Local Educational Agency Medi-Cal Billing Option Program

Report to the Legislature, September 2006

Report Period April 2005 through March 2006

(With Additional Information for January 2003 through March 2005)

Governor Arnold Schwarzenegger
State of California

Secretary S. Kimberly Belshé
Health and Human Services Agency

Director Sandra Shewry
Department of Health Services

TABLE OF CONTENTS

PAGE

EXECUTIVE SUMMARY……1

I. INTRODUCTION 6

II. BACKGROUND 9

III. OTHER STATES' SCHOOL-BASED MEDICAID PROGRAMS 11

IV. OFFICIAL RECOMMENDATIONS MADE TO CDHS 22

V. ONE-YEAR TIMETABLE FOR STATE PLAN AMENDMENTS 26

VI. BARRIERS TO REIMBURSEMENT 28

VII. APPENDICES 30

EXECUTIVE SUMMARY

Schools play a critical role in providing health services to students, particularly those requiring special education services. For many schools nationwide, federal Medicaid reimbursements are a crucial source of revenues in providing needed health services. Under the Local Educational Agency (LEA) Medi-Cal Billing Option Program (LEA Program), California's school districts and County Offices of Education (COE) are reimbursed by the federal government for health services provided to Medi-Cal eligible students. A report published by the United States General Accounting Office (GAO)[1] in April 2000 estimated that California ranked in the bottom quartile, with respect to the average claim per Medicaid-eligible child, of states with school-based Medicaid programs. To reduce the gap in per child recovery for Medicaid school-based reimbursements between California and the three states recovering the most per child from the federal government, Senate Bill 231 (SB 231) was signed into law in October 2001.

SB 231 requires the California Department of Health Services (CDHS) to amend California's Medicaid state plan to accomplish various goals to enhance Medi-Cal services provided at school sites and access by students to those services.

Since the passage of SB 231, 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 significantly increased at the national level. OIG audits of Medicaid school-based programs in seventeen states have identified millions of dollars in federal disallowances for services provided in schools. "Free Care" and "Other Health Coverage" (OHC) requirements mandated by CMS during the summer of 2003 affect the ability of

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

schools to bill for health services that are provided to Medi-Cal eligible students[2]. During the past year, issues related to funding mechanisms for school-based programs, including Certified Public Expenditures (CPEs) used by the LEA Program will impact upcoming requirements for LEA providers. In addition, the federal government is clearly moving towards a more restrictive stance in light of the on-going federal budget deficit. The President's proposed budget for fiscal year 2007 presents a series of Medicaid administrative changes that may impact school-based services. For example, the Administration proposes to prohibit federal reimbursement for school-based administration or transportation costs established under the Individuals with Disabilities Education Act (IDEA). The proposed budget also discusses the potential clarification and restriction of services claimed as rehabilitation services. The programmatic and fiscal impacts of the Administration's proposals are unclear at this time. Despite these developments, important progress towards accomplishing the goals of SB 231 continued in 2005. LEA funding (measured in federal share dollars) increased seven percent since the passage of the legislation, despite the significant federal restrictions that have forced LEA providers to eliminate certain billing practices.

LEA Medi-Cal reimbursement trends by State Fiscal Year (SFY) follow:

Fiscal Year	Total Medi-Cal Reimbursement
SFY 00/01	$59.6 million
SFY 01/02	$67.9 million
SFY 02/03	$92.2 million
SFY 03/04	$90.9 million
SFY 04/05	$63.9 million

[2] Under the Free Care principle, Medicaid funds may not be used to pay for services that are available without charge to everyone in the community. Free Care, or services provided without charge, are services for which there is no beneficiary liability or Medicaid liability.

OHC is another insurance program that is or may be liable to pay all or part of the costs for medical assistance for Medicaid-covered services. Under Medicaid law and regulations, Medicaid will pay for health care only after a beneficiary's other health care coverage has been exhausted.

The resulting percentage change, based on SB 231 approval follows:

Fiscal Year	Percentage Change
SFY 00/01 to 01/02	14%
SFY 00/01 to 02/03	55%
SFY 00/01 to 03/04	53%
SFY 00/01 to 04/05	7%

LEA reimbursement decreased approximately 30 percent between SFY 2003-2004 and SFY 2004-2005, reflecting a reduction in claims for health services due to Free Care and OHC requirements that were mandated by CMS. In April 2004, CMS provided clarification on Free Care and OHC requirements; this information was communicated to LEA providers June 2004 via a provider letter. In addition, the Federal Medicaid Assistance Percentage (FMAP) for California decreased between SFY 2003-2004 and 2004-2005, dropping from 52.95 percent to 50.00 percent over this period.

The LEA Ad-Hoc Workgroup (LEA Workgroup) was organized in early 2001. Regular LEA Workgroup meetings, currently conducted every other month, coupled with extensive field visits have identified barriers for both existing and potential LEA providers, and have resulted in recommended new services to be considered for the LEA Program. Operational bottlenecks are being addressed and improved. These include improvements made to the data match eligibility process, as well as continued enhancements to the LEA website and other communication venues that address on-going provider issues. In addition, Free Care and OHC federal guidelines have historically been debated and acted on in a variety of ways. At CDHS' request, CMS formally clarified their stance on Free Care and OHC issues, determining that LEA providers must adhere to strict billing procedures regarding these issues. In June 2004, CDHS communicated this information to the LEA provider community via a provider letter. This provider letter continues to be posted on the LEA Program website.

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. This substantially increases both treatment and assessment rates for over 15 of the 28 LEA practitioner services provided to California's children in a school-based setting. New LEA assessment and treatment rates are scheduled to be implemented on July 1, 2006.

Additional 2005 progress included work related to transportation, personal care services and other existing or potential LEA service benefits. This included significant field work identifying school-based accounting and operational practices and applying these findings to the development of standardized cost reporting forms. Collaborative efforts also resulted in developing CPE program protocols and reconciliation standards for SFY 2006-07. A series of regional cost report and reconciliation training seminars for LEA providers have been completed in recent months. Additional training sessions are scheduled in 2006.

On the practitioner side, much progress was made to define and focus on who can provide and supervise LEA services. CDHS, in collaboration with the California Commission on Teacher Credentialing (CCTC), successfully established equivalency for credentialed speech-language pathology professionals with Clinical or Rehabilitative Services (CRS) credentials. Once CMS approves the equivalency language, speech-language pathology practitioners with CRS credentials will no longer require supervision when providing services to Medi-Cal eligible children. This equivalency language was submitted to CMS for approval in SPA 05-010; however, CMS has required an affirmation of equivalency from the California Office of the Attorney General (AG) prior to approving the SPA. CDHS and CCTC are in the process of establishing an equivalency ruling from the AG. The equivalency will be implemented subject to the SPA and regulations approval process.

Additional progress has been made on an extensive revision of the Medi-Cal Provider Manual sections specific to LEA services (LEA Provider Manual). This, as well as other implementation tasks such as assisting Payment Systems Division (PSD) and Electronic Data Systems (EDS) in implementing claims processing system changes, developing audit

protocols in conjunction with CDHS Audits and Investigations (A&I), communicating re-billing technicalities with LEA providers and CMS, and developing SPA implementation provider training materials represents much of CDHS' technical work in 2005.
We expect that additional SPAs will be developed and submitted to CMS in 2006 and beyond, along with the requisite and supportive rate studies, fieldwork, claims analysis, provider training, CMS negotiation and other due diligence required to successfully expand the LEA Program.

The work completed in 2005 has largely been due to the positive and on-going relationship between CDHS, the California Department of Education (CDE), and the many officials of school districts, COE, and professional associations representing LEA services who have participated in the LEA Workgroup.

I. INTRODUCTION

Under the LEA Program, California's school districts and COE are reimbursed by the federal government for health services provided to Medi-Cal eligible students. The report published by the United States GAO in April 2000 estimated that California ranked in the bottom quartile, with respect to the average claim per Medicaid-eligible child, of states with school-based programs[3]. To reduce the gap in per child recovery for Medicaid school-based reimbursements between California and the three states recovering the most per child from the federal government, SB 231 was signed into law in October 2001.

SB 231, Statutes of 2001, Chapter 655, Welfare and Institutions Code, Section 14115.8 requires CDHS to amend California's Medicaid state plan to accomplish various goals to enhance Medi-Cal services provided at school sites and access by students to those services. SB 231 requires CDHS to:

- Amend the Medicaid state plan with respect to the LEA Program to ensure that schools shall be reimbursed for all eligible school-based services that they provide that are not precluded by federal law;
- Examine methodologies for increasing school participation in the LEA Program;
- Simplify, to the extent possible, claiming processes for LEA Program billing;
- Eliminate and modify state plan and regulatory requirements that exceed federal requirements when they are unnecessary;
- Implement recommendations from the LEA Program rate study (LEA Rate Study) to the extent feasible and appropriate[4];

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

[4] Assembly Bill 430 authorized LEAs to contribute to a rate study to evaluate existing rates and develop rates for new services in the LEA Program. The rate study was completed in 2003.

