Local Educational Agency
Medi-Cal Billing Option Program

Report to the Legislature

Report Period Fiscal Year 2015-16
(July 2015 through June 2016)

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EXECUTIVE SUMMARY

Schools nationwide play a critical role in providing health services to students, particularly those requiring special education services. For many schools, federal Medicaid reimbursements are an important source of revenue for providing necessary health services to students. Under the Local Educational Agency (LEA) Medi-Cal Billing Option Program (LEA Program), California's participating school districts and County Offices of Education (COEs) are partially reimbursed by the federal government for health services provided to Medi-Cal eligible students. A report published by the United States General Accounting Office (GAO)[1] in April 2000 estimated that California ranked in the bottom quartile with respect to the average claim per Medicaid-eligible child of states with school-based Medicaid programs. Senate Bill (SB) 231 (Ortiz, Chapter 655, Statutes of 2001) was signed into law in October 2001 to reduce the gap in per child recovery for Medicaid school-based reimbursement among California and the three states receiving the most per child from the federal government. SB 231 which added Welfare & Institutions Code Section 14115.8 was amended by Assembly Bill (AB) 1540 (Committee on Health, Chapter 298, Statutes of 2009) and in AB 2608 (Bonilla, Chapter 755, Statutes of 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. This report covers the timeframe from fiscal year (FY) 2015-16.

Since SB 231 was originally chaptered into law, federal oversight of school-based programs by the Centers for Medicare and Medicaid Services (CMS) and its audit agency, the Office of the Inspector General (OIG), has increased. OIG audits of Medicaid school-based programs in twenty-seven states have identified millions of dollars in federal disallowances for services provided in schools. Between July 2015 and June 2016, the OIG issued one school-based audit. However, school-based programs continue to be an area of focus for the OIG. The OIG work plans for federal fiscal years (FFY) 2016 and 2017 both indicate that the OIG will review states' cost allocation plans to determine whether claimed school-based Medicaid costs were supported and allocated using acceptable statistical sampling practices under random moment sampling systems. Since July 2016, OIG found significant unallowable payments based on random moment sampling systems that deviated from acceptable standards in other states. OIG will most likely continue to review Medicaid payments for school-based services in selected states to determine whether the costs claimed are reasonable.

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

The table below identifies LEA Medi-Cal fee-for-service (FFS) interim reimbursement trends by FY. The LEA Program reimbursement has grown by approximately 150 percent since its authorization under SB 231, due to LEA Program expansion and increased participation and claiming of covered Medi-Cal services by qualified practitioners.

LEA Program Trends FY 2000-01 to FY 2014-15

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

Notes:

(1) Total Medi-Cal reimbursement was significantly impacted by the Free Care policy implemented by CMS that stated Medicaid payment was not allowed for services that were available without charge to the beneficiary or community at large.
(2) Total Medi-Cal reimbursement is based on date of service and updated to reflect paid claims after implementation of Erroneous Payment Corrections (EPCs) for LEA services, correcting previous claims processing errors that were incorrectly paid and denied.
(3) Total Medi-Cal reimbursement also reflects increased Federal Medical Assistance Percentage (FMAP) through the American Recovery and Reinvestment Act of 2009. The increased FMAP was effective October 2008 through June 2011.

After a lengthy review process by CMS, the first State Plan Amendment (SPA) prepared as a result of SB 231 was approved in March 2005, and systematically implemented on July 1, 2006. SPA 03-024 increased both treatment and assessment reimbursement rates for a majority of LEA services provided to California's Medi-Cal eligible children in a school-based setting. Since this SPA's implementation in FY 2006-07, LEA interim reimbursement has increased 115 percent.

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

DHCS considers collaboration with its LEA stakeholders an important aspect of the LEA Program's success. DHCS routinely works with LEA stakeholders to address concerns and improve the LEA Program. The LEA Advisory Workgroup is comprised of a large group of LEA stakeholders that meets every other month to discuss program issues and concerns. This group assists DHCS in identifying barriers to reimbursement for LEAs, provides LEA perspective and feedback on important issues, and recommends new services and improvements to the LEA Program. In addition, the LEA Advisory Workgroup suggests and recommends enhancements to the LEA Program website and other communication venues, to improve LEA provider communication and address relevant provider issues. As part of the bi-monthly meetings, the group conducts breakout sessions to brainstorm challenges and barriers, utilizing the expertise of members to provide guidance to DHCS and suggesting potential solutions and recommendations. Approximately 50 to 60 LEA Program stakeholders are present at these meetings, in addition to representatives from DHCS, the California Department of Education (CDE), and Navigant Consulting.

In addition to collaboration with the LEA Advisory Workgroup, DHCS works closely with a limited group of technically qualified stakeholders, known as the Implementation Advisory Group (IAG), regarding the upcoming implementation of a RMTS for LEA providers. The IAG is comprised of several representatives from small, medium and large school districts; Local Education Consortium (LEC) and Local Governmental Agency representatives; a representative from the California School Nurses Organization; CDE; and DHCS. DHCS'

operational consultant, Navigant Consulting, facilitates these meetings. In FY 2015-16, the IAG met monthly and provided feedback to DHCS on many subjects surrounding the incorporation of RMTS in the LEA Program. These meetings included topics such as RMTS training, communication to LEAs, cost reporting, roles and responsibilities of all parties involved in RMTS, and technical RMTS implementation concerns. The IAG continues to meet on a bi-monthly basis to address the upcoming implementation of RMTS.

During this reporting period, DHCS has continued its work to identify and resolve LEA Program barriers, expand the services provided to Medi-Cal students and enhance communication to LEA stakeholders. DHCS accomplished many goals in FY 2015-16, including work surrounding the submission of SPA 15-021 to CMS. In addition to the significant effort required to prepare and submit SPA 15-021, DHCS staff continued to support LEA Program growth in many ways, including:

- Identifying and resolving technical claims processing issues and system changes;
- Revising the LEA portion of the Medi-Cal Provider Manual (LEA Program Provider Manual);
- Conducting a September 2015 annual LEA Program training session;
- Providing technical assistance to LEAs during LEA site visits;
- Implementing the annual rate inflation adjustment for FY 2014-15;
- Issuing the Annual Accounting of Funds Report for FY 2014-15, providing transparency to LEAs on administrative, auditing, and contractor costs;
- Working with the Fiscal Intermediary (FI) to implement a System Development Notice (SDN) that exempted cost settlement payments over collected withhold reimbursements and electronic health record provider incentive payments from LEA provider withholds;
- Developing policy and preparing to implement the telehealth modality for speech-language services in FY 2016-17;
- Assisting LEAs with International Classification of Diseases-10 implementation, effective October 1, 2015;
- Developing a compliance process for LEAs that fail to submit required reports in a timely manner;
- Gaining approval and implementing a transportation regulations package that aligns State regulations pertaining to school-based medical transportation services with federal law;

- Providing additional resources and guidance to LEA providers, including Frequently Asked Questions (FAQs), and Policy and Procedure Letters (PPLs); and
- Working on Cost and Reimbursement Comparison Schedule (CRCS) form submissions, auditing issues, and policies and procedures for delinquent CRCS submissions.

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

I. INTRODUCTION

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

- Ensure that schools shall be reimbursed for all eligible school-based services that they provide that are not excluded by federal law;
- Examine methodologies for increasing school participation in the LEA Program;
- Simplify, to the extent possible, claiming processes for LEA Program billing;
- Eliminate and modify State Plan and regulatory requirements that exceed federal requirements when they are unnecessary;
- Implement recommendations from the LEA Program rate study (LEA Rate Study) to the extent feasible and appropriate[2];
- Consult regularly with CDE, representatives of urban, rural, large and small school districts and COEs, LECs and LEAs;
- Consult with staff from Region IX of CMS, experts from the fields of both health and education, and state legislative staff;
- Undertake necessary activities to ensure that an LEA shall be reimbursed retroactively for the maximum period allowed by the federal government for any change that results in an increase in reimbursement to LEAs;
- Encourage improved communications with the federal government, CDE, and LEAs;
- Develop and update written guidelines to LEAs regarding best practices to avoid audit exceptions, as appropriate;
- Establish and maintain a user-friendly, interactive LEA Program website; and
- File an annual report with the Legislature. Table 1 on the following page includes the annual legislative report requirements.

[2] AB 430 (Chapter 171, Statutes of 2001) authorized LEAs to contribute to a rate study to evaluate existing rates and develop rates for new services in the LEA Program. DHCS completed the rate study in 2003.

Table 1: Annual Legislative Report Requirements

Report Section	Report Requirements
III	• An annual comparison of other states' school-based Medicaid programs in comparable states. • A state-by-state comparison of school-based Medicaid total and per eligible child claims and federal revenues. The comparison shall include a review of the most recent two years for which completed data is available. • A summary of DHCS activities and an explanation of how each activity contributed toward narrowing the gap between California's per eligible student federal fund recovery and the per student recovery of the top three states. • A listing of all school-based services, activities, and providers[3] approved for reimbursement by CMS in other state plans that are not yet approved for reimbursement in California's State Plan and the service unit rates approved for reimbursement.
IV	• The official recommendations made to DHCS by the entities named in the legislation and the action taken by DHCS regarding each recommendation. The entities are CDE, representatives of urban, rural, large and small school districts and COEs, the LEC, LEAs, staff from Region IX of CMS, experts from the fields of both health and education, and state legislative staff.
V	• A one-year timetable for SPAs and other actions necessary to obtain reimbursement for the school-based services, activities, and providers approved for reimbursement by CMS in other state plans that are not yet approved for reimbursement in California's State Plan.
VI	• Identify any barriers to LEA reimbursement, including those specified by the entities named in the legislation (listed in Section IV of this table) that are not imposed by federal requirements, and describe the actions that have been and will be taken to eliminate them.

