Local Educational Agency
Medi-Cal Billing Option Program

Report to the Legislature

Report Period Fiscal Year 2018-19
(July 2018 through June 2019)

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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 are partially reimbursed by the Federal Government for health services provided to Medi-Cal eligible students. A report published by the United States General Accounting Office (GAO)[1] in April 2000 estimated that California ranked in the bottom quartile, with respect to the average claim per Medicaid-eligible child, of states with school-based Medicaid programs. Senate Bill (SB) 231 (Ortiz, Chapter 655, Statutes of 2001) was signed into law in October 2001, to reduce the gap in per child recovery for Medicaid school-based reimbursement among California and the three states receiving the most per child from the Federal Government. The mandates of SB 231 were amended by Assembly Bill (AB) 1540 (Committee on Health, Chapter 298, Statutes of 2009) and by AB 2608 (Bonilla, Chapter 755, Statutes of 2012). Welfare & Institutions (W&I) Code Section 14115.8 requires the California Department of Health Care Services (DHCS) to amend California's Medicaid State Plan with the goal of enhancing Medi-Cal services provided at school sites and access by students to those services. This report contains information on California's school-based Medicaid reimbursement program and covers the timeframe of fiscal year (FY) 2018-19.

Since SB 231 was chaptered into law, federal oversight of school-based programs by the Centers for Medicare and Medicaid Services (CMS) and its audit agency, the Office of the Inspector General (OIG), has increased. OIG audits of Medicaid school-based programs in 30 states have identified over a billion dollars in federal disallowances for services provided in schools. These reports were part of a series in a multi-state initiative to review costs claimed for Medicaid school-based services. Between July 2018 and June 2019, the OIG did not issue any audits that were specific to a state school-based program. However, in December 2018, the OIG did issue a general report identifying inadequate oversight regarding Random Moment Time Studies (RMTS) as a basis to allocate costs, titled "Vulnerabilities Exist in State Agencies' Use of Random Moment Sampling to Allocate Costs for Medicaid School-Based Administrative and Health Services Expenditures."[2] This compilation report, representative of ten state Medicaid agencies[3], highlighted previous OIG findings with the goal of helping CMS and

[1] The General Accounting Office is now known as the Government Accountability Office (GAO).
[2] U.S. Department of Health and Human Services, Office of Inspector General. "Audit (A-07-18-04107)." December 6, 2018. https://oig.hhs.gov/oas/reports/region7/71804107.asp.
[3] Alabama, Arizona, Colorado, Kansas, Massachusetts, Mississippi, Missouri, New Jersey, North Carolina, and Texas.

state agencies improve oversight of school-based costs charged to the Medicaid program. The compilation report included the following findings:

- States claimed unallowable costs in excess of $221 million that were not reasonable, allowable, or adequately supported;
- States claimed costs without having properly submitted their cost allocation plans or amendments that described their RMTS methodologies;
- States did not comply with federal requirements and guidance in developing the RMTS methodologies;
- States claimed unallowable health service costs in their annual cost settlements;
- Medical record documentation did not exist to support a significant portion of random moment responses provided by RMTS participants; and
- RMTS methodologies used sample universes that were or may have been inaccurate.

School-based programs continue to be an area of focus for the OIG, especially with more significant findings in recent years regarding the RMTS process. Since July 2017, the OIG identified significant unallowable payments based on random moment sampling systems that deviated from acceptable standards. This is notable, as the LEA Program is currently in the process of implementing RMTS as part of the direct medical service reimbursement methodology. The OIG's current work plan indicates that they expect to issue a report in 2020 on whether states claimed Medicaid costs that were supported and allocated on the basis of random moment sampling systems that deviated from acceptable statistical sampling practices. In addition, the OIG's active work plan includes reviewing Medicaid school-based costs claimed based on contingency fees.

California's LEA Program reimbursement has grown by approximately 124 percent since its authorization under SB 231 due to LEA Program expansion, increased participation, and claiming of covered Medi-Cal services by qualified practitioners. The following table identifies LEA Medi-Cal fee-for-service (FFS) interim reimbursement trends by fiscal year.

LEA Program Trends FY 2000-01 to FY 2017-18

Fiscal Year	Number of Participating LEA Providers	Total Medi-Cal Reimbursement[1]	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 [2]	461	$63.9 million	7%
FY 2005-06 [2]	470	$63.6 million	7%
FY 2006-07 [3]	461	$69.5 million	17%
FY 2007-08 [3]	472	$81.2 million	36%
FY 2008-09 [3][4]	479	$109.9 million	84%
FY 2009-10 [3][4]	484	$130.4 million	119%
FY 2010-11 [3][4]	497	$147.8 million	148%
FY 2011-12 [3]	519	$137.9 million	132%
FY 2012-13 [3]	531	$145.6 million	144%
FY 2013-14 [3]	535	$148.7 million	150%
FY 2014-15 [3]	536	$149.5 million	151%
FY 2015-16 [3][5]	537	$143.9 million	142%
FY 2016-17 [3][5]	538	$131.6 million	121%
FY 2017-18 [3][5]	539	$133.7 million	124%

Notes:

[1] Total Medi-Cal reimbursement amounts are rounded.

[2] 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.

[3] 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.

[4] Total Medi-Cal reimbursement also reflects increased Federal Medical Assistance Percentage (FMAP) through the American Recovery and Reinvestment Act (ARRA) of 2009. The increased FMAP was effective October 2008 through June 2011.

[5] Total Medi-Cal reimbursement for FY 2015-16 through FY 2017-18 reflects the suspension of reimbursement for Targeted Case Management (TCM) services, effective 7/1/2015, until a new rate methodology is approved by CMS.

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 implemented on July 1, 2006 with an effective date of April 1, 2003. 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 approximately 92 percent.

In September 2015, DHCS submitted a second SPA to CMS to expand the LEA Program. SPA 15-021 proposes to add several new practitioner types, as well as incorporate new covered assessment and treatment services in the LEA Program. In addition, the SPA proposes incorporating a RMTS component to the LEA Program reimbursement methodology that will capture the amount of time spent providing direct health services by qualified health practitioners. Finally, the SPA proposes to remove the 24 services in a 12-month period limitation, which currently applies to Medi-Cal general education students receiving LEA covered services. DHCS submitted the SPA due to CMS' December 2014 Letter to the State Medicaid Directors, which established a Free Care rule that allows Medicaid reimbursement 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. The SPA is consistent with CMS' goal to facilitate and improve access to quality healthcare services and improve the health of communities. DHCS worked collaboratively with CMS in 2018-19 to obtain SPA approval and anticipates implementing SPA 15-021 by July 2020. This SPA was subsequently approved during the 2019-20 fiscal year and further details will be reported in the 2019-20 LEA BOP Report to the Legislature.

DHCS considers collaboration with its LEA stakeholders an important aspect of the LEA Program's success. For instance, while not occurring in the 2018-19 program year, DHCS began and is currently engaged in the SB 75 Stakeholder workgroup, which aims to improve participation in the LEA BOP program and generate recommendations on how to improve access to healthcare delivered at schools. Additional information on the SB 75 workgroup will be provided in the 2019-20 LEA BOP Report to the Legislature. DHCS routinely works with LEA stakeholders to address concerns and improve the LEA Program. The LEA Advisory Workgroup is comprised of a large group of LEA stakeholders that meets every other month to discuss program issues and concerns. This group assists DHCS in identifying barriers to reimbursement for LEAs, provides LEA perspective and feedback on important issues, and recommends new services and improvements to the LEA Program. In addition, the LEA Advisory Workgroup suggests and recommends enhancements to the LEA Program website and other communication venues to improve LEA provider communication and address relevant provider issues.

