	180	31,683	63,366	209
ALABAMA	28,900	57,496	165	23,561	47,119	135
CALIFORNIA	277,070	510,023	148	139,937	279,873	81
MISSOURI	29,310	57,019	136	30,123	58,565	140
MONTANA	4,835	7,722	127	4,817	7,961	131
WISCONSIN	33,782	50,462	125	68,397	125,258	311
OREGON	17,001	30,086	119	15,535	29,040	115
MISSISSIPPI	14,837	29,674	111	7,274	14,548	55
COLORADO	³ 16,783	29,002	108	9,494	18,988	71
ARIZONA	31,553	44,863	84	5,519	11,038	21
NEW MEXICO	12,891	19,467	80	15,306	25,534	105
VIRGINIA	18,600	34,619	79	17,873	35,746	82
CONNECTICUT	9,375	15,952	76	8,209	16,418	78
LOUISIANA	30,466	39,077	73	30,324	49,639	93
MARYLAND	15,575	26,502	71	14,898	29,795	80
NORTH CAROLINA	30,303	53,544	68	-	-	-
DISTRICT OF COLUMBIA	2,031	2,945	48	4,819	6,884	112
KENTUCKY	9,516	15,878	44	6,801	10,756	30
OHIO	25,600	36,117	40	-	-	-
ALASKA	1,325	2,224	39	2,196	4,392	78
FLORIDA	⁴ 18,245	28,152	23	14,105	25,169	20
WASHINGTON	5,479	9,115	17	8,334	16,668	31
OKLAHOMA	4,485	6,068	17	4,484	7,020	20
HAWAII	833	1,291	14	619	1,226	13
INDIANA	4,469	6,089	12	6,448	10,924	22
NEVADA	402	658	5	-	-	-
TENNESSEE	⁵ -	-	-	-	-	-
WYOMING	⁵ -	-	-	-	-	-
ARKANSAS	⁶ -	-	-	-	-	-
GEORGIA	⁶ -	-	-	-	-	-
KANSAS	⁶ -	-	-	-	-	-
NEW HAMPSHIRE	⁶ -	-	-	-	-	-
NEW YORK	⁶ -	-	-	-	-	-
NORTH DAKOTA	⁶ -	-	-	-	-	-
SOUTH CAROLINA	⁶ -	-	-	-	-	-
SOUTH DAKOTA	⁶ -	-	-	-	-	-
TEXAS	⁶ -	-	-	-	-	-

- (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) 2009-10. (Source: Medicaid Program Statistics, Centers for Medicare and Medicaid Services, http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/02_MSISData.asp)
- (3) State reimbursement amounts were reported by Federal Fiscal Year (October 1 - September 30) instead of by State Fiscal Year (July 1- June 30).
- (4) 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>)
- (5) This state did not have a school-based Medicaid health services program or administrative claiming program during SFY 2010-2011 and/or SFY 2011-12.
- (6) This state did not respond to the survey or submitted an incomplete survey that could not be used to calculate the Average Claim Per Medicaid Eligible Child.

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Summary of Departmental Activities

Since the passage of SB 231, Medi-Cal reimbursement in the LEA Program increased 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” non-IEP/IFSP population. The following eight IEP/IFSP assessment types exist in the LEA Program:

- Psychological;
- Psychosocial Status;
- Health;
- Health/Nutrition;
- Audiological;
- Speech-Language;
- Physical Therapy; and,
- Occupational Therapy.

In addition, the following six non-IEP/IFSP assessment types are covered, pursuant to certain strict billing guidelines:

- Psychosocial Status;
- Health/Nutrition;
- Health Education and Anticipatory Guidance;
- Hearing;
- Vision; and,
- Developmental.

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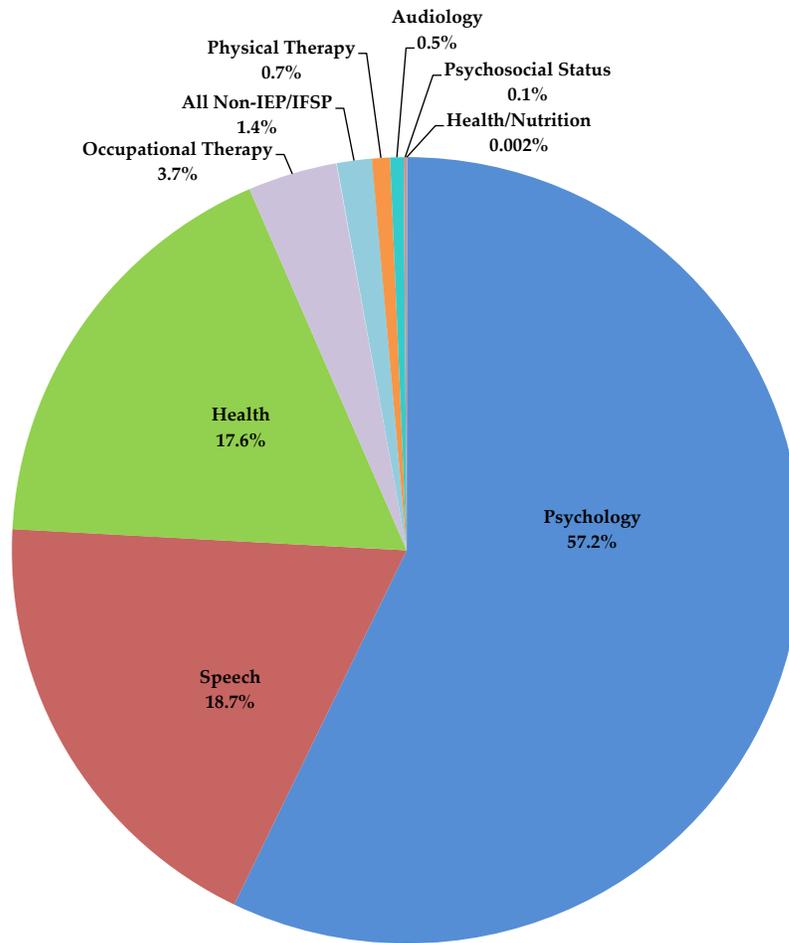
Treatment services, which may be provided to IEP/IFSP students and non-IEP/IFSP students, include:

- 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, and medical transportation/mileage reimbursement is only available for transportation services for the IEP/IFSP student population, with the requirement that the child receive transportation to a Medi-Cal covered service and both the service and transportation are included in the child's IEP/IFSP.

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Figure 1: Total LEA Assessment Reimbursement by Assessment Type, SFY 2010-11



Note: Total LEA assessment service reimbursement for SFY 2010-11 was \$30.41 million.