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

II. BACKGROUND

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

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

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

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

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

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

Since the passage of SB 231, federal oversight by CMS and the OIG has increased at the national level. Between October 2001 and June 2015, the OIG has published over sixty audits on school-based services, representing work in twenty-six states. These reports were part of a series in a multi-state initiative to review costs claimed for Medicaid school-based services. However, since July 2015, these audit reports have significantly declined in number. In FY 2015-16, the OIG only released one additional audit report related to school-based health services: a September 2015 report related to Massachusetts's on-site review of its school-based services for FY 2011-12. The OIG's objective in Massachusetts was to determine whether the agency complied with federal and state requirements when using an RMTS to claim direct medical service costs. Although the OIG noted some minor findings, they indicated that Massachusetts generally complied with federal and state requirements when using an RMTS to claim direct medical service costs related to Medicaid school-based health services. Over the past fifteen years, reported school-based health service OIG findings have resulted in millions of dollars in alleged overpayments to schools, largely due to the following:

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

Regardless of the OIG's decreased school-based audits in recent years, the OIG continues to focus on compliance issues surrounding school-based services, especially concerning the statistical validity of the random moment sampling methodology used to calculate health service costs. The recent OIG findings surrounding statistical sampling issues provide timely guidance for California as RMTS will be rolled out in the LEA Program.

III. OTHER STATES' SCHOOL-BASED MEDICAID PROGRAMS

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

School-Based Medicaid Systems in Comparable States

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

Table 2: Factors Considered in Selecting Comparable States

Factor	Source of Information
Number of Medicaid-eligible children aged 6 to 20.	Medicaid Program Statistics, FFY 2014-15, CMS.
Number of IDEA eligible children aged 3 to 21.	U.S. Department of Education, Office of Special Education Programs, Data Collections, Part B: Child Count and Educational Environments dataset, 2014.
Average salaries of instructional staff (classroom teachers, principals, supervisors, librarians, guidance and psychological personnel, and related instructional staff).	Rankings of the States 2015 and Estimates of School Statistics 2016, National Education Association (NEA), May 2016.
Per capita personal income.	Rankings of the States 2015 and Estimates of School Statistics 2016, NEA, May 2016.

The number of Medicaid-eligible and IDEA-eligible children provides a measure of the number of students that qualify for Medicaid school-based services. The average salaries of instructional staff and per-capita personal income provide a comparison of the cost of living among states. The ten states with the greatest number of Medicaid-eligible children aged 6 through 20 were identified. Each of these states was ranked from highest to lowest based on each of the four factors. From this analysis, four states were identified as comparable to California: Illinois, New York, Ohio, and Pennsylvania. Although two states (Texas and Florida) 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 utilizing CPEs, 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 LEAs annually submit the standardized CRCS report, used to compare the interim Medi-Cal reimbursement received throughout the fiscal year to the estimated Medi-Cal costs to provide the health services. LEAs report the actual costs and annual hours worked for all qualified practitioners who provide and bill for LEA services, and the units of service, encounters and related Medi-Cal reimbursement for the appropriate fiscal year on the CRCS forms. The CRCS compares estimated costs to Medi-Cal interim reimbursement to ensure that each LEA provider is not reimbursed more than the costs of providing these services, which is a requirement when utilizing CPEs. This reconciliation results in an amount owed to or from the LEA; underpayments are paid to LEAs in a lump sum, while overpayments are withheld from future LEA claims reimbursement.

As part of the cost reconciliation process, the LEA providers certify that the public funds expended for the provision of LEA services are eligible for FFP. As of this reporting period, the LEA Program is in its ninth cost certification year. DHCS worked with its FI to create a downloadable Annual Reimbursement Report for each LEA that received Medi-Cal reimbursement for services rendered during FY 2013-14, to assist LEAs in completing the CRCS. This report summarized total units and reimbursement information for each LEA service and practitioner type. LEA providers could access the report on the LEA Program website to assist them in completing the FY 2013-14 CRCS.

DHCS is responsible for auditing the CRCS reports and calculating the final cost settlement. The Financial Audits Branch (FAB) of DHCS has completed all audits for FYs 2006-07 through 2010-11 CRCS reports, resulting in LEAs receiving their final reconciled overpayment/underpayment amounts for the first five CRCS reporting periods. In addition, DHCS has completed over 99 percent of FY 2011-12 CRCS report audits, and expects the final settlement for these reports to be complete in 2017. DHCS is currently auditing

FYs 2012-13, 2013-14 and 2014-15 CRCS reports, submitted in November 2014, 2015 and 2016, respectively.

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

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

In December 2014, CMS approved New York's SPA, requiring New York schools (outside of New York City) that receive Medicaid payments for health services provided on or after October 1, 2011, to operate under the CPE methodology. This SPA is effective only for schools outside the New York City school district; New York City schools will be addressed in a separate SPA. Schools outside of New York City will continue FFS Medicaid claiming and will receive interim payments that are subject to cost settlement. However, New York now initiates a cost settlement process after each school district, county, and qualifying school entity has participated in a quarterly RMTS and completed an annual cost report. The first cost-reporting period was for the October 1, 2011–June 30, 2012 period. Future cost reporting periods will be on a July through June fiscal year basis, with a cost report due no later than December 31 of each year. LEAs submitted the first cost reports under the CPE methodology for FYs 2011-12 and 2012-13 in late 2014, and resubmitted the cost reports again in January 2016 to reflect new state and federal directives regarding the calculations

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

of the IEP and the Health Related Tuition Percentages ratios for these school years. New York does not currently operate a Medicaid school-based administrative claiming program. In December 2016, New York submitted a SPA to CMS that proposes to expand behavioral health services to Medicaid-eligible children through the Early and Periodic Screening Diagnostic and Treatment benefit. The SPA, which was a collaborative effort between New York's Office of Mental Health, Office of Alcoholism and Substance Abuse Services, Office of Children and Family Services and the Department of Health, covers five services that will be available to any Medicaid-eligible child. Services include crisis intervention, community psychiatric supports and treatment, psychosocial rehabilitation, family peer support services, and youth peer advocacy and training. New York also submitted a SPA to allow for delivery of services in the community by a non-physician licensed behavioral health practitioner. These SPAs stemmed from a multi-year initiative to redesign the children's Medicaid service system in New York with services provided across a broad range of community-based settings (newly added services are not reimbursable in an institutional setting).

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

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

DHCS administered its twelfth state survey in November 2016. DHCS contacted states to obtain claims and revenue information for FYs 2014-15 and 2015-16. Multiple follow-up contacts via phone calls and e-mail were made between December 2016 through February 2017 to states that did not respond to the survey. Some states indicated that they were unable to complete the survey on a timely basis due to a variety of reasons, such as unconfirmed reimbursement totals, internal data request issues, and timing problems. several states did not respond to multiple follow-ups. Twenty-five of 50 states contacted returned the survey[6]. However, four[7] of the 25 survey respondents did not provide any

[6] Arkansas is not included in the count of 25, since they did not submit a survey response. However, DHCS used the direct and administrative claiming reimbursement data that is available online for analysis purposes.

Medicaid reimbursement figures, since they were not yet final at the time of the survey.

Table 3 (See page 18) summarizes survey results for Medicaid reimbursement (federal share) for direct claiming and administrative services for FYs 2014-15 and 2015-16. As noted above, several states did not have finalized figures available for both FYs. When states provided data, federal direct claiming and administrative services Medicaid reimbursement (federal share) was divided by each state's FMAP to calculate total estimated claiming dollars. These figures were then divided by the number of Medicaid-eligible children aged six through 20 to estimate the average claim amount per Medicaid-eligible child. Additional supportive information for Table 3 can be found in Appendices 1(a) and 1(b).

In April 2000, the GAO report, as referenced on page one, estimated that California ranked in the bottom quartile with respect to the average claim per Medicaid eligible child. It is important to note that the GAO report and DHCS surveying results cannot definitively compare direct claiming program dollars spent per Medicaid-eligible student among states. This is primarily due to the basic inability to split Medicaid-eligible students between direct claiming FFS and administrative claiming programs. For those states that operate both programs (20 states in the 2016 survey, including California), only the combined program dollars can be divided by the number of Medicaid-eligible students to calculate a practical result. As such, Table 3 comparisons for those dual-program states that attempt to compare direct claiming dollars per eligible student are inadvertently impacted by the inclusion of administrative claiming program dollars.

In the state survey, some states did not provide both direct claiming and administrative claiming reimbursements for various reasons. For example, out of the 20 states that reported having both programs, five states did not report complete data for their direct claiming program and/or administrative claiming program. Five additional states reported having either a direct claiming program or an administrative claiming program, but not both programs. Without complete direct claiming and administrative claiming reimbursement information, the ranking of the average claim per Medicaid-eligible child is skewed and does not allow for a fair comparison.

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

[7] New York, Ohio, Tennessee, and Wyoming responded to the state survey but did not provide Medicaid reimbursement figures. Tennessee and Wyoming do not currently have a school-based health services program or an administrative claiming program. New York and Ohio have a school-based health services program and/or an administrative claiming program, but did not provide reimbursement figures.