As part of the bi-monthly meetings, the group conducts general discussion sessions to brainstorm challenges and barriers related to a specific discussion topic. Using this forum, DHCS is able to leverage the expertise of members to suggest potential solutions and recommendations to enhance the LEA Program. Approximately 50 to 75 LEA Program stakeholders are present at these meetings, in addition to representatives from DHCS, the California Department of Education (CDE), and Navigant Consulting, DHCS' operational consultant. In February 2019, DHCS implemented remote participation to allow for broader stakeholder participation. DHCS now routinely provides a dial in number and WebEx presentation to allow remote stakeholders the opportunity to listen in and hear general LEA Program updates in the morning session.

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 2018-19, including preparing to implement SPA 15-021 upon CMS approval. In addition to the significant effort required to respond to and discuss Requests for Additional Information (RAIs) from CMS regarding SPA 15-021, DHCS continued to support LEA Program growth in many ways, including:

- Identifying and resolving technical claims processing issues and system changes;
- Drafting revised information in the LEA portion of the Medi-Cal Provider Manual (LEA Program Provider Manual), with stakeholder input, to prepare for SPA 15-021 implementation;
- Updating LEA Program regulations.
- Conducting two regional in-person trainings in April and May 2019 to prepare for SPA 15-021 implementation;
- Providing technical assistance to LEAs, including answering provider questions;
- Completing rebasing of reimbursement rates for FY 2019-20;
- Finalizing the Annual Accounting of Funds Report for FY 2016-17, providing transparency to LEAs on administrative, auditing, and contractor costs;
- Providing additional resources and guidance to LEA providers, including publication of Policy and Procedure Letters to provide clarity on LEA Program policy and updating the LEA Program website; and
- Working on Cost and Reimbursement Comparison Schedule form submissions, auditing issues, and policies and procedures for outstanding Cost and Reimbursement Comparison Schedule 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, County Offices of Education, CDE, and professional associations representing LEAs. DHCS 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 per-child Medicaid school-based reimbursements among California and the three states that receive the most per child from the Federal Government. With this goal in mind, SB 231 added W&I Code Section 14115.8 requiring DHCS to amend California's Medicaid State Plan with the goal of enhancing 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[4];
- Consult regularly with CDE, representatives of urban, rural, large, and small school districts and County Offices of Education, Local Educational Consortiums (LECs), and LEAs;
- Consult with staff from 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.

[4] AB 430 (Cardenas, Chapter 171, Statutes of 2001) authorized LEAs to contribute to a rate study to evaluate existing rates and develop rates for new services in the LEA Program. DHCS completed the rate study in 2003. DHCS rebased rates in FY 2010-11 using the 2003 rate study and annually updates the rates for inflation.

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.[5] 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[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	• Identification of any barriers to LEA reimbursement, including those specified by the entities named in the legislation that are not imposed by federal requirements, and describe the actions that have been and will be taken to eliminate them. • Official recommendations made to DHCS by the entities named in the legislation and the action taken by DHCS regarding each recommendation. The entities are CDE, representatives of urban, rural, large and small school districts and County Offices of Education, the LEC, LEAs, staff from Region IX of CMS, experts from the fields of both health and education, and internal departmental 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.

[5] For this reporting period, Medicaid-eligible data for children is not available. For the calculations contained in Table 5, DHCS used federal fiscal year18 Medicaid enrollment data, based on unduplicated counts of children who were enrolled in Medicaid.

[6] In this report, "providers" refer to allowable practitioners who provide services to eligible students; "LEAs" or "LEA providers" refer to school districts, County Offices of Education, charter schools and community colleges 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 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 (referred to as non-IEP/IFSP services). However, if the student has other health coverage, the LEA must bill the student's other health coverage prior to billing Medi-Cal for non-IEP/IFSP services.

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 methodology. Federal Financial Participation funds for Medicaid expenditures are available for two types of services: medical assistance (referred to as "health services" or "direct services" in this report) and administrative activities. School-based health services reimbursable under Medicaid are:

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

DHCS classifies LEA services into two main categories: assessments and treatments. The following eight IEP/IFSP assessment types, representing approximately 99 percent of total assessment reimbursement in FY 2017-18, are reimbursable in the LEA Program:

IEP/IFSP Assessment Type	Qualified Practitioners
Psychological	Licensed psychologists Licensed educational psychologists Credentialed school psychologists

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

In addition, the LEA Program covers the following six non-IEP/IFSP assessment types, representing approximately one percent of total assessment reimbursement in FY 2017-18:

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

Non-IEP/IFSP Assessment Type	Qualified Practitioners
Hearing	Licensed physician/psychiatrist Licensed speech-language pathologists Credentialed speech-language pathologists Licensed audiologists Credentialed audiologist Registered school audiometrist
Vision	Licensed physician/psychiatrist Registered credentialed school nurses Licensed optometrists
Developmental	Licensed physical therapists Registered occupational therapists Licensed speech-language pathologists Credentialed speech-language pathologists

The majority of LEA Program expenditures are comprised of treatment services, representing approximately 67 percent of FY 2017-18 total LEA Program interim reimbursement. The LEA Program covers the following medically necessary treatment services for all Medi-Cal eligible students:

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

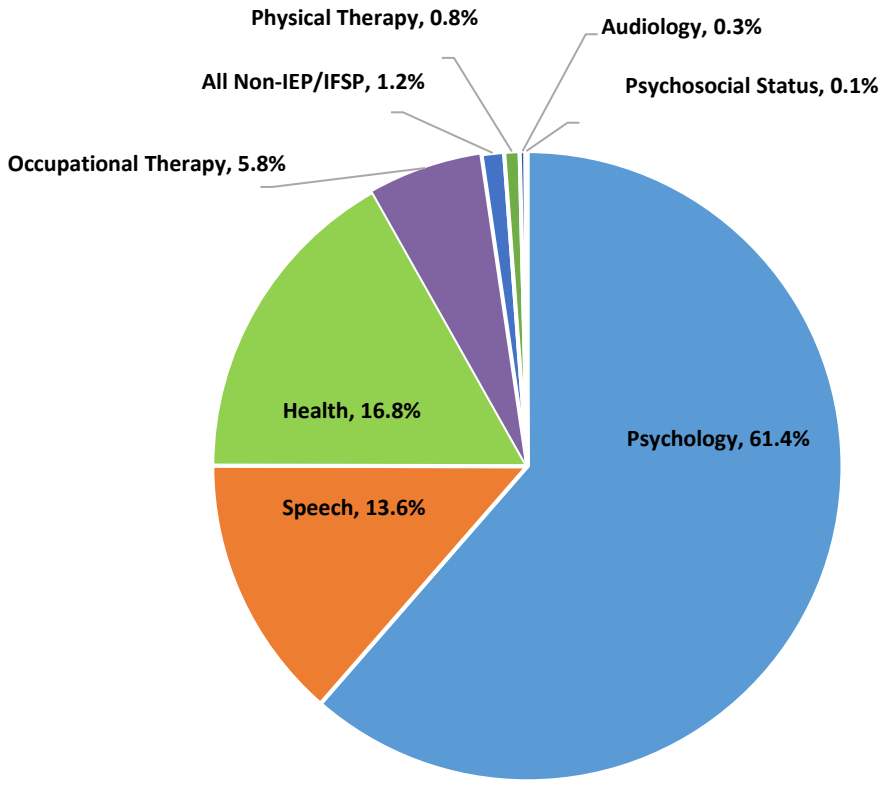
In addition, the LEA Program covers medical transportation/mileage services for Medi-Cal students with an IEP/IFSP. Transportation services, which represent approximately three percent of total FY 2017-18 LEA Program interim reimbursement, are billable when LEAs can meet the following requirements:

- LEAs provide transportation in a specially adapted vehicle or vehicle that contains specialized equipment, including but not limited to lifts, ramps, or restraints, to accommodate the LEA eligible beneficiary's disability;
- The need for LEA covered health services and LEA covered specialized medical transportation services is documented in the student's IEP/IFSP;

- LEAs maintain a transportation trip log that includes the mileage, origination and destination point for each student, student's full name, and date of transportation;
- School attendance records can verify that the student was in school and received an approved LEA Program covered medical service (other than LEA medical transportation) on the date the transportation was provided; and
- The covered service (received on the same day that the student received transportation services) meets all the necessary standards to be billed through the LEA Program.