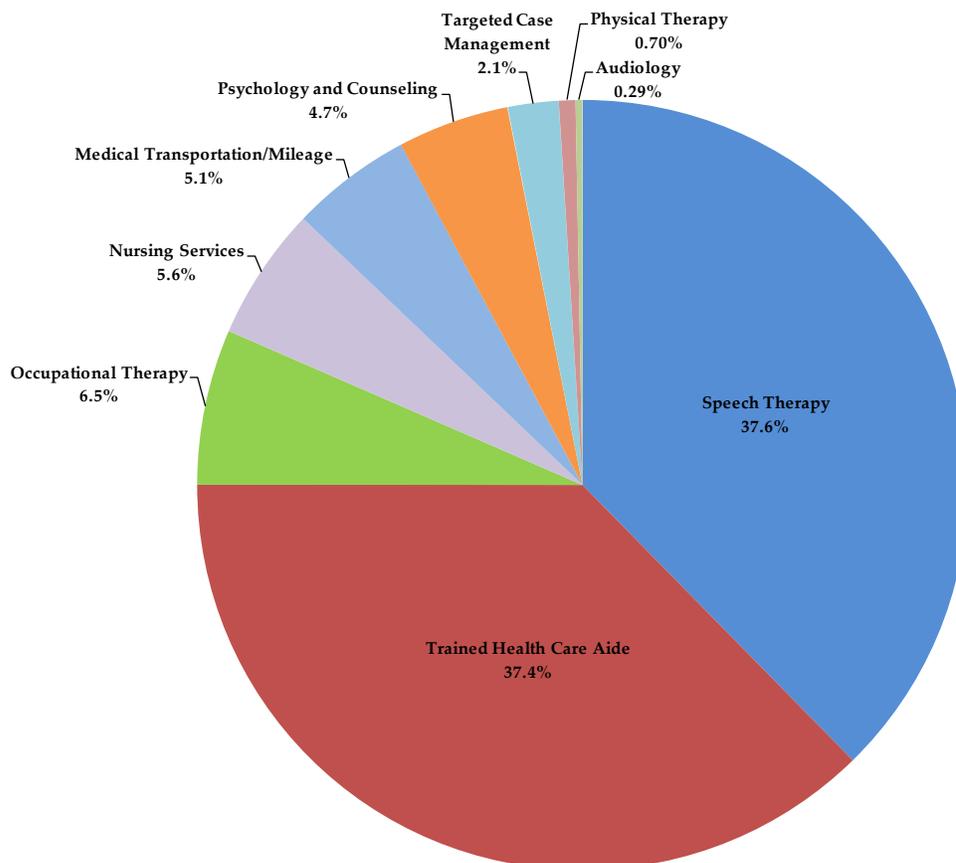
Figure 1 depicts each assessment type as a percentage of total assessment reimbursement for SFY 2010-11. As demonstrated in Figure 1, approximately 94 percent of assessment reimbursement is attributable to three IEP/IFSP assessment types: psychological, health and speech-language assessments. Although there were more LEA health assessment claims billed in SFY 2010-11, the majority of all LEA assessment reimbursement is attributable to psychological assessments. Psychological assessments, provided by licensed psychologists, licensed educational psychologists and credentialed school psychologists, have the highest reimbursement rates among assessment types.⁵ Over a third of total assessment reimbursement is attributed to health and speech-language assessments at 17.6 percent and 18.7 percent, respectively. The remaining six assessment

⁵ Psychological assessments were reimbursed at \$455.70 for initial/triennial assessments and \$151.90 for annual and amended assessments in SFY 2010-11.

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types, including all non-IEP/IFSP assessments, account for only 6.5 percent of total assessment reimbursement in SFY 2010-11.

Figure 2: Total LEA Treatment Reimbursement by Treatment Type, SFY 2010-11



Note: Total LEA treatment, transportation/mileage and TCM service reimbursement for SFY 2010-11 was \$117.40 million. Less than one percent of total treatment, transportation/mileage and TCM reimbursement is attributable to non-IEP/IFSP services.

Figure 2 demonstrates each treatment type as a percentage of total treatment reimbursement for SFY 2010-11. Three-fourths of treatment service reimbursement are attributed to speech therapy and trained health care aide services. The remaining seven treatment service types account for the remaining 25 percent of treatment service reimbursement in SFY 2010-11.

As demonstrated in the following Figure 3, all but four LEA services experienced an increase in reimbursement between SFY 2009-10 and 2010-11. Percentage increases vary from seven percent for IEP/IFSP health assessments to 59 percent for IEP/IFSP physical therapy assessments, with most services experiencing an increase greater than 15 percent between SFY 2009-10 and 2010-11. Although the increase in IEP/IFSP health/nutrition assessments

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is the largest percentage increase (290 percent), this type of assessment is not billed frequently and was not included in Figure 3 due to scalability issues. In SFY 2009-10, there were 15 IEP/IFSP health/nutrition assessment claims submitted for a total of \$163 in reimbursement, compared to 70 claims reimbursed for a total of \$635 in SFY 2010-11. IEP/IFSP health/nutrition assessments are only provided by licensed physicians; very few LEA providers employ licensed physicians to provide services.

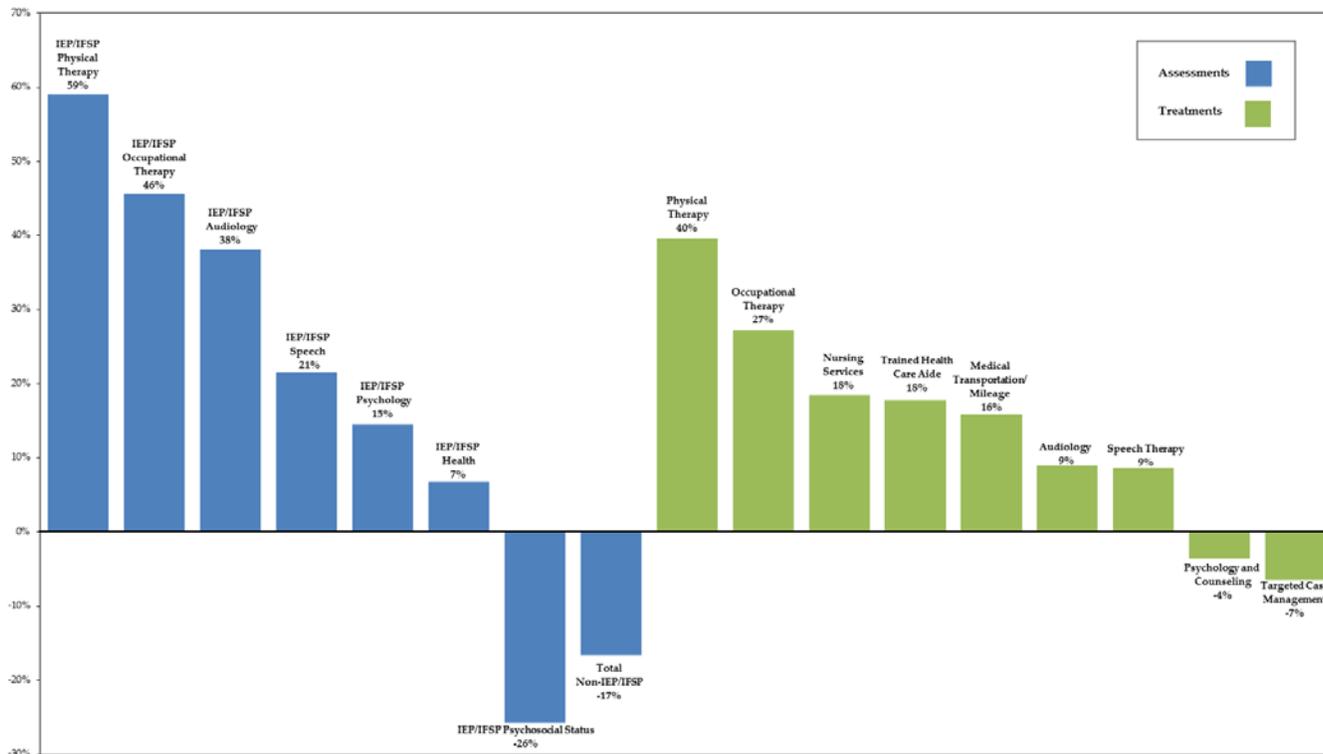
As illustrated in Figure 3, four services experienced a decrease in reimbursement between SFY 2009-10 and 2010-11. Even though reimbursement for IEP/IFSP psychosocial status assessments experienced the greatest decline (26 percent), this service only accounted for approximately \$13,000 in reduced reimbursement, some of which is attributable to the decreased FMAPs associated with ARRA. Additionally, the interim reimbursement rates for IEP/IFSP psychosocial status assessments that are conducted by social workers and counselors decreased by \$2.56 per 15-minute increment due to rate rebasing. The FMAP decrease and decline in interim reimbursement rates may also explain some of the reduction in psychology and counseling treatment service reimbursement between the two periods, seen in Figure 3. Although the number of Medi-Cal beneficiaries receiving psychology and counseling treatment services remained relatively constant between the two fiscal years, this service did experience a decrease in billed units by eight percent. The LEA Program reimburses both individual and group psychology and counseling treatments; these are billed in initial treatment services (15-45 minutes) and additional treatment services billed in 15-minute increments for treatment beyond 45 minutes. Further analysis of psychology and counseling treatment services trends indicate that all psychology and counseling treatment, except for additional group treatment, decreased. The increase in additional group treatment reimbursement (16 percent) and units (17 percent) did not offset the decrease in other billable psychology and counseling treatment.