- FMAPs vary among states: Since federal direct claiming and administrative Medicaid reimbursement are divided by each state's FMAP to calculate total estimated claiming dollars, the FMAP influences the average claim per Medicaid-eligible child. FMAPs ranged from 50 percent to 73.58 percent among states for FY 2014-15 and from 50 percent to 74.17 percent in FY 2015-16.
- Covered services differ from state to state: The cost of school-based service providers can range from expenditures for physicians to non-skilled health aide workers. Depending on which services states cover and the associated cost of the rendering practitioners, direct claiming expenditures may vary.
- Timing of finalized reimbursement information: As more states move to a CPE reimbursement methodology (where interim payments are compared to actual costs and result in an end-of-year cost settlement), interim reimbursement diverges from what is eventually paid to school-based providers. The timing of this state survey does not align with the availability of final state cost settlement figures used in the analysis of the average claim per Medicaid-eligible child, due to the length of time that individual states have to conduct their audit or review of LEA provider costs. Of the 20 states that reported having both programs, fifteen states were able to provide final reimbursement figures for both direct claiming and administrative services.

In the April 2000 GAO Report, Maryland had the highest average claim per Medicaid-eligible child of $818, while California's average claim was $19, a difference of $799. Maryland did not respond to the 2016 DHCS survey. However, publicly available data indicates that Maryland no longer has an administrative claiming program, which would decrease their total cost per Medicaid-eligible child figures originally reported in the 2000 GAO Report. As illustrated in Table 3, Vermont had the highest FY 2014-15 average claim of $1,541, while California's average claim was $113. California's average claim per Medicaid-eligible child of $113 in FY 2014-15 has increased almost 500 percent compared to the $19 figure published in the April 2000 GAO Report. Even though California's federal Medicaid reimbursement for LEA direct billing services decreased approximately 5 percent between FY 2014-15 and 2015-16[8], California's average claim per Medicaid-eligible child continued to increase to $189 per child in FY 2015-16.

Although California's average claim per Medicaid-eligible child has significantly increased since the 2000 GAO Report, this benchmark alone does not represent an accurate measurement of California's school-based programs. The federal revenues from administrative activities claimed in the California School-Based Medi-Cal Administrative Activities (SMAA) program over the last several years have not been consistent due to a

[8] California's reimbursement figures for FY 2015-16 are preliminary and will be revised in Fall 2017.

deferral executed by CMS in 2012 through 2013. SMAA reimbursement was $32.5 million in FY 2013-14, then up to $90 million in FY 2014-15, and is estimated to exceed $250 million in FY 2015-16.[9] This was the result of a settlement agreement reached between DHCS and CMS on October 14, 2014, that created a sliding scale reimbursement percentage for interim payments based on the total claim amount for all deferred claims. This agreement allowed for an interim payment on deferred claims for costs incurred prior to July 2012, as well as for FYs 2012-13, 2013-14 and quarters one and two of FY 2014-15. The reconciliation of interim payment to actual costs will be based on a "backcasting" methodology, which was approved by CMS on October 28, 2015. As of FY 2015-16, reimbursement will no longer use the worker log methodology, and instead, will be based on results from the RMTS.

According to a CMS summary of Medicaid eligibles by age group, California had over 4.2 million Medicaid eligibles aged 6 to 20 in FFY 2014-15 (approximately 16 percent of the total U.S. school-aged Medicaid eligible population). In comparison, Vermont, with the highest average claim per Medicaid-eligible child in Table 3, had approximately 30,000 school-aged Medicaid eligible children[10]. As indicated in Table 3, California has the highest federal Medicaid reimbursement and total claims figures in FY 2014-15. However, California's average claim per Medicaid-eligible child is substantially lower when compared to other states. Based on California's FY 2014-15 direct service paid claims reimbursement data, the number of actual unduplicated LEA beneficiaries who received LEA Program services was approximately 350,000 students. By using the actual LEA beneficiary count and the total FY 2014-15 direct claiming FFS interim reimbursement, the average reimbursement per beneficiary receiving direct claiming services in FY 2014-15 is $427.

A comparison of the average claim in the April 2000 GAO Report to the average claim per Medicaid-eligible child in Table 3 shows an increase in 17 of the 23 states that reported federal reimbursement in FY 2014-15 and an increase in 15 of the 21 states that reported federal reimbursement in FY 2015-16. The average claim between these periods decreased in six states for FY 2014-15 and six states for FY 2015-16. Two states, Hawaii and Indiana,

[9] Effective June 26, 2012, CMS implemented a deferral on California's School-Based Administrative Activities program for all claims submitted for reimbursement beginning with the quarter ending in December 2011, (inclusive of FYs 2009-10 through 2013-14 and FY 2014-15 quarter one and two) due to non-compliance with requirements defined in 45 Code of Federal Regulation (CFR) Part 75, including the worker log time study used as a basis for developing invoices. The CMS deferral is a result of fieldwork conducted and based on a financial management review of school-based administrative expenditures. The FY 2012-13 figures represent approximately 95 percent of the total interim payment on deferred claims. Beginning with FY 2014-15, Q3 and Q4 expenditures ($73.6 million) are based on RMTS.

[10] Vermont's Medicaid eligible count dropped in the CMS source data from 56,665 eligible children in FFY 2013-14 to 29,599 children in 2014-15. When looking at the past several years of Medicaid eligibility data, the 29,599 figure for Vermont is lower than the historical figures. If the 2013-14 eligible count was used in Table 3, their cost per Medicaid eligible child figures would have been approximately $805 and $895 in FY 2014-15 and 2015-16, respectively.

did not have data reported in the April 2000 GAO Report. California's average claim per Medicaid-eligible child of $189 in FY 2015-16 has increased almost 900 percent compared to the figure published in the April 2000 GAO Report. It is important to note that these survey results do not generally reflect any past, current or expected adjustments due to prior or on-going OIG or CMS investigations or audits in any state. The direct claiming figures for California are based on interim payments and do not include any audit adjustments made by DHCS.

Table 3: Medicaid Reimbursement and Claims by State, Ranked by 2015-16 Average Claim per Medicaid-Eligible Child

State		SFY 2014-2015 [1]			SFY 2015-2016 [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	3	$ 24,632	$ 45,606	$ 1,541	$ 27,327	$ 50,699	$ 1,713
NEBRASKA		84,687	160,233	1,519	82,364	161,430	1,530
KANSAS	8	25,670	47,756	523	25,670	48,080	527
MINNESOTA	4	44,636	89,272	417	44,976	89,952	420
MISSOURI		30,572	59,050	331	31,962	61,781	347
ILLINOIS		169,440	335,412	374	149,190	294,790	328
IOWA	4	55,492	99,914	244	56,288	102,509	251
ALABAMA		39,641	69,903	230	42,968	75,663	249
TEXAS	9	217,491	379,210	259	201,808	354,309	242
MICHIGAN		175,377	270,920	254	163,757	252,133	236
MASSACHUSETTS	7	82,200	164,400	358	50,300	100,600	219
ARKANSAS	5, 8	39,952	65,100	179	44,230	72,069	199
CALIFORNIA	11	239,084	478,167	113	399,587	799,174	189
DISTRICT OF COLUMBIA	4	3,632	5,189	50	13,242	18,917	181
COLORADO	10	31,116	61,134	230	23,863	47,176	177
NEW MEXICO	8	19,020	31,953	146	21,309	35,515	162
PENNSYLVANIA		91,208	178,698	186	68,831	134,184	140
CONNECTICUT	3	18,391	36,783	125	19,070	38,141	129
FLORIDA		90,079	175,418	87	113,857	221,773	110
INDIANA		10,380	17,395	29	11,206	18,380	31
ALASKA	4	2,201	4,402	54	1,199	2,397	29
WISCONSIN	3	72,302	127,391	468	-	-	-
KENTUCKY	3	20,804	33,577	24	-	-	-
ARIZONA	6, 8	-	-	-	-	-	-
DELAWARE	6	-	-	-	-	-	-
GEORGIA	6	-	-	-	-	-	-
HAWAII	6	-	-	-	-	-	-
IDAHO	6	-	-	-	-	-	-
LOUISIANA	6	-	-	-	-	-	-
MAINE	6	-	-	-	-	-	-
MARYLAND	6	-	-	-	-	-	-
MISSISSIPPI	6	-	-	-	-	-	-
MONTANA	6	-	-	-	-	-	-
NEVADA	6	-	-	-	-	-	-
NEW HAMPSHIRE	6	-	-	-	-	-	-
NEW JERSEY	6	-	-	-	-	-	-
NEW YORK	3, 4	-	-	-	-	-	-
NORTH CAROLINA	6	-	-	-	-	-	-
NORTH DAKOTA	6	-	-	-	-	-	-
OHIO	3	-	-	-	-	-	-
OKLAHOMA	6	-	-	-	-	-	-
OREGON	6	-	-	-	-	-	-
RHODE ISLAND	6	-	-	-	-	-	-
SOUTH CAROLINA	6, 8	-	-	-	-	-	-
SOUTH DAKOTA	6	-	-	-	-	-	-
TENNESSEE	4	-	-	-	-	-	-
UTAH	6	-	-	-	-	-	-
VIRGINIA	6	-	-	-	-	-	-
WASHINGTON	6, 8	-	-	-	-	-	-
WEST VIRGINIA	6	-	-	-	-	-	-
WYOMING	4	-	-	-	-	-	-

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

(2) Calculated as total claims divided by the number of individuals determined eligible for Medicaid in Federal Fiscal Year (FFY) 2014-15. The Medicaid and Statistical Information System (MSIS) no longer provides data by age through the Centers for Medicare and Medicaid Services (CMS). (Source: CMS, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/monthly-reports/previous-monthly-medicaid-and-chip-application-eligibility-determination-and-enrollment-reports-and-updated-data.html).