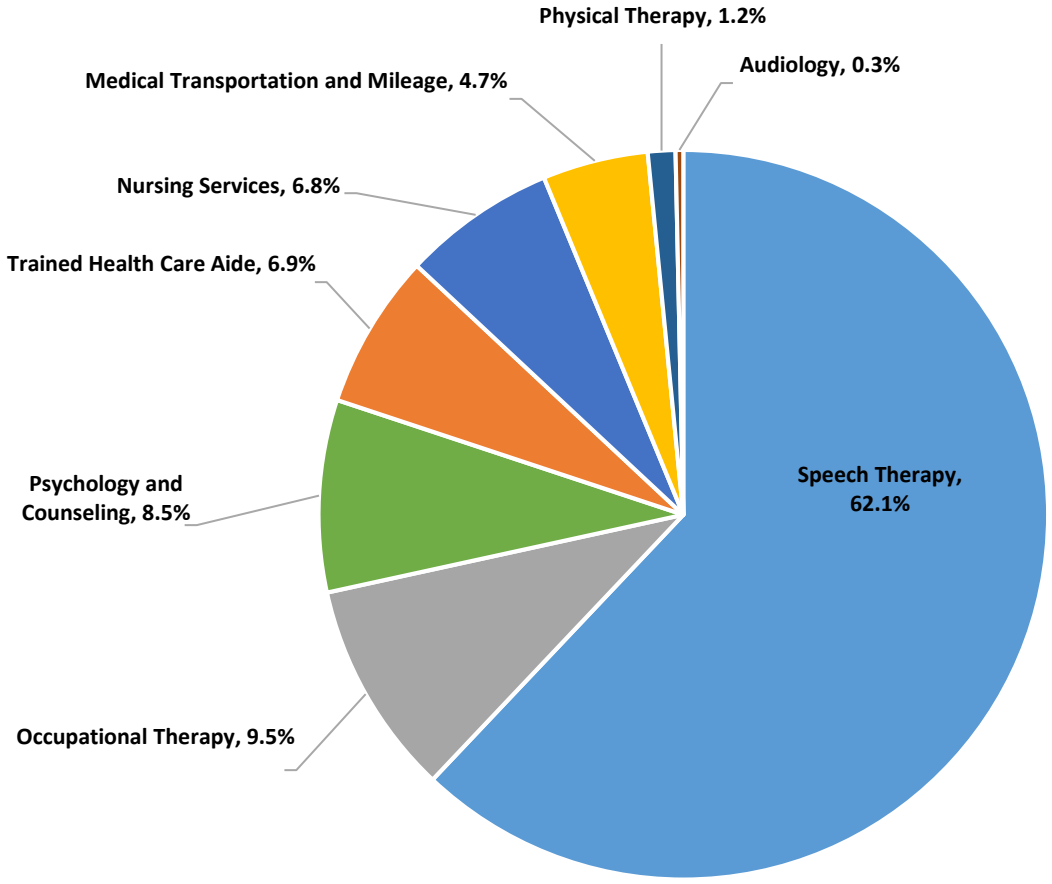
The following figures illustrate the breakdown of covered assessment and treatment services for FY 2017-18.

Figure 1: Total LEA Assessment Reimbursement by Assessment Type, FY 2017-18



Note: Total LEA assessment service reimbursement for FY 2017-18 was $44.2 million.

Figure 2: Total IEP/IFSP LEA Treatment Reimbursement by Treatment Type, FY 2017-18



Note: Total LEA IEP/IFSP treatment and transportation/mileage service reimbursement for FY 2017-18 was approximately $88.7 million. Less than one percent of total treatment reimbursement is attributable to non-IEP/IFSP services.

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 through the survey with publicly available information by reviewing provider manuals and other sources of program information.

School-Based Medicaid Systems in Comparable States

To narrow the list of comparable states, DHCS identifies states that are similar to California using four factors. Table 2 describes the four factors considered and the information source.

Table 2: Factors Considered in Selecting Comparable States

Factor	Source of Information
Number of Medicaid-enrolled children.	Medicaid Program Statistics, Medicaid & Children's Health Insurance Program Enrollment Data, Annual Enrollment Reports, 2018.
Number of IDEA eligible children aged 3 to 21.	U.S. Department of Education, Data Collections, Part B: Child Count and Educational Environments dataset, 2017.
Average salaries of instructional staff (classroom teachers, principals, supervisors, librarians, guidance and psychological personnel, and related instructional staff).	Rankings of the States 2018 and Estimates of School Statistics 2019, National Education Association (NEA), April 2019.
Per capita personal income.	Bureau of Economic Analysis, Personal Income Summary, 2018.

The number of Medicaid-enrolled and IDEA-eligible children provides a measure of the number of students that qualify for Medicaid school-based services. The average salaries of instructional staff and per-capita personal income provide a comparison of the cost of living among states. The ten states with the greatest number of Medicaid-enrolled children were identified. Each of these states was ranked from highest to lowest based on the previous four factors. From this analysis, DHCS identified four states as comparable to California: Illinois, New York, Pennsylvania, and Texas. Table 3 compares California's school-based program to the four states selected as comparable to California for this reporting period. These four states were also identified in DHCS' comparable state analysis for the previous reporting period (Fiscal Year 2017-18).

Table 3: Direct Service Claiming in California versus Comparable States

Covered Service	CA	IL	NY	PA	TX
Assessments/Screenings					
IEP/IFSP	X	X	X	X	X
Non-IEP/IFSP[7]	X	**Not Currently Covered**			
Treatments (pursuant to an IEP/IFSP[8])					
Assistive Devices				X	
Audiology	X	X		X	X
Physician Services	X	X		X	X
Psychology and Counseling	X	X	X	X	X
Speech Therapy	X	X	X	X	X
Medical Equipment/Supplies		X			
Nursing Services	X	X	X	X	X
Occupational Therapy	X	X	X	X	X
Orientation & Mobility				X	
Personal Care				X	X
Physical Therapy	X	X	X	X	X
School Health Aide Services	X	X			
Transportation	X	X	X	X	X

[7] Several states are broadening the school health services that can be covered under Medicaid to include services outside of those authorized under provisions of IDEA (termed "non-IEP/IFSP" services in this report). Many states, including some of the comparable states, are currently undergoing discussions regarding the potential expansion to direct service claiming. To date, more than ten states have made changes to their direct service claiming programs or are in the process of doing so, in order to claim federal funds for allowable services provided to all Medicaid-eligible students.

[8] California currently covers all treatment services for students outside of an IEP/IFSP, with limitation. Specialized transportation services must be pursuant to an IEP/IFSP to be eligible for reimbursement.

Many states, including those identified above, finance their school-based direct health service claiming programs utilizing Certified Public Expenditures, which are cost-settled on a retroactive basis. Under this reimbursement methodology, providers must complete an annual cost report as part of the cost reconciliation process. In California, the LEAs annually submit the Cost and Reimbursement Comparison Schedule, which compares the interim Medi-Cal reimbursement received throughout the fiscal year to the estimated Medi-Cal costs to provide the health services. LEAs report the actual costs and annual hours worked for all qualified practitioners who provide and bill for LEA services, the units of service, encounters, and related Medi-Cal reimbursement for the appropriate fiscal year on the Cost and Reimbursement Comparison Schedule forms. The Cost and Reimbursement Comparison Schedule compares estimated costs to Medi-Cal interim reimbursement to ensure that DHCS is not reimbursing each LEA provider more than the costs of providing these services, a requirement when utilizing Certified Public Expenditures. This reconciliation results in an amount owed to or from the LEA; DHCS reimburses underpayments to LEAs in a lump sum, while overpayments are withheld from future LEA claims reimbursement.

