# Local Educational Agency
# Medi-Cal Billing Option Program

## Report to the Legislature, March 2009

Report Period April 2008 through March 2009

Department of Health Care Services

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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 a crucial source of revenues in providing necessary health services to students. Under the Local Educational Agency (LEA) Medi-Cal Billing Option Program (LEA Program), California's school districts and County Offices of Education (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. Senate Bill 231 (SB 231) was signed into law in October 2001 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 requires the California Department of Health Care Services (DHCS) to amend California's Medicaid state plan to accomplish various goals to enhance Medi-Cal services provided at school sites and access by students to those services.

Since SB 231 was 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 significantly increased. OIG audits of Medicaid school-based programs in twenty 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 continue to impact the ability of schools to bill for health services that are provided to Medi-Cal eligible students[2].

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

[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.

In December 2007, CMS published CMS-2287-F, the final rule to eliminate Medicaid reimbursement for school administration expenditures (administrative claiming) and costs related to transportation of school-age children between home and school. CMS also issued CMS-2237-IFC, an interim final rule related to case management services that clarifies when Medicaid will reimburse for case management activities. Subject to Obama Administration orders and the American Recovery and Reinvestment Act, both CMS rules were placed on moratorium in State Fiscal Year (SFY) 2008-09 and CMS rescinded the Medicaid regulations in June 2009.

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.

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

| Fiscal Year | Total Medi-Cal Reimbursement | Percentage Change from SFY 2000-01 |
|---|---|---|
| SFY 2000-01 | $59.6 million | N/A |
| SFY 2001-02 | $67.9 million | 14% |
| SFY 2002-03 | $92.2 million | 55% |
| SFY 2003-04 | $90.9 million | 53% |
| SFY 2004-05 | $63.9 million | 7% |
| SFY 2005-06 | $63.6 million | 7% |
| SFY 2006-07 (1) | $60.6 million | 2% |
| SFY 2007-08 (2) | $62.5 million | 5% |

Notes:
(1) SFY 2006-07 total Medi-Cal reimbursement includes incorrectly paid and denied LEA claims due to EDS claims processing issues. The preliminary amount ($60.6 million) does not include any adjustments for corrected claims processing issues.
(2) SFY 2007-08 total Medi-Cal reimbursement includes incorrectly paid and denied LEA claims due to EDS claims processing issues. The preliminary amount ($62.5 million) includes some positive and negative adjustments for corrected claims processing issues during SFY 2007-08. As of this report submission date, the majority of the claims processing issues have been resolved, but claims that were inadvertently denied or incorrectly reimbursed in SFY 2006-07 and SFY 2007-08 will be reprocessed in SFY 2008-09.

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 increased both treatment and assessment reimbursement rates for most LEA practitioner services provided to California's children in a school-based setting. New LEA assessment and treatment rates were systematically implemented on July 1, 2006. Subsequent to implementation, DHCS and the LEA Ad-Hoc Workgroup (LEA Workgroup) identified substantial claims processing issues that have erroneously denied payment for legitimate LEA claims, as well as underpaid or overpaid LEAs for claims submitted since SFY 2006-07. DHCS, Fiscal Intermediary and Contracts Oversight Division (FI-COD) and Electronic Data Systems (EDS) collaborated during SFY 2006-07 and 2007-08 to correct the system errors. The SFY 2006-07 and SFY 2007-08 total reimbursement amounts are expected to increase as these claims

processing issues become corrected in the payment system. In addition, the continuous reduction in claims for health services due to Free Care and OHC requirements mandated by CMS have forced LEA providers to adhere to strict billing procedures and eliminate certain billing practices for health services, particularly regarding assessment services.

The LEA Workgroup was organized in early 2001. Regular LEA Workgroup meetings, currently conducted every other month, assist to identify barriers for both existing and potential LEA providers, and have resulted in recommended new services to be considered for the LEA Program. Operational bottlenecks continue to be addressed and improved based on feedback from the LEA Workgroup members. In addition, the LEA Workgroup continues to suggest enhancements to the LEA Program website and other communication venues, in order to improve LEA provider communication and address relevant provider issues.

Additional 2008 progress included benefits research related to expanding LEA services to include Durable Medical Equipment (DME) and Assistive Technology Devices. Progress was made on the practitioner side to further define who can provide and supervise LEA services. In 2006, DHCS, in collaboration with the California Commission on Teacher Credentialing (CCTC) and the California Speech-Language-Hearing Association (CSHA) established equivalency for a credentialed speech-language pathologist as a “speech pathologist” under the federal standards governing Medicaid reimbursement. CMS subsequently required an equivalency ruling from the California Attorney General (AG). In November 2006, the AG opinion was rendered, concluding that the federal requirements were met for practitioners holding a State preliminary or professional clear services credential in speech-language pathology. Once CMS reviews the AG opinion and approves the SPA equivalency language (SPA 05-010), speech-language pathology practitioners with preliminary or professional clear services credentials in speech-language pathology will no longer require supervision when providing services to Medi-Cal eligible children. In addition, practitioners with professional clear services credentials in speech-language pathology will be qualified to provide supervision to other credentialed speech-language pathologists

providing LEA services. DHCS re-submitted SPA 05-010 to CMS in September 2008 for review. This equivalency will be implemented subject to the SPA and regulations approval process.

Assembly Bill (AB) 2950, chaptered in August 2006, eliminated timeliness cut backs for LEA claims submitted for reimbursement between the seventh and twelfth month after the month of service. Therefore, LEA claims submitted with dates of service on or after January 1, 2007 are no longer subject to reduced reimbursement rates of 25 and 50 percent for claims submitted between the seventh and twelfth months after the month of service. In June 2007, claims processing system updates were successfully implemented. Effective for dates of service on or after January 1, 2007, LEAs have twelve months after the month of service to submit claims that are eligible for maximum reimbursement. LEA claims submitted after the twelfth month of service without a legitimate delay reason code will continue to be denied.

Some progress has been made on the development of a proposed regulations package to revise existing State regulations, as well as develop new regulations related to LEA services. DHCS expects the proposed regulations package will be formally submitted for review in 2010.

In addition to beginning the formal rulemaking process, DHCS accomplished the following tasks in 2008: assisting FI-COD and EDS in identifying and resolving claims processing issues that have resulted from technical claims processing system changes; revising the Medi-Cal Provider Manual sections specific to LEA services (LEA Provider Manual), as necessary; developing audit protocols in conjunction with DHCS Audits and Investigations (A&I); and discussing Certified Public Expenditure (CPE) cost settlement requirements with CMS.

Additional SPAs may be developed and submitted to CMS in 2009 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

submission of additional SPAs will likely be determined based on current CMS policy direction relative to school-based programs.