Figure 3 also illustrates a decrease in non-IEP/IFSP reimbursement. The total non-IEP/IFSP assessments billed in SFY 2010-11 has decreased by 17 percent. LEAs are continuing to decrease their billing for non-IEP/IFSP assessments due to the stringent Free Care and OHC requirements.

Additionally, TCM decreased by seven percent, which may be due to LEAs claiming TCM under the MAA Program, as there are less stringent documentation requirements. The LEA Program requires that providers retain a service plan, document case management activities, and record student and/or family progress. In addition, since TCM rates were not updated by SPA 03-024, they have remained static for many years. The historic TCM rates are not subject to annual rate inflation and will remain at the current levels unless they are included in a future SPA.

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Figure 3: Percentage Change in Reimbursement by Service Type, SFY 2009-10 Versus 2010-11



Note: IEP/IFSP health/nutrition assessment experienced a 290 percent increase between SFY 2009-10 and 2010-11, but were not included in Figure 3. These assessments are infrequently billed in the LEA Program and only account for \$635 in reimbursement in SFY 2010-11.

Numerous DHCS activities during this Legislative Report period have contributed to the substantial increase in school-based reimbursement since the passage of SB 231. These include the following activities in 2012:

- **Rate Inflat**

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 June 2012, the SFY 2011-12 inflated reimbursement rates were implemented in the claims processing system. An EPC was required to reprocess LEA claims with dates of service in SFY 2011-12 and was implemented in June 2013.

In May 2013, DHCS submitted the SFY 2012-13 inflated reimbursement rate table to its fiscal intermediary for implementation and in August 2013, it was implemented in the claims processing system. Another EPC was required to reprocess claims with dates of service in SFY 2012-13 and was implemented in July 2014.

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- **Rate Rebasing**

Per SPA 03-024, DHCS is required to rebase LEA reimbursement rates for IEP/IFSP assessments and treatment services and non-IEP/IFSP assessments and treatment services periodically. DHCS reviewed and analyzed the as-submitted SFY 2007-08 CRCS costs to rebase interim reimbursement rates. The majority of the LEA practitioner's costs per hour increased. In August 2011, DHCS implemented the SFY 2010-11 rebased rates. An EPC was implemented for LEA services with dates of service in SFY 2010-11, and a second EPC to reprocess claims with dates of service in SFY 2009-10. DHCS implemented the EPC in June 2013.

- **SB 231 Withhold**

As a requirement of SB 231, 2.5 percent is withheld from LEA claims to fund activities mandated in Welfare and Institutions Code, Section 14115.8. Between July 2012 and December 2012, DHCS did not collect the 2.5 percent on LEA paid claims, effectively increasing LEA reimbursement during this time frame. In January 2013, DHCS reinstated the 2.5 percent withhold on paid claims after the SFY 2012-13 reimbursement met the mandated baseline of \$60 million in total LEA Program reimbursement.

- **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. In addition, DHCS and the LEA Advisory Workgroup co-chairs have met in the intervening months between LEA Advisory Workgroup bi-monthly meetings to discuss LEA Program planning and 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 states (for example, targeted case management services). However, there are some services that are allowable in other states, which are not currently reimbursable in

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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;
- IEP review services;
- 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 requires submission of a new SPA to CMS. DHCS continues to evaluate the extent and timing of adding new services to the LEA Program.

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IV. OFFICIAL RECOMMENDATION MADE TO DHCS

Recommendations are made to DHCS 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	Action Taken/To Be Taken
<ul style="list-style-type: none"> Update the LEA Provider Manual to improve the organization and content of the policy information, as necessary. 	<ul style="list-style-type: none"> The LEA Provider Manual, containing information regarding LEA Program billing policies and procedures, is available on the LEA Program and Medi-Cal websites. DHCS continued to update the LEA Provider Manual throughout 2012 to ensure clarity on LEA policy. The 2012 LEA Provider Manual updates and revisions included updating LEA Program contact information, clarifying new transportation updates, and noting new maximum allowable rates. DHCS also created a searchable PDF document of all the LEA Provider Manual sections that is available on the LEA Program website. This is intended to assist LEAs and improve access to policy information in the LEA Provider Manual. DHCS will maintain a current PDF of the document and update as necessary. Upon implementation of SFY 2012-13 interim rates in the claims processing system, DHCS will update the LEA maximum allowable rates and LEA claim submission examples to reflect the new rates. DHCS continued revisions and policy clarification to the LEA Provider Manual and will also re-evaluate the content and organization of the LEA Provider Manual sections.
<ul style="list-style-type: none"> Monitor LEA claims processing system to ensure claims are reimbursed according to LEA Program policy. 	<ul style="list-style-type: none"> Continued collaboration with the DHCS fiscal intermediary was ongoing in 2013 to monitor the claims processing system to ensure that the LEA Program is continuing to process claims appropriately.

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Recommendation	Action Taken/To Be Taken
<ul style="list-style-type: none"> Develop and maintain an interactive LEA Program website. 	<ul style="list-style-type: none"> In 2012, DHCS continued to modify and organize the LEA Program content to ensure that LEA Program information is readily accessible and compliant with the Americans with Disabilities Act. 2012 LEA website maintenance activities included posting the following documents: LEA Advisory Workgroup meeting minutes; Provider Participation Agreement/Annual Report (PPA/AR) forms; LEA Frequently Asked Questions (FAQs); increased maximum allowable reimbursement rate charts reflecting inflation increases; May 2012 Annual Legislative Report; LEA Program training announcements and presentation materials; LEA paid claims data summaries, and other LEA policy clarification. In addition, DHCS posted the updates to the eligibility verification process and data match, Data Usage Agreement and relevant LEA EPC letters. CRCS-related information was also posted on the website and included the SFY 2009-10 CRCS resubmission forms, SFY 2010-11 CRCS forms, CRCS submission and deadline requirements, IRUS reports, CRCS audit process, and subsequent guidance and sample materials. DHCS continued to maintain an updated electronic mailing list that LEA personnel may subscribe to and automatically receive e-mail notifications when new or updated information has been posted on the LEA Program website. DHCS continues to update the website, reflecting changes recommended by the LEA Advisory Workgroup and increasing communication to the LEA provider community regarding LEA Program billing and policy information.

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Recommendation	Action Taken/To Be Taken
<ul style="list-style-type: none"> • Provide LEA Program trainings to the LEA provider community. 	<ul style="list-style-type: none"> • DHCS prepared and sent an LEA CRCS training survey to gauge interest in specific CRCS topics and issues for the September 2012 training. This helped DHCS incorporate high priority training topics, as determined by the responses from the training survey. Additionally, the survey helped to determine the level of experience of LEA personnel. • DHCS conducted an annual LEA Program policy training webinar in September 2012. This training provided new LEAs and new personnel with general information on the LEA Program, including resources; how to become an LEA provider; participation requirements; LEA reimbursable services and LEA provider billing requirements. In addition, the training emphasized updates to LEA policy or procedure; including eligibility and data tape match requirements; credentialed speech-language pathologists' qualifications; claims processing updates and CRCS updates, overview and process. The webinar was recorded and the training presentation is available on the LEA Program website. DHCS also responded to the FAQs that were generated from the training. • DHCS planned the feasibility and timing of conducting another LEA Program training webinar in Fall 2013 to update providers on any LEA Program policy changes. The annual training was conducted in September 2013.
<ul style="list-style-type: none"> • Provide LEA CRCS trainings to the LEA provider community. 	<ul style="list-style-type: none"> • In September 2012, DHCS dedicated a portion of the annual LEA Program training webinar to update LEA providers on the SFY 2010-11 CRCS submission requirements and SFY 2009-10 resubmission process. • In addition, DHCS prepared a SFY 2010-11 CRCS supplemental training presentation to assist LEA providers or staff that are new to the LEA Program on the completion of the CRCS. The training included detail on the CRCS form, flow of calculations between CRCS worksheets, and sample documentation. This is currently available on the LEA Program website as a resource to LEAs.