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

DHCS administered its 15th state survey in September 2019. DHCS contacted states to obtain claims and revenue information for FYs 2017-18 and 2018-19. Multiple follow-up calls and e-mails were conducted between October and December 2019 to states that did not respond to or complete the survey. Some states indicated that they were unable to complete the survey on a timely basis due to a variety of reasons, such as unconfirmed reimbursement totals, internal data request issues, and timing problems; several states did not respond to multiple follow-ups. Twenty-five of 51 states (including Washington, D.C.) completed the survey.[9] However, of the 25 respondents, four states that currently administer both a school-based health services program and an administrative claiming program did not provide both reimbursement figures for FY 2018-19, since figures were not yet final at the time of the survey.[10] One state (Idaho) that administers a school-based health services program, but not an administrative claiming program, did not provide health services program reimbursement figures for FY 2017-18 and FY 2018-19. One state does not currently

[9] DHCS also included Arkansas and Wyoming as part of the state-by-state comparison. Arkansas is not included in the count of 25, since they did not submit a survey response, but data was collected for Arkansas through publicly available information on its state website. DHCS used Arkansas' direct and administrative claiming reimbursement data available online for analysis purposes. Wyoming is also not included in the count of 25, since they did not submit a survey response, but DHCS confirmed they do not have a direct and administrative claiming reimbursement program at this time.

[10] Kansas, Minnesota, West Virginia and Wisconsin responded to the state survey but did not provide reimbursement figures for FY 2018-19.

have a school-based health services program or an administrative claiming program.[11] The following Table 4 provides a complete list of survey respondents.

Table 4: Summary of States that Completed 2019 DHCS Survey

				Administrative Claiming		Direct Claiming	
Count	State	Administrative Claiming Program	Direct Claiming Program	Reported for FY 2017-18	Reported for FY 2018-19	Reported for FY 2017-18	Reported for FY 2018-19
1	ALASKA	No	Yes	N/A	N/A	X	X
2	ARIZONA	Yes	Yes	X	X	X	X
3	ARKANSAS(1)	Yes	Yes	X	Not Reported	X	Not Reported
4	CALIFORNIA	Yes	Yes	X	X	X	X
5	CONNECTICUT	Yes	Yes	X	X	X	X
6	DISTRICT OF COLUMBIA	No	Yes	N/A	N/A	X	X
7	IDAHO	No	Yes	N/A	N/A	Not Reported	Not Reported
8	INDIANA	Yes	Yes	X	Not Reported	X	X
9	IOWA	No	Yes	N/A	N/A	X	X
10	KANSAS	Yes	Yes	X	X	Not Reported	Not Reported
11	MARYLAND	No	Yes	N/A	N/A	X	X
12	MASSACHUSETTS	Yes	Yes	X	X	X	X
13	MINNESOTA	Yes	Yes	Not Reported	Not Reported	X	Not Reported
14	MISSOURI	Yes	Yes	X	X	X	X
15	MONTANA	Yes	Yes	X	X	X	X
16	NEW HAMPSHIRE	No	Yes	N/A	N/A	X	X
17	NEW MEXICO	Yes	Yes	X	X	X	X
18	NEW YORK(2)	No	Yes	N/A	N/A	X	X
19	OKLAHOMA	No	Yes	N/A	N/A	X	X
20	OREGON	Yes	Yes	X	X	X	X
21	RHODE ISLAND	Yes	Yes	X	X	X	X
22	VERMONT	Yes	Yes	Not Reported	Not Reported	X	X
23	VIRGINIA	Yes	Yes	X	X	X	X
24	WASHINGTON	Yes	Yes	X	Not Reported	X	X
25	WEST VIRGINIA	Yes	Yes	X	Not Reported	X	Not Reported
26	WISCONSIN	Yes	Yes	X	Not Reported	X	Not Reported
27	WYOMING(3)	No	No	N/A	N/A	N/A	N/A
	Counts	**18**	**26**	**16**	**11**	**24**	**20**

Notes:
(1) Arkansas did not submit a survey response, but DHCS collected data for Arkansas through publicly available information on its State website. Only FY 2017-18 Arkansas data was available online at the time of this report.
(2) Of the four states that are considered comparable to California, only one responded to the survey (New York). New York reported data only for direct services, as they do not have an administrative program. Illinois, Pennsylvania, and Texas did not respond to the survey.
(3) Wyoming did not submit a survey response, but DHCS confirmed that Wyoming does not have an administrative or direct program.

In April 2000, the GAO report, as referenced on page three, estimated that California ranked in the bottom quartile with respect to the average claim per Medicaid eligible child. It is important to note that the GAO report and DHCS surveying results cannot definitively compare direct claiming program dollars spent per Medicaid-eligible or Medicaid-enrolled students among states. This is primarily due to the basic inability to split Medicaid-eligible students between direct claiming and administrative claiming

[11] Wyoming does not currently have a school-based health services program or an administrative claiming program.

programs. Also, since Medicaid-eligible data for children was not available at the time of this report for all states, DHCS used Medicaid-enrolled data for this year's state comparison, making a direct comparison to the 2000 GAO report difficult. For those respondent states that operate both programs (17 states, including California), only the combined program dollars can be divided by the number of Medicaid-enrolled children, in order to calculate a practical result. As such, Table 5 (page 21) comparisons for those dual-program states that attempt to compare direct claiming dollars per enrolled child are inadvertently impacted by the inclusion of administrative claiming program dollars.

Furthermore, in the state survey, some states did not provide both direct claiming and administrative claiming reimbursements for various reasons. For example, out of the 17 respondent states that administer both programs, seven states did not report complete data for their direct claiming program and/or administrative claiming program. Eight additional states reported having either a direct claiming program or an administrative claiming program, but not both programs. Without complete direct claiming and administrative claiming reimbursement information, the ranking of the average claim per Medicaid-enrolled child is skewed and does not allow for a fair comparison among states and to the GAO 2000 report.

In addition to a lack of complete program reimbursement data from states, there are several other reasons that direct comparisons among states make it difficult to draw sound conclusions from Table 5.

- Federal Medical Assistance Percentages (FMAP) vary among states: DHCS calculates each state's total estimated claiming expenditures (federal share) by dividing the reported direct and administrative Medicaid reimbursement by the state's FMAP. The differences in state FMAP influence the average claim per Medicaid-eligible child. FMAPs ranged from 50 percent to 75.65 percent in FY 2017-18 and from 50 percent to 76.39 percent in FY 2018-19.
- Covered services differ from state to state: The cost of school-based service providers can range from expenditures for physicians to non-skilled health aide workers. Depending on which services states cover and the associated cost of the rendering practitioners, direct claiming figures will vary among states, particularly those with a cost settlement reimbursement methodology.
- Timing of finalized reimbursement information: As more states move to a Certified Public Expenditure reimbursement methodology (where interim payments are compared to actual costs and result in an end-of-year cost settlement), interim reimbursement diverges from what is eventually paid to school-based providers. The timing of this state survey does not align with the

availability of final state cost settlement figures used in the analysis of the average claim per Medicaid-enrolled child, due to the length of time that individual states may conduct their audit or review of LEA provider costs. For example, California's direct claiming program is not required to complete the cost settlement process until more than four years after the close of the fiscal year in which interim payments were made to LEAs.