The work completed in 2008 has largely been due to the positive and on-going relationship between DHCS and the many officials of school districts, COE, the California Department of Education (CDE) 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 DHCS to amend California's Medicaid state plan to accomplish various goals to enhance Medi-Cal services provided at school sites and access by students to those services. SB 231 requires DHCS to:

- Amend the Medicaid state plan with respect to the LEA Program to ensure that schools 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.<br>• A state-by-state comparison of school-based Medicaid total and per eligible child claims and federal revenues. The comparison shall include a review of the most recent two years for which completed data is available.<br>• A summary of 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.<br>• 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 DHCS by the entities named in the legislation and the action taken by DHCS 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 the Individuals with Disabilities Education Act (IDEA) to provide appropriate educational services to all children with disabilities.

School-based health services reimbursed by the LEA Program are primarily provided to students with disabilities receiving special education services through an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP). For several of these IEP/IFSP children, additional services, many of them health-related, are necessary to assist them in attaining their educational goals. The LEA Program also provides reimbursement for health services, such as nursing care, rendered to general education students, assuming the LEA can satisfy the stringent Free Care and OHC requirements.

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

Medicaid is financed jointly by the states and the federal government. In 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 increased at a national level. The OIG did not release any additional reports on school-based health services during this Legislative Report period. The total number of states with audit reports issued on school-based health services since October 2001 remains at twenty. These reports are part of a series in a multi-state initiative reviewing costs claimed for Medicaid school-based health services. Reported findings related to school-based health services, which have resulted in millions of dollars in alleged overpayments to schools, 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;
- Insufficient rate-setting methodologies; and
- Non-compliance with the state plan.

In May 2003, CMS issued a final guide 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." CMS still has yet to publish additional guidance on these issues.

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

In December 2007, CMS issued a final rule (CMS-2287-F) eliminating Medicaid reimbursement for school administration expenditures (administrative claiming) and costs related to transportation of school-age children between home and school. CMS indicated in the final rule that these activities are not necessary for the proper and efficient administration of the Medicaid State Plan. In addition, CMS noted that transportation from home to school and back is not within the scope of the optional medical transportation benefit. Under these regulations, administrative activities provided through California's Medi-Cal Administrative Activities Program (MAA Program) will no longer be reimbursed with federal Medicaid dollars. In addition, transportation provided through California's LEA Program will be restricted. According to CMS-2287-F, FFP "…would no longer be available for the costs of transportation from home to school and back for school-age children with an IEP or IFSP established pursuant to the IDEA." However, "CMS would continue to reimburse States for transportation costs related to children who are not yet school-age and are being transported from home to another location, including a school, and back to receive direct medical services, as long as the visit does not include an educational component or any activity unrelated to the covered direct medical service." In mid-2008 a moratorium was placed on CMS' ability to enforce the new rules. The February 13, 2009 passage of the American Recovery and Reinvestment Act of 2009 has extended the moratorium to June 30, 2009. In June 2009, CMS rescinded the regulation.

In December 2007, CMS also issued an interim final rule (CMS-2237-IFC with comment period) related to case management services. This ruling redefines the term "case management services" as services that will "…assist individuals eligible under the State plan in gaining access to needed medical, social, educational and other services." This definition is consistent with Section 6052 of the Deficit Reduction Act of 2005. Similarly to CMS 2287-F, a moratorium was placed on CMS' ability to enforce CMS-2237-IFC; however, in June 2009, CMS also rescinded the regulation.

Additionally, as part of the American Recovery and Reinvestment Act of 2009, the federal government has approved a 6.2 percent Federal Medical Assistance Percentage (FMAP) increase to all states and territories. Effective October 2008, the California FMAP increased from 50 percent to 61.59 percent and will continue at the higher rate until December 31, 2010, resulting in higher federal match dollars for the LEA program. Since the LEA Program is a local-federal match program, the increase in FMAP will result in additional funding for LEA providers in California.

## 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. In addition, a comparison of school-based Medicaid systems in comparable states was conducted using annual survey data.

School-Based Medicaid Systems in Comparable States

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

**Table 2: Factors Considered in Selecting Comparable States**

| Factor | Source of Information |
|---|---|
| Number of Medicaid-eligible children aged 6 to 20 | Medicaid Program Statistics, Federal Fiscal Year (FFY) 2005-06, CMS |
| Number of IDEA eligible children aged 3 to 21 | Twenty-eighth Annual Report to Congress on the Implementation of the IDEA, 2006, U.S. Department of Education, Office of Special Education and Rehabilitative Services |
| Average salaries of instructional staff (classroom teachers, principals, supervisors, librarians, guidance and psychological personnel, and related instructional staff) | Rankings of the States 2008 and Estimates of School Statistics 2009, National Education Association (NEA), December 2008 |
| Per capita personal income | Rankings of the States 2008 and Estimates of School Statistics 2009, NEA, December 2008 |

The number of Medicaid-eligible and IDEA eligible children provide a measure of the number of students that may be qualified for Medicaid school-based services. The average salaries of instructional staff and per-capita personal income 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. In addition, Ohio's school-based services claiming program ended in June 2005; however, Ohio is in the process of developing a new and more expansive school-based services claiming program.

Recent program changes to California's LEA Program compared to school-based Medicaid systems in the comparable states are summarized below:

- California's SPA 03-024 was approved in March 2005 and implemented on July 1, 2006. Implementation of the SPA resulted in increased reimbursement rates for most LEA services and the transition from local codes to national Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes, as required by the Health Insurance Portability and Accountability Act (HIPAA). Comparable state school-based health service providers are also billing claims with national CPT and HCPCS codes, in order to comply with HIPAA requirements.
- LEA providers will annually complete a cost report as part of the reconciliation process required by California's CPE program. The standardized cost report, known as the Medi-Cal Cost and Reimbursement Comparison Schedule (CRCS), will be used to compare the interim Medi-Cal reimbursements received during the fiscal year with the actual costs to provide the health services rendered during this period. LEA providers will report actual costs and annual hours worked for all practitioners who

provided health-related services during the appropriate fiscal year on the CRCS forms. Costs will be reconciled to Medi-Cal reimbursement to ensure that each LEA provider is not paid more than the costs of providing these services. The reconciliation results in a difference owed to or from the LEA; underpayments will be paid to LEAs and overpayments will be withheld from future LEA reimbursement. 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 for the SFY 2006-07 was scheduled to be due on November 30, 2007, however the deadline was delayed until claims processing issues were resolved to ensure that accurate Medi-Cal reimbursement and units of service data is available for the reconciliation process. Since DHCS is still working with EDS to determine an efficient way to summarize and provide reimbursement and units information to each LEA for inclusion on the CRCS, the deadline for LEAs to submit the completed CRCS is yet to be determined; however, LEAs should be prepared to submit practitioner costs and hours by June 1, 2009 for the SFY 2006/07 CRCS. In addition, DHCS has made the providers aware that LEAs should be prepared to submit practitioner costs and hours by August 1, 2009 for the SFY 2007/08 CRCS.