- Consult regularly with the CDE, representatives of urban, rural, large and small school districts, and COE, the Local Education Consortium (LEC), LEAs and the LEA technical assistance project[5];
- 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 department change that results in an increase in reimbursement to LEAs;
- Encourage improved communications with the federal government, the CDE, and LEAs;
- Develop and update written guidelines to LEAs regarding best practices to avoid audit exceptions, as needed;
- Establish and maintain an LEA friendly interactive website; and
- File an annual report with the Legislature. The annual report requirements and corresponding sections in this report are summarized in Table 1 on the following page.

[5] The LEA technical assistance project disbanded in 2002.

Table 1: Annual Legislative Report Requirements

Report Section	Report Requirements
III	• An annual comparison of school-based Medicaid systems in comparable states. • A state-by-state comparison of school-based Medicaid total and per eligible child claims and federal revenues. The comparison shall include a review of the most recent two years for which completed data is available. • A summary of department activities and an explanation of how each activity contributed toward narrowing the gap between California's per eligible student federal fund recovery and the per student recovery of the top three states. • A listing of all school-based services, activities, and providers[6] 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 CDHS by the entities named in the legislation and the action taken by CDHS regarding each recommendation. The entities are the CDE, representatives of urban, rural, large and small school districts, and COE, the LEC, LEAs, the LEA technical assistance project[7], 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.

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

[7] The LEA technical assistance project disbanded in 2002.

II. BACKGROUND

Schools play a critical role in providing health services to students, particularly those requiring special education services. Since the 1970s, schools have been mandated by IDEA to provide appropriate educational services to all children with disabilities. School-based health services reimbursed by the LEA Program are primarily provided to students with disabilities receiving special education services through an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP). For a large number of these children, additional services, many of them health-related, are necessary to assist them in attaining their educational goals. The LEA Program also provides reimbursement for health services, such as nursing care, rendered to general education students.

Medicaid is the program that provides health care coverage and medical services to low-income children, pregnant women, families, persons with disabilities, and elderly citizens. Each state establishes a state Medicaid plan that outlines eligibility standards, provider requirements, payment methods, and benefit packages. States must submit SPAs to CMS for approval to make modifications to their Medicaid programs, including adding new services or updating the reimbursement rate methodology.

Medicaid is financed jointly by the states and the federal government. In school-based programs, LEAs fund the state share of Medicaid expenditures through CPEs. Federal Financial Participation (FFP) funds for Medicaid program expenditures are available for two types of services: medical assistance (referred to as “health services” in this report) and administrative activities. School-based health services reimbursable under Medicaid are:

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

Since the passage of SB 231, federal oversight by CMS and the OIG has significantly increased at a national level. Since October 2001, the OIG has issued audit reports for school-based programs in seventeen states. These reports are part of a series in a multi-state initiative reviewing costs claimed for Medicaid school-based health services. Reported findings, which have resulted in overpayments of millions of dollars to school, include:

- Insufficient documentation of services;
- Claims submitted for services provided by unqualified personnel;
- Inadequate referral and/or prescription for applicable services;
- Violation of Free Care requirements; and
- Insufficient rate-setting methodologies.

In May 2003, CMS issued a final guide, previously issued in drafts dated November 2002 and February 2000, on Medicaid school-based administrative claiming. The guide clarified and consolidated requirements for administrative claiming. In addition, CMS noted in its distribution letter that the guide "…is one of several publications we are issuing on Medicaid claiming for school-based health programs. In the future, we propose to publish additional guidance on payment for specialized transportation, as well as an addendum to the 1997 guide, 'Medicaid and School Health: A Technical Assistance Guide[8], that will address such issues as IEP services, state plan requirements, documentation for services, and rate setting." Upcoming guidance and clarification of requirements from CMS may affect the future approval of SPAs related to school-based health services by California and other states.

[8] This publication provides guidelines for school-based health services programs such as the LEA Program.

III. OTHER STATES' SCHOOL-BASED MEDICAID PROGRAMS

The annual survey of other states' school-based Medicaid programs was conducted to compare California's school-based programs to other states' programs. The responses obtained from the survey were supplemented by reviewing provider manuals and other sources of program information, as available, and/or interviewing state personnel.

School-Based Medicaid Systems in Comparable States

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

Table 2: Factors Considered in Selecting Comparable States

Factor	Source of Information
Number of Medicaid-eligible children aged 6 to 20	Medicaid Program Statistics, Federal Fiscal Year (FFY) 2002-03, CMS
Number of IDEA eligible children aged 3 to 21	Twenty-fifth Annual Report to Congress on the Implementation of the IDEA, 2003, U.S. Department of Education
Average salaries of instructional staff (classroom teachers, principals, supervisors, librarians, guidance and psychological personnel, and related instructional staff)	Rankings of the States 2004 and Estimates of School Statistics 2005, National Education Association (NEA), June 2005
Per capita personal income	Rankings of the States 2004 and Estimates of School Statistics 2005, NEA, June 2005

The first two factors provide a measure of the number of students that may be eligible for Medicaid school-based services. The third and fourth factors provide a comparison of the cost of living between states. The ten states with the greatest number of Medicaid-eligible children aged 6 through 20 were identified. Each of these states was ranked from highest to lowest based on each of the four factors. From this analysis, four states were selected as

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

Program changes during the past year are summarized below:

- California sent a letter to LEA providers in June 2004 to communicate federal clarification from CMS regarding Free Care and OHC requirements, including billing for state-mandated health assessments. The letter clarified that LEA providers must seek OHC information from all of their students and receive a 100 percent response rate to bill for non-IDEA services. In an effort to assist LEAs in obtaining a 100 percent response rate, CDHS published information in 2005 to the LEA Program website summarizing results from an OHC Survey, conducted to obtain information about the scope of benefits provided for services rendered by LEAs under insurance plans. Free Care and OHC requirements, as clarified in the June letter to LEA providers, are not relevant in the school-based programs of comparable states because their providers do not bill for non-IDEA services.
- SPA 03-024 was approved in March 2005. The SPA includes CPE requirements to reconcile the interim Medi-Cal reimbursements each LEA provider receives during the fiscal year with the actual costs to provide the health services rendered during this period. The reconciliation schedules were initially developed by CDHS, and subsequently collaborated on with CMS. On an annual basis, each LEA provider will complete a standardized cost report, known as the Cost and Reimbursement Comparison Schedule (CRCS). Using the CRCS forms, LEA providers will submit actual costs and annual hours worked for all practitioners who provided health-related services during the preceding fiscal year. After submission, CDHS will annually reconcile these costs to Medi-Cal reimbursement to ensure that each LEA provider is not paid more than its actual costs. Finally, the LEA providers will certify that the public funds expended for LEA services provided are eligible for FFP. The first cost

certification by LEAs will be for SFY 2006-07, due in November 2007.
In comparison, the LEA-specific rates in Illinois and Pennsylvania are developed based on each provider's actual costs on an annual basis, and no reconciliation is made at fiscal year end. New York and Michigan reimburse school providers based on statewide rates, and these programs currently do not require annual cost reconciliation. However, pursuant to CMS mandate, Michigan is in the process of developing a new rate methodology for its school-based services fee-for-service program.

- No new services were added to the LEA Program in 2005. Similarly, the comparable states did not add any new services to their programs in 2005. However, Pennsylvania indicated they were considering adding behavioral health services to their program in the future.
- The OIG released final reports of audit findings regarding school-based health services programs in two comparable states, New York and Illinois. The OIG disallowed significant Medicaid payments due to improper billing of services, insufficient documentation of services, inadequate referral information for speech therapy services, unqualified personnel rendering services, and non-compliance with transportation service requirements. Both states have contested the audit findings.

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

Administration of the third state survey began in October 2005. States were contacted to update information provided in the 2004 survey; states that did not participate in 2004 were given the opportunity to complete the current survey. Follow-up calls were made during Winter 2005, to states that had not responded 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 lack of staffing; several states did not respond to follow-up calls. 38 of 47 states completed the survey, including five states that did not participate last year.

Table 3 summarizes Medicaid reimbursement (federal share) for health services and administrative services for SFYs 2003-04[9] and 2004-05. Several states did not have data available for both SFYs. Federal Medicaid reimbursement was divided by each state's FFP rate to estimate total claim dollars. Total claim dollars were divided by the number of Medicaid-eligible children aged 6 through 20 to estimate the average claim amount per Medicaid-eligible child. Additional supportive information for Table 3 is provided in Appendices 1(a) and 1(b).

A comparison of the SFY 2003-04 average claim per Medicaid-eligible child in Table 3 to the average claim in the April 2000 report published by the GAO shows an increase in 27 of the 36 states that reported federal reimbursement (including California). The average claim decreased in seven states and remained the same in two states. California's average claim increased from $19 to $224 in SFY 2003-04[10]. California's average claim decreased to $142 in SFY 2004-05. This decrease is partially attributable to LEAs complying with Free Care and OHC requirements, as discussed earlier in this section[11]. In addition, the FMAP for California decreased between SFY 2003-2004 and 2004-2005, dropping from 52.95 percent to 50.00 percent over this period.