Of the 17 respondent states that have both programs, including California, ten were able to submit reimbursement figures for both direct claiming and administrative services for FY 2017-18 and FY 2018-19. However, of these ten, only four states were able to provide the final reimbursement figures for both direct claiming and administrative services for each of these years.

Table 5 summarizes survey results for Medicaid reimbursement (federal share) for direct claiming and administrative services for the two most recent periods, FYs 2017-18 and 2018-19. Several states did not have finalized figures available for FY 2018-19 due to timing of cost settlement. When states provided data for any or all of the fiscal years surveyed, Medicaid direct claiming and administrative services reimbursement (federal share) was divided by each state's FMAP to calculate total estimated claiming dollars. These figures were then divided by each state's number of Medicaid-enrolled children to estimate the average claim amount per Medicaid-enrolled child.

As illustrated in Table 5, Vermont had the highest FY 2017-18 and FY 2018-19 average claim of $759 and $781, respectively, while California's average claim was $121 and $138 for these two periods.[12] However, using California's direct service paid claims reimbursement data and the number of actual unduplicated LEA beneficiaries who received LEA Program services (approximately 325,000 for FY 2017-18 and 322,000 students for FY 2018-19), the total average direct service claim per Medicaid-enrolled student was approximately $396 for FY 2017-18 and $372 for FY 2018-19.

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.

[12] California's direct health service claiming figure for FY 2018-19 includes reimbursement paid to LEAs as of December 2019. LEAs have until July 2020 to submit claims for services rendered in FY 2018-19, which results in an understated cost per child figure for that year.

Table 5: Medicaid Reimbursement and Claims by State, Ranked by 2018-19 Average Claim per Medicaid-Enrolled Child

		SFY 2017-2018 [1]			SFY 2018-2019 [1]		
State		Federal Medicaid Reimbursement (000's)	Total Claims (000's)	Average Claim Per Medicaid-Enrolled Child [2]	Federal Medicaid Reimbursement (000's)	Total Claims (000's)	Average Claim Per Medicaid-Enrolled Child [2]
VERMONT	3, 8	$ 29,358	$ 54,906	$ 759	$ 30,449	$ 56,502	$ 781
NEW HAMPSHIRE	4	27,286	54,573	593	26,380	52,760	573
RHODE ISLAND		28,071	54,994	489	28,381	54,817	488
DISTRICT OF COLUMBIA	4, 8	28,839	41,198	487	21,756	31,080	367
IOWA	4	63,206	108,082	322	67,237	112,193	335
MASSACHUSETTS	8	97,900	195,800	357	83,600	167,200	305
MARYLAND	4	59,144	118,287	234	63,051	126,102	249
NEW YORK	4, 8	181,462	362,925	167	167,296	334,592	154
CALIFORNIA	8	**283,681**	**567,361**	**121**	**323,340**	**646,681**	**138**
CONNECTICUT	8	21,949	43,898	125	23,160	46,321	132
MONTANA		10,225	17,561	126	9,652	16,687	119
OREGON		20,398	38,226	95	21,676	40,572	101
NEW MEXICO	8	43,910	67,102	164	23,760	39,631	97
MISSOURI		30,602	58,216	93	28,276	53,863	86
KANSAS	3, 8	11,752	23,503	88	9,143	18,287	69
ARIZONA	8	30,100	45,970	52	36,800	56,574	64
VIRGINIA	8	39,163	78,326	119	20,656	41,313	63
ALASKA	4	2,175	4,349	42	1,878	3,756	37
INDIANA	3	19,411	33,400	50	13,890	21,058	31
WASHINGTON	3	8,296	16,592	20	4,908	9,817	12
OKLAHOMA	4	260	444	1	1,342	2,152	4
WISCONSIN	3, 8	89,322	157,989	305	-	-	-
NEW JERSEY	5, 7	108,822	217,643	299	-	-	-
IDAHO	3, 4, 7	38,600	54,236	259	-	-	-
ILLINOIS	5, 7	138,342	273,981	193	-	-	-
WEST VIRGINIA	3, 8	29,170	40,473	171	-	-	-
ARKANSAS	3, 6	43,335	69,691	169	-	-	-
MINNESOTA	3, 8	50,802	101,604	155	-	-	-
ALABAMA	5, 7	43,452	75,771	141	-	-	-
FLORIDA	5, 7	113,662	220,925	93	-	-	-
COLORADO	5, 7	9,904	19,807	40	-	-	-
DID NOT RESPOND	9	-		-	-	-	-

(1) Amounts for health and administrative services are included in federal Medicaid reimbursement and total claims. Federal payment disallowances resulting from completed or on-going Office of Inspector General audits may not be reflected in these amounts.
(2) Calculated as total claims divided by the number of children enrolled for Medicaid in Federal Fiscal Year (FFY) 2017-18 and FFY 2018-19. (Source: CMS, https://www.medicaid.gov/chip/downloads/fy-2018-childrens-enrollment-report.pdf)
(3) Total federal reimbursement for this state's health services program and/or administrative claiming program was not provided for SFY 2017-18 and/or SFY 2018-19.
(4) This state did not have a school-based Medicaid health services program and/or administrative claiming program in effect during SFY 2017-18 and/or SFY 2018-19.
(5) Did not complete DHCS 2019 survey used to collect Medicaid reimbursement (federal share) for direct claiming and administrative services for SFYs 2017-18 and 2018-19.
(6) Health services program and administrative claiming program expenditures for Arkansas for SFY 2017-18 were obtained from the Arkansas Medicaid in the Schools website (Source: MITS profiles, https://arksped.k12.ar.us/applications/sbmh/documents/profiles/2018_Medicaid_Profiles.pdf). SFY 2018-19 data not available at the time of this report.
(7) SFY 2017-18 health services program and/or administrative claiming program reimbursement amount is from the DHCS 2018 survey results.
(8) SFY 2018-19 health services program and/or administrative claiming program figures are estimated amounts and subject to change.
(9) The following states had no survey data from either DHCS's 2018 or 2019 surveys and, therefore, are not pictured: Delaware, Georgia, Hawaii, Kentucky, Louisiana, Maine, Michigan, Mississippi, Nebraska, Nevada, North Carolina, North Dakota, Ohio, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, and Wyoming. Wyoming does not have a school-based Medicaid health services program or administrative claiming program.

The following Table 6 compares state survey respondents that only administer a direct service claiming program. Since the impact of administrative claiming dollars are eliminated in Table 6, the calculation allows for a more accurate representation of how the LEA Program compares to other state direct claiming programs. However, it should be noted that although Table 6 figures are limited to direct service expenditures, the number of Medicaid-enrolled children used as the denominator in this calculation is not necessarily representative of the actual beneficiary count for these state programs, which likely results in an understated cost per child amount.

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

	Average Direct Service Claim per Medicaid-Enrolled Child	
State	**FY 2017-18**	**FY 2018-19**
NEW HAMPSHIRE	$593	$573
DISTRICT OF COLUMBIA	$487	$367
CALIFORNIA	**$396**	**$372**
IOWA	$322	$335
IDAHO	$259	N/A
MARYLAND	$234	$249
NEW YORK	$167	$154
ALASKA	$42	$37

Note: Although California operates both Administrative and Direct Claiming Programs, a direct-claiming reimbursement per child figure may be calculated based on the total interim LEA direct service reimbursement and the actual LEA beneficiary count for the respective fiscal year. The LEA Program actual average direct service claim per Medicaid beneficiary was approximately $396 for FY 2017-18 and $372 for FY 2018-19.