In comparison to California's LEA Program, 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 reimburses school providers based on statewide rates, and this program currently does not require annual cost reconciliation. Pursuant to a CMS mandate, Michigan has developed a new fee-for-service rate methodology for its school-based services. Michigan's interim payments are calculated based on an estimated monthly reimbursement cost formula, which utilizes prior year costs plus any inflation or program changes. Interim monthly payments are reconciled on an annual basis to the current year costs (July 1 through June 30 of each year). Within 18 months after the school fiscal year end, the state will review, certify and finalize the Medicaid expenditure report and the final settlement process begins.

- No new services were added to the LEA Program in 2008. As of July 1, 2008 Michigan added personal care services as a reimbursable service when medically necessary, documented in an IEP or IFSP (including details, frequency and duration), and ordered at least annually by a physician in accordance with an individual plan of service.

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

Administration of the sixth state survey began in October 2008. States were contacted to update information provided in the 2007 survey; states that did not participate in 2007 were given the opportunity to complete the current survey. Follow-up calls were made during Winter 2009 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 unconfirmed reimbursement totals and internal auditing issues; several states did not respond to follow-up calls. 35 of 46 states contacted completed the survey, including five states that did not participate in 2007 and one state that had not participated in any previous survey. Three of the survey respondents did not provide updated reimbursement figures for SFY 2006-07.

Table 3 summarizes Medicaid reimbursement (federal share) for health services and administrative services for SFYs 2006-07[9] and 2007-08. Several states did not have finalized 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).

[9] A few states adjusted Medicaid reimbursement for SFY 2006-07 provided in their 2007 survey; the adjusted amounts are reflected in Table 3.

In the April 2000 GAO Report, Maryland had the highest average claim per Medicaid-eligible child of $818[10], while California's average claim was $19, a difference of $799. A comparison of the average claim in the April 2000 report published by the GAO to the SFY 2006-07 average claim per Medicaid-eligible child in Table 3 shows an increase in 30 of the 35 states that reported federal reimbursement (including California). The average claim decreased in five states.

In the 2007 state survey, Vermont had the highest average SFY 2007-08 claim of $740. There is currently no accurate way to measure California's average claim amount due to several factors: post-SPA implementation claims processing issues resulting in claims being incorrectly reimbursed or denied, LEAs holding claims until the claims processing issues are resolved, and LEAs complying with Free Care and OHC requirements, as noted earlier in this section. However, federal revenues from administrative activities claimed in the MAA Program increased from $113.8 million in SFY 2006-07 to $159.7 million.

[10] Based on SFY 2004-05 data, Maryland had an average claim per Medicaid-eligible child of $358. Maryland did not participate in the 2007 survey to update Medicaid reimbursement for health and administrative services.

## Table 3: Medicaid Reimbursement and Claims by State, Ranked by 2007-08 Average Claim Per Medicaid-Eligible Child

| State | | SFY 2006-2007 [1] Federal Medicaid Reimbursement (000's) | SFY 2006-2007 [1] Total Claims (000's) | SFY 2006-2007 [1] Average Claim Per Medicaid-Eligible Child [2] | SFY 2007-2008 [1] Federal Medicaid Reimbursement (000's) | SFY 2007-2008 [1] Total Claims (000's) | SFY 2007-2008 [1] Average Claim Per Medicaid-Eligible Child [2] |
|---|---|---|---|---|---|---|---|
| VERMONT | | 24,707 | 42,888 | $ 872 | 21,487 | 36,399 | $ 740 |
| NEBRASKA | | 30,857 | 60,672 | 622 | 32,788 | 64,741 | 664 |
| MASSACHUSETTS | | 111,689 | 223,378 | 608 | 116,346 | 232,692 | 633 |
| MONTANA | | 12,360 | 18,719 | 492 | 14,288 | 21,531 | 565 |
| RHODE ISLAND | | 23,039 | 44,354 | 601 | 20,778 | 39,986 | 542 |
| DELAWARE | | 12,956 | 25,911 | 462 | 15,088 | 30,175 | 538 |
| WEST VIRGINIA | | 39,367 | 54,061 | 402 | 38,313 | 51,599 | 384 |
| PENNSYLVANIA | | 133,640 | 249,615 | 344 | 133,626 | 251,091 | 346 |
| MICHIGAN | | 126,981 | 229,534 | 320 | 133,882 | 236,340 | 330 |
| IDAHO | | 15,353 | 21,820 | 234 | 21,216 | 30,366 | 326 |
| ILLINOIS | | 108,524 | 217,049 | 247 | 117,757 | 235,514 | 269 |
| KANSAS | | 37,621 | 63,037 | 502 | 18,224 | 31,812 | 253 |
| NEW YORK | | 171,820 | 343,641 | 259 | 147,162 | 294,324 | 221 |
| WISCONSIN | | 41,698 | 72,736 | 229 | 39,621 | 68,762 | 216 |
| CONNECTICUT | | 18,340 | 36,680 | 198 | 19,020 | 38,040 | 205 |
| VIRGINIA | | 30,720 | 61,440 | 186 | 24,543 | 49,086 | 149 |
| IOWA | | 12,125 | 19,563 | 124 | 13,679 | 22,160 | 141 |
| CALIFORNIA | [3] | 174,358 | 348,717 | 108 | 222,182 | 444,364 | 137 |
| FLORIDA | | 67,888 | 132,520 | 128 | 64,392 | 126,322 | 122 |
| ARKANSAS | | 16,271 | 26,326 | 84 | 18,735 | 30,763 | 99 |
| NORTH DAKOTA | | 970 | 1,498 | 64 | 1,466 | 2,300 | 98 |
| ARIZONA | | 35,708 | 55,147 | 123 | 26,730 | 43,966 | 98 |
| COLORADO | | 9,438 | 18,875 | 103 | 8,921 | 17,842 | 97 |
| ALABAMA | | 13,548 | 26,848 | 87 | 14,205 | 28,256 | 91 |
| NORTH CAROLINA | | 16,466 | 28,469 | 51 | 25,630 | 46,675 | 84 |
| NEW MEXICO | | 10,727 | 16,595 | 80 | 9,757 | 14,802 | 71 |
| WASHINGTON | | 19,048 | 38,046 | 82 | 15,410 | 30,524 | 66 |
| MISSOURI | | 25,937 | 50,710 | 118 | 8,593 | 15,625 | 36 |
| NEVADA | | 4,259 | 7,898 | 91 | 1,228 | 2,334 | 27 |
| OKLAHOMA | | 3,430 | 5,033 | 17 | 4,048 | 6,033 | 20 |
| KENTUCKY | | 16,873 | 31,847 | 105 | 3,217 | 4,611 | 15 |
| INDIANA | | 2,799 | 4,470 | 11 | 1,828 | 2,976 | 7 |
| SOUTH DAKOTA | [4] | 7,305 | 13,805 | 270 | - | - | - |
| MINNESOTA | [4] | 27,702 | 55,403 | 212 | - | - | - |
| SOUTH CAROLINA | [4] | 39,737 | 60,141 | 172 | - | - | - |
| GEORGIA | [4, 5] | 20,587 | 37,854 | 57 | - | - | - |
| OHIO | [5] | - | - | - | - | - | - |
| TENNESSEE | [5] | - | - | - | - | - | - |
| WYOMING | [5] | - | - | - | - | - | - |

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

(2) Calculated as total claims divided by the number of Medicaid-eligible children (ages 6-20) in Federal Fiscal Year (FFY) 2005-06, if available. (Source: Medicaid Program Statistics, Centers for Medicare and Medicaid Services, http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/02_MSISData.asp

(3) California SFY 2006-07 and 2007-08 Federal Medicaid reimbursement and total claims include incorrectly paid and denied LEA claims due to EDS claims processing issues. The preliminary amounts include some positive and negative adjustments for corrected claims processing issues during both SFYs.