[9] A few states adjusted Medicaid reimbursement for SFY 2003-04 provided in the 2004 survey; the adjusted amounts are reflected in Table 3.

[10] California's average claim in SFY 2003-04 experienced a large increase partially due to the fact that the Medi-Cal Administrative Activities (MAA) Unit was able to process a backlog of administrative claims between July 2003 and June 2004.

[11] LEA reimbursement for health services decreased by approximately thirty percent between SFYs 2003-04 and 2004-05. The average claim per Medicaid-eligible child reflects reimbursement from health services as well as administrative services. Administrative billings decreased between SFYs 2003-04 and 2004-05 due to a backlog of MAA claims that were processed in SFY 2003-04.

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. In the 2005 state survey, Nebraska had the highest average claim of $818 for respondents providing information for SFY 2004-05, while California's average claim was $142, a difference of $676[12]. The gap between the state with the highest average claim and California's average claim has decreased by 15 percent since the April 2000 GAO Report was issued.

[12] For 2005 survey respondents providing information for SFY 2003-04, Rhode Island had the highest average claim per Medicaid-eligible child of $731, compared to California's average claim of $224, a difference of $507.

Table 3: Medicaid Reimbursement and Claims by State, Ranked by 2004-05 Average Claim Per Medicaid-Eligible Child

		SFY 2003-2004 [1]			SFY 2004-2005 [1]		
State		Federal Medicaid Reimbursement (000's)	Total Claims (000's)	Average Claim Per Medicaid-Eligible Child [2]	Federal Medicaid Reimbursement (000's)	Total Claims (000's)	Average Claim Per Medicaid-Eligible Child [2]
NEBRASKA		$ 11,625	$ 22,147	$ 231	$ 39,797	$ 78,438	$ 818
NEW HAMPSHIRE		15,380	29,046	659	16,196	32,392	734
RHODE ISLAND		27,759	49,350	731	23,652	43,537	645
MASSACHUSETTS		88,600	171,707	574	90,500	181,000	605
NEW YORK		393,062	742,327	655	294,027	588,054	519
DELAWARE		10,360	19,566	415	11,228	22,287	472
ILLINOIS		122,300	239,330	385	122,400	244,800	394
MARYLAND		64,562	121,930	419	55,723	111,446	383
PENNSYLVANIA		91,880	163,730	272	109,000	205,019	341
WEST VIRGINIA		21,843	28,131	231	30,439	40,938	337
GEORGIA		29,692	52,737	99	77,009	147,990	279
SOUTH DAKOTA		395	576	12	6,059	11,260	230
CONNECTICUT		21,000	39,660	233	19,500	39,000	230
IOWA		11,016	17,026	143	14,787	23,361	196
SOUTH CAROLINA		33,816	50,968	159	35,609	54,593	171
CALIFORNIA		298,593	587,055	224	185,528	371,056	142
FLORIDA		55,339	108,489	122	64,114	125,835	141
UTAH		8,585	11,497	153	7,223	10,012	133
VIRGINIA		12,660	24,823	100	15,962	31,924	129
IDAHO		5,121	6,929	92	6,453	9,138	121
COLORADO		8,841	16,697	114	8,466	16,932	116
OHIO		51,960	83,601	133	42,081	70,511	112
WASHINGTON		20,000	38,886	93	20,000	40,000	96
NEW MEXICO		6,683	8,590	45	8,031	11,515	60
ALASKA		-	-	-	1,410	2,791	60
LOUISIANA		8,418	11,287	27	11,413	18,338	44
ARKANSAS		5,375	6,925	28	5,079	6,795	28
INDIANA		3,629	5,560	17	5,434	8,656	26
OKLAHOMA		4,453	6,058	24	3,898	5,554	22
MISSISSIPPI		1,142	1,895	8	1,319	2,175	10
ALABAMA	3	20,817	41,410	149	-	-	-
KANSAS	3	42,411	68,780	653	-	-	-
KENTUCKY	3	9,875	18,589	67	-	-	-
MICHIGAN	3	108,978	190,436	320	-	-	-
MINNESOTA	3	39,063	76,275	327	-	-	-
MONTANA	3	7,526	10,949	321	-	-	-
NORTH CAROLINA	3	9,614	17,831	39	-	-	-
HAWAII	4	-	-	-	-	-	-
NORTH DAKOTA	4	-	-	-	-	-	-
TENNESSEE	4	-	-	-	-	-	-
WYOMING	4	-	-	-	-	-	-

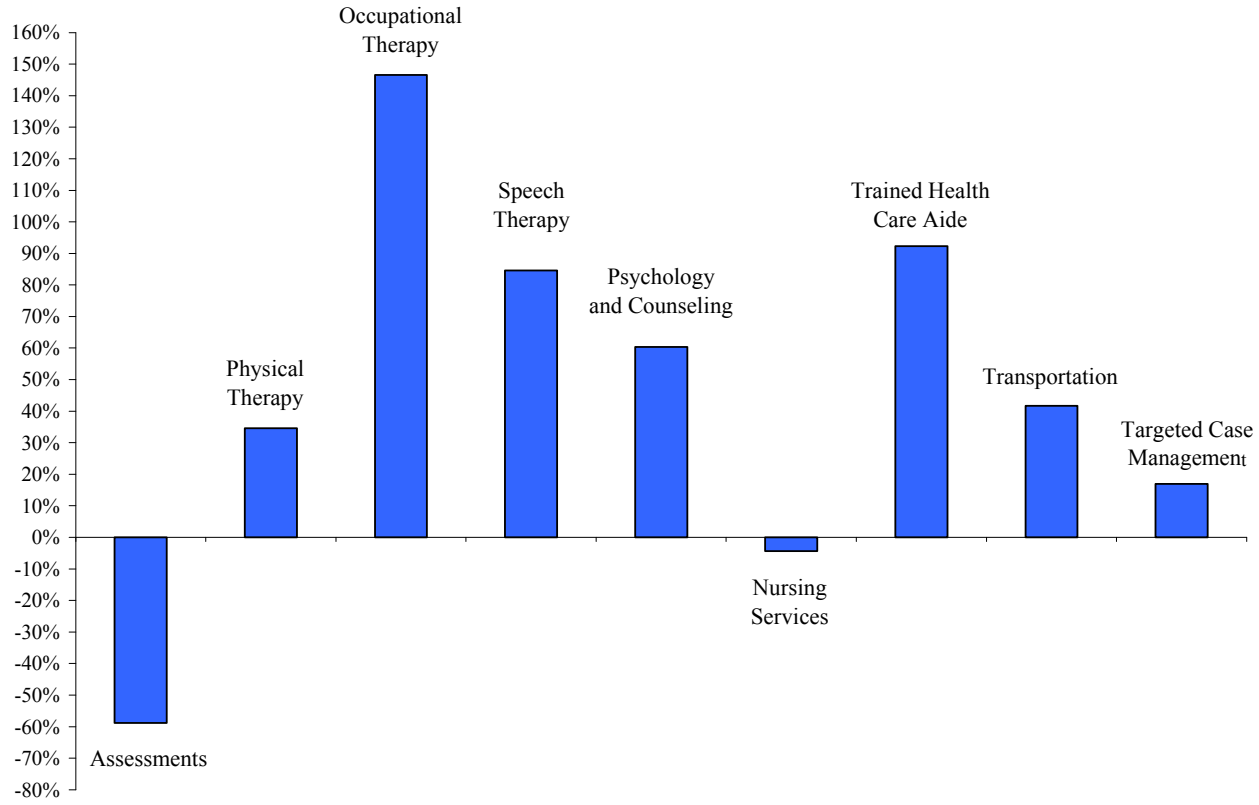
Notes:
(1) Amounts for health and administrative services are included in federal Medicaid reimbursement and total claims. Federal payment disallowances resulting from completed or on-going OIG audits may not be reflected in these amounts.
(2) Calculated as total claims divided by the number of Medicaid-eligible children (ages 6-20) in FFY 2002-03, if available, or FFY 2001-02. (Source: Medicaid Program Statistics, Centers for Medicare and Medicaid Services, http://new.cms.hhs.gov/MedicaidDataSourcesGenInfo/02_MSISData.asp)
(3) Federal reimbursement in SFY 2004-05 for this state's health services program and/or administrative claiming program was not available.
(4) This state did not have a school-based Medicaid health services program or administrative claiming program during SFY 2003-04 or SFY 2004-2005.

It should be noted that these survey results do not include any past, current or expected adjustments due to prior or on-going OIG or CMS investigations or audits.