Summary of Departmental Activities

Numerous DHCS activities occurred during this reporting period that have affected school-based health services reimbursement. These include the following activities between July 2018 and June 2019:

- **AB 3192 LEA Medi-Cal Billing Option: Program Guide**
  AB 3192 (O' Donnell, Chapter 658, Statutes of 2018) requires DHCS, in consultation with the LEA Ad Hoc Workgroup, to prepare and complete a Program Guide for the LEA Program. The Program Guide would contain fiscal and programmatic compliance information regarding processes, documentation and guidance necessary for the proper submission of claims and auditing of LEAs. DHCS would be required to distribute the initial Program Guide to LEAs by January 1, 2020. DHCS published the Program Guide on January 28, 2020.

- **Specialized Medical Transportation**

  Policy and Procedure Letter 18-027, notified LEAs that DHCS added a definition for "LEA Specialized Medical Transportation Services" and amended numerous California Code of Regulations (CCR) sections to be consistent with state regulations, effective April 1, 2016. Title 22, section 51190.4.1 defines "LEA Specialized Medical Transportation Services" as "medical transportation services provided to an LEA eligible beneficiary who requires a specially adapted vehicle or use of specialized equipment, including but not limited to lifts, ramps or restraints, to accommodate the LEA eligible beneficiary's disability." As a result of this policy change, DHCS also updated the Transportation Billing Guide on the LEA Program website to reflect the new policy.

- **LEA Reimbursement Rate Rebasing**

  In FY 2018-19, DHCS completed a rebasing of the LEA Program reimbursement rates, using the latest available as-submitted cost report data (FY 2015-16 Cost and Reimbursement Comparison Schedule reports). The rebasing of the LEA Program rates is required per the State Plan once every three years. Expenditures considered in rebasing included LEA employee salaries, benefits and other costs, as well as contractor costs. A cost per hour was calculated per practitioner type, these costs were then arrayed, and the median cost per hour was identified. The median cost was then applied to an existing time study from FY 2001-02, using the established rate development methodology, to arrive at the new rates (effective July 1, 2019) used for all LEA providers. In May 2019, DHCS submitted an Operating Instruction Letter instructing the fiscal

intermediary to install the new FY 2019-20 rates in the claims processing system. DHCS expects the rates to be installed in early FY 2019-20, requiring an Erroneous Payment Correction (EPC) to reprocess claims that pay at the older, uninflated rate. DHCS will initiate this EPC as soon as the new rates are installed in the claims processing system. Overall, the rebased rates will result in increased interim reimbursement provided to LEAs.

- **LEA Program Withhold Increase**

  An Operating Instruction Letter was implemented to increase the withhold percentage from 1.5 percent to 2 percent, effective July 1, 2018. The withhold increase was needed to cover the DHCS contractor expenditures for Navigant Consulting, Inc. at $1,500,000 and the Audits and Investigation function at $1,000,000.

- **Termination of Psychological Assessment CPT Code 96101**

  Effective January 1, 2019, Current Procedural Terminology (CPT) code 96101, used to bill initial/triennial, annual, and amended psychological assessments, was terminated and replaced with a new CPT code. The new CPT replacement code for psychological assessments – 96130 – was effective for dates of service beginning January 1, 2019. DHCS issued Policy and Procedure Letter #18-029 in December 2018 with guidance to stakeholders on the code change. This issue did not impact interim reimbursement to LEAs.

- **Termination of Occupational Therapy and Physical Therapy Assessment CPT Codes 97001 - 97004**

  Effective July 1, 2018, DHCS replaced CPT codes 97001-97004, used to bill initial/triennial, annual, and amended physical therapy (PT) and occupational therapy (OT) assessments, with new replacement codes. The new CPT codes for PT and OT assessments – 97163, 97164, 97167 and 97168 – are effective for dates of service on or after July 1, 2018. This issue did not impact interim reimbursement to LEAs.

- **Guidance on Revenue Code for LEA Claim Submissions**

  Effective January 1, 2019, DHCS notified LEAs that they should report revenue code “0001” on submitted claims, rather than revenue code “001”. The LEA Provider Manual was updated to reflect this new policy guidance. This issue did not impact reimbursement to LEAs.

- **FY 2015-16 Payment of Over-Collected Withholds**

  In FY 2015-16, DHCS over-collected withholdings from LEA providers by approximately one million dollars. In March 2019, these over-collected funds were returned to LEAs. As a result of the FY 2015-16 Annual Accounting of Funds analysis, DHCS also determined that they under-withheld approximately $150,000 from LEAs. Recoupment of the under-withheld funds was also processed in March 2019.

- **FY 2016-17 Annual Accounting of Funds**

  W&I Code Section 14132.06(j) 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 requires DHCS to make it publicly available to LEAs. On October 3, 2018, DHCS finalized and posted the FY 2016-17 Annual Accounting of Funds Summary report on the LEA Program website. This issue did not impact reimbursement to LEAs.

- **Ordering, Referring, or Prescribing (ORP) Practitioner Requirements**

  A Policy and Procedure Letter notified LEAs that practitioners who order, refer, or prescribe (ORP) direct medical treatment services must have a National Provider Identifier (NPI) and must be individually enrolled as a Medi-Cal ORP provider. LEAs are required to include the NPI of the ORP practitioner on claims for treatment services, effective for dates of service on or after July 1, 2018. Assessment services were not affected by this Policy and Procedure Letter.

- **Physician Prescription Policy**

  A Policy and Procedure Letter notified LEAs that authorizations for direct medical treatment services may be signed by Physician Assistants (PAs) or Nurse Practitioners (NPs), as appropriate, in place of an authorization signed by a physician, effective for dates of service on or after July 1, 2019. The PA or NP who signs the order may be employed or contracted by the LEA provider, or may be the student's primary care provider. LEA providers must ensure that they comply with the ORP Provider policy.

- **SPA 19-0009 (Vision Services)**

  DHCS formally submitted SPA 19-0009 to CMS on March 20, 2019. The SPA will provide additional comprehensive vision services to Medi-Cal eligible students in the LEA Program. The proposed effective date is January 1, 2019. SPA 19-0009 is currently on hold, pending CMS approval of SPA 15-021. However, as SPA

15-021 is now approved, DHCS will move forward with answering CMS' request for additional information on the SPA 19-0009.

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

  An EPC to reprocess claims with updated reimbursement rates for claims submitted by LEAs with dates of service in FY 2016-17 was completed in August 2018. This action increased interim reimbursement provided to LEAs.

- **FY 2018-19 Rate Inflation Update**

  The LEA rate table was adjusted for inflation for claims with dates of service between July 1, 2018 and June 30, 2019. Rate table adjustments were installed in April 2019, part way through FY 2018-19. This action increased interim reimbursement provided to LEAs. In May 2019, DHCS initiated an EPC to adjust LEA claims processed before the rate table update was installed by the fiscal intermediary. DHCS expects the EPC to process in FY 2019-20.

- **Exempting LEA Procedure Codes from Managed Care Edits**

  In April 2019, the fiscal intermediary (FI) exempted all current and future LEA CPT Codes from other health coverage edits. In May 2019, DHCS approved an EPC for installation, resulting in a payout of approximately $4,400 related to newly implemented CPT code 96130 that was impacted by the other health coverage edits. In early FY 2019-20, this EPC is expected to reimburse LEAs for erroneously denied claims. As part of the table update, it was also discovered that newly implemented CPT codes 97163, 97164, 97167 and 97168 were also impacted by other health coverage edits. DHCS plans to initiate an EPC in FY 2019-20 to pay these erroneously denied claims after the EPC for CPT code 96130 is implemented by the fiscal intermediary.

- **LEA Provider Outreach**

  Pending the approval of SPA 15-021, DHCS initiated an outreach campaign to inform LEAs about upcoming RMTS requirements that will impact participating LEA providers. Specifically, the outreach is targeted at LEAs that only participate in one of the two school-based programs in California. On July 1, 2020, the LEA Program will fold into the existing School Based Medi-Cal Administrative Activities (SMAA) RMTS process, per SPA 15-021. The DHCS outreach campaign is initially focused on informing LEAs that currently do not participate in RMTS through the SMAA program, since those LEAs are more likely to be unaware of the upcoming RMTS requirement. DHCS is informing LEAs that in order to continue LEA Program participation as of July 1, 2020, they must

contract with a LEC or Local Governmental Agency (LGA) in their region to participate in RMTS. As part of the outreach, DHCS is also trying to inform LEAs of the benefits of participating in both school-based programs.