(4) Federal reimbursement in SFY 2007-08 for this state's health services program and/or administrative claiming program was not available.

(5) This state did not have a school-based Medicaid health services program or administrative claiming program during SFY 2006-2007 or SFY 2007-2008.

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

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

- **Implementation Activities Related to SPA 03-024**
  FI-COD and EDS implemented the HIPAA-compliant national codes on July 1, 2006, resulting in updated reimbursement rates and policy changes related to modifiers, qualified practitioner types, maximum units of services and general utilization controls for the LEA Program. Much focus during 2008 was related to the continued resolution of claims processing errors that occurred post-implementation of SPA 03-024. Claims processing issues were identified by DHCS, the LEA Workgroup, FI-COD and EDS. DHCS has worked extensively to resolve multiple claims processing issues after implementation of the new national codes. Billing system issues resulted in LEA claims being erroneously overpaid, underpaid or denied. Many of the issues are related to the complexity of system coding required to distinguish the multiple procedure code and modifier combinations. Each procedure code and modifier combination distinguishes the specific LEA service type, rendering practitioner, reimbursement rate and utilization control. As of March 2009, all of the identified issues have been corrected in the claims processing system. Throughout 2008 and 2009, EDS implemented various EPCs that automatically reprocessed LEA claims and adjusted LEA reimbursements to the appropriate payment amount. An additional two EPCs will be forthcoming in 2009 that are expected to correctly reimburse LEAs for specific services due to other health care denials and claim timeliness cutbacks.

  As previously noted, DHCS has extended the SFY 2006-07 CRCS deadline to allow time to determine an efficient way to summarize and provide reimbursement and units

information to each LEA for inclusion on the CRCS. The original submission date for the first CRCS was November 30, 2007. LEAs should be prepared to submit practitioner costs and hours by June 1, 2009 for the SFY 2006/07 CRCS and by August 1, 2009 for the SFY 2007/08 CRCS. DHCS has communicated the new CRCS due date to LEAs via the LEA Program website and LEA March 2009 training. The electronic version of the CRCS is currently available on the LEA Program website. Additionally, CRCS training Digital Video Disks (DVDs) are still available upon request to DHCS.

Other tasks related to the implementation of SPA 03-024 included extensive edits to the LEA Provider Manual in 2006 to include information on new policy and billing changes resulting from the implementation of SPA 03-024. In 2008 additional LEA Provider Manual updates included clarification of supervision requirements for non-credentialed nurses and a HIPAA-compliant description of LEA Program modifier usage. The LEA Provider Manual is currently available on the LEA Program website, as well as the general Medi-Cal website.

- **Assembly Bill (AB) 2950**

  Chapter 131, statutes of 2006 (AB 2950) amended Welfare and Institutions Code, Section 14115, to eliminate reductions in reimbursement for certain Medi-Cal programs for which there is no State General Fund match, including the LEA Program. Timeliness cut backs were previously applied to LEA claims submitted for reimbursement between the seventh and twelfth month after the month of service. For dates of service prior to January 1, 2007, LEA claims were subject to reduced reimbursement rates of 25 and 50 percent for claims submitted between the seventh and twelfth months after the month of service. In June 2007, claims processing system changes were implemented to comply with AB 2950, and have resulted in increased reimbursement for LEA services.

- **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, DHCS, 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. The LEA Workgroup has been instrumental in identifying claims processing issues and providing input on the operational aspect of LEA Program policies within the school-based setting for specific LEA services, which has resulted in updates to the LEA Program.

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, updated reviews 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;
- 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 are located in Appendix 2.

## IV. OFFICIAL RECOMMENDATIONS MADE TO DHCS

Official recommendations are made to DHCS during LEA Workgroup meetings. The following table summarizes the recommendations made to DHCS 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 DHCS and Actions Taken/To Be Taken by DHCS**

| Recommendation | Action Taken/To Be Taken |
|---|---|
| • Update the LEA Provider Manual to improve the organization and content of the policy information, as necessary. | The LEA Provider Manual, containing information regarding LEA Program billing policies and procedures, is available on the LEA Program and Medi-Cal websites. DHCS continued to update the LEA Provider Manual throughout 2008 to ensure clarity on LEA policy implemented as a result of SPA 03-024. 2008 LEA Provider Manual updates and revisions included language reflecting: clarification of licensing, credentialing and supervision requirements for nursing practitioners; clarification of IEP/IFSP assessment utilization controls; addition of national modifier descriptions for LEA modifiers; and updating LEA Program contact and resource information. Continued revisions to the LEA Provider Manual will be published in 2009, as necessary. |

| 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[11] and treatment services. | • On July 1, 2006, DHCS implemented the LEA Rate Study, SPA 03-024 recommendations, and the HIPAA-mandated conversion to national billing codes. Since that date, DHCS has identified errors in the claims processing system, which have caused certain claims to be inadvertently denied or paid incorrectly. In 2008, DHCS, FI-COD and EDS continued to hold bi-weekly meetings to discuss and resolve claiming errors. Considerable time and effort was expended clarifying and responding to paid claims issues raised by the LEA Workgroup, FI-COD and EDS regarding audit protocols, utilization controls, and inaccurate reimbursement for LEA services. In addition, Medi-Cal Safety Net Financing worked closely with FI-COD and EDS, as well as the LEA Workgroup to test system implementation fixes to confirm that the claims processing system will correct system errors. As of February 2009, DHCS, FI-COD and EDS successfully implemented system updates for all of the original issues identified. The first EPC implemented in December 2007 and subsequent EPCs throughout 2007, 2008 and early 2009, re-processed claims and adjusted LEA payments for claims mistakenly overpaid, underpaid or denied. DHCS, FI-COD and EDS determined proper prioritization to minimize the overlap of claims issues and potential reprocessing of issues for claims impacted by multiple errors. The last two EPCs are scheduled to be implemented by Spring 2009. Continued collaboration with FI-COD and EDS will be on-going in 2009 to monitor the claims processing system and ensure that all claims processing issues have been resolved and no additional issues arise. |