(3) Total federal reimbursement for this state's health services program and/or administrative claiming program was not provided for SFY 2014-15 and/or SFY 2015-16.

(4) This state did not have a school-based Medicaid health services program and/or administrative claiming program in effect during SFY 2014-15 and/or SFY 2015-16.

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

(6) Did not complete the state survey used to collect Medicaid reimbursement (federal share) for direct claiming and administrative services for SFYs 2014-15 and 2015-16.

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

(8) FFY 2014 Medicaid Eligible data used as complete data was not available for FFY 2015.

(9) Outlier survey reponse was unverified for SFY 2014-15 direct service expenditures; as a placeholder, used CMS-64 Medicaid Financial Management Report (line item for "School Based Services") for direct health service expenditures. Following up with State contact to confirm survey amount.

(10) FY 2015-16 direct health expenditures obtained from online state report (Source: https://www.colorado.gov/pacific/sites/default/files/Health%20Care%20Policy%20and%20Financing%20FY%202016-17%20RFI%205.pdf)

(11) Administrative amount based on estimated SFY 2015-16 payments (not all invoices have been received for SFY 2015-16). Direct health service expenditures for 2015/16 are estimates that will be revised once payment of a large Erroneous Payment Correction is completed in September 2017.

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

Summary of Departmental Activities

Since the passage of SB 231, Medi-Cal reimbursement in the LEA Program has increased by over 150 percent, growing from $59.6 million in FY 2000-01 to $149.5 million in FY 2014-15. DHCS classifies LEA services into two main categories: assessments and treatments. In addition, services are defined as those that are provided pursuant to an IEP or IFSP (commonly referred to as "IEP/IFSP services"), versus those that are provided to the "general education" or non-IEP/IFSP population. The following eight IEP/IFSP assessment types, representing approximately 99 percent of total assessment reimbursement in FY 2014-15, are reimbursable in the LEA Program:

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

In addition, the LEA Program covers the following six non-IEP/IFSP assessment types, pursuant to strict billing guidelines for Free Care and OHC[11]:

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

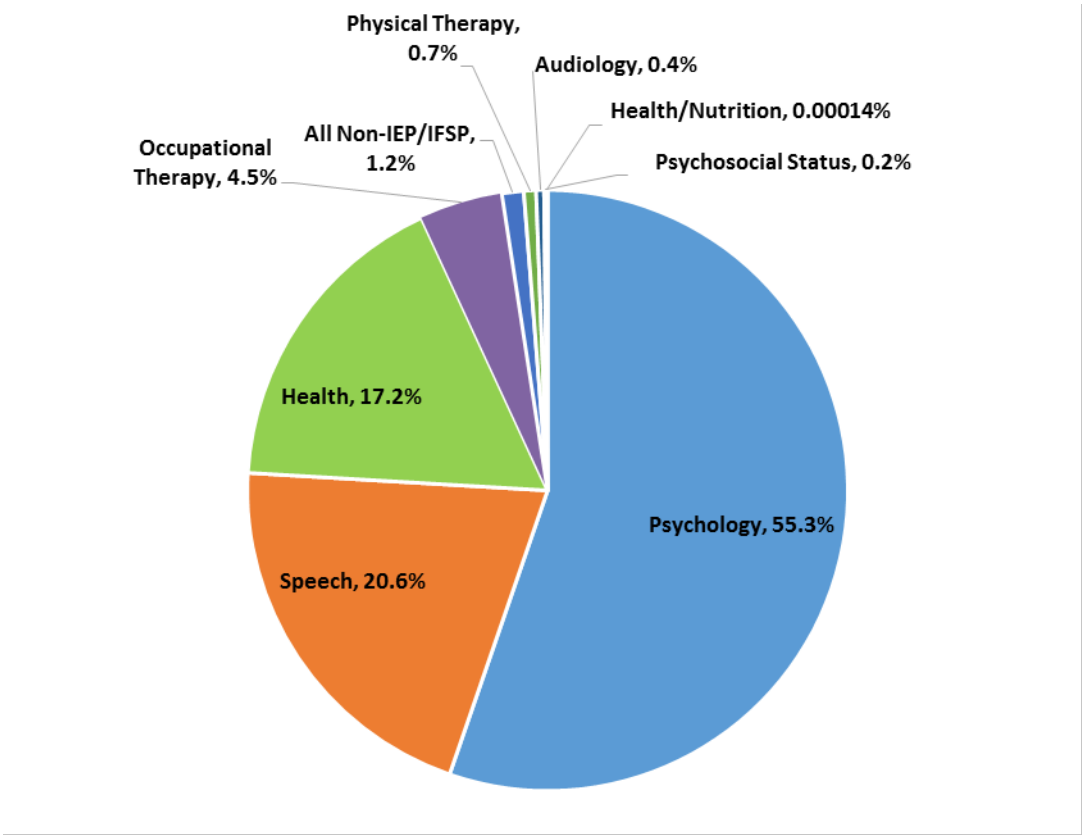
[11] Despite CMS' relaxation of the Free Care Principle as of December 2014, the LEA Program's current policy (as of April 2017) remains limited with regard to billing services that are also offered free to non-Medi-Cal recipients. CMS must approve SPA 15-021 before the LEA Program can expand the definition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

The majority of LEA Program expenditures are classified as treatment services; representing approximately 71 percent of FY 2014-15 total LEA Program expenditures. The LEA Program covers the following treatment services for all students:

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

In addition, the LEA Program covers medical transportation/mileage services for students with an IEP/IFSP. In December 2015, the Office of Administrative Law approved a regulations package that aligns state regulations pertaining to school-based medical transportation services with less restrictive federal law. The regulations, effective on April 1, 2016, result in greater access to specialized medical transportation for Medi-Cal eligible students by not requiring students be transported in a prone or supine position, or in a wheelchair, unless their medical condition requires such transport. SPA 15-021 proposes to expand the mode of LEA medical transportation to include “specially-adapted vehicles,” in addition to litter vans and wheelchair vans.

Figure 1: Total LEA Assessment Reimbursement by Assessment Type, FY 2014-15



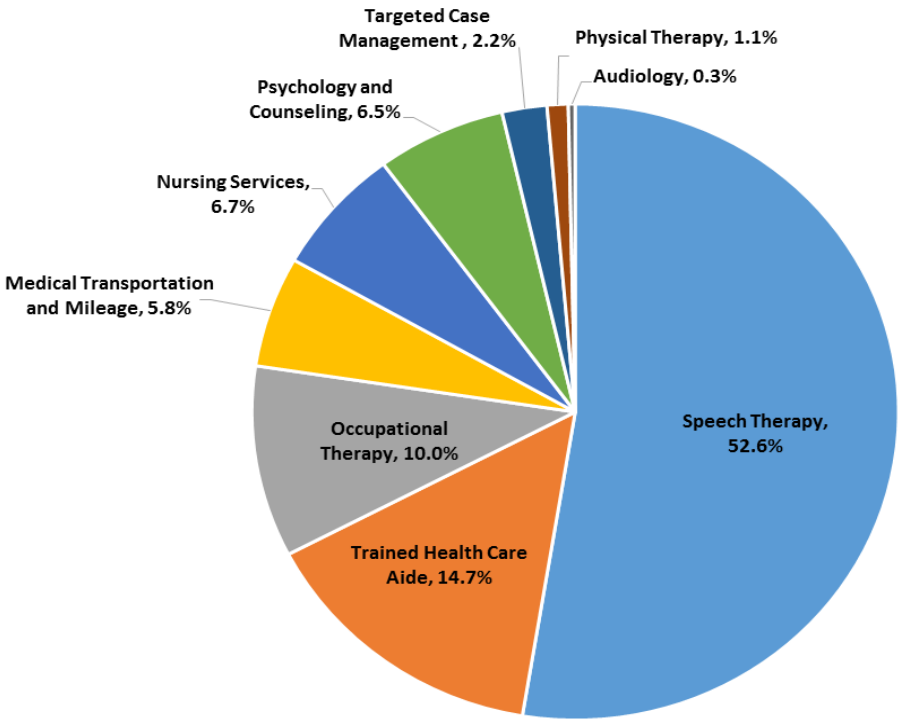
Note: Total LEA assessment service reimbursement for FY 2014-15 was $42.13 million.

The above Figure 1 depicts each assessment type as a percentage of total assessment reimbursement for FY 2014-15. As demonstrated in Figure 1, approximately 93 percent of assessment reimbursement ($39.8 million) is attributable to three IEP/IFSP assessment types: psychological, speech-language, and health assessments. The majority of all LEA assessment reimbursement ($23.6 million) is attributable to psychological assessments, representing approximately 112,000 claims. Psychological assessments, provided by licensed psychologists, licensed educational psychologists, and credentialed school psychologists have the highest interim reimbursement rates among assessment types.[12] While 55 percent of assessment reimbursement is attributable to psychological assessments, over a third of total assessment reimbursement is attributable to speech-language and health assessments, representing 20.6 percent and 17.2 percent of assessment reimbursement, respectively. The remaining five assessment types, including all

[12] In FY 2014-15, psychological assessments were reimbursed at $489.90 for initial/triennial assessments and $163.30 for annual and amended assessments.

non-IEP/IFSP assessments, account for approximately seven percent of total assessment reimbursement in FY 2014-15.