Summary of Departmental Activities

Since the passage of SB 231, Medi-Cal reimbursement in the LEA Program has increased by seven percent, growing from $59.6 million in SFY 2000-01 to $63.9 million in SFY 2004-05. LEA services may be classified into nine service types: occupational therapy, physical therapy, speech therapy, psychology and counseling, nursing services, trained health care services, assessments, Targeted Case Management (TCM) services, and transportation. As indicated in Figure 1, percentage increases in service type reimbursement between SFYs 2000-01 and 2004-05 vary from a decrease of 59 percent (assessments) to an increase of 147 percent (occupational therapy). The 59 percent decrease in assessments reflects the more restrictive federal Free Care and OHC requirements discussed earlier in this section; the large volume of these assessment claims have significantly mitigated the sizeable growth in most other services, as noted in Figure 1.

Figure 1: Percentage Change In Reimbursement By Service Type, SFYs 2000-01 Through 2004-05



The state-by-state comparison of Medicaid reimbursement and claims in Table 3 includes reimbursement for health services as well as administrative services. In addition to the increase in LEA Program reimbursement, federal revenues from administrative activities claimed in the MAA Program have also increased since the GAO report was published in 2000. MAA reimbursement in SFY 2004-05 was $121.7 million[13].

[13] MAA reimbursement in SFY 2003-04 was $207.7 million, representing an increase due to a claim backlog that the MAA Unit was able to process between July 2003 and June 2004.

Various departmental activities have contributed to the increase in school-based reimbursement since the passage of SB 231. These include the following:

- **Implementation Activities Related to SPA 03-024**

  The focus of 2005 has been related to activities surrounding the upcoming implementation of SPA 03-024. CDHS has worked in conjunction with PSD and EDS to update existing LEA-specific local codes with Health Insurance Portability and Accountability Act (HIPAA) compliant national codes. In addition, CDHS has worked with PSD/EDS to institute policy changes related to modifiers, qualified practitioner types, maximum units of service, and general utilization controls. PSD/EDS expect the updated reimbursement rates resulting from SPA 03-024 will be implemented on July 1, 2006.

  The LEA Program has worked in conjunction with CDHS A&I to design and train the LEA provider community on the CRCS forms and instructions. Other tasks related to implementation of SPA 03-024 included discussing re-billing technicalities with LEA providers and CMS, restructuring and re-writing the LEA Provider Manual, and developing SPA implementation provider training materials.

- **LEA Workgroup**

  The LEA Workgroup was organized in early 2001. Members of the LEA Workgroup represent large, medium, and small school districts, COE, professional associations representing LEA services, CDHS, and the CDE. Meetings are held every other month and provide a forum for Workgroup members to identify relevant issues and make recommendations for changes to the LEA Program. Some of these recommendations have resulted in updates to the LEA Program and increased federal reimbursement. For example, group therapy for speech and audiology services, as well as assessments provided by occupational therapists and physical therapists were added as reimbursable services. These changes resulted in reimbursement increases for assessments and treatment services.

- **SPA 98-002**

  In June 2001, CMS approved SPA 98-002, which added several reimbursable services to the LEA Program. These included treatment services provided by credentialed language, speech and hearing specialists,[14] school psychologists, and school social workers. The addition of these services contributed to increased reimbursement for speech therapy and audiology services, as well as psychology and counseling services.

- **Data Match System**

  Effective June 2005, Information Technology Services Division added all eligible LEA aid codes to the Medi-Cal Eligibility Data System, which is used in data match processing. This modification updated valid Medi-Cal eligibility codes for the LEA Program to include foster children, adopted children, and other eligible populations in the data match system. The additions of the eligible aid codes have resulted in increased reimbursement for LEAs serving Medi-Cal eligible beneficiaries.

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. However, there are additional 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, review of relevant provider manuals and Medicaid state plans, and interviews with other states' program personnel. These services are listed below:

- Behavioral services provided by a behavioral aide, certified behavioral analyst, certified associate behavioral analyst, or intern;

[14] Under SPA 03-024, approved by CMS in March 2005, services provided by credentialed language, speech and hearing specialists must be provided under the direction of a licensed speech-language pathologist within their scope of practice.

- Dental assessment and health education provided by a licensed dental hygienist;
- Durable medical equipment and assistive technology devices;
- IEP review services;
- Interpreter services;
- Occupational therapy services provided by an occupational therapy assistant;
- Orientation and mobility services;
- Personal care services;
- Physical therapy services provided by a physical therapy assistant;
- Respiratory therapy services;
- Services for children with speech and language disorders provided by a speech-language pathology assistant; and
- Specialized transportation.

Detailed information, consisting of descriptions, qualified practitioners, and rates for additional services provided in other state programs can be found in Appendix 2.

IV. OFFICIAL RECOMMENDATIONS MADE TO CDHS

Official recommendations are made to CDHS during LEA Workgroup meetings. The following table summarizes the recommendations made to CDHS and the action taken/to be taken regarding each recommendation. Recommendations related to new services and providers that have not been added to the state plan or included in a proposed SPA are noted in Section V.

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

Recommendation	Action Taken/To Be Taken
• Implement LEA Rate Study recommendations related to assessments conducted to determine a student's eligibility for services under IDEA[15] and treatment services. • Revise state regulations to expand the provider types that are authorized to prescribe, refer, and recommend services, as appropriate.	• CDHS prepared a System Development Notice (SDN) which contains instructions regarding changes in the claims processing system to implement LEA Rate Study recommendations. These changes include conversion to new national billing codes required by HIPAA. In 2005, CDHS expended considerable time and effort to respond to issues raised by PSD/EDS regarding implementation of the SDN, audit protocols, and utilization controls for LEA services. • A regulation proposal package is being prepared in consultation with the LEA Workgroup. CDHS will propose revisions to State regulations that are required to implement LEA Rate Study recommendations, and are consistent with SPA 03-024, federal law and regulations, and State law. Continued work on a regulation proposal package will be a major focus in 2006.

[15] Schools are mandated by the IDEA to provide appropriate educational services to all children with disabilities. School-based health services reimbursed by the LEA Program are primarily provided to students with disabilities receiving special education services through an IEP or IFSP. The LEA Program also provides reimbursement for health services, such as nursing care, rendered to general education students.

Recommendation	Action Taken/To Be Taken
• Re-write sections of the LEA Provider Manual to improve the organization and content of the information. • Research utilization controls related to LEAs and beneficiaries.	• CDHS continued work on the re-organization and content revision of the LEA Provider Manual in 2005. Utilization controls, provider qualifications, and numerous other topics were researched to support proposed changes. A total of six State Plan Amendment (SPA) 03-024 Implementation trainings were conducted in April and May of 2006. The reorganization and content revision of the LEA Provider Manual replete with information regarding billing policies and procedures is complete and available on the LEA website as of July 1, 2006.
• Develop and maintain an interactive website.	• Maintenance activities in 2005 included posting copies of the 2004-05 Provider Annual Report forms, OHC Survey schedules, Workgroup Meeting Summaries, updated Data Match Record Layout form, CRCS training materials, and Medi-Cal reimbursement reports. • CDHS created an electronic mailing list that LEA personnel may subscribe to and automatically receive e-mails to be notified when new or updated information has been posted on the LEA Program website. • Additional time will be spent to update the website based on recommendations for changes from the LEA Workgroup.
• Establish equivalency for credentialed speech-language pathologists.	• CDHS, in collaboration with the CCTC, established that the educational and work requirements for credentialed speech-language pathologists with CRS credentials were equivalent to federal standards. CDHS submitted a SPA in 2005 to remove supervision requirements for these practitioners. Prior to CMS approval, the federal government has indicated that they will require an equivalency ruling from the AG. CDHS will continue to work with the AG to establish such a ruling.

Recommendation	Action Taken/To Be Taken
• Improve communications regarding policy issues (to the extent allowed by Executive Order S-2-03) and status of SB 231 implementation with LEA providers.	• In 2005, CDHS conducted the first of a series of training sessions to provide LEAs with information on how to complete the CRCS forms. In addition, the training provided information to help LEAs identify changes that may be required of their financial reporting systems, in order to comply with the CRCS reporting requirements. Future trainings will occur in 2006 and a taped training session will eventually be available. • In Fall 2005, CDHS created an e-mail address for providers to submit questions regarding the CRCS process. • Cost and Reimbursement Comparison Schedule (CRCS) trainings were held in Downey, Fresno, and a taped session in Sacramento on March 16, 2006. From the taped session in Sacramento, Digital Video Disks (DVDs) were made. The DVDs are scheduled to be distributed to participating LEAs by the end of July 2006. The CRCS will be used to compare each LEAs total actual costs for LEA services with interim Medi-Cal reimbursement for a specific fiscal year. • CDHS continues to prepare LEA Workgroup Meeting Summaries, containing information regarding items discussed during the bi-monthly Workgroup meetings. The meeting summaries are posted on the LEA Program website. • In 2006, CDHS plans to disseminate information on upcoming training sessions through industry trade association meetings and conferences.
• Update the statewide LEA provider contact list.	• The statewide LEA provider contact list was updated with addresses and contact names from training sessions held in 2005. This list will be further updated with information, including e-mail addresses, from future training sessions and the LEA Program website electronic mailing list.
• Update valid Medi-Cal eligibility codes for the LEA Program to include foster children, adopted children, and other eligible populations in the data match system.	• CDHS identified valid eligibility codes for the LEA Program. Changes to the Medi-Cal Eligibility Data Systems files used in data match processing were completed in 2005.