[11] 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, provided the LEA meet the Free Care and OHC requirements.

| Recommendation | Action Taken/To Be Taken |
|---|---|
| • Develop and maintain an interactive LEA Program website. | • In late 2007 the LEA Program website underwent a significant design transition to reflect DHCS' new website format and template. In 2008, DHCS continued to modify and organize the LEA Program content using the required State format to ensure that LEA Program information is readily accessible and the website is easy to navigate.<br>• 2008 LEA website maintenance activities included posting: LEA Workgroup meeting summaries and updating Provider Participation Agreement forms, updating LEA Frequently Asked Questions (FAQs), and FY 2006/07 paid claims data reports. In addition, the March 2009 LEA training announcement and registration form was posted on the LEA website.<br>• A claims processing issues matrix is maintained on the LEA Program website containing a summary of identified issues and status of resolution. This matrix is updated periodically as claim issues are resolved, and includes projected system implementation dates, and/or when EPCs are expected to be implemented. The EPC letters that are sent to impacted LEA providers are also posted on the LEA Program website.<br>• DHCS was also able to implement and create an electronic mailing list that LEA personnel may subscribe to and automatically receive e-mails notifications when new or updated information has been posted on the LEA Program website.<br>• Additional time in 2009 will be spent to update the website, reflect changes recommended by the LEA Workgroup and to increase communication to the LEA provider community regarding LEA Program billing and policy information. |

| Recommendation | Action Taken/To Be Taken |
|---|---|
| • Establish equivalency for credentialed speech-language pathologists. | • DHCS originally submitted a SPA in 2005 to remove supervision requirements for credentialed speech-language practitioners. The SPA was placed on hold because CMS required an equivalency ruling from the California Attorney General. AB 2837, chaptered in September 2006, successfully created three types of credentialed speech-language practitioners: 1) practitioners with a preliminary services credential in speech-language pathology, 2) practitioners with a professional clear services credential in speech-language pathology, and 3) practitioners with a valid credential issued by CCTC on or before January 1, 2007. This established new educational and work requirements that are equivalent to federal standards for two of the three credentialed speech-language pathologists. The California AG issued an opinion in November 2006 stating that the California credentialing requirements for speech-language pathologists with preliminary or professional clear services credentials in speech-language pathology, defined in Education Code, Section 44265.3(a), are equivalent to the federal credentialing requirements. DHCS re-submitted the SPA and responded to CMS' request for additional information in September 2008. Ultimately, after CMS SPA approval, speech-language pathology practitioners with preliminary or professional clear services credentials in speech-language pathology will no longer require supervision when providing services to Medi-Cal eligible children. In addition, practitioners with professional clear services credentials in speech-language pathology will be qualified to provide supervision to other credentialed speech-language pathologists providing LEA services. |

| 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 March 2009, DHCS conducted a videoconference training to provide LEAs with updated information on LEA Program policy and procedures, as well as summarizing recent audit findings on LEA claims. Training topics included reimbursable LEA services; LEA Program billing requirements; prescription, referral and recommendation requirements; practitioner qualifications; Free Care and OHC requirements; and CRCS updates. In addition, A&I participated in the training, providing an overview of documentation requirements for LEA providers, as well as illustrating specific examples of appropriate and inappropriate supporting documentation for LEA claims.<br>• In February 2009, DHCS conducted an LEA vendor meeting to discuss the communication of LEA policy information, as well as DHCS expectations between LEAs and their vendors.<br>• DHCS 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.<br>• DHCS continues to disseminate information to LEA providers via the LEA Program website, including current status of claims processing issues, EPC letters to providers, FAQs, and information on the CRCS reporting requirement deadline.<br>• DHCS will work with CDE to post important LEA Program information on the CDE website and utilize CDE's e-mail distribution to school superintendents to increase dissemination of program information to LEA providers. |

| Recommendation | Action Taken/To Be Taken |
|---|---|
| • Update the statewide LEA provider contact list. | • The statewide LEA provider contact list was updated with e-mail addresses and contact names from the SFY 2005-06 LEA Annual Report and prior LEA training contacts. This list will be further updated with information from future training sessions.<br>• The statewide LEA provider contact list was used to disseminate information and announce the March 2009 LEA Program training. |
| • Provide quarterly status reports describing how SB 231 funds are spent. | • The contractor that assists DHCS in implementing the provisions of SB 231 continues to prepare monthly status reports of actual and projected activities. Reports detailing activities DHCS conducted in 2008 were provided at the LEA Workgroup meetings on a periodic basis. |
| • Submit SPAs and subsequent updates to CMS on a timely basis. | • DHCS will continue to work towards submission of future SPAs within a reasonable time frame, as appropriate, based on CMS' policy direction and temperament. |

| Recommendation | Action Taken/To Be Taken |
|---|---|
| • Conduct meetings with Medi-Cal Safety Net Financing, A&I and LEA providers regarding audit procedures. | • DHCS facilitated a conference call in March 2007 and a meeting in April 2007 with LEA providers and A&I to discuss the LEA findings in the Medi-Cal Payment Error Study and documentation of medical necessity relating to LEA services. LEA representatives and A&I discussed types of documentation maintained by schools, general information on the audit process, how A&I arrived at the study findings, including discussion on LEA contestment of findings and letters of disposition. An A&I representative attended the LEA Workgroup meeting in October 2008 and presented information regarding the types of audits and reviews that occur in LEAs, general audit findings, as well as LEA expectations during the audit process.<br>• An A&I medical consultant also participated and presented at the March 2009 training, explaining A&I's role in the LEA Program, identifying recent audit findings, documentation requirements, and example LEA documentation to support claims. |
| • Update interim reimbursement rates for LEA services per allowances in SPA 03-024. | • DHCS will begin work in 2009 to apply an approved inflation adjustment to the current interim reimbursement rates for LEA services, subject to regulation and SPA 03-024 limitations. DHCS is currently in discussions with CMS to determine if retroactive inflation is required for each individual year since the effective date of SPA 03-024. An SDN that incorporates the updated reimbursement rates in the claims processing system will be developed in collaboration with FI-COD and EDS. Inflating the current interim reimbursement rates for LEA services will be a priority in 2009. |