Figure 2: Total IEP/IFSP LEA Treatment Reimbursement by Treatment Type, FY 2014-15

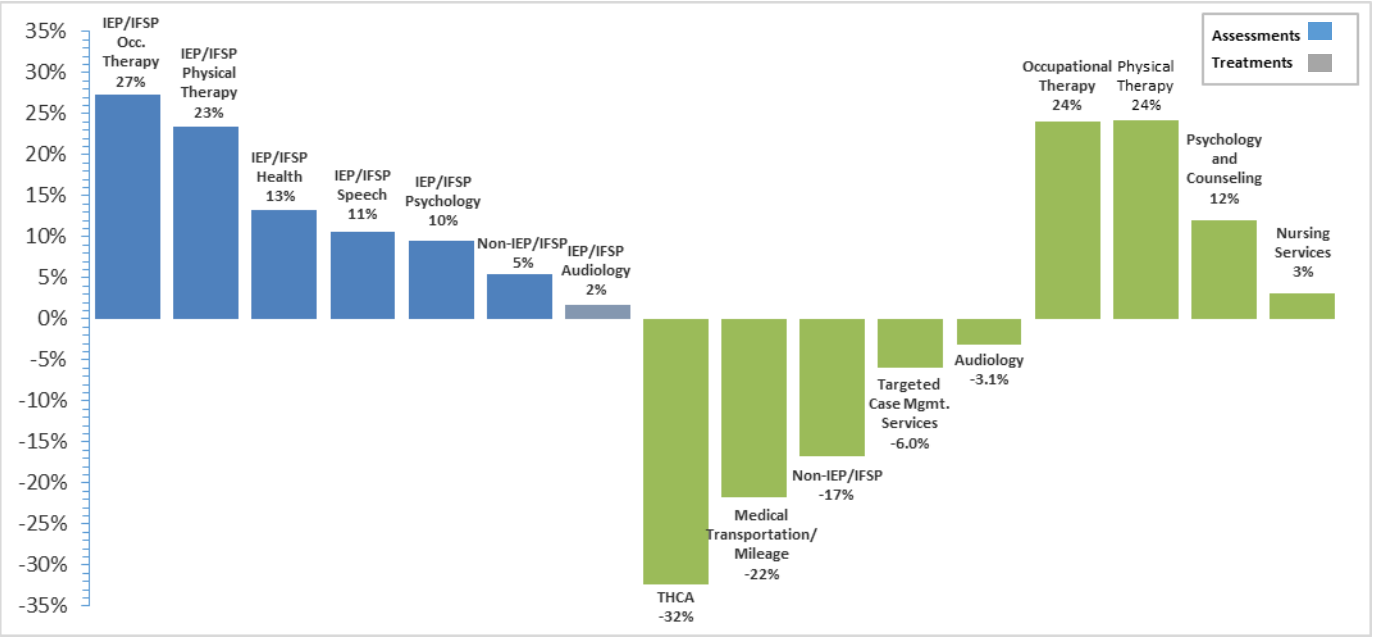


Note: Total LEA IEP/IFSP treatment, transportation/mileage and Targeted Case Mangagement (TCM) service reimbursement for FY 2014-15 was $105.97 million. Less than one percent of total treatment and transportation/mileage reimbursement is attributable to non-IEP/IFSP services.

Figure 2 above demonstrates each IEP/IFSP treatment type as a percentage of total treatment reimbursement for FY 2014-15. Approximately 67 percent of treatment service reimbursement is attributable to speech therapy and school health aide services that are provided by trained health care aides (THCAs). Speech therapy treatment services ($55.8 million) account for approximately 53 percent of total IEP/IFSP treatment service reimbursement and approximately 67 percent of total IEP/IFSP treatment service claims. In the LEA Program, speech-therapy treatment is reimbursable in an individual or group setting. In FY 2014-15, approximately 76 percent of speech-therapy treatment expenditures were attributable to group speech therapy treatment. THCA treatment services accounted

for 15 percent of total IEP/IFSP treatment service reimbursement in FY 2014-15 and approximately 8 percent of total treatment claims. THCAs are required to have training in the administration of specialized physical health care services, such as gastric tube feeding, suctioning, oxygen administration, and catheterization, and may render LEA services only if supervised by a licensed physician or surgeon, a registered credentialed school nurse or a certified public health nurse. The remaining seven treatment service types account for the remaining 39 percent of IEP/IFSP treatment service reimbursement and 29 percent of claims in FY 2014-15.

Figure 3: Percentage Change in Reimbursement by Service Type, FY 2013-14 Versus FY 2014-15



Notes: Services with a total reimbursement amount of less than $80,000 in FY 2014-15 are excluded from the above chart. This includes two assessments: (1) IEP/IFSP psychosocial status assessments, which experienced a 27 percent decrease in reimbursement between FY 2013-14 and 2014-15, from approximately $108,000 to $79,000, and (2) health/nutrition assessments, which experienced an increase of 204 percent between FY 2013-14 and 2014-15 from approximately $19 to $59 in total reimbursement, respectively.

As demonstrated in the above Figure 3, many of the LEA services experienced an increase in reimbursement between FY 2013-14 and FY 2014-15. LEAs received $4.3 million more in assessment reimbursement in FY 2014-15 than the previous year, representing an 11 percent increase in reimbursement for the assessments listed on Figure 3. Similarly, LEAs received $6.1 million more in treatment reimbursement in FY 2014-15 as compared to the prior year. Overall, approximately 15,000 more Medi-Cal eligible students received LEA direct health services in FY 2014-15 than in FY 2013-14.

As illustrated in Figure 3, five treatment services experienced a decrease in reimbursement between FYs 2013-14 and 2014-15. The three services with the largest declines were school health aide services provided by THCAs, medical transportation and mileage services, and treatments that are not pursuant to an IEP/ISP. School health aide services experienced the largest decrease in reimbursement, representing a 32 percent decline in reimbursement year over year. This decline coincides with a decrease in the number of LEAs reimbursed for school health aide services, from 305 LEAs in FY 2013-14 to 274 LEAs the following fiscal year. Of the 251 LEAs that received reimbursement for school health aide services in both years, 165 providers realized a decrease in reimbursement in the most recent period because they billed approximately two million fewer units than the prior year, resulting in over $8 million less in total school health aide reimbursement in FY 2014-15. The remaining 86 LEAs increased billing for school health aide services by 436,000 units between the two periods, adding approximately $1.9 million to this service category's total in FY 2014-15. Fifty-four LEAs that received reimbursement for their THCAs in FY 2013-14 did not bill for these practitioners in FY 2014-15. In recent years, DHCS has continued to provide guidance to LEAs regarding what services are billable by THCAs. For example, in the 2015 training to LEAs, DHCS addressed audit findings regarding school health aide services provided by THCAs. In this training, DHCS clarified that personal care services are not considered specialized physical health care, and any time spent undressing/dressing, toileting, or performing personal hygiene of a Medi-Cal student should not be counted toward THCA billable minutes. In addition, this training clarified the documentation requirements for THCAs that provide continuous monitoring of students throughout the day, and discussed medical necessity requirements. Over the last several years, DHCS' additional guidance and examples to LEAs on what constitutes reimbursable school health aide services has resulted in a decrease in reimbursement in this area. Reimbursement for school health aide services has decreased approximately $22 million from FYs 2010-11 to 2014-15, representing a 58 percent decrease in school health aide services reimbursement over this time. DHCS is working with CMS on SPA 15-021 to allow billing by THCAs that provide assistance with activities of daily living, such as feeding, toileting and transferring. If this new service is approved by CMS, DHCS expects the LEA Program reimbursement to grow substantially.

Another service that experienced a decrease in reimbursement over this period is medical transportation and mileage services. In July 2014, DHCS posted a Transportation Claiming Guide on the LEA Program website, which provides helpful information and resources on billing for transportation under the LEA Program. Originally, DHCS estimated a ten percent

annual growth rate for LEA transportation claiming based on passage of AB 2608[13], which expands LEA claiming for transportation services to those students. DHCS was successful in gaining approval of a resulting transportation regulations package. However, as seen in Figure 3, transportation billing saw a decrease in reimbursement between FYs 2013-14 and 2014-15. Of the 166 LEAs that received reimbursement for IEP/IFSP transportation in both fiscal years, 109 LEAs (66 percent) decreased their transportation billing in FY 2014-15, resulting in a $2.2 million decrease in transportation reimbursement for these LEAs. The remaining 57 LEAs account for a modest increase of eight percent of total transportation reimbursement between the two periods. In addition, 36 LEAs were reimbursed approximately $887,000 for transportation in FY 2014-15 that did not bill in the prior year. DHCS will continue to monitor transportation reimbursement in the coming year to determine what overall impact the new regulations have on LEA Program reimbursement.

Non-IEP/IFSP treatment services also experienced a decline between FYs 2013-14 and 2014-15. However, this decrease only represents a $158,000 reduction in reimbursement to LEAs. Once CMS approves pending SPA 15-021, DHCS expects assessment and treatment reimbursement for non-IEP/IFSP students to grow substantially, since SPA 15-021 proposes to remove the annual limitation for non-IEP/IFSP students.

Per an agreement with CMS via SPA 12-009, a sunset date of June 30, 2015 was established for the current LEA Program TCM reimbursement methodology. DHCS submitted SPA 12-009 to CMS on January 29, 2015, and CMS approved the SPA on April 10, 2015. Policy published in PPL 15-061 instructed LEAs that TCM services provided on or after July 1, 2015, would cease and restart once CMS approved a new reimbursement methodology for TCM services in the pending SPA 16-001. LEAs were informed prior to the July 1, 2015, sunset date that TCM claims would no longer be reimbursed as of July 1, 2015, and some LEAs reduced claiming in the last part of FY 2014-15. Once CMS approves SPA 16-001, LEAs may begin claiming for TCM services under a new reimbursement methodology. This change in reimbursement methodology helps explain the six percent drop in reimbursement between FYs 2013-14 and 2014-15.