Recommendation	Action Taken/To Be Taken
• Conduct an insurance carrier survey and post results to the LEA Program website.	• CDHS will conduct an updated insurance carrier survey in 2006 to determine if carriers provide coverage for LEA Program services. The survey will be based on the new HIPAA-compliant national codes to be implemented in July 2006. Results will be posted on the LEA Program website.
• Provide quarterly status reports describing how SB 231 funds are spent.	• The contractor that assists CDHS in implementing the provisions of SB 231 prepares monthly status reports of actual and projected activities. CDHS distributes the monthly status reports to the LEA Workgroup. Reports detailing activities conducted in 2006 will be provided at the LEA Workgroup meetings on a periodic basis.
• Establish a hotline to answer questions regarding billing policies.	• The State's fiscal intermediary, EDS, has a hotline to answer billing questions from LEA providers and billing vendors. EDS also provides on-site training to providers, as requested.
• Submit SPAs and subsequent updates to CMS on a timely basis.	• CDHS will continue to work towards submission of future SPAs within a reasonable time frame. However, the CMS approval process is lengthy, particularly in this period of federal budget deficits. CDHS cannot offer any assurance that future SPAs will move more quickly or smoothly.

V. ONE-YEAR TIMETABLE FOR STATE PLAN AMENDMENTS

The SPA submitted in June 2003 was re-submitted to CMS in December 2004, and finally approved in March 2005. The delays associated with CMS approval have extended the original expected timetable related to subsequent SPA submissions. We estimate the following:

Table 5: Timetable for Proposed State Plan Amendments

Service Description	Estimated Submission Date
• TCM services: These services include IEP review services performed by a case manager to coordinate the development of an IEP/IFSP and attendance at meetings by health service providers to write the IEP/IFSP. In September 2004, CDHS submitted proposed language for a SPA to expand TCM services in the LEA Program. CMS responded that it could not approve the proposed language, as written, citing issues with duplicative and target population coverage and recipient freedom of choice of agencies. Follow-up with CMS is pending.	• On hold, pending resolution of federal administration's proposed budget language and potential restrictions.
• Speech-language equivalency. The SPA to remove supervision requirements for credentialed speech-language pathologists was submitted to CMS in Summer 2005. CMS has required a letter of equivalency from the AG, as discussed in Section IV.	• Pending CMS approval
• Personal care services.	• SFY 2006/07
• Physician services: These services include IEP/IFSP assessments, specialized evaluations, and consultations. Although these services were considered in the LEA Rate Study, sufficient data was not collected to develop rates for the SPA submitted in June 2003. Rates for these services may be developed after additional physician cost data is collected.	• SFY 2006/07
• Vision assessments.	• SFY 2006/07

Service Description	Estimated Submission Date
• Services provided by physical therapy, occupational therapy, and speech therapy assistants.	• SFY 2006/07
• Behavioral services provided by certified behavioral analysts, certified associate behavioral analysts, behavioral health aides, and interns.	• SFY 2006/07

VI. BARRIERS TO REIMBURSEMENT

Barriers to reimbursement continue to be identified through discussions with LEA Workgroup members and personnel from other LEAs during field visits. Table 6 describes the barriers to reimbursement identified in 2005, as well as the actions that have been and will be taken by CDHS.

Table 6: Barriers to Reimbursement

Barriers	Actions Taken /To Be Taken
• Certain health and mental health services are provided by LEAs but are not currently reimbursable in the LEA Program.	• Extensive research on personal care, therapy assistants, and behavioral intervention services was conducted in 2005. CDHS will propose to meet with CMS regarding potential new services in 2006. • Assuming the current Medi-Cal fee schedule rate can be adopted for therapy assistants, a SPA will be developed and submitted in SFY 2006-07 to expand the list of qualified practitioners in the LEA Program. • A cost survey will be designed in SFY 2006-07 to collect information from a sample of LEAs employing practitioners providing behavioral services, dieticians, physicians, and other practitioners. • SPAs to add new services and/or qualified providers will be submitted to CMS, as discussed in Section V.
• Enrollment requirements may hinder new school districts and COE from enrolling in the LEA Program.	• Orientations for school districts and COE that are not LEA providers, including steps required to become a participating provider and an overview of billing policies and procedures, will be planned subsequent to implementation of the first submitted SPA.
• An LEA may not bill for services that are provided by its contractors unless it employs one or more personnel that provide the same service rendered by its contractors.	• CDHS is seeking clarification from CMS regarding the models of service delivery, including retaining contracted practitioners to provide LEA services.

Barriers	Actions Taken /To Be Taken
• LEA Program billing policies and procedures are not well documented.	• Training sessions for LEA providers will be held in Spring 2006 to inform LEAs of billing policies and procedures related to SPA 03-024. • The reorganization and content revision of the LEA Provider Manual, as described in Section IV, will further help to clarify LEA Program billing policies and procedures. • SPA implementation training FAQs are being reviewed with an estimated completion time of early August 2006. Once the review is complete, the FAQs will be posted to the LEA program website.
• Funds received as reimbursement for services provided under the LEA Program must be reinvested in services for children and their families. The reinvestment requirements, which stipulate that funds must be used to supplement and not supplant existing services are difficult to interpret and apply.	• The LEA Program was established in 1993 to help sustain activities funded by state grants under the Healthy Start program which is administered by the CDE. CDE is responsible for interpreting reinvestment requirements. CDHS will collaborate with CDE and post a narrative summary of the results on the CDHS website.
• The LEA Program will not reimburse for services that are provided free of charge unless the LEA complies with Free Care and OHC requirements.	• In 2004, Oklahoma appealed a federal disallowance related to Free Care services (non-IDEA services) that were identified in an OIG audit. The federal Department of Health and Human Services Departmental Appeals Board (Board) agreed with Oklahoma's opinion that federal legislation did not support CMS' Free Care policy. The Board reaffirmed its decision in January 2005. CDHS requested guidance from CMS regarding the impact of the Oklahoma decision on reimbursement of non-IDEA services in the LEA Program. • CDHS submitted a letter to CMS requesting that the Free Care policy be discontinued for the LEA Program in California based on the Oklahoma decision. CMS denied the waiver and Free Care requirements are still applicable to LEA providers. • In 2006, CDHS plans to submit a third party liability waiver request to CMS for IDEA students only.

VII. APPENDICES

Appendix 1(a): Medicaid Reimbursement And Claims By State
Ranked By Average Claim Per Medicaid-Eligible Child, State Fiscal Year (SFY) 2004-2005

		SFY 2003-2004					
		Federal Reimbursement (Federal Share)			Claims		
State	FMAP (1)	Health (000's)	Administrative (000's)	Total (000's)	Health (000's) (2)	Administrative (000's) (3)	Total (000's)
NEBRASKA	62.84%	2,700	8,925	11,625	4,297	17,850	22,147
NEW HAMPSHIRE	52.95%	15,380	-	15,380	29,046	-	29,046
RHODE ISLAND	58.98%	20,257	7,502	27,759	34,346	15,004	49,350
MASSACHUSETTS	52.95%	49,300	39,300	88,600	93,107	78,600	171,707
NEW YORK	52.95%	393,062	-	393,062	742,327	-	742,327
DELAWARE	52.95%	10,360	-	10,360	19,566	-	19,566
ILLINOIS	52.95%	47,300	75,000	122,300	89,330	150,000	239,330
MARYLAND	52.95%	64,562	-	64,562	121,930	-	121,930
PENNSYLVANIA	57.71%	74,963	16,917	91,880	129,896	33,834	163,730
WEST VIRGINIA	78.14%	21,597	246	21,843	27,639	492	28,131
GEORGIA	62.55%	16,565	13,127	29,692	26,483	26,254	52,737
SOUTH DAKOTA	68.62%	395	-	395	576	-	576
CONNECTICUT	52.95%	21,000	-	21,000	39,660	-	39,660
IOWA	66.88%	9,917	1,099	11,016	14,828	2,198	17,026
SOUTH CAROLINA	72.81%	26,596	7,220	33,816	36,528	14,440	50,968
CALIFORNIA	52.95%	90,920	207,673	298,593	171,709	415,346	587,055
FLORIDA	61.88%	5,702	49,637	55,339	9,215	99,274	108,489
UTAH	74.67%	8,585	-	8,585	11,497	-	11,497
VIRGINIA	53.48%	3,819	8,841	12,660	7,141	17,682	24,823
IDAHO	73.91%	5,121	-	5,121	6,929	-	6,929
COLORADO	52.95%	8,841	-	8,841	16,697	-	16,697
OHIO	62.18%	51,865	95	51,960	83,411	190	83,601
WASHINGTON	52.95%	10,000	10,000	20,000	18,886	20,000	38,886
NEW MEXICO	77.80%	6,683	-	6,683	8,590	-	8,590
ALASKA	61.34%	-	-	-	-	-	-
LOUISIANA	74.58%	8,418	-	8,418	11,287	-	11,287
ARKANSAS	77.62%	5,375	-	5,375	6,925	-	6,925
INDIANA	65.27%	3,629	-	3,629	5,560	-	5,560
OKLAHOMA	73.51%	4,453	-	4,453	6,058	-	6,058
MISSISSIPPI	80.03%	519	623	1,142	649	1,246	1,895
ALABAMA	73.70%	349	20,468	20,817	474	40,936	41,410
KANSAS	63.77%	37,145	5,266	42,411	58,248	10,532	68,780
KENTUCKY	73.04%	1,841	8,034	9,875	2,521	16,068	18,589
MICHIGAN	58.84%	91,589	17,389	108,978	155,658	34,778	190,436
MINNESOTA	52.95%	16,608	22,455	39,063	31,365	44,910	76,275
MONTANA	75.91%	6,010	1,516	7,526	7,917	3,032	10,949
NORTH CAROLINA	65.80%	2,909	6,705	9,614	4,421	13,410	17,831
HAWAII [4]	61.85%	-	-	-	-	-	-
NORTH DAKOTA [4]	67.49%	-	-	-	-	-	-
TENNESSEE [4]	67.54%	-	-	-	-	-	-
WYOMING [4]	64.27%	-	-	-	-	-	-