- **LEA Advisory Workgroup**

  Members of the LEA Advisory Workgroup represent large, medium, and small school districts, County Offices of Education, professional associations representing LEA services, DHCS, and CDE. DHCS holds meetings every other month, providing a forum for LEA Advisory Workgroup members to identify and discuss relevant issues and make recommendations for changes to the LEA Program. The emphasis of the meeting is to complete various goals and activities aimed at expanding and enhancing the Medi-Cal services provided on school sites and access by students to these services, by increasing federal reimbursement to LEAs for the cost of providing these services. The LEA Advisory Workgroup, which met five times during FY 2018-19, has been instrumental in improving the LEA Program.

- **Joint School-Based Medi-Cal Meeting**

  In October 2018, DHCS hosted a joint school-based Medi-Cal meeting that brought together both LEA Program and SMAA program stakeholders in preparation for the combined RMTS. At the meeting, DHCS provided a status update on SPA 15-021, discussed the implementation timeline, and provided an overview of the potential backcasting methodology (DHCS noted that the backcasting methodology was pending CMS negotiation at the time of the meeting). DHCS also addressed recent OIG audit findings and provided some detail on RMTS moment documentation, noting that they would provide detail on additional compliance requirements after further discussions with CMS.

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

California's LEA Program provides many of the same "core" services that exist in other states' school-based programs. Although California's school-based services program is quite robust, there are some services that are allowable in other state programs that are not currently reimbursable in California's LEA Program. To gather information on these services and qualified practitioners, DHCS has relied on numerous sources, including responses from the state survey, updated reviews of relevant provider manuals and Medicaid state plans, and interviews with other state Medicaid program personnel. Other state school-based services not currently reimbursable in the LEA Program include:

- Behavioral services provided by a behavioral aide, certified behavioral analyst, certified associate behavioral analyst, or intern;
- Dental assessment and health education provided by a licensed dental hygienist;
- Durable medical equipment and assistive technology devices;
- 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; and
- Services for children with speech and language disorders provided by a speech-language pathology assistant.

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;
- Assistance with activities of daily living;
- Respiratory therapy services; and
- EPSDT screening services.

In addition to the services listed above, SPA 15-021 proposes to reimburse for psychological services provided by a registered associate clinical social worker or associate marriage and family therapist.

While most states provide reimbursement for behavioral services, dental, durable medical equipment, and interpreter services, the LEA Program does not provide reimbursement for these services, since DHCS covers these services through other Medi-Cal programs such as Managed Care, Denti-Cal, and School-Based Medi-Cal Administrative Activities. For example, Denti-Cal covered services include dental screenings, x-rays, prophylaxis (cleanings), fluoride treatments, and other medically necessary services. The School-Based Medi-Cal Administrative Activities program provides reimbursement to school districts for the federal share of costs for administering the Medi-Cal Program. These activities include outreach, referral, Medi-Cal application assistance, and arranging non-emergency/non-medical transportation. Upon implementation of SPA 15-021, California will have one of the most robust school-based service programs in the nation.

IV. BARRIERS TO REIMBURSEMENT AND OFFICIAL RECOMMENDATIONS MADE TO DHCS

Barriers to reimbursement and recommendations regarding proposed LEA Program changes are identified during LEA Advisory Workgroup (AWG) meetings. Table 7 summarizes barriers identified by the AWG and the action taken/to be taken regarding each barrier.

Table 7: Summary of Barriers to Reimbursement and Official Recommendations Identified by the LEA Advisory Workgroup

Barrier to Reimbursement and Official Recommendation Identified by the AWG	DHCS Action
Need for guidance on additional topics (cost reporting, transportation, covered service requirements) for future SPA 15-021 claiming.	• DHCS developed and is incorporating guidance into training materials. • DHCS conducted regional trainings in April and May 2019 and will continue to provide training following approval of SPA 15-021. • At the SPA Implementation Trainings, DHCS distributed draft CPT codes and modifiers for new services and new practitioners so that LEAs could begin preparing their systems for future claiming. • DHCS will post the revised Cost and Reimbursement Comparison Schedule and instructions once approved by CMS.
Need for clarification and guidance regarding documentation standards.	• In September 2018, AB 3192 was chaptered, requiring DHCS, in consultation with the LEA Ad Hoc Workgroup, to issue and regularly maintain a program guide for the LEA Program by January 1, 2020. The program guide will contain fiscal and programmatic compliance information for the proper submission of claims. Per AB 3192, the guide will include state plan amendments, frequently asked questions, policy and procedure letters, trainings, provider manuals, and all other types of instructional materials relevant to the LEA Program. • DHCS developed a LEA Program Guide sub-committee, comprised of DHCS representatives and several volunteers from the Ad Hoc Workgroup, to collect feedback from stakeholders regarding organization/content of the guide. • DHCS updated and shared the Program Guide draft outline and archive log with the sub-committee for feedback.

Barrier to Reimbursement and Official Recommendation Identified by the AWG	DHCS Action
	• DHCS presented the structure and proposed content of the Program Guide to a broader audience of LEA stakeholders at AWG meetings. • DHCS published the Program Guide on January 28, 2020.
Need for guidance regarding upcoming RMTS implementation in the LEA Program.	• DHCS opened an e-mail account specific to LEA RMTS questions (RMTS@dhcs.ca.gov). Questions are reviewed by both LEA Program and SMAA program staff. • DHCS shared stakeholder RMTS questions and responses with the AWG and discussed related issues and solutions. • DHCS presented information at the SMAA Summit meeting and the SMAA Coder Training session in summer 2019 to address questions. • DHCS hosted a joint LEA/SMAA program meeting in October 2018 to discuss SPA 15-021 and the integrated RMTS methodology. At this meeting, stakeholders discussed potential standards for RMTS direct service moment (Code 2A) documentation. • DHCS conducted two regional trainings in FY 2018-19 on SPA 15-021 and RMTS requirements. • DHCS plans to provide additional training following approval of SPA 15-021.
Need to expand physician authorization to Physician Assistants (PAs) and Nurse Practitioners (NPs) for LEA Program services.	• DHCS implemented a Medi-Cal policy to allow PA/NP authorization for services. DHCS confirmed that PAs and NPs working under a physician may authorize LEA Program services, effective July 1, 2019. DHCS confirmed that the policy is not retroactive to earlier dates of service. • DHCS published a Policy and Procedure Letter in June 2019 to notify LEAs of the policy change and the policy effective date. • DHCS will include the policy in the revised LEA Provider Manual that will be published upon approval of SPA 15-021. DHCS also plans to incorporate this new policy into upcoming Program trainings.