[13] In September 2012, AB 2608 (Chapter 755, Statutes of 2012) was chaptered to allow LEA medical transportation services to be provided in a litter van or wheelchair van for Medi-Cal eligible students who are not confined to a wheelchair or in a prone or supine position.

Numerous DHCS activities during this reporting period have contributed to the increase in school-based health services reimbursement since the passage of SB 231. These include the following activities between July 2015 and June 2016:

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

  In May 2015, DHCS submitted the FY 2014-15 inflated reimbursement rate table to its FI for implementation in the claims processing system. In August 2015, DHCS updated the claims processing system with the new rates. The EPC to reprocess claims with dates of service in FY 2014-15 occurred in March 2016.

- **Technical Assistance Site Visits to LEAs**

  In FY 2014-15, DHCS began offering technical assistance site visits to LEAs requesting support on various aspects of the program, including content and submission of required program documents, such as the cost report or provider participation agreement; clarification of program policies and Medicaid billing requirements; and discussing LEA provider questions on specific areas, such as enrollment or other health coverage. In FY 2015-16, DHCS completed five site visits and identified additional LEAs that could use technical assistance, such as providers that are delinquent in submitting their cost report or other required documents. DHCS continues to schedule site visits with LEAs, in-person or via telephone, and maintains a site visit request form on the program website.

- **Annual Accounting of Funds and Payment of Over-Collected Withholds**

  W&I Code Section 14132.06(k) requires DHCS to provide an annual accounting of all funds collected by DHCS from LEA Medi-Cal payments and expended by the LEA Program and make it publicly available to LEAs. In 2013, DHCS finalized the methodology to determine the fair share of withholds from each LEA, resulting in a proportionate collection of withholds across all participating LEA providers. In March 2015, DHCS posted the FY 2013-14 Annual Accounting of Funds report on the LEA Program website. As of June 2015, DHCS was working with the FI to compile the data needed to calculate the fair share reimbursement or collection for FY 2013-14. In addition, DHCS was collecting information from the FI to complete the annual accounting of funds report for FY 2014-15. Once data are provided by the FI, DHCS expects to reconcile the withhold collection/reimbursement for both FYs 2013-14 and 2014-15.

- **Reduction of LEA Withhold Amount**

  To assist in funding the costs of running the LEA Program, LEAs are assessed a withhold on each claim that is paid through the claims processing system. Historically, LEAs have paid one percent of their total reimbursement to help fund the administrative costs of the LEA Program, and 2.5 percent of their reimbursement to help fund the auditing and consulting costs associated with the LEA Program. In late 2015, DHCS worked with its FI to reduce the withhold amount for LEA Program auditing and consulting costs from 2.5 percent to 1.5 percent, resulting in increased reimbursement to the LEAs. In March 2016, the FI completed this project, and LEA Program claims are now subject to a 2.5 percent total withhold, versus the previous 3.5 percent withhold, on LEA Program payments.

- **Erroneous Claims Processing Issues**

  Two claims processing issues resulted in payment corrections to LEAs between July 2015 and June 2016: (1) In December 2015, DHCS reimbursed LEAs for erroneous claim denials on certain transportation claims processed between March and June 2015. These inadvertently denied claims affected 75 LEAs and resulted in an additional $101,000 of reimbursement to LEAs. (2) In April 2016, DHCS notified LEAs of a claims processing error that caused LEA Program claims for current procedural terminology (CPT) code 99401 (health education and anticipatory guidance) to deny if more than one unit of service was billed. Under the LEA Program, providers may bill up to four units of service for CPT code 99401. This error, affecting claims from May 2015 to May 2016, is expected to be corrected in fall of 2016.

- **LEA Advisory Workgroup**

  Members of the LEA Advisory Workgroup represent large, medium, and small school districts, COEs, professional associations representing LEA services, DHCS and CDE. DHCS holds meetings every other month, and provides a forum for LEA Advisory Workgroup members to identify and discuss relevant issues and make recommendations for changes to the LEA Program. The emphasis of the meeting is to complete various goals and activities aimed at expanding and enhancing the Medi-Cal services provided on school sites and access by students to these services, by increasing federal reimbursement to LEAs for the cost of providing these services. The LEA Advisory Workgroup has been instrumental in 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. In addition, the

LEA Advisory Workgroup has provided valuable LEA perspectives to identify barriers regarding the pending SPA, including issues surrounding RMTS implementation.

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

California's LEA Program provides many of the same "core" services that exist in other states' school-based programs. California's program reimburses some services that are not covered in other state's programs (for example, non-IEP/IFSP services). However, there are some services that are allowable in other state programs, which are not currently reimbursable in California's LEA Program. In order to gather information on these services and qualified practitioners, we have relied on numerous sources, including responses from the state survey, updated reviews of relevant provider manuals and Medicaid state plans, and interviews with other state Medicaid program personnel. Other state school-based services not currently reimbursable in the LEA Program include:

- Behavioral services provided by a behavioral aide, certified behavioral analyst, certified associate behavioral analyst, or intern;
- Dental assessment and health education provided by a licensed dental hygienist;
- Durable medical equipment and assistive technology devices;
- Interpreter services;
- Occupational therapy services provided by an occupational therapy assistant;
- Orientation and mobility services;
- Personal care services;
- Physical therapy services provided by a physical therapy assistant;
- Respiratory therapy services;
- Services for children with speech and language disorders provided by a speech-language pathology assistant; and
- Specialized transportation services beyond transportation in a wheelchair van or litter van.

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

- Occupational therapy, physical therapy and speech-language therapy services provided by assistants;
- Orientation and mobility services;
- Support for activities of daily living (referred to as “personal care services” in other school-based programs);
- Respiratory therapy services; and
- Specialized transportation services beyond transportation provided in a wheelchair van or litter van.

In addition to the services listed above, SPA 15-021 proposes to reimburse for psychological services provided by a registered associate clinical social worker or registered marriage and family therapist intern. Also notable is that DHCS is in the process of adding the telehealth modality for speech-language services performed via telemedicine, and will implement this new benefit on July 1, 2016 for students that contain speech-language services as part of their IEP or IFSP. While most states provide reimbursements for behavioral services, dental, durable medical equipment, and interpreter services, the LEA Program does not provide reimbursements for these services since they are covered through other Medi-Cal programs. Once CMS approves SPA 15-021, California will have one of the most robust school-based service programs in the nation.

IV. OFFICIAL RECOMMENDATIONS MADE TO DHCS

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

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

Recommendation	Action Taken/To Be Taken
• Update the LEA Program Provider Manual to improve the organization and content of the policy information, as necessary.	• The Billing Codes and Reimbursement Rates section of the provider manual was updated to include the updated maximum allowable rates as well as identifying the current FMAP percentage of 50 percent. • The Nursing Service section of the provider manual was updated to include clarifying language regarding the requirement of the supervising practitioner's signature, title, and date on nursing treatment logs. • The Provider's Guide section of the provider manual was updated to include information about the Provider Participation Agreement (PPA) changing to an 'evergreen' term. Updates to this section provided more detailed information regarding the provider's responsibilities. • The Billing and Reimbursement Overview section of the provider manual was updated to include new information on the requirements for OHC. • The TCM section of the provider manual included more information on the components of TCM based on SPA 12-009 in November of 2015.

Recommendation	Action Taken/To Be Taken
• Update and maintain the LEA Program website, including development of LEA reimbursement reports and enrollment trends.	• Annually required compliance documents, including the Annual Report, CRCS, Data Use Agreement and PPA, were updated and posted on the LEA Program website. • FY 2014-15 Inflated Reimbursement Rates table was posted. • The NEW ICD-10 General Equivalence Mapping list was posted. • Medi-Cal Reimbursements by LEA Provider and LEA Enrollment Trends for FY 2013-14 are posted on the Paid Claims Data Reports page. • 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. • The May 2013 Legislative Report was posted on the LEA Program's website.
• Provide LEA Program trainings and resources to the LEA provider community.	• DHCS conducted a program training in September 2015. The training covered several topics that included: o Refresher on LEA Program Resources, Participation Requirements Updates, Site Visits and Technical Assistance, Claims Processing Updates, In-Progress Work, Paid Claims Overview, CRCS Updates, Overview of CRCS Acceptance Process, Common CRCS Errors, CRC Submission Non-Compliance, Common CRCS Audit Findings, LEA Documentation Responsibilities, ICD-10, RMTS. o The September 2015 Program Training Video Slides and FAQs were posted. • The Onboarding Handbook was updated in September 2015, providing more up-to-date information on the LEA Program. • LEA Tool Box was published on the LEA Program website in September 2015. It provides quick access to resources and information. • The At-a-Glance Self-Audit Checklist was published on the LEA Program website in September 2015. It is a guide for basic program requirements regarding program compliance, claim documentation for billing, and requirements for practitioners and services.