(1) The Federal Medical Assistance Percentage (FMAP) for each state was obtained from the Federal Register, published on June 17, 2003.

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

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

(4) This state did not have a school-based Medicaid health services program or administrative claiming program in effect during SFY 2003-04 or SFY 2004-05.

Appendix 1(b): Medicaid Reimbursement And Claims By State
Ranked By Average Claim Per Medicaid-Eligible Child, State Fiscal Year (SFY) 2004 - 2005

			SFY 2004-2005					
			Federal Reimbursement (Federal Share)			Claims		
State		FMAP (1)	Health (000's)	Administrative (000's)	Total (000's)	Health (000's) (2)	Administrative (000's) (3)	Total (000's)
NEBRASKA		59.64%	3,576	36,221	39,797	5,996	72,442	78,438
NEW HAMPSHIRE		50.00%	16,196	-	16,196	32,392	-	32,392
RHODE ISLAND		55.38%	19,386	4,266	23,652	35,005	8,532	43,537
MASSACHUSETTS		50.00%	53,900	36,600	90,500	107,800	73,200	181,000
NEW YORK		50.00%	294,027	-	294,027	588,054	-	588,054
DELAWARE		50.38%	11,228	-	11,228	22,287	-	22,287
ILLINOIS		50.00%	34,000	88,400	122,400	68,000	176,800	244,800
MARYLAND		50.00%	55,723	-	55,723	111,446	-	111,446
PENNSYLVANIA		53.84%	91,000	18,000	109,000	169,019	36,000	205,019
WEST VIRGINIA		74.65%	30,193	246	30,439	40,446	492	40,938
GEORGIA		60.44%	17,449	59,560	77,009	28,870	119,120	147,990
SOUTH DAKOTA		66.03%	1,768	4,291	6,059	2,678	8,582	11,260
CONNECTICUT		50.00%	19,500	-	19,500	39,000	-	39,000
IOWA		63.55%	14,570	217	14,787	22,927	434	23,361
SOUTH CAROLINA		69.89%	29,209	6,400	35,609	41,793	12,800	54,593
CALIFORNIA		50.00%	63,881	121,647	185,528	127,762	243,294	371,056
FLORIDA		58.90%	7,917	56,197	64,114	13,441	112,394	125,835
UTAH		72.14%	7,223	-	7,223	10,012	-	10,012
VIRGINIA		50.00%	4,515	11,447	15,962	9,030	22,894	31,924
IDAHO		70.62%	6,453	-	6,453	9,138	-	9,138
COLORADO		50.00%	8,466	-	8,466	16,932	-	16,932
OHIO		59.68%	42,081	-	42,081	70,511	-	70,511
WASHINGTON		50.00%	10,000	10,000	20,000	20,000	20,000	40,000
NEW MEXICO		74.30%	6,951	1,080	8,031	9,355	2,160	11,515
ALASKA		57.58%	110	1,300	1,410	191	2,600	2,791
LOUISIANA		71.04%	7,576	3,837	11,413	10,664	7,674	18,338
ARKANSAS		74.75%	5,079	-	5,079	6,795	-	6,795
INDIANA		62.78%	5,434	-	5,434	8,656	-	8,656
OKLAHOMA		70.18%	3,898	-	3,898	5,554	-	5,554
MISSISSIPPI		77.08%	659	660	1,319	855	1,320	2,175
ALABAMA	4	70.83%	-	-	-	-	-	-
KANSAS	4	61.01%	-	-	-	-	-	-
KENTUCKY	4	69.60%	-	-	-	-	-	-
MICHIGAN	4	56.71%	-	-	-	-	-	-
MINNESOTA	4	50.00%	-	-	-	-	-	-
MONTANA	4	71.90%	-	-	-	-	-	-
NORTH CAROLINA	4	63.63%	-	-	-	-	-	-
HAWAII	5	58.47%	-	-	-	-	-	-
NORTH DAKOTA	5	67.49%	-	-	-	-	-	-
TENNESSEE	5	64.81%	-	-	-	-	-	-
WYOMING	5	57.90%	-	-	-	-	-	-

(1) The Federal Medical Assistance Percentage (FMAP) for each state was obtained from the Federal Register, published on December 3, 2003.

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

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

(4) Total federal reimbursement for this state's health services program and/or administrative claiming program was not available for SFY 2004-05.

(5) This state did not have a school-based Medicaid health services program or administrative claiming program in effect during SFY 2003-04 or SFY 2004-2005.

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

Service	Qualified Provider(s)	Example Rates
Behavioral services provided by a behavioral aide Behavioral aide services prevent or correct maladaptive behavior on the part of the child. The interventions are used to change specific behaviors. A behavioral plan is designed by a mental health professional and carried out by behavioral aides. The plan provides a description of the behavior to be addressed and positive or negative incentives to encourage appropriate behavior.	**Mental health behavioral aide** A paraprofessional working under the direction of a mental health professional.	**Iowa:** $10.20 per 15-minute increment. **Minnesota:** Based on each school district's cost of providing service.
Behavioral services provided by a certified behavioral analyst or certified associate behavioral analyst Behavioral services include behavioral evaluations and functional assessments, analytic interpretation of assessment results, and design and delivery of treatments and intervention methods.	**Certified behavior analyst** A person with a bachelor's or master's degree who meets state requirements for a certified behavioral analyst. A person with a bachelor's degree must work under the supervision of a certified behavioral analyst with a master's degree. **Certified associate behavioral analyst** A person with a bachelor degree or higher who meets state requirements for a certified associate behavioral analyst and who works under supervision of a certified behavioral analyst with a master's degree.	**Florida:** Certified behavior analyst, $8.00 per 15-minute increment. Certified behavior analyst (bachelor's level), $6.70 per 15-minute increment. Certified associate behavior analyst, $6.70 per 15-minute increment.
Behavioral services provided by an intern Behavioral services include testing, assessment and evaluation that appraise cognitive, developmental, emotional, and social functioning; therapy and counseling, and crises assistance.	**Psychologist intern, Social worker intern** A psychologist or social worker with a master's degree or higher obtaining the required work experience for licensure and working under the supervision of a qualified provider.	**Florida:** Psychologist, $9.66 per 15-minute increment. Social worker, $8.97 per 15-minute increment. **Illinois:** Based on each school district's cost of providing service.