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Recommendation	Action Taken/To Be Taken
<ul style="list-style-type: none"> Improve communications regarding policy issues with LEA providers. 	<ul style="list-style-type: none"> 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. DHCS continues to disseminate information to LEA providers via the LEA Program website, including FAQs, information on the CRCS reporting requirement deadline and other policy information. DHCS continues to work with CDE to utilize CDE's e-mail distribution to school superintendents to increase dissemination of program information to LEA providers. DHCS continued to utilize this channel to further communicate with LEAs in 2013. DHCS continues to write Policy and Procedure Letters (PPLs) to participating LEA Providers. DHCS utilizes PPLs as a formal notification process to disseminate guidance, information and instruction to the LEAs participating in the LEA Program. These are sent out to LEA contacts and available on the LEA Program website.
<ul style="list-style-type: none"> Update the statewide LEA provider contact list. 	<ul style="list-style-type: none"> The statewide master LEA provider contact list was compiled and updated with e-mail addresses and contact names from the LEA Program webinar trainings, the LEA PPA/AR, and LEA Contact Information Form. This list will be continuously updated and maintained by DHCS with new LEA contact information.
<ul style="list-style-type: none"> Submit SPAs and subsequent updates to CMS. 	<ul style="list-style-type: none"> DHCS will continue to work towards submission of future SPAs, as appropriate, subject to CMS policy and timelines.

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Recommendation	Action Taken/To Be Taken
<ul style="list-style-type: none"> Conduct meetings with DHCS and LEA providers regarding audit procedures. 	<ul style="list-style-type: none"> In 2012, DHCS continued to work together to define the CRCS reconciliation process, identify reporting issues and implement the overpayment/underpayment process. DHCS continued to collaborate and had meetings in 2013 to discuss the CRCS reconciliation process, as necessary. Audits and Investigations (A&I) staff attend the LEA Advisory Workgroup meetings and provide status updates regarding the CRCS updates, audit procedures and review process. In March and May 2013, LEA Program personnel and A&I discussed the CRCS intake process and post-audit payment and reimbursement process. Additional meetings on this topic continued in 2013, as necessary. A&I personnel have been invited to attend the LEA Advisory Workgroup meetings. In 2013, DHCS supported and fostered communication between A&I and the LEA Advisory Workgroup through meetings. The goal was to improve understanding of differences between medical documentation and educational documentation in a school-based setting, and to develop adequate documentation guidance for LEAs that will support billing for LEA Medi-Cal services.

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Recommendation	Action Taken/To Be Taken
<ul style="list-style-type: none"> • Update interim reimbursement rates for LEA services per allowances in SPA 03-024. 	<ul style="list-style-type: none"> • In 2011, DHCS finalized rebasing the interim reimbursement rates pursuant to SPA 03-024. These interim rates were implemented August 2011. Rebased rates were implemented retroactively to SFY 2010-11 and the EPC was implemented August 2012 to reprocess claims with dates of service in SFY 2010-11. DHCS initiated a subsequent EPC to reprocess TCM claims that were erroneously denied due to another Medi-Cal program's Operating Instruction Letter (OIL) implementation. DHCS implemented the EPC in June 2013. • As part of the requirements specified in SPA 03-024, 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. In April 2012, DHCS applied an approved inflation adjustment to the SFY 2010-11 interim reimbursement rates for LEA services. The EPC to reprocess all claims with dates of service in SFY 2011-12 was implemented in June 2013. • DHCS also submitted a new rate table to apply the inflation adjustment to SFY 2011-12 interim reimbursement rates in May 2013. The new rate table was implemented in August 2013.

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Recommendation	Action Taken/To Be Taken
<ul style="list-style-type: none"> Review SB 231 2.5 percent withhold, one percent administrative withhold and A&I one percent withhold applied to all claims. 	<ul style="list-style-type: none"> A one percent administrative fee is levied against LEA claims for claims processing and related costs, as well as an additional 2.5 percent to fund activities mandated by SB 231. The annual amount of the 2.5 percent withhold is not to exceed \$1.5 million. The fees are subtracted from the total reimbursement amount on the Medi-Cal Remittance Advice Details (RAD) with RAD code 795 denoting the one percent withhold and RAD code 798 denoting the 2.5 percent withhold. LEAs also incur an additional one percent withhold to fund the auditor positions required to staff the workload on the CRCS reconciliation. The annual amount of the one percent withhold is not to exceed \$650,000. The one percent fee is subtracted from the total reimbursement amount on the Medi-Cal RAD. The SFY 2012-13 one percent withhold was initiated with the August 27, 2012 checkwrite. DHCS monitored and tracked the one percent funding and turned off the withhold in April 2013 because the \$650,000 cap was exceeded. DHCS tracked the LEA Program reimbursement until the total reimbursement exceeded the baseline amount of approximately \$60 million, and then initiated the 2.5 percent withhold as required in SB 231. LEAs were not charged the 2.5 percent SB 231 withhold for the first half of SFY 2012-13. Beginning January 2013, DHCS reinstated the 2.5 percent withhold on paid claims. DHCS will monitor and track the 2.5 percent funding and subsequently turn off the withhold when the total amount reaches \$1.5 million or at the end of the fiscal year, whichever comes first. 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. Effective SFY 2013-14, DHCS implemented a combined and simplified single withhold throughout the year.

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Recommendation	Action Taken/To Be Taken
<ul style="list-style-type: none"> Institute a fair share withhold methodology and provide an accounting of withholds collected from LEAs. 	<ul style="list-style-type: none"> 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 worked on developing the methodology to collect the fair share of withholds from each LEA, resulting in a proportionate collection of withholds across all participating LEA Providers. Additionally, DHCS worked with its fiscal intermediary to develop a report that identifies the amount of withholds collected by each LEA. In 2013, DHCS continued to work on implementing a fair share withhold methodology for LEAs to collect the appropriate amount of withholds that will cover the financial cost of administering the LEA Program.
<ul style="list-style-type: none"> Review SB 231 2.5 percent withhold, one percent administrative withhold and A&I one percent withhold applied to cost settlement and EPCs. 	<ul style="list-style-type: none"> The one percent administrative withhold is not exempt from the CRCS cost settlement and EPC process. However, the SB 231 2.5 percent withhold and the A&I one percent withhold should not be applied to the CRCS cost settlement and EPC process. DHCS is currently working with its fiscal intermediary to ensure that these withholds will not be applied to future cost settlements and EPCs.

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Recommendation	Action Taken/To Be Taken
<ul style="list-style-type: none"> Review of CRCS forms submitted by LEAs and final cost settlements. 	<ul style="list-style-type: none"> DHCS created a CRCS import application to process and review submitted CRCS reports. The import application reviews CRCS submissions and checks for accuracy, validation and completeness. In 2012, DHCS continued to review and update the import application and the CRCS reports generated for SFYs 2009-10 and 2010-11. These reports assist A&I in their audit and review. DHCS spent considerable time finalizing the import application, importing the CRCS files and preparing the application to transfer to A&I. In 2012 and 2013, A&I completed minimal audits on all SFY 2006-07 and 2007-08 CRCS submissions. A&I sent CRCS 15-day letters to LEAs and issued audit reports and the necessary action notices to implement the final reconciliation. In 2013, A&I continued to review CRCS submissions and finalize reconciliations for SFYs 2008-09 and 2009-10. DHCS created a flow chart to document the audit process for LEAs, including the process for issuing underpayments (amount due to LEAs from the State) and recouping overpayments (amount due to the State from LEAs). This is available on the LEA Program website.