| Recommendation | Action Taken/To Be Taken |
|---|---|
| • Determine CRCS submission deadline for FY 2006/07 and FY 2007/08 and notify LEA providers. | • The original FY 2006/07 CRCS submission deadline of November 30, 2007 has been delayed. This delay subsequently postponed the FY 2007/08 CRCS deadline as well. LEAs should be prepared to submit practitioner costs and hours by June 1, 2009 for the SFY 2006/07 CRCS and by August 1, 2009 for the SFY 2007/08 CRCS. LEA providers have been notified of the upcoming CRCS deadlines via the LEA Program website, and March 2009 LEA training. LEA providers will be notified via similar channels of communication with any further updates regarding the CRCS submission deadlines. |
| • Revise the CP-O-888 Report provided monthly to LEAs by EDS. | • Each month, LEAs that submit claims receive a service and reimbursement report from EDS. The report lists the number of services rendered, dollar amounts reimbursed and procedure codes paid by month, quarter-to-date and year-to-date on a fiscal year basis. Currently, the report does not recognize multiple LEA modifiers that were implemented on July 1, 2006, and is not useful for LEAs to reconcile claims. EDS system modifications and an SDN would be required in order for EDS to generate the report with multiple modifiers; DHCS submitted the SDN to EDS in 2009. The SDN is requesting EDS to implement system changes to expand and modify the report to: 1) include procedure codes and multiple modifiers combinations; 2) be generated monthly based on date of payment so LEAs can reconcile claims submitted; and 3) be generated annually, per DHCS request, based on date of service so the CP-O-888 report can be utilized to obtain paid units and reimbursement figures for annual CRCS reporting requirements. In 2009, DHCS will collaborate with FI-COD and EDS to implement the required system changes for this SDN. |

| Recommendation | Action Taken/To Be Taken |
|---|---|
| • SB 231 2.5 percent withhold and one percent administrative withhold applied to all claims. | • A one percent administrative fee is levied against LEA claims for claims processing and related costs and an additional 2.5 percent to fund activities mandated by SB 231. The annual amount of the 2.5 percent withhold is not to exceed $1.5 million. The fees are subtracted from the total reimbursement amount on the Medi-Cal Remittance Advice Details (RAD) with RAD code 795 for the one percent withhold and code 798 for the 2.5 percent withhold. DHCS prepared the necessary policy letter for EDS to stop the SB 231 2.5 percent withhold for FY 2007/08 when the $1.5 million cap has been reached or at the end of the fiscal year, whichever comes first. Another policy letter was implemented to restart the 2.5 percent withhold for FY 2008/09.<br>• The Workgroup requested written documentation of the 2.5 percent withhold amounts collected from LEA claims for FY 2005/06 and FY 2006/07. In addition, DHCS will work with Audits and Investigations to develop a process for LEAs to recoup any excess withhold over the $1.5 million cap from previous fiscal years, if necessary. |

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

The first SPA after SB 231 was submitted in June 2003 was re-submitted to CMS in December 2004, and finally approved in March 2005. The delays were associated with the CMS approval process. We estimate the following SPA submissions:

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

| Service Description | Estimated Submission Date |
|---|---|
| • TCM services:<br>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 and develop the IEP/IFSP. In September 2004, DHCS 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. | • On hold |
| • Speech-language equivalency:<br>The SPA to remove supervision requirements for credentialed speech-language pathologists was originally submitted to CMS in Summer 2005 and re-submitted by DHCS in September 2008. CMS required a letter of equivalency from the AG, as noted in Section IV. DHCS has subsequently established that the requirements for credentialed speech-language pathologists with preliminary or professional clear services credentials in speech-language pathology are equivalent to federal standards. | • Pending CMS approval |

## VI. BARRIERS TO REIMBURSEMENT

Barriers to reimbursement continue to be identified through discussions with LEA Workgroup members. Table 6 describes the barriers to reimbursement identified in 2008, as well as the actions that have been and will be taken by DHCS.

### 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. | • Additional research on DME and Assistive Technology Devices and site visits were conducted in 2008 to obtain further information on the feasibility of adding DME as a reimbursable service under the LEA Program. Potential barriers of adding DME were identified as a result of site visits, including issues such as ownership; repair/ replacement and liability of equipment; prior authorization; scope of reimbursable equipment; and requirements to become a DME provider. These barriers were researched, evaluated and discussed with the LEA Workgroup, where a collective decision was reached not to pursue DME reimbursement through the LEA Program at this time.<br>• Research on behavioral intervention services, personal care services and therapy assistants was conducted in 2007. In 2009, DHCS will continue research on these services and consider expanding the scope of reimbursable services for LEAs.<br>• Potential national codes for dietician services and modifiers for autism medical teams have been identified and may be implemented in 2009.<br>• A cost survey may be designed in SFY 2008/09 to collect information from a sample of LEAs employing practitioners providing behavioral services, dieticians, physicians, and other practitioners.<br>• SPAs to expand services may be submitted to CMS, as discussed in Section V. |

| Barriers | Actions Taken /To Be Taken |
|---|---|
| • 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, may be planned for 2009. |
| • 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. | • CMS requires that LEAs must employ a practitioner type in order to bill for contracted practitioners of the same type. The LEA Provider Manual (loc ed a prov) reflects the models of service delivery policy for LEA services provided by employed and contracted practitioners. In addition, the contracted practitioner requirements were addressed at the March 2009 LEA provider training. |
| • LEA Program billing policies and procedures are not well documented. | • Training sessions for LEA providers were conducted in March 2009 to inform LEAs of current billing policies and procedures and LEA Program changes, including A&I audit findings and documentation requirements.<br>• The reorganization, content revision and ongoing updates of the LEA Provider Manual, as described in Section IV, has further helped to clarify LEA Program billing policies and procedures.<br>• FAQs are posted on the LEA Program website to assist providers with common questions regarding billing and program policies. FAQs are periodically reviewed and updated to reflect current LEA Program policy, as well as add new FAQs based on questions submitted from LEA providers. FAQs will also be developed and/or updated based on the March 2009 training questions. |

| Barriers | Actions Taken /To Be Taken |
|---|---|
| • 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. DHCS will collaborate with CDE to clarify the reinvestment requirements and disseminate the information via the LEA Program 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. DHCS requested guidance from CMS regarding the impact of the Oklahoma decision on reimbursement of non-IDEA services in the LEA Program.<br>• DHCS 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; Free Care requirements are still applicable to LEA providers.<br>• On April 24, 2006, notification was published in the Federal Register regarding proposed rulemaking that would codify the Free Care requirement.<br>• The Free Care and OHC requirements were again emphasized in the March 2009 LEA provider training. In 2009, DHCS will continue to follow this issue and communicate the status of the Free Care requirement to the LEA provider community via the LEA Program website and LEA Provider Bulletins. |

| Barriers | Actions Taken /To Be Taken |
|---|---|
| • Post SPA implementation claims processing issues have been identified and have resulted in LEA claims being incorrectly paid or denied. | • Medi-Cal Safety Net Financing will continue conducting bi-weekly meetings and working closely with FI-COD and EDS to resolve the claims processing issues identified after the SDN was implemented in July 2006. In 2008, DHCS continued to clarify LEA Program billing policies and requirements for EDS to alter system design, provided example claims to test system changes, and reviewed test results to ensure LEA claims are processing properly prior to implementation of system changes. DHCS determined appropriate timelines to resolve the claims processing errors through EPCs for LEAs impacted by the claiming errors. The first EPC was implemented in December 2007 and additional EPCs were implemented in 2007, 2008 and 2009 to adjust LEA payments for inadvertently denied or incorrectly paid claims. The last EPC will be forthcoming in Spring 2009. The LEA Program website contains a current summary of claims processing issues and status of resolution for system change and EPC implementation. |