Recommendation	Action Taken/To Be Taken
• Communicate policy issues with LEA providers and stakeholders.	• Implementation of the Evergreen PPA in the LEA Program; no DUNS number required, Addition of Business Associate Addendum (BAA) and Data Layout Attachments, PPA for Community College Districts, California State University Campuses, or University of California Campuses. • DHCS provided guidance to LEAs on the future implementation of Free Care, based on CMS letter from December 2014. Medi-Cal may reimburse LEA providers for services provided to Medi-Cal eligible students regardless of whether there is any charge for the service to the student or the community at large. • DHCS published PPL 16-010 regarding the implementation of the electronic signature policy and the requirements. • DHCS published PPL 16-012 regarding Third Party Liability Recoupment Requirements when a Medi-Cal beneficiary has OHC, specifically that the LEAs bill private insurance companies for direct medical services rendered to the beneficiaries before billing Medi-Cal. In addition, the State must recoup any funds from OHC.
• Conduct meetings with DHCS and LEA providers regarding audit procedures	• In FY 2015-16, DHCS continued to work with LEAs to explain, refine and answer any questions regarding the CRCS reconciliation, and audits processes. DHCS addressed reported issues regarding the overpayment/underpayment process and provided status updates regarding the CRCS, audit procedures, and the review process. • In FY 2015-16, DHCS educated LEAs on common audit findings. DHCS discussed how audit findings are incorporated into trainings, and reminded LEAs that the September 2015 training included information on common audit findings.

Recommendation	Action Taken/To Be Taken
• Determine and enforce a compliance process for LEAs that did not timely submit CRCS reports.	• DHCS published PPL 15-019 on July 24, 2015, notifying the LEAs of the compliance process for LEAs that do not submit the CRCS by the mandated due date. The compliance process consists of placing the LEA on 100 percent withhold from future reimbursements. • In FY 2015-16, DHCS continued to enforce a penalty process for non-submission of the CRCS by implementing a 100 percent withhold on payment for delinquent CRCS reports. LEA providers were issued a warning letter in January 2016, prior to the withhold initiation, and was allowed a grace period in which to submit delinquent reports. • In FY 2015-16, DHCS continued to call and send e-mail notifications to non-compliant LEAs with delinquent CRCS reports for FYs 2009-10, 2011-12, 2012-13, and 2013-14, that they are on 100 percent withhold until delinquent reports are submitted. • DHCS provided the LEAs with resources and offered technical assistance in order for LEAs to become compliant.
• Update interim reimbursement rates for LEA services per the State Plan.	• In September 2015, DHCS sent an e-blast to stakeholders to inform them that the FY 2014-15 inflated reimbursement rates were posted on the LEA Program website. • In March 2016, an EPC was implemented to reprocess claims with dates of service in FY 2014-15 based on the updated rates.
• Monitor the LEA claims processing system to ensure claims are reimbursed according to LEA Program policy, and implement EPCs and SDN, as needed.	• EPC for Resubmission of Erroneously Denied LEA Claims: DHCS identified a claims processing issue causing some LEA claims for medical transportation to erroneously deny. The error was corrected by the FI in December 2015, and adjustments began appearing December 10, 2015. • EPC for Void and Resubmission of TCM LEA Claims: DHCS identified a claim processing issue causing some TCM claims to erroneously pay. The issue was resolved and adjustments began appearing in June 2016. • DHCS monitored SDN 14-002, which fixed the additional withhold that was being applied to cost settlements erroneously. The final implementation was completed September 28, 2015.

Recommendation	Action Taken/To Be Taken
• Institute a fair share withhold methodology and provide an accounting of withholds collected from LEAs.	• At the April 6, 2016, LEA Advisory Workgroup meeting DHCS presented the draft version of the FY 2014-15 LEA Program Annual Accounting of Funds Summary Report. DHCS will post the report on the LEA website once the Total Paid Claims data has been verified by the FI. • DHCS received individual LEA claims data from the FI for FY 2013-14 and is compiling a Fair Share reimbursement or collection for each LEA for that FY.
• Review withholds applied to LEA Program claims reimbursements to determine if LEAs are being over or under withheld.	• The final implementation of SDN 14-002 on September 28, 2015, allowed DHCS to initiate a withhold reduction. In October 2015 DHCS instructed the FI to reduce the single year-round withhold of 2.5 percent to 1.5 percent, to result in a closer yearly Fair Share reconciliation. The withhold reduction was implemented in March 2016. This does not affect the one percent administrative withhold.
• Implement Telehealth as a modality for the provision of existing LEA Program reimbursable services.	• In December 2015, DHCS published PPL 15-024, notifying LEAs that covered speech assessment and treatment services, when performed via telemedicine, are billable. • DHCS provided information, in the PPL and in the annual training, on the requirements for LEAs to bill for Telehealth.
• Removal and development of CPT codes.	• DHCS drafted a PPL regarding the removal and development of CPT codes for the LEA Program, and worked with an Advisory Workgroup "PPL subgroup" to gather stakeholder input. The draft PPL was submitted to this group in October 2015 for final review. PPL 15-023 "Elimination of CPT Code 92506; and Implementation of Four New Replacement CPT Codes 92521-92524; and Implementation of New Audiology Code 92557" was published on December 1, 2015. • DHCS submitted LEA Program Provider Manual updates regarding the CPT code changes to Bulletin Headquarters for targeted July 2016 publication. • DHCS worked with the FI to update the rate table and utilization controls to reflect the CPT code changes, for a targeted July 1, 2016, implementation. • On June 28, 2016, DHCS notified stakeholders via e-blast that implementation of the five replacement CPT codes in the claims processing system was not expected to be completed until October 1, 2016. Instructions were provided on how to bill those claims from July 1, 2016 forward.

Recommendation	Action Taken/To Be Taken
• Transportation Regulations: Update the LEA transportation services section of the State regulations to be compliant with AB 2608.	• The Public Notice for the LEA Program Specialized Medical Transportation Services regulations was published in the California Regulatory Notice Register on July 31, 2015. Stakeholders were notified via e-blast September 1, 2015. The public comment period ended September 14, 2015. • On December 10, 2015, the transportation regulation package DHCS-12-015 was approved by the Office of Administrative Law, and filed with the Secretary of State, with an effective date of April 1, 2016. Stakeholders were notified via e-blast December 18, 2015.
• Implementation of International Classification of Diseases, 10th Revision (ICD-10).	• DHCS followed up with the FI to see if there were any issues with the implementation of ICD-10. Evaluation led DHCS to conclude that there were no issues with this new implementation.
• Update on the LEA Program on SPA 15-021 and RMTS Methodology Implementation.	• DHCS submitted SPA 15-021, which proposes new services, practitioners and a new RMTS Methodology, to CMS on September 30, 2015. It also proposes to include coverage for all individuals under the age 22 who are Medicaid eligible beneficiaries without any limitations. • DHCS received requests for additional information (RAIs) from CMS in December 2015. • DHCS continued to communicate with CMS regarding SPA 15-021 during FY 2015-16. • DHCS continued to work with the RMTS IAG throughout FY 2015-16, working on design/technical phases, identifying barriers to implementation and possible solutions. • A stakeholder feedback tool was developed and posted on the LEA website as a way for all LEAs to provide DHCS with any concerns they may have regarding the implementation of RMTS. • The RMTS IAG meeting minutes for FY 2015-16 were published on the LEA website.
• SPA 16-001	• SPA 16-001 was sent to CMS in March 2016, proposing to include all Medicaid eligibles, including those with an IEP/IFSP/IHSP, for TCM Services with an effective date of January 1, 2016. • The reimbursement methodology for TCM services is proposed in SPA 15-021, which will allow TCM services to be reimbursed at incremental cost of a school nurse proxy rate. • Per CMS, SPA 16-001 cannot be considered until SPA 15-021 is approved.

Recommendation	Action Taken/To Be Taken
• Discuss the new CMS policy regarding Free Care with LEA stakeholders.	• In July 2015, DHCS researched how the new CMS guidance will affect Medi-Cal programs, including the LEA Program. • In November 2015, DHCS sent an e-blast to stakeholders with a general update regarding Free Care. In December 2015, stakeholders were notified via e-blast that the LEA Program Provider Manual was updated to include the removal of the requirement that LEAs must request OHC information for all students served (both Medi-Cal and non-Medi-Cal) and obtain a 100 percent response on this request, prior to billing Medi-Cal. • In February 2016, DHCS sent an e-blast to stakeholders regarding the 45-day response requirement included in SB 276. DHCS prepared LEA Program Provider Manual updates regarding Free Care and OHC Requirements for Fall 2016 publication.

V. ONE-YEAR TIMETABLE FOR STATE PLAN AMENDMENTS

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

In September 2015, DHCS submitted SPA 15-021 to CMS. In December 2015, DHCS received numerous RAIs from CMS regarding SPA 15-021. At the recommendation of CMS, DHCS and CMS have been working outside of the CMS required 90-day timeline to address the RAIs. Since December 2015, CMS and DHCS have engaged in a series of conference calls and written communication to address the RAIs. To date, DHCS has addressed a large majority of the RAIs with CMS, and both parties have informally agreed to those responses. However, there are still several outstanding RAIs to be discussed with CMS before DHCS can re-submit the SPA and RAIs for final review. This package is intended to complete the process that CMS requested and DHCS began in early 2016 – an "off the clock" informal discussion of all RAI responses prior to resubmission of the SPA package for final approval.

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

- Change 1: Incorporation of a RMTS as part of the cost settlement process.
- Change 2: Addition of new service providers and services covered under the LEA Program, including:

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

- Change 3: Expansion of the population covered under the LEA Program to include Medicaid beneficiaries outside of special education, including those covered by an

Individualized Health and Support Plan (IHSP) or a "plan of care." In December 2014, CMS provided guidance to state Medicaid Directors that allows schools to bill Medicaid for "free care" services, or services not covered under the IDEA.[14] Since Medi-Cal beneficiaries covered under an IHSP are carved out of the California managed care contracts[15], this population will be eligible to receive services under SPA 15-021.