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Recommendation	Action Taken/To Be Taken
<ul style="list-style-type: none"> Review the LEA Annual Report (AR) and provide assistance and guidance to LEA providers. 	<ul style="list-style-type: none"> LEAs are required to submit an Annual Report each year by October 10th. The Annual Report requires LEAs to list collaborative members, report expenditures and activities for the prior year and anticipate service priorities for the current fiscal year. Effective SFY 2010-11, DHCS combined the Annual Report document with the LEA Provider Participation Agreement (PPA). All LEAs will now be required to review the contract requirements to participate in the LEA Program and sign the participation agreement with the State every three years and complete the Annual Report every year. In 2012, DHCS and the LEA Advisory Workgroup reviewed the information requested in the Annual Report to determine if modifications could be made to remove duplicative information. DHCS has made revisions to simplify the reporting requirements by removing unnecessary attachments and clarified instructions for SFY 2012-13. DHCS also revised the electronic forms to accommodate pop-up boxes and links to relevant information/resources to assist LEAs to complete the PPA/AR. In addition, DHCS clarified the definition of consortium billing, authorized signers and collaborative members. DHCS also completed a sample PPA/AR as a reference on the LEA Program website. DHCS also reviewed the reinvestment of funds guidelines to determine if changes or updates are necessary. In 2013, DHCS updated the reinvestment of funds guidelines and developed language to specify and emphasize that LEA Program reimbursement may be reinvested in allowable LEA services.
<ul style="list-style-type: none"> Determine penalty process for LEAs that do not submit CRCS forms timely. 	<ul style="list-style-type: none"> A&I implemented penalty policies for LEAs that are non-compliant with CRCS submission requirements for SFY 2009-10 CRCS submissions. DHCS is implementing an initial 20 percent withhold penalty on claims payments, and ultimately LEA Program termination, if LEAs do not submit mandatory annual CRCS forms.

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Recommendation	Action Taken/To Be Taken
<ul style="list-style-type: none"> Identify non-compliant LEAs that have not submitted the annual PPA/AR. 	<ul style="list-style-type: none"> DHCS identified and reviewed all PPA/AR submissions and contacted LEAs if information was incomplete, missing and/or incorrect. In addition, DHCS created and maintains a tracking system of LEAs that did not submit a PPA/AR, as required, and has contacted these LEAs. DHCS is providing technical assistance to these LEAs to ensure they properly complete and submit their PPA/ARs as required. In 2013, DHCS implemented a penalty for LEAs that have not submitted their PPA/ARs timely.
<ul style="list-style-type: none"> Produce LEA reimbursement reports and post on the LEA website. 	<ul style="list-style-type: none"> In 2012, DHCS worked with its fiscal intermediary to determine the feasibility of providing quarterly reimbursement reports to assist LEAs to track reimbursement by procedure code/modifier combinations. The goal is to post the quarterly reports on the LEA website so that LEAs can access and download the information online. In February 2012, DHCS submitted a data request for its fiscal intermediary to produce a sample LEA reimbursement report for two quarters (dates of service 7/1/11 through 9/30/11 and 10/1/11 through 12/31/11). DHCS reviewed the report output to ensure the data specifications were accurate and the year-to-date information was calculating appropriately. After all of the SFY 2011-12 EPCs have been implemented, DHCS will submit a data request to produce reimbursement reports for SFY 2011-12.

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V. ONE-YEAR TIMETABLE FOR STATE PLAN AMENDMENTS

DHCS is continuing to work with CMS on potential new services to expand the LEA Program reimbursable services. Discussions will include the types of new services, qualified practitioners and how to develop interim reimbursement rates. Based on discussions with CMS, DHCS will prioritize the new services and determine the best approach for new SPA submissions.

Table 5: Timetable for Proposed State Plan Amendments

Service Description	Estimated Submission Date
<ul style="list-style-type: none">TCM services: DHCS submitted SPA 12-009 to CMS to remove the reference of Individualized Health and Support Plan (IHSP) in response to a companion letter requesting the State to confirm the rate methodology for IHSP and all TCM services. In addition, CMS requested DHCS submit a new template for TCM Services to Children with an IEP/IFSP related to the LEA Program. The SPA was submitted January 2015 to CMS.	<ul style="list-style-type: none">DHCS completed the CMS proposed template and the SPA was submitted 1/2015.

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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 in 2012, as well as the actions that have been and will be taken by DHCS to remove these barriers.

Table 6: Barriers to Reimbursement

Barriers	Actions Taken /To Be Taken
<ul style="list-style-type: none"> Certain health and mental health services and services provided by assistants are provided by LEAs but are not currently reimbursable in the LEA Program. 	<ul style="list-style-type: none"> DHCS maintains a list of potential LEA services to expand the LEA Program. The list was compiled in collaboration with the LEA Advisory Workgroup and is being considered and reviewed by DHCS. In addition, DHCS must determine the necessary means to implement specific new services, including new SPA requirements and how to develop interim reimbursement rates. DHCS is continuing to work with CMS on adding new services to the LEA Program. In 2012, 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. DHCS will continue to research services such as behavioral intervention services, personal care services and specialized assessments, as they consider expanding the scope of reimbursable services for LEAs in California.

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Barriers	Actions Taken /To Be Taken
<ul style="list-style-type: none"> Implement telehealth as a modality for the provision of existing LEA reimbursable services. 	<ul style="list-style-type: none"> In October 2011, Assembly Bill 415, Chapter 547, Statutes of 2011 (AB 415) 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. In 2012, DHCS researched school-based and general Medicaid telemedicine and telehealth standards and met with Benefits, Waiver Analysis, and Rates Division (BWARD) 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 November and December 2012, DHCS conducted a telehealth survey to identify LEA provider interest and feasibility of providing school-based services via telehealth. DHCS also researched other state's school-based provider manuals and conducted conference calls to identify states that allow school-based telehealth services. DHCS researched and summarized support information for conducting speech-language services via telehealth. In 2013, DHCS continued work on their implementation plan to allow for reimbursement for speech-language telehealth services. DHCS will work with the LEA Advisory Workgroup and other LEAs to define services, practitioners, supervision and documentation requirements.

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Barriers	Actions Taken /To Be Taken
<ul style="list-style-type: none"> Enrollment requirements may hinder new school districts and COEs from enrolling in the LEA Program. 	<ul style="list-style-type: none"> In 2012, DHCS continued analyzing LEA Program reimbursement to determine under-participating LEAs and trends throughout SFY 2008-09 through 2010-11. Outreach was conducted in 2013 for those LEAs enrolled in the LEA Program that receive limited reimbursement. As a result of this outreach, under-participating LEAs may consider expanding the scope of services provided to Medi-Cal eligible students. Additional analyses was conducted in 2013 to determine which LEAs to target and the most appropriate method to reach providers, such as site visits, webinars, regional meetings, or conference calls. NCI conducted conference calls to a small test group of providers with low participation rates in May and June 2013. As part of DHCS' analysis to determine California school districts that are currently not participating in the LEA Program, DHCS researched information regarding California charter schools and identified the charter school population. In October 2012, a representative from the California Charter Schools Association presented at the LEA Advisory Workgroup meeting and provided insight on charter school special education structure.
<ul style="list-style-type: none"> LEA Program billing policies and procedures have not always been consistently documented. 	<ul style="list-style-type: none"> FAQs are posted on the LEA Program website to assist providers with common questions regarding billing and program policies. FAQs are intended to clarify policy in the LEA Provider Manual. In 2012, DHCS evaluated the FAQs in order to eliminate redundant questions. DHCS is currently working on reorganizing the FAQs into separate documents by topic that will be posted on the corresponding LEA webpage. This will allow for LEAs to more efficiently access the relevant information regarding each specific topic. FAQs will continue to be periodically reviewed and updated to reflect current LEA Program policy. DHCS actively monitors and responds to LEA Program specific e-mail address where providers can e-mail specific questions regarding policy and billing requirements.