| Barriers | Actions Taken /To Be Taken |
|---|---|
| • IEP/IFSP assessment utilization controls are currently on a "rolling month" basis, instead of fiscal year. | • IEP/IFSP initial/triennial and annual assessments and corresponding utilization controls are intended to follow the school year. Since the school year generally aligns with the state fiscal year, the LEA Program originally requested that the utilization controls be conducted on a state fiscal year basis, rather than a "rolling months" basis. However, FI-COD and EDS could not implement a fiscal year utilization control at the time the original SPA implementation and HIPAA changes occurred in July 2006. Therefore, DHCS submitted an SDN in 2009 to repeal the "rolling months" utilization controls for IEP/IFSP assessments and replace them with utilization controls that will operate on a fiscal year basis. In addition, the SDN requests a utilization control change related to IEP/IFSP amended assessments, which is expected to provide additional reimbursement for these services to LEA providers. The new amended assessment utilization control will allow for an amended assessment every 30 days (per beneficiary per LEA provider per service type), rather than every three months. DHCS will focus on efforts with FI-COD and EDS to implement this SDN as quickly as possible. |
| • Seven percent interest charged on all outstanding debts established by EDS. | • Due to the claims processing issues, LEAs were originally overpaid for LEA services conducted in FY 2006/07. After the first EPC was implemented in December 2007, several LEAs had an accounts receivable balance (overpayment). DHCS was notified that according to Welfare and Institutions Code, Sections 14170-14178, seven percent interest would be charged on all outstanding debts owed to the State and would be automatically applied 60 days after LEA notification of the outstanding debt. DHCS has determined that LEAs are exempt from the seven percent interest rate penalties on outstanding overpayments resulting from claims processing issues. LEAs received their refunds on the interest accrued on overpayments in October 2008; however, the one percent administrative and 2.5 percent SB 231 withholds were applied to the refund in error. DHCS, FI-COD and EDS are working to correct this issue and refund LEAs their full interest amount. |

| Barriers | Actions Taken /To Be Taken |
|---|---|
| • SB 231 2.5 percent withhold and one percent administrative withhold applied to all claims, including claims reprocessed during EPCs. | • LEA claims are subject to the SB 231 2.5 percent and one percent administrative withholds. Due to the claims processing issues, the first EPC implemented in December 2007 left several LEAs with an overpayment, as described above. For LEAs with overpayments, an account receivable was set up with 100 percent of the claims reimbursement amount; 100 percent of future LEA claims reimbursement is withheld until the LEA's account receivable has a zero balance. The 3.5 percent withhold will not be applied until the account receivable has been cleared and then will be applied at the time the LEA has a positive claims payout. For underpayments, the 3.5 percent will be applied at the time of the check write. |
| • Eligibility Data Match is missing the Beneficiary Identification Card (BIC) numbers for some students and LEAs can no longer use Social Security Numbers (SSNs) on Medi-Cal claims. | • Effective for dates of service on or after February 1, 2008, providers may no longer bill Medi-Cal using a beneficiary's SSN. Providers are now required to bill with the Medi-Cal identification number from the recipients Beneficiary Identification Card (BIC). LEAs submitting Medi-Cal claims using a beneficiary's SSN as the Medi-Cal ID number will deny with RAD Code 0046 "SSN not permitted for billing Medi-Cal". Potential reimbursable services for eligible students are being denied. A waiver for LEAs to be exempt from not using SSNs is not an option and only certain provider type exceptions apply, as specified in the Welfare and Institution Code. DHCS recommends that LEAs leave the BIC number blank when the BIC is not provided on the LEA eligibility Data Match. LEAs can reprocess the claims after the 30-day waiting period for BIC numbers or contact their county office for a temporary County Identification Number (CIN). |

## VII. APPENDICES

**Appendix 1(a): Medicaid Reimbursement And Claims By State**
**Ranked By Average Claim Per Medicaid-Eligible Child, State Fiscal Year (SFY) 2006 - 2007**

| | | SFY 2006 - 2007 | | | | | |
|---|---|---|---|---|---|---|---|
| | | 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) |
| VERMONT | 58.93% | 21,532 | 3,175 | 24,707 | 36,538 | 6,349 | 42,888 |
| NEBRASKA | 57.93% | 3,805 | 27,052 | 30,857 | 6,568 | 54,104 | 60,672 |
| MASSACHUSETTS | 50.00% | 65,813 | 45,876 | 111,689 | 131,626 | 91,752 | 223,378 |
| MONTANA | 69.11% | 10,849 | 1,511 | 12,360 | 15,698 | 3,021 | 18,719 |
| RHODE ISLAND | 52.35% | 19,195 | 3,844 | 23,039 | 36,666 | 7,689 | 44,354 |
| DELAWARE | 50.00% | 12,956 | - | 12,956 | 25,911 | - | 25,911 |
| WEST VIRGINIA | 72.82% | 39,367 | - | 39,367 | 54,061 | - | 54,061 |
| PENNSYLVANIA | 54.39% | 109,428 | 24,212 | 133,640 | 201,191 | 48,424 | 249,615 |
| MICHIGAN | 56.38% | 107,939 | 19,042 | 126,981 | 191,449 | 38,085 | 229,534 |
| IDAHO | 70.36% | 15,353 | - | 15,353 | 21,820 | - | 21,820 |
| ILLINOIS | 50.00% | 37,761 | 70,764 | 108,524 | 75,521 | 141,528 | 217,049 |
| KANSAS | 60.25% | 35,871 | 1,750 | 37,621 | 59,538 | 3,499 | 63,037 |
| NEW YORK | 50.00% | 171,820 | - | 171,820 | 343,641 | - | 343,641 |
| WISCONSIN | 57.47% | 41,003 | 695 | 41,698 | 71,346 | 1,389 | 72,736 |
| CONNECTICUT | 50.00% | 18,340 | - | 18,340 | 36,680 | - | 36,680 |
| VIRGINIA | 50.00% | 11,102 | 19,618 | 30,720 | 22,204 | 39,236 | 61,440 |
| IOWA | 61.98% | 12,125 | - | 12,125 | 19,563 | - | 19,563 |
| CALIFORNIA [4] | 50.00% | 60,600 | 113,758 | 174,358 | 121,200 | 227,517 | 348,717 |
| FLORIDA | 58.76% | 10,919 | 56,969 | 67,888 | 18,582 | 113,938 | 132,520 |
| ARKANSAS | 73.37% | 9,759 | 6,512 | 16,271 | 13,302 | 13,024 | 26,326 |
| NORTH DAKOTA | 64.72% | 970 | - | 970 | 1,498 | - | 1,498 |
| ARIZONA | 66.47% | 32,829 | 2,878 | 35,708 | 49,390 | 5,757 | 55,147 |
| COLORADO | 50.00% | 9,438 | - | 9,438 | 18,875 | - | 18,875 |
| ALABAMA | 68.85% | 452 | 13,096 | 13,548 | 656 | 26,191 | 26,848 |
| NORTH CAROLINA | 64.52% | 9,914 | 6,551 | 16,466 | 15,366 | 13,103 | 28,469 |
| NEW MEXICO | 71.93% | 7,967 | 2,760 | 10,727 | 11,076 | 5,519 | 16,595 |
| WASHINGTON | 50.12% | 10,670 | 8,378 | 19,048 | 21,290 | 16,756 | 38,046 |
| MISSOURI | 61.60% | 3,092 | 22,845 | 25,937 | 5,019 | 45,691 | 50,710 |
| NEVADA | 53.93% | 4,259 | - | 4,259 | 7,898 | - | 7,898 |
| OKLAHOMA | 68.14% | 3,430 | - | 3,430 | 5,033 | - | 5,033 |
| KENTUCKY | 69.58% | 3,373 | 13,500 | 16,873 | 4,847 | 27,000 | 31,847 |
| INDIANA | 62.61% | 2,799 | - | 2,799 | 4,470 | - | 4,470 |
| SOUTH DAKOTA | 62.92% | 1,957 | 5,348 | 7,305 | 3,110 | 10,695 | 13,805 |
| MINNESOTA | 50.00% | 19,828 | 7,874 | 27,702 | 39,656 | 15,747 | 55,403 |
| SOUTH CAROLINA | 69.54% | 34,402 | 5,335 | 39,737 | 49,470 | 10,670 | 60,141 |
| GEORGIA | 61.97% | 8,591 | 11,995 | 20,587 | 13,864 | 23,990 | 37,854 |
| OHIO [5] | 59.66% | - | - | - | - | - | - |
| TENNESSEE [5] | 63.65% | - | | - | - | - | - |
| WYOMING [5] | 52.91% | - | | - | - | - | - |