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

Service	Qualified Provider(s)	Example Rates
Dental assessment and health education provided under Early and Periodic Screening, Diagnostic and Treatment services Dental assessment services include a dental oral exam using a mouth mirror and explorer to identify abnormalities, such as abscess, growth or lesion, traumatic injury and periodontal problems. Dental health education includes one-on-one teaching of awareness, prevention and education, including awareness of teeth and dental hygiene techniques.	**Dental hygienist** A person who is a licensed dental hygienist.	**Delaware:** $29.28 per 15-minute increment.
Durable medical equipment and assistive technology devices Purchase or rental of medically necessary and appropriate assistive devices such as augmentative communication devices, crouch screen voice synthesizers, prone standers, corner chairs, wheelchairs, crutches, walkers, auditory trainers, and suctioning machines. The equipment is for the exclusive use of the child and is the property of the child.	**Not applicable**	**Illinois:** Medically necessary equipment may be claimed up to a total of $1,000 per day based on the cost of the equipment. **Minnesota:** Based on purchase price, rental costs or costs of repairs.
IEP review services Coordination and management of the activities leading up to and including the writing of the IEP or IFSP, including convening and conducting the meeting to write the IEP or IFSP.	**Case manager** A person who has a bachelor's degree with a major in special education, social services, psychology, or related field; or a registered nurse.	**Georgia (interim rates):** Initial: $217 (one per lifetime) Triennial: $217 Review: $145 **West Virginia:** Initial or Triennial: $662.29 Annual: $161.77

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

Service	Qualified Provider(s)	Example Rates
Interpreter services Interpretive services rendered to a child who requires an interpreter to communicate with the professional or paraprofessional providing the child with a health-related service. Services include oral language interpretation for children with limited English proficiency or sign language interpretation for children who are deaf or hard of hearing. Services must be provided in conjunction with another Medicaid service.	**Interpreter** Oral language: A person who speaks the language understood by the child and who is employed by or has a contract with the school district to provide oral language interpreter services. Sign language: A person with a bachelor's degree or higher who has graduated with a valid certification from a recognized interpreters' evaluation program.	**Minnesota:** $12.50 per 15-minute increment (oral language). **Pennsylvania:** Based on each school district's cost of providing service.
Occupational therapy services provided by an occupational therapy assistant Services rendered to a child to develop, improve, or restore functional abilities related to self-help skills, adaptive behavior and sensory, motor, postural development, and emotional deficits that have been limited by a physical injury, illness, or other dysfunctional condition.	**Occupational therapy assistant** A person who meets state requirements as an occupational therapy assistant and works under the direction of a qualified occupational therapist.	Most states do not have separate rates for occupational therapy services provided by occupational therapists and occupational therapy assistants. The rate listed below applies to occupational therapy assistants only. **Florida:** $13.58 per 15-minute increment.
Orientation and mobility services Evaluation and training designed to correct or alleviate movement deficiencies created by a loss or lack of vision in order to enhance the child's ability to function safely, efficiently and purposefully in a variety of environments.	**Orientation and mobility provider** - Orientation and mobility specialist certified by the Association for the Education and Rehabilitation of the Blind and Visually Impaired; - Teacher of special education with approval as teacher of the visually impaired; or - Assistive technology consultant with a master's degree in special education or speech pathology.	**Michigan:** $31.34 per 15-minute increment. **South Carolina:** Comprehensive assessment: $120 (one per lifetime). Reassessment: $82.50 Treatment: $13.75 per 15-minute increment.

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

Service	Qualified Provider(s)	Example Rates
Personal Care Services Services and support furnished to an individual to assist in accomplishing activities of daily living (eating, toileting, grooming, dressing, bathing, transferring, mobility, and positioning); health related functions through hands-on assistance, supervision, and cuing; and redirection and intervention for behavior, including observation.	**Health aide, Personal care assistant** A paraprofessional supervised by a qualified health care professional.	**Arizona:** 1 hour per day: $13.96 3 hours per day: $41.88 6 hours per day: $83.76 **West Virginia:** Full-day students: $173.79 Partial-day students: $86.90
Physical therapy services provided by a physical therapy assistant Services rendered to a child to develop, improve or restore neuromuscular or sensory-motor function, relieve pain, or control postural deviations to attain maximum performance.	**Physical therapy assistant** A person who meets state requirements for a physical therapy assistant and works under the direction of a qualified physical therapist. One state allows a physical education teacher or an adaptive physical education teacher to bill for services as a paraprofessional if the services are prescribed and supervised by a licensed physical therapist.	Most states do not have separate rates for physical therapy services provided by physical therapists and physical therapy assistants. The rate listed below applies to physical therapy assistants only. **Florida:** $13.58 per 15-minute increment.
Respiratory therapy services Respiratory therapy services assist a child who has breathing or other cardiopulmonary disorders. Procedures include, but are not limited to, the assessment and therapeutic use of the following: medical gases (excluding anesthetic gases); aerosols, humidification, environmental control systems; ventilator support; and maintenance and care of natural and artificial airways.	**Licensed respiratory therapist** A person who meets state requirements as a licensed respiratory therapist.	**Kentucky:** $3.75 per 15-minute increment.

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

Service	Qualified Provider(s)	Example Rates
Services for children with speech and language disorders provided by a speech-language pathology assistant Services rendered to a child to treat speech and language disorders of verbal and written language, articulation, voice, fluency, phonology, and mastication.	**Speech-language pathology assistant** A person who meets state requirements for a speech-language pathology assistant and works under the direction of a qualified speech pathologist.	Most states do not have separate rates for speech therapy services provided by speech pathologists and speech-language pathology assistants. The rate listed below applies to speech-language pathology assistants only. **Florida:** $13.58 per 15-minute increment.
Specialized transportation Transportation in a vehicle adapted to serve the needs of the disabled to and from school when the child receives a Medicaid-covered service in school and when transportation is specifically listed in the IEP or IFSP as a required service. Transportation from the school to a provider in the community also may be billed to Medicaid. (Transportation for students that require a litter van or wheelchair van is currently reimbursable in the LEA Program.)	**Not Applicable**	**Michigan:** Wheelchair van/Other specialized vehicles: $45.37 per round trip. Special education vehicle: $25.77 per round trip. **New York:** $12.23 – 25.33 per day. In Michigan and New York, providers may not bill separately for an attendant.

Appendix 3
Additional Information for January 2003 through March 2005

Medicaid Reimbursement and Claims by State, Ranked by Average Claim Per Medicaid-Eligible Child, State Fiscal Year

	SFY 2001-2002 [A] * (Numbers in thousands.)		
State	Federal Medicaid Reimbursement * (000's)	Total Claims * (000's)	Average Claim Per Medicaid Eligible Child [B]
RHODE ISLAND	$ 22,626	$ 43, 675	$ 720
MICHIGAN [C]	192,973	367,644	673
MASSACHUSETTS	95,100	190,200	565
NEW HAMPSHIRE	11,129	22,258	510
KANSAS	29,984	51,088	490
ALASKA	11,982	23,964	478
MARYLAND	56,824	113,648	417
DELAWARE	8,262	16,524	384
CONNECTICUT	30,000	60,000	379
NEW JERSEY [C]	56,641	113,282	367
UTAH	12,805	21,334	345
WISCONSIN	37,000	64,050	290
ARIZONA [C]	36,744	65,696	240
MINNESOTA	19,800	39,600	182
PENNSYLVANIA	51,024	95,623	169
WEST VIRGINIA	14,745	19,753	167
FLORIDA	66,000	130,633	159
ALABAMA [C]	15,472	30,859	138
IOWA	8,170	14,552	131
COLORADO	7,515	15,030	113
OHIO	39,446	67,108	112
SOUTH CAROLINA	23,235	34,210	103
NEBRASKA [C]	4,940	9,880	103
NORTH CAROLINA [C]	20,604	40,328	90
VERMONT	2,673	4,239	86
CALIFORNIA	82,174	160,650	60
NEW MEXICO [C]	6,804	10,254	56
GEORGIA	14,201	25,188	55
IDAHO	2,609	3,674	54
SOUTH DAKOTA	938	1,423	33
MONTANA [C]	766	1,052	31
VIRGINIA	1,757	3,415	14
INDIANA	2,468	3,978	13
KENTUCKY [C]	1,797	2,569	10
MISSISSIPPI	107	141	1
ARKANSAS	5	7	0
HAWAII [D]	-	-	-
TENNESSEE [D]	-	-	-
WYOMING [D]	-	-	-