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Barriers	Actions Taken /To Be Taken
<ul style="list-style-type: none"> Claims processing issues have been identified and have resulted in LEA claims being incorrectly paid or denied. 	<ul style="list-style-type: none"> DHCS conducted meetings and worked closely with its fiscal intermediary to resolve outstanding claims processing issues. Throughout 2012, DHCS monitored and researched claims processing issues and clarified LEA Program billing policies and requirements for the fiscal intermediary to alter system design to ensure LEA claims were processing properly prior to implementation of system changes. As of July 2012, some LEA TCM claims may have been denying 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). An OIL amendment was implemented in October 2012 to exempt LEA providers from the original OIL. An EPC will be implemented to reprocess denied TCM claims.
<ul style="list-style-type: none"> IEP/IFSP assessment utilization controls are denying legitimate claims. 	<ul style="list-style-type: none"> LEAs received denials for IEP/IFSP assessment claims with RAD Codes 9921 and 9922. In September 2011, the former fiscal intermediary implemented the necessary changes to the claims processing system to ensure that claims were not erroneously denied. In July 2012, a "Phase One" EPC was implemented to retroactively pay claims with dates of service between July 1, 2010, through the system implementation date (September 26, 2011). The DHCS fiscal intermediary is in the process of implementing a subsequent "Phase Two" EPC to reprocess claims back to the policy effective date (July 1, 2009) and for claims with dates of service in SFY 2009-10. DHCS has submitted early claims placeholders with CMS to ensure that LEAs will be reimbursed for claims with dates of service beyond the two year claiming limit. In May 2013, DHCS reviewed the EPC criteria for the "Phase Two" EPC to ensure that RAD Codes 9921 and 9922 denials are reprocessed correctly to reimburse legitimate claims and deny improper claims and this EPC was implemented 2013.

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Barriers	Actions Taken /To Be Taken
<ul style="list-style-type: none"> Update the LEA transportation services section of the State regulations to be compliant with Assembly Bill (AB 2608). 	<ul style="list-style-type: none"> AB 2608, approved September 2012, allows 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. 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. In 2012, DHCS began the development of a proposed regulation package related to transportation updates mandated in AB 2608. DHCS will propose 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 proposed regulations package for Office of Regulations review and feedback on May 12, 2014.

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Barriers	Actions Taken /To Be Taken
<ul style="list-style-type: none"> Revise state regulations to be no more restrictive than federal requirements. 	<ul style="list-style-type: none"> DHCS intends to propose revisions to existing State regulations that are required to implement the LEA Rate Study. The regulations will be consistent with SPA 03-024 and SPA 05-010 requirements, existing federal law and regulations, and existing State law. DHCS will discuss a timeline and priorities with Office of Regulations to work on the proposed regulations package.
<ul style="list-style-type: none"> Review the LEA Program models of service delivery. 	<ul style="list-style-type: none"> In 2012, DHCS reviewed the models of services delivery for employed and contracted practitioners. LEAs may employ or contract with qualified medical practitioners to provide LEA services to Medi-Cal eligible students. DHCS reviewed the CMS Medicaid Technical Assistance Guide, which outlines four models of service delivery. 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. DHCS will move forward and implement the policy and publish a PPL and update the LEA Provider Manual accordingly. This expanded model of service delivery is expected to reduce a significant barrier to LEA reimbursement in both rural and urban settings.

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Barriers	Actions Taken /To Be Taken
<ul style="list-style-type: none"> Assembly Bill 114 (AB 114) eliminated funding for mental health services provided through county mental health agencies. 	<ul style="list-style-type: none"> In June 2011, AB 114 was signed into law, which ended the state mandate on county mental health agencies to provide mental health services to students with disabilities. As a result, school districts are now solely responsible for ensuring that students with disabilities receive special education and related mental health services in accordance with IDEA. CDE formed a transition workgroup to assist in transition of mental health services that were provided under AB 3632 to related services under IDEA, evaluate the mental health services and identify other potential funding sources available. DHCS joined the transition workgroup and assisted to prepare and present LEA Program information to the workgroup. CDE created LEA Program overview handouts and guidance that is posted on their website for potential providers. In 2012, DHCS and CDE continued to discuss and evaluate mental health services that were provided by county mental health agencies. The AB 114 workgroup provided a variety of guidance documents for schools that is available on their website. In addition, CDE is currently finalizing a series of five different PowerPoint trainings on IEP development, which will assist LEAs and stakeholders by outlining the process for developing and formulating student IEPs. In 2013, DHCS will continue to work with CDE and the LEA Advisory Workgroup to further define “mental health” services and determine what services may be reimbursable under the LEA Program.

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Barriers	Actions Taken /To Be Taken
<ul style="list-style-type: none"> LEA tape match and data release requirements must meet HIPAA requirements. 	<ul style="list-style-type: none"> Due to HIPAA restrictions, DHCS has been working to ensure that the LEA eligibility tape match system, which is provided by DHCS to LEAs to determine Medi-Cal eligibility for students who receive Medi-Cal covered services, effectively produces student eligibility for LEA providers and is HIPAA compliant. In 2012, DHCS finalized the necessary modifications to the LEA tape match fields. DHCS also made updates to the eligibility match program logic to ensure accurate Medi-Cal eligibility. LEA providers have two options to receive LEA eligibility information: 1) LEAs may utilize the Medi-Cal web portal and must submit a Medi-Cal Point of Service Network/Internet Agreement; or 2) LEAs may continue to order eligibility data tape match, however LEAs must submit a Data Usage Agreement (DUA) Package, which includes a data file attachment, security controls, notification of breach and a social security administration agreement. The DUA was due November 30, 2012, with a term of three years. DHCS prepared a detailed LEA DUA instructions document that identifies all of the requirements. In addition, DHCS prepared responses to questions submitted via email and identified the major updates to the LEA tape match file. This information is posted on the LEA Program website.
<ul style="list-style-type: none"> CMS Rule 6028 requires practitioners to obtain an NPI. 	<ul style="list-style-type: none"> Effective January 1, 2013, CMS Rule 6028 requires that all ordering and referring physicians and other professionals providing Medicaid services must enroll as a Medi-Cal provider and obtain an NPI. In 2012, DHCS participated in the stakeholder workgroup, and researched to determine the rule's impact on LEAs. DHCS developed waiver language to exempt LEAs from this requirement since the LEA is the provider and the rendering practitioners work under the LEA's NPI. In addition, LEAs do not refer or order services. After additional discussions, DHCS determined that CMS Rule 6028 does not apply to LEA providers billing in the LEA Medi-Cal Billing Option Program.

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Barriers	Actions Taken /To Be Taken
<ul style="list-style-type: none">• Transition to version 5010 electronic file format and impact on LEAs.	<ul style="list-style-type: none">• In January 2009, the Secretary of the federal Department of Health and Human Services published the final rule for ASC X12 version 5010. This is the HIPAA standard to regulate electronic transmissions of health care transactions and improve standards. This was supposed to be implemented January 1, 2012, but there have been subsequent delays to implementation and LEAs were still allowed to bill on the ASC X12N 4010A1 forms throughout 2012. As of January 1, 2013, all LEAs must be compliant with version 5010 and 4010 claims will no longer be accepted.• DHCS is aware that the line item control number is not being returned on the LEA claim lines, which makes it difficult for LEAs to reconcile processed claims information. The Office of HIPAA Compliance is coordinating with the DHCS fiscal intermediary to implement a fix for this issue.