(1) The Federal Medical Assistance Percentage (FMAP) for each state was obtained from the Federal Register, published on November 30, 2005.
(2) Calculated as Medicaid reimbursement (federal share) divided by each state's FMAP.
(3) Calculated as Medicaid reimbursement (federal share) divided by 50%.
(4) California SFY 2006-07 Federal Medicaid reimbursement and total claims include incorrectly paid and denied LEA claims due to EDS claims processing issues. The preliminary amounts include some positive and negative adjustments for corrected claims processing issues during the SFY.
(5) This state did not have a school-based Medicaid health services program or administrative claiming program in effect during SFY 2005-06 or SFY 2006-07.

**Appendix 1(b): Medicaid Reimbursement And Claims By State**
**Ranked By Average Claim Per Medicaid-Eligible Child, State Fiscal Year (SFY) 2007 - 2008**

| | | SFY 2007 - 2008 | | | | | |
|---|---|---|---|---|---|---|---|
| | | 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) |
| VERMONT | 59.03% | 21,487 | - | 21,487 | 36,399 | - | 36,399 |
| NEBRASKA | 58.02% | 3,026 | 29,763 | 32,788 | 5,215 | 59,526 | 64,741 |
| MASSACHUSETTS | 50.00% | 58,661 | 57,685 | 116,346 | 117,322 | 115,370 | 232,692 |
| MONTANA | 68.53% | 13,026 | 1,262 | 14,288 | 19,008 | 2,523 | 21,531 |
| RHODE ISLAND | 52.51% | 16,408 | 4,369 | 20,778 | 31,248 | 8,738 | 39,986 |
| DELAWARE | 50.00% | 15,088 | - | 15,088 | 30,175 | - | 30,175 |
| WEST VIRGINIA | 74.25% | 38,313 | - | 38,313 | 51,599 | - | 51,599 |
| PENNSYLVANIA | 54.08% | 107,104 | 26,522 | 133,626 | 198,047 | 53,044 | 251,091 |
| MICHIGAN | 58.10% | 112,703 | 21,179 | 133,882 | 193,981 | 42,359 | 236,340 |
| IDAHO | 69.87% | 21,216 | - | 21,216 | 30,366 | - | 30,366 |
| ILLINOIS | 50.00% | 53,462 | 64,295 | 117,757 | 106,924 | 128,590 | 235,514 |
| KANSAS | 59.43% | 14,605 | 3,618 | 18,224 | 24,575 | 7,237 | 31,812 |
| NEW YORK | 50.00% | 147,162 | - | 147,162 | 294,324 | - | 294,324 |
| WISCONSIN | 57.62% | 39,621 | - | 39,621 | 68,762 | - | 68,762 |
| CONNECTICUT | 50.00% | 19,020 | - | 19,020 | 38,040 | - | 38,040 |
| VIRGINIA | 50.00% | 14,523 | 10,020 | 24,543 | 29,047 | 20,040 | 49,086 |
| IOWA | 61.73% | 13,679 | - | 13,679 | 22,160 | - | 22,160 |
| CALIFORNIA [4] | 50.00% | 62,529 | 159,653 | 222,182 | 125,059 | 319,306 | 444,364 |
| FLORIDA | 56.83% | 10,243 | 54,149 | 64,392 | 18,024 | 108,298 | 126,322 |
| ARKANSAS | 72.94% | 10,662 | 8,073 | 18,735 | 14,617 | 16,146 | 30,763 |
| NORTH DAKOTA | 63.75% | 1,466 | - | 1,466 | 2,300 | - | 2,300 |
| ARIZONA | 66.20% | 19,400 | 7,331 | 26,730 | 29,305 | 14,662 | 43,966 |
| COLORADO | 50.00% | 8,921 | - | 8,921 | 17,842 | - | 17,842 |
| ALABAMA | 67.62% | 296 | 13,909 | 14,205 | 437 | 27,818 | 28,256 |
| NORTH CAROLINA | 64.05% | 10,454 | 15,177 | 25,630 | 16,321 | 30,354 | 46,675 |
| NEW MEXICO | 71.04% | 7,955 | 1,802 | 9,757 | 11,197 | 3,605 | 14,802 |
| WASHINGTON | 51.52% | 5,021 | 10,389 | 15,410 | 9,746 | 20,778 | 30,524 |
| MISSOURI | 62.42% | 3,923 | 4,670 | 8,593 | 6,285 | 9,340 | 15,625 |
| NEVADA | 52.64% | 1,228 | - | 1,228 | 2,334 | - | 2,334 |
| OKLAHOMA | 67.10% | 4,048 | - | 4,048 | 6,033 | - | 6,033 |
| KENTUCKY | 69