State	SFY 2002 - 2003 [A] * (Numbers in thousands.)			SFY 2003 - 2004 [A] * (Numbers in thousands.)		
	Federal Medicaid Reimbursement * (000's)	Total Claims * (000's)	Average Claim Per Medicaid Eligible Child [B]	Federal Medicaid Reimbursement * (000's)	Total Claims * (000's)	Average Claim Per Medicaid Eligible Child [B]
RHODE ISLAND	$ 26,600	$ 49,311	$ 720	$ 27,759	$ 49,350	$ 721
KANSAS	32,836	55,613	514	42,411	68,780	636
NEW HAMPSHIRE	12,894	25,788	548	15,380	29,046	617
DELAWARE	9,957	19,914	427	10,360	19,566	419
MARYLAND	63,983	127,966	439	64,562	121,930	419
MINNESOTA	35,065	70,130	299	39,063	76,275	325
PENNSYLVANIA	76,660	143,115	238	91,880	163,730	272
CONNECTICUT	20,000	40,000	238	21,000	39,660	236
WEST VIRGINIA	16,712	22,412	181	21,843	28,131	227
NEBRASKA	11,709	22,035	214	11,625	22,147	215
CALIFORNIA	103,593	207,186	71	298,593	587,055	202
UTAH	13,216	21,988	314	8,585	11,497	164
SOUTH CAROLINA	35,463	56,223	164	33,816	50,968	149
FLORIDA	64,301	126,526	139	55,339	108,489	119
OHIO	53,409	90,785	141	47,588	76,533	119
COLORADO	11,166	22,332	159	8,841	16,697	119
GEORGIA	13,310	23,683	46	29,857	53,067	102
IDAHO	3,463	4,880	61	5,969	8,076	101
IOWA	12,200	20,446	166	7,609	12,391	101
VIRGINIA	3,996	7,932	30	12,660	24,823	95
NEW MEXICO	2,772	3,718	20	6,683	8,590	47
ARKANSAS	6,209	8,359	35	5,375	6,925	29
OKLAHOMA	5,654	8,013	29	4,453	6,058	22
INDIANA	3,367	5,433	16	3,629	5,560	16
SOUTH DAKOTA	825	1,264	27	395	576	12
KENTUCKY	1,797	2,571	9	1,963	2,688	10
MISSISSIPPI	584	762	3	1,142	1,895	7
MASSACHUSETTS [C]	101,300	202,600	564	-	-	-
ALASKA	13,007	26,014	492	-	-	-
MICHIGAN [C]	142,711	270,822	461	-	-	-
WISCONSIN [C]	34,400	59,740	245	-	-	-
NORTH CAROLINA [C]	25,790	50,523	111	-	-	-
VERMONT [C]	1,812	2,904	58	-	-	-
MONTANA [C]	1,460	2,001	56	-	-	-
HAWAII [D]	-	-	-	-	-	-
TENNESSEE [D]	-	-	-	-	-	-
WYOMING [D]	-	-	-	-	-	-

Notes:

(A) For comparative purposes, amounts for health and administrative services are included in federal Medicaid reimbursement and total claims. Federal payment disallowances resulting from completed or ongoing OIG audits may not be reflected in these amounts.

(B) Calculated as total claims divided by the number of Medicaid-eligible children aged 6-20 in FFY 2001-02, FFY 2000-01, or FFY 1999-00. (Source: Medicaid Program Statistics, CMS, http://cms.hhs.gov/medicaid/msis/mstats.asp)

(C) Federal reimbursement for this state's health services program and/or administrative claiming program was not available.

(D) This state did not have a school-based Medicaid health services program or administrative claiming program during SFY 2001-02, SFY 2002-03 or SFY 2003-04.

Summary of Significant Recommendations Made to CDHS and Actions Taken/To Be Taken by CDHS

Recommendation	Action Taken
• Enter into a contract for the LEA Rate Study. • Provide training to LEAs in completing cost and time surveys for the Rate Study.	• CDHS entered into a contract to conduct the Rate Study, which began during the fall of 2001. • Cost and time survey training was provided to LEAs between May and November of 2002. Additional assistance completing the cost and time surveys, including on-site visits and conference calls, was provided between Summer 2002 and Spring 2003.
• Implement LEA Rate Study recommendations related to assessments conducted to determine a student's eligibility for services under IDEA[1] and treatment services. • Revise state regulations to expand the provider types that are authorized to prescribe, refer, and recommend services, as appropriate.	• The Rate Study was completed during Spring 2003. A SPA was submitted to CMS in June 2003 to update existing rates for treatments and to add rates for assessments conducted to determine a student's eligibility for services under IDEA. • In 2004, CDHS, in collaboration with the LEA Workgroup, expended considerable time and effort to respond to issues raised by CMS. The first SPA was re-submitted in January 2004 and again in December 2004. Major revisions included adding CPE requirements (discussed in Section III) and updating rates for non-IDEA assessments. The SPA was eventually approved by CMS in March 2005. • CDHS prepared a System Design Notice which contains instructions regarding changes in the claims processing system to implement LEA Rate Study recommendations. These changes include conversion to new national billing codes required by the Health Insurance Portability and Accountability Act. • A proposed regulation package will be prepared. CDHS will propose revisions to state regulations that are required to implement LEA Rate Study recommendations and are consistent with the state plan, federal law and regulations, and state law.

[1] Schools are mandated by the IDEA to provide appropriate educational services to all children with disabilities. School-based health services reimbursed by the LEA Program are primarily provided to students with disabilities receiving special education services through an IEP or IFSP. The LEA Program also provides reimbursement for health services, such as nursing care, rendered to general education students.

Recommendation	Action Taken
• Automate the data match system that verifies student eligibility for Medi-Cal.	• CDHS modified the data match system during 2003 to accept and return encrypted data match files directly to LEAs. This replaced the previous process of transferring files on diskettes through the mail and reduced the data match time substantially. Further improvements to the data match system will made in the future.
• Modify the requirement that group psychology and counseling treatments last a minimum of 90 minutes.	• The SPA decreases the minimum time to 15 minutes for group psychology and counseling treatments.
• Revise re-enrollment requirements, which require LEA providers to re-enroll every five years.	• CDHS eliminated the re-enrollment requirements for LEA providers in April 2002.
• Provide training related to billing and supervision of credentialed language, speech and hearing specialists.	• Training related to these topics was provided to LEAs in November 2003.
• Develop and maintain an interactive website.	• The LEA website was re-designed to be more interactive and comprehensive. Conversion of the website to the California standard template began in November 2003 and was completed in March 2004. • Maintenance activities in 2004 included posting updated copies of Provider Enrollment forms, 2003-04 Provider Annual Report forms, and claims expenditure reports. • Future changes to the website will include a provider resource page and expansion of the links to the revised LEA Provider Manual. Additional time will be spent to update the website based on recommendations for changes from the LEA Workgroup.
• Re-write the sections of the Medi-Cal Provider Manual related to the LEA Program (LEA Provider Manual) to improve the organization and content of the information. • Research utilization controls related to LEAs and beneficiaries.	• Work on these recommendations started during the summer of 2003. CDHS continued work on the re-organization and content revision of the LEA Provider Manual in 2004. Changes to the LEA Provider Manual and utilization controls will incorporate requirements related to SPA 03-024. Utilization controls, provider qualifications, and numerous other topics were researched to support proposed changes. Work on the LEA Provider Manual continued in 2005.

Recommendation	Action Taken
• Establish equivalency for credentialed speech-language pathologists.	• CDHS, in collaboration with the CCTC, established that the educational and work requirements for credentialed speech-language pathologists with clinical or rehabilitative services credentials were equivalent to federal standards. CDHS submited a SPA in 2005 to remove supervision requirements for these practitioners.
• Improve communications regarding policy issues (to the extent allowed by Executive Order S-2-03) and status of SB 231 implementation with LEA providers.	• CDHS sent a letter to LEA providers in June 2004 regarding the status of SB 231 implementation and federal Free Care and OHC requirements. • LEA providers were sent a questionnaire to solicit feedback regarding potential new services to be considered for the LEA Program. The mailing also notified providers of the LEA Program website address. • CDHS prepared LEA Workgroup Meeting Summaries and started to post them on the website to inform LEA providers of items discussed during the meetings.
• Update the statewide LEA provider contact list.	• The statewide LEA provider contact list was updated with addresses and contact names from training sessions held in late 2003 to prepare the mailing of the potential new services questionnaire. This list will be further updated with information, including E-mail addresses, from completed questionnaires and 2004 Provider Annual Reports.
• Update valid Medi-Cal eligibility codes for the LEA Program to include foster children, adopted children, and other eligible populations in the data match system.	• CDHS identified valid eligibility codes for the LEA Program. Changes to the Medi-Cal Eligibility Data Systems files used in data match processing was completed in early 2005. Further improvements to the data match system will be discussed with Information Technology Services Division in 2005.
• Post results of the insurance carrier survey on the LEA website.	• CDHS completed an insurance carrier survey in 2004 to determine if carriers provide coverage for LEA Program services. Preliminary results were distributed to the LEA Workgroup in June 2004. Final results were posted on the LEA Program website.

Recommendation	Action Taken
• Provide quarterly status reports describing how SB 231 funds are used.	• The contractor that assists CDHS in implementing the provisions of SB 231 prepares monthly status reports of actual and projected activities. CDHS distributed the monthly status reports for the first nine months of 2004 to the LEA Workgroup. Subsequent reports will be provided at the LEA Workgroup meetings on a periodic basis.
• Provide an annual or semi-annual regional meeting with LEAs and vendors to reinforce best practices.	• CDHS will provide training to providers and vendors.
• Fund a full-time equivalent position to be filled by LEAs performing work on SB 231 activities.	• CDHS held a meeting with the LEA Workgroup to discuss the requirements of this position as well as other options in 2005.
• Establish a hotline to answer questions regarding billing policies.	• The state's fiscal intermediary, Electronic Data Systems (EDS), has a hotline to answer billing questions from LEA providers and billing vendors. EDS also provides on-site training to providers, as requested.
• Submit SPAs and subsequent updates to CMS on a timely basis.	• CDHS will continue to work towards submission of future SPAs within a reasonable time frame. However, the CMS approval process is lengthy, particularly in this period of federal budget deficits. CDHS cannot offer any assurance that future SPAs will move more quickly or smoothly.