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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) 2010-2011**

SFY 2010 - 2011							
State	FMAP ⁽¹⁾	Federal Reimbursement (Federal Share)			Calculated Claim Dollars		
		Health (000's)	Administrative (000's)	Total (000's)	Health (000's) ⁽²⁾	Administrative (000's) ⁽³⁾	Total (000's)
WASHINGTON	60.11%	\$ 540,000	-	\$ 540,000	\$ 898,353	\$ -	\$ 898,353
VERMONT	67.13%	24,372	-	24,372	36,305	-	36,305
RHODE ISLAND	61.39%	20,945	6,453	27,398	34,118	12,907	47,024
WEST VIRGINIA	80.23%	50,540	-	50,540	62,994	-	62,994
IDAHO	76.35%	29,779	-	29,779	39,003	-	39,003
PENNSYLVANIA	63.76%	134,865	31,110	165,975	211,519	62,220	273,740
IOWA	69.68%	41,664	-	41,664	59,793	-	59,793
DELAWARE	61.55%	12,060	-	12,060	19,594	-	19,594
NEBRASKA	65.84%	3,073	13,688	16,762	4,668	27,377	32,044
MASSACHUSETTS	58.77%	42,100	24,700	66,800	71,635	49,400	121,035
MAINE	⁴ 72.03%	20,083	-	20,083	27,882	-	27,882
ILLINOIS	59.05%	103,581	62,566	166,147	175,413	125,132	300,545
NEW JERSEY	58.77%	62,000	2,500	64,500	105,496	5,000	110,496
MICHIGAN	72.74%	115,565	6,698	122,264	158,875	13,397	172,271
UTAH	77.95%	16,700	3,282	19,982	21,424	6,564	27,988
MINNESOTA	58.77%	32,209	-	32,209	54,805	-	54,805
ALABAMA	75.17%	454	28,446	28,900	604	56,891	57,496
CALIFORNIA	58.77%	147,822	129,248	277,070	251,527	258,496	510,023
MISSOURI	71.61%	2,652	26,658	29,310	3,703	53,316	57,019
MONTANA	75.17%	2,908	1,927	4,835	3,868	3,854	7,722
WISCONSIN	67.80%	32,569	1,212	33,782	48,037	2,424	50,462
OREGON	70.14%	6,821	10,180	17,001	9,725	20,361	30,086
MISSISSIPPI	82.03%	-	14,837	14,837	-	29,674	29,674
COLORADO	⁴ 58.77%	15,295	1,488	16,783	26,025	2,977	29,002
ARIZONA	73.10%	28,866	2,687	31,553	39,488	5,374	44,863
NEW MEXICO	77.66%	8,864	4,027	12,891	11,414	8,054	19,467
VIRGINIA	58.77%	8,645	9,955	18,600	14,709	19,910	34,619
CONNECTICUT	58.77%	9,375	-	9,375	15,952	-	15,952
LOUISIANA	78.65%	29,997	469	30,466	38,140	937	39,077
MARYLAND	58.77%	15,575	-	15,575	26,502	-	26,502
NORTH CAROLINA	72.16%	11,499	18,804	30,303	15,936	37,608	53,544
DISTRICT OF COLUMBIA	68.95%	2,031	-	2,031	2,945	-	2,945
KENTUCKY	77.78%	4,414	5,102	9,516	5,675	10,203	15,878
OHIO	70.88%	25,600	-	25,600	36,117	-	36,117
ALASKA	59.58%	1,325	-	1,325	2,224	-	2,224
FLORIDA	⁵ 64.81%	18,245	-	18,245	28,152	-	28,152
OKLAHOMA	73.90%	4,485	-	4,485	6,068	-	6,068
HAWAII	64.52%	833	-	833	1,291	-	1,291
INDIANA	73.39%	4,469	-	4,469	6,089	-	6,089
NEVADA	61.10%	402	-	402	658	-	658
TENNESSEE	⁶ 72.79%	-	-	-	-	-	-
WYOMING	⁶ 58.77%	-	-	-	-	-	-

- (1) The Federal Medical Assistance Percentage (FMAP) adjusted for the American Recovery and Reinvestment Act (ARRA) for each state was obtained from the Federal Register, published on June 3, 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) State reimbursement amounts were reported by Federal Fiscal Year (October 1 - September 30) instead of by State Fiscal Year (July 1 - June 30).
- (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>)
- (6) This state did not have a school-based Medicaid health services program or administrative claiming program in effect during SFY 2010-11 and/or SFY 2011-12.

**Appendix 1(b): Medicaid Reimbursement And Claims By State
Ranked By Average Claim Per Medicaid-Eligible Child, State Fiscal Year (SFY) 2010- 2011**

SFY 2011- 2012							
State	FMAP ⁽¹⁾	Federal Reimbursement (Federal Share)			Calculated Claim Dollars		
		Health (000's)	Administrative (000's)	Total (000's)	Health (000's) ⁽²⁾	Administrative (000's) ⁽³⁾	Total (000's)
WASHINGTON	50.00%	\$ 700,000	-	\$ 700,000	\$ 1,400,000	\$ -	\$ 1,400,000
VERMONT	57.58%	24,248	-	24,248	42,112	-	42,112
RHODE ISLAND	52.12%	19,616	6,890	26,506	37,637	13,780	51,417
WEST VIRGINIA	72.62%	41,487	-	41,487	57,129	-	57,129
IDAHO	70.23%	26,431	-	26,431	37,635	-	37,635
PENNSYLVANIA	⁴ 55.07%	-	-	-	-	-	-
IOWA	60.71%	43,945	-	43,945	72,386	-	72,386
DELAWARE	⁴ 54.17%	-	-	-	-	-	-
NEBRASKA	56.64%	2,922	16,277	19,199	5,158	32,555	37,713
MASSACHUSETTS	50.00%	47,800	26,200	74,000	95,600	52,400	148,000
MAINE	⁵ 63.27%	45,853	-	45,853	72,472	-	72,472
ILLINOIS	50.00%	167,546	56,301	223,847	335,092	112,601	447,694
NEW JERSEY	⁴ 50.00%	-	-	-	-	-	-
MICHIGAN	66.14%	104,976	8,415	113,391	158,717	16,831	175,548
UTAH	70.99%	20,300	3,157	23,457	28,596	6,313	34,909
MINNESOTA	50.00%	31,683	-	31,683	63,366	-	63,366
ALABAMA	68.62%	6	23,555	23,561	9	47,110	47,119
CALIFORNIA	50.00%	134,604	5,332	139,937	269,209	10,665	279,873
MISSOURI	63.45%	3,967	26,157	30,123	6,252	52,313	58,565
MONTANA	66.11%	3,435	1,382	4,817	5,197	2,764	7,961
WISCONSIN	60.53%	33,156	35,242	68,397	54,775	70,483	125,258
OREGON	62.91%	4,949	10,587	15,535	7,866	21,174	29,040
MISSISSIPPI	74.18%	-	7,274	7,274	-	14,548	14,548
COLORADO	⁵ 50.00%	8,106	1,388	9,494	16,211	2,776	18,988
ARIZONA	67.30%	-	5,519	5,519	-	11,038	11,038
NEW MEXICO	69.36%	9,097	6,209	15,306	13,116	12,417	25,534
VIRGINIA	50.00%	9,905	7,968	17,873	19,810	15,936	35,746
CONNECTICUT	50.00%	8,209	-	8,209	16,418	-	16,418
LOUISIANA	61.09%	30,324	-	30,324	49,639	-	49,639
MARYLAND	50.00%	14,898	-	14,898	29,795	-	29,795
NORTH CAROLINA	⁴ 65.28%	-	-	-	-	-	-
DISTRICT OF COLUMBIA	70.00%	4,819	-	4,819	6,884	-	6,884
KENTUCKY	71.18%	4,783	2,018	6,801	6,720	4,037	10,756
OHIO	⁴ 64.15%	-	-	-	-	-	-
ALASKA	50.00%	2,196	-	2,196	4,392	-	4,392
FLORIDA	⁶ 56.04%	14,105	-	14,105	25,169	-	25,169
OKLAHOMA	63.88%	4,484	-	4,484	7,020	-	7,020
HAWAII	50.48%	619	-	619	1,226	-	1,226
INDIANA	66.96%	3,891	2,556	6,448	5,812	5,112	10,924
NEVADA	⁴ 56.20%	-	-	-	-	-	-
TENNESSEE	⁷ 66.36%	-	-	-	-	-	-
WYOMING	⁷ 50.00%	-	-	-	-	-	-

(1) The Federal Medical Assistance Percentage (FMAP) adjusted for the American Recovery and Reinvestment Act (ARRA) for each state was obtained from the Federal Register, published on November 10, 2010.