While this list of changes included in SPA 15-021 is not exhaustive, it covers a majority of the components included in the SPA. Upon submission of the full set of RAI responses to CMS, DHCS should expect to receive additional questions from CMS that will require responses before DHCS can officially resubmit hat require lead-time prior to implementation. Even though DHCS and CMS are working outside of the SPA approval process 90-day timeline, DHCS has continued to move forward with developing materials that will assist LEAs in implementing the SPA, once approved. For example, DHCS has created a draft LEA RMTS Implementation Guide that will be published upon CMS approval, drafted new cost report forms and instructions, worked to identify new CPT codes and modifiers for new practitioner types and services, and has been updating the LEA Program Provider Manual in anticipation of SPA approval. DHCS has made consistent progress in developing implementation materials for LEAs that will be available once CMS approves SPA 15-021. Table 5 below addresses the timetable for proposed SPA 15-021.

[14] State Medicaid Director Letter 14-006, Medicaid Payment for Services Provided without Charge (Free Care). Available online: https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf

[15] California DHCS, COHS Boilerplate Contract. Available online: http://www.dhcs.ca.gov/provgovpart/Documents/COHSBoilerplate032014.pdf

Table 5: Timetable for Proposed State Plan Amendments

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

VI. BARRIERS TO REIMBURSEMENT

The LEA Advisory Workgroup continues to play a key role in identifying barriers to reimbursement for LEA Program services. Table 6 describes the barriers to reimbursement identified by the Workgroup between July 2015 and June 2016, as well as the actions DHCS has taken or plans to take to remove those barriers.

Table 6: Barriers to Reimbursement

Barriers	Actions Taken /To Be Taken
• Certain practitioner types and services were not included in the initial draft of SPA 15-021, but are among the services provided by LEAs in California.	• During this report period, DHCS researched the requested practitioner types and services requested by the LEA Advisory Workgroup. Practitioners recommended by the Advisory Workgroup included the Marriage and Family Therapist Interns and Registered Associate Clinical Social Workers; services included occupational and physical therapy, group treatment services. After consideration of State and federal requirements, DHCS added these practitioners and services to the latest draft of SPA 15-021. The addition of these qualified rendering practitioners and expansion on scope of billable services provided by occupational and physical therapists will increase reimbursement for LEAs in California.

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

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

Barriers	Actions Taken /To Be Taken
• Develop and publish a policy on electronic signatures for the LEA Program.	• During site visits, DHCS noted that there was confusion about policies surrounding electronic signatures. • In the December 2015 Advisory Workgroup Meeting, DHCS led a breakout session on electronic signature requirements and discussed pending policy in this area. • DHCS informed LEAs that the use of an electronic signature is acceptable as of July 1, 2016, if the signing unit has administrative safeguards to ensure that the electronic signature meets certain criteria. DHCS will publish the criteria in PPL 16-010, in July 2016.
• LEAs would like all policies included in the LEA Program Provider Manual.	• In February 2016, Advisory Workgroup Members requested that all policies under which LEAs are to be audited, be included in the provider manual, noting that some information is located in training slides or FAQs. Stakeholders also requested that DHCS create an effective date on policy publications so that documentation requirements and timing are clear to all parties. • DHCS has identified common audit findings and provided guidance to LEAs, placing information in the provider manual or PPLs, when necessary. LEA Program Provider Manual updates and PPLs include the publication date. In addition, DHCS sends an e-blast to all LEAs on the listserv when it publishes provider manual updates or important documents on the LEA Program website. DHCS welcomes feedback on areas that LEAs believe need additional guidance in the provider manual. LEAs can always e-mail DHCS' LEA mailbox with questions or concerns. • DHCS included information in the annual Program training so that LEAs are aware of systemic documentation concerns that result from audits. DHCS plans to continue working with MRB and FAB to identify areas where LEAs may benefit from additional education or guidance.

Barriers	Actions Taken /To Be Taken
• Conduct a training webinar to help LEAs further understand the audit process and required documentation	• In February 2016, stakeholders requested that DHCS would offer an annual LEA Program training that walks LEAs through a "mock financial audit" process. LEAs requested that FAB use redacted documents from a real audit to show LEAs the documentation requirements expected by FAB. • Since the Medi-Cal audit plans are confidential, DHCS is limited with the type of information that they may present regarding audits of providers. However, FAB did conduct a CRCS documentation training in 2011, which is still publicly available. This training included details on the various types of audits, what to expect during an audit, and screen shots of sample documentation that could support expenditures reported on the CRCS. The FAQs for this training are also available on the FAB LEA Program website, along with a sample "bridging" schedule that an LEA could produce to link its accounting system with reported CRCS expenditures. • DHCS plans to continue including presentations by FAB and MRB in the annual LEA Program training. The training will include common audit findings for the year, as well as any areas that DHCS believes need further provider education.

Barriers	Actions Taken /To Be Taken
• Implement telehealth as a modality for the provision of existing LEA Program reimbursable services.	• In October 2011, AB 415 (Chapter 547, Statutes of 2011) was chaptered and defined telehealth as the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. AB 415 allows DHCS to reimburse providers for Medi-Cal covered services provided via telehealth. 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 rendering telehealth services. Providers can now obtain and document verbal consent. • DHCS prepared for implementation of telehealth services, including revising the LEA Program Provider Manual with respect to telemedicine and developing a rate table and corresponding utilization controls for speech services provided under the telehealth modality. In December 2015, DHCS published PPL 15-024, titled "Implementation of Telehealth for Speech Therapy Services in the Local Educational Agency Medi-Cal Billing Option Program." This PPL provided guidance on telehealth services, including practitioner qualification requirements. DHCS expects to implement reimbursement for LEA speech-language telehealth services in FY 2016-17. • Once CMS approves SPA 15-021 and DHCS implements the provisions of the SPA, DHCS will consider other service types where the telehealth modality may be appropriate for the LEA Program.

Barriers	Actions Taken /To Be Taken
• Claims processing issues resulted in LEA Program claims being incorrectly paid or denied.	• DHCS worked closely with its FI to resolve outstanding claims processing issues. Throughout this reporting period, DHCS monitored and researched claims processing issues and clarified LEA Program billing policies and requirements for the FI. When claims were not paying correctly, DHCS worked with the FI to alter the system design to ensure LEA Program claims were processing properly prior to implementation of system changes. • In March 2015, the FI inadvertently deleted category of service 075 from certain procedure codes, causing denial of mileage claims for some LEAs. The FI corrected this issue in May 2015 and DHCS instructed the FI in December 2015 to conduct an EPC to reprocess denied mileage claims. • National Correct Coding Initiative edits were inadvertently applied to LEA claims, resulting in the denial of preventative medicine counseling claims when more than one unit of service per day was billed for CPT code 99401. The FI corrected this error in May 2016, and is moving forward with an EPC to correctly pay these claims. • DHCS suspended TCM claiming in the LEA Program as of July 1, 2015. TCM claims submitted by LEA providers for dates of service between July 1, 2015, and December 22, 2015, were paid up to when the claims processing system was updated in December 2015. In June 2016, the FI voided these incorrectly paid TCM claims, resulting in a collection from a limited number of LEAs.

Barriers	Actions Taken /To Be Taken
• Withholds are being incorrectly applied to cost settlements, incentive payments and over-collected withhold reimbursement amounts.	• Prior to July 2015, LEA Program payments relating to cost settlement, electronic health record incentive payments, and over-collected withhold reimbursements were inappropriately discounted by the withhold amounts. • DHCS proportionately reduces payment on LEA Program claims to fund administrative activities, auditor positions and AB 2608 activities. • In 2014 and 2015, DHCS worked with its FI to implement SDN 14-002, whereby certain reimbursements would be exempt from the withhold process. The FI completed implementation of the SDN on June 22, 2015. During the post-implementation testing, DHCS identified a discrepancy affecting some LEA Program claims in which the withholds were incorrectly credited from a recoupment amount. The discrepancy was resolved on September 28, 2015.

Barriers	Actions Taken /To Be Taken
• Update the LEA Program transportation services section of the State regulations to be compliant with AB 2608.	• In September 2012, AB 2608 (Chapter 755, Statutes of 2012) was chaptered to allow LEA Program 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 Program medical transportation services based on AB 2608. • In 2014, DHCS developed a proposed regulation package related to transportation updates mandated in AB 2608. This package includes revisions to existing State regulations that are required to implement AB 2608, as well as expand LEA Program medical transportation services to include specialized medical transportation services. DHCS submitted the final proposed regulations package to Office of Regulations in December 2014. • In December 2015, the Office of Administrative Law approved the regulations package and it was filed with the Secretary of State. The updated regulations became effective on April 1, 2016, amending three California Codes of Regulations (CCRs): 22 CCR § 51231.1, 22 CCR § 51231.2 and 22 CCR § 51323. The new CCRs align state regulations pertaining to school-based medical transportation services with federal law, resulting in greater access to specialized medical transportation for Medi-Cal eligible students.
• Revise state regulations to be no more restrictive than federal requirements.	• Once CMS approves SPA 15-021, DHCS will propose revisions to existing state regulations that are required to implement recent LEA Program changes. The regulations will be consistent with SPA 03-024, SPA 05-010, and SPA 12-009, and SPA 15-021 requirements, existing federal law and regulations, and existing state law.