Barrier to Reimbursement and Official Recommendation Identified by the AWG	DHCS Action
LEA claims processing system errors are impacting LEA Program reimbursement.	• DHCS continues to investigate denials on behalf of LEA providers and works with the fiscal intermediary to adjust the affected claims. • DHCS continues to request that potential claims processing errors be communicated to the LEA Program inbox (LEA@dhcs.ca.gov). • DHCS is proactively working with the California Medicaid Management Information System (CA-MMIS) on SPA 15-021 system changes in an attempt to avoid programming errors upon system implementation.
Lack of CMS approval of SPA 15-021 and delay of the RMTS methodology implementation.	• During this reporting period, DHCS received many additional Request for Additional Information from CMS in FY 2018-19, some of which were brand new items that hadn't been discussed in prior Requests for Additional Information. • DHCS maintained RMTS and SPA implementation as standing agenda items at the AWG meetings during FY 2018-19, keeping stakeholders informed of progress. • DHCS worked with the AWG sub-committees regarding forthcoming Policy and Procedure Letters and Provider Manual updates related to SPA 15-021. • DHCS worked to incorporate guidance and clarification in its stakeholder meetings and program materials as information becomes available through discussions with CMS. • DHCS developed training materials and presented a SPA 15-021 Implementation Training at two locations in FY 2018-19. • DHCS continues to work with LECs/LGAs on the RMTS implementation timeline. • DHCS is working on system updates with the fiscal intermediary so that once SPA 15-021 is approved, stakeholders have the opportunity to bill for additional services rendered on or after July 1, 2015 for new services and new practitioners.

Barrier to Reimbursement and Official Recommendation Identified by the AWG	DHCS Action
Technical issues encountered in registering ORP providers.	• Effective July 1, 2018, practitioners who order, refer, or prescribe (ORP) LEA direct medical treatment services must have a NPI and must be individually enrolled as a Medi-Cal ORP provider. • LEAs attempting to enroll practitioners as Medi-Cal ORP providers were receiving denials and unable to successfully register some of their practitioners. DHCS revised the ORP application process for certain practitioner types experiencing difficulties registering as an ORP provider. Solutions were communicated to LEA stakeholders. • Enrollment as an ORP provider will be effective one year prior to the date DHCS received the complete application package. This retroactive effective date allowed DHCS to clear up any enrollment difficulties so that claims with dates of service on or after July 1, 2018 would not be impacted by the ORP policy. • DHCS developed and posted the “ORP Guide” located on the LEA Program website June 2018.

V. ONE-YEAR TIMETABLE FOR STATE PLAN AMENDMENTS

As of June 2019, DHCS was still working with CMS and involved in discussions regarding SPA 15-021.

In addition, DHCS has submitted a related SPA (SPA 16-001) which proposes expanding the population of students eligible to receive Targeted Case Management (TCM) services, when approved. Under SPA 16-001, TCM will be a covered service for all Medi-Cal eligible students and not limited to students with an IEP/IFSP.

In FY 2018-19, DHCS also submitted SPA 19-0009, which proposes to provide comprehensive vision services to LEA Medi-Cal eligible students. SPA 16-001 and SPA 19-0009 are currently inactive, pending SPA 15-021 approval. DHCS will work with CMS toward approval of SPA 16-001, followed by SPA 19-0009.

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

Table 8: Timetable for Proposed State Plan Amendments

State Plan Amendment 15-021 Submission
September 30, 2015 DHCS submits SPA 15-021 to CMS, which proposes the following: • 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 for services provided to the general education population • 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

CMS Requests for Additional Information (RAIs)
SPA 15-021 – Initial RAIs from CMS
December 2015 • Initial RAIs received from CMS **January 2016 through October 2016** • Initial RAI responses to CMS (completed in phases)
SPA 15-021 – Supplemental RAIs from CMS
November 2016 through December 2018 • Additional RAIs received regarding Service Coverage and Managed Care • Additional RAIs received regarding transportation services **December 2015 through March 2017** • Personal Care Services questions received from CMS (Same-Page Review) • Personal Care Services responses to CMS • Revised Cost and Reimbursement Comparison Schedule /draft instruction package provided to CMS • CMS approval of Personal Care Services responses • DHCS submits responses on Service Coverage and Managed Care questions **October 2017 through November 2019** • Additional RAIs related to Specialized Medical Transportation, RMTS, Medi-Cal Eligibility Rate, Cost and Reimbursement Comparison Schedule submission deadline **December 2017, May 2018** • Additional RAIs received regarding SMAA Manual and RMTS Guide **April 2018, May 2018** • DHCS submits responses on SMAA Manual and RMTS Guide **January 2019** • DHCS submits latest draft of complete SPA package, matrix of SPA updates over time and full RAI package, including a response to CMS questions on care coordination **February 2019** • CMS informs DHCS that Memorandums of Understanding will not be required to formalize care coordination between LEAs and Managed Care Organizations **March 2019** • CMS informs DHCS that the cost report will be due eight months after the close of the fiscal year and that an interim settlement should be incorporated into the cost settlement process **April 2019** • CMS submits questions related to the SPA backcasting methodology; DHCS submits responses to CMS **June 2019** • DHCS submits RAI responses regarding transportation and the Medicaid Eligibility Ratio to CMS

SMAA Manual Updates that Incorporate RMTS Changes Impacting SMAA Program and LEA Program

November 2017

- DHCS updates SMAA Manual Sections 5 and 6 and submitted to CMS

December 2017

- CMS submits questions to DHCS on draft SMAA Manual

March 2018

- DHCS submits feedback on new CMS time survey policy regarding prior notification and response timeline

April 2018, June 2018

- DHCS submits responses to CMS questions, including the notification and response timeline

May 2018

- CMS provides draft approval of SMAA Manual, excluding the notification and response timeline

October 2018

- CMS issues conditional approval letter for revisions to the SMAA Manual regarding the LEA Program and grants an exception to the CMS notification/response

December 2018

- DHCS submits revised SMAA Manual to CMS for review

Spring 2019

- CMS and DHCS discuss components of the draft manual

State Plan Amendment 16-001 Submission
March 29, 2016 • DHCS submits SPA 16-001 to CMS, which proposes to include all Medicaid eligible beneficiaries, including those with an IEP/IFSP/Individualized Health and Support Plan (IHSP), for TCM services with an effective date of January 1, 2016 • The reimbursement methodology for TCM services is proposed in SPA 15-021, which will allow TCM services to be reimbursed at incremental cost of a school nurse proxy rate **June 3, 2016** • Per CMS, SPA 16-001 cannot be considered until SPA 15-021 is approved
State Plan Amendment 19-0009 Submission
March 2019 • DHCS submits SPA 19-0009 to CMS, which proposes to provide comprehensive vision services to Medi-Cal eligible students with an effective date of January 1, 2019 • SPA 19-0009 includes expanded access to needed vision services by providing comprehensive eye exams, corrective lenses, and frames at school sites **April 2019** • CMS sent informal comments/questions on reimbursement for vision services **May 2019** • DHCS responded to CMS comments/questions • CMS sent informal comments/questions regarding service coverage • DHCS responded to CMS comments/questions **June 2019** • CMS sent formal RAIs to DHCS • DHCS requested to postpone its response to SPA 19-0009 RAI until SPA 15-021 is approved and finalized; CMS accepts this proposal, putting SPA 19-0009 formally off the clock until DHCS responds to the CMS RAIs issued in June 2019

While DHCS and CMS were working to finalize the remaining issues on SPA 15-021, DHCS has continued to move forward with developing materials that will assist LEAs in

implementing the SPA, once approved. For example, DHCS has worked on the following areas since SPA 15-021 was submitted in September 2015:

- Incorporation of the LEA Program into the current RMTS process, resulting in a revised draft of the SMAA Manual that will be published upon CMS approval;
- Drafting of new cost report forms and instructions;
- Providing training to stakeholders on upcoming LEA Program changes related to SPA 15-021;
- Identification of new CPT codes and modifiers that will be used to submit claims for newly covered benefits;
- Developing reimbursement rates for new LEA Program services;
- Updating the LEA Program Provider Manual in anticipation of SPA approval;
- Drafting new Policy and Procedures Letters to provide guidance to stakeholders; and
- Developing training materials that will be presented to stakeholders upon SPA approval.

DHCS anticipates that the SPA will be implemented in FY 2020-21 and looks forward to working with LEAs to successfully roll-out the expanded services and practitioner types, as well as partner with LECs and LGAs in the successful implementation of RMTS in the LEA Program.