(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 available for SFY 2011-12.

(5) State reimbursement amounts were reported by Federal Fiscal Year (October 1 - September 30) instead of by State Fiscal Year (July 1- June 30).

(6) 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>)

(7) This state did not have a school-based Medicaid health services program or administrative claiming program in effect during SFY 2010-11 and/or SFY 2011-12.

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

Service	Potential Qualified Practitioner(s)	Example Rates
<p>Behavioral services provided by a behavioral aide</p> <p>Behavioral aide services prevent or correct maladaptive behavior on the part of the child. The interventions are used to change specific behaviors. A behavioral plan is designed by a mental health professional and carried out by behavioral aides. The plan provides a description of the behavior to be addressed and positive or negative incentives to encourage appropriate behavior.</p>	<p>Mental health behavioral aide</p> <p>A paraprofessional working under the direction of a mental health professional.</p>	<p>Iowa: Based on each school district's cost of providing service.</p> <p>Health and behavior intervention, per 15-minute increment: \$3.57-11.64</p> <p>Health and behavior intervention by contracted staff, per 15-minute increment: \$2.32-7.56</p> <p>Health and behavior intervention, group (2 or more) per 15-minute increment: \$2.29-7.45</p> <p>Minnesota: Based on school district's cost of providing service.</p>
<p>Behavioral services provided by a certified behavioral analyst or certified associate behavioral analyst</p> <p>Behavioral services include behavioral evaluations and functional assessments, analytic interpretation of assessment results, and design and delivery of treatments and intervention methods.</p>	<p>Certified behavior analyst</p> <p>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.</p> <p>Certified associate behavioral analyst</p> <p>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.</p>	<p>Florida: Certified behavior analyst, Individual: \$8.00 per 15-minute increment Group: \$4.00 per 15-minute increment</p> <p>Certified behavior analyst (bachelor's level), Individual: \$6.70 per 15-minute increment Group: \$3.35 per 15-minute increment</p> <p>Certified associate behavior analyst, Individual: \$6.40 per 15-minute increment Group: \$3.20 per 15-minute increment</p>
<p>Behavioral services provided by an intern</p> <p>Behavioral services include testing, assessment and evaluation that appraise cognitive, developmental, emotional, and social functioning; therapy and counseling, and crises assistance.</p>	<p>Psychologist intern, Social worker intern</p> <p>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.</p>	<p>Florida: Psychologist, Individual: \$9.66 per 15-minute increment Group: \$4.95 per 15-minute increment</p> <p>Social worker, Individual: \$8.97 per 15-minute increment Group: \$4.25 per 15-minute increment</p> <p>Illinois: Based on each school district's cost of providing service.</p>

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

Service	Potential Qualified Practitioner(s)	Example Rates
<p>Dental assessment and health education provided under Early and Periodic Screening, Diagnostic and Treatment services</p> <p>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.</p>	<p>Licensed dentist A person who is a licensed dentist.</p> <p>Dental hygienist A person who is a licensed dental hygienist.</p>	<p>Oklahoma: Dentist: \$22.06</p> <p>Delaware: Dental hygienist: 0-29 minutes: \$13.50 30-44 minutes: \$27.00 45-59 minutes: \$40.50 60 minutes and over: \$54.00</p>
<p>Durable medical equipment and assistive technology devices</p> <p>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.</p>	<p>Not applicable</p>	<p>Illinois: Medically necessary equipment may be claimed up to a total of \$1,000 per day based on the cost of the equipment.</p> <p>Minnesota: Based on purchase price, rental costs or costs of repairs.</p>
<p>IEP review services</p> <p>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.</p>	<p>Case manager</p> <p>A person who has a bachelor's degree with a major in special education, social services, psychology, or related field; or a registered nurse.</p>	<p>West Virginia: Initial or Triennial: \$703.66 Annual: \$171.97</p>

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

Service	Potential Qualified Practitioner(s)	Example Rates
<p>Interpreter services</p> <p>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.</p>	<p>Interpreter</p> <p>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.</p> <p>Sign language: A person with a bachelor's degree or higher who has graduated with a valid certification from a recognized interpreters' evaluation program.</p>	<p>Minnesota: Based on each school district's cost of providing service.</p>
<p>Occupational therapy services provided by an occupational therapy assistant</p> <p>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.</p>	<p>Occupational therapy assistant</p> <p>A person who meets state requirements as an occupational therapy assistant and works under the direction of a qualified occupational therapist.</p>	<p>Most states do not have separate rates for occupational therapy services provided by occupational therapists and occupational therapy assistants. The rate listed below applies to occupational therapy assistants only.</p> <p>Florida: Individual: \$13.58 per 15-minute increment Group: \$2.60 per 15-minute increment</p>
<p>Orientation and mobility services</p> <p>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.</p>	<p>Orientation and mobility provider</p> <ul style="list-style-type: none"> - 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 - Teacher of special education with approval as teacher of the visually impaired; or - Assistive technology consultant with a master's degree in special education or speech pathology. 	<p>Michigan: Based on each school district's cost of providing service from prior year.</p> <p>Pennsylvania: Based on each school district's cost of providing service from prior years.</p> <p>Rate Ceiling: \$31.25 per 15-minute increment</p>

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

Service	Potential Qualified Practitioner(s)	Example Rates
<p>Personal care services</p> <p>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.</p>	<p>Health aide, Personal care assistant</p> <p>A paraprofessional supervised by a qualified health care professional.</p>	<p>Arizona: \$3.88 per 15-minute increment. Based on each school district's cost of providing service from prior year.</p> <p>Michigan: Based on each school district's cost of providing service from prior year.</p> <p>Virginia: Based on estimated costs for services furnished in 15-minute increments.</p> <p>West Virginia: Full-day students: \$192.68 Partial-day students: \$96.34</p>
<p>Physical therapy services provided by a physical therapy assistant</p> <p>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.</p>	<p>Physical therapy assistant</p> <p>A person who meets state requirements for a physical therapy assistant and works under the direction of a qualified physical therapist.</p> <p>One state allows a physical education teacher or an adaptive physical education teacher to bill for services as a paraprofessional if the services are prescribed and supervised by a licensed physical therapist.</p>	<p>Most states do not have separate rates for physical therapy services provided by physical therapists and physical therapy assistants. The rate listed below applies to physical therapy assistants only.</p> <p>Florida: Individual: \$13.58 per 15-minute increment Group: \$2.60 per 15-minute increment</p>
<p>Respiratory therapy services</p> <p>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.</p>	<p>Licensed respiratory therapist</p> <p>A person who meets state requirements as a licensed respiratory therapist.</p>	<p>Kentucky: \$3.50 per 15-minute increment</p>

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

Service	Potential Qualified Practitioner(s)	Example Rates
<p>Services for children with speech and language disorders provided by a speech-language pathology assistant</p> <p>Services rendered to a child to treat speech and language disorders of verbal and written language, articulation, voice, fluency, phonology, and mastication.</p>	<p>Speech-language pathology assistant</p> <p>A person who meets state requirements for a speech-language pathology assistant and works under the direction of a qualified speech pathologist.</p>	<p>Most states do not have separate rates for speech therapy services provided by speech pathologists and speech-language pathology assistants. The rate listed below applies to speech-language pathology assistants only.</p> <p>Florida: Individual: \$13.58 per 15-minute increment Group: \$2.60 per 15-minute increment</p>
<p>Specialized transportation</p> <p>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.)</p>	<p>Not Applicable</p>	<p>Michigan: Based on each school district's cost of providing service from prior year.</p> <p>New York: School rate: \$7.92 – \$21.69 per day based on county Pre-school rate: \$14.21 – \$36.50 per day based on county</p> <p>In Michigan and New York, providers may not bill separately for an attendant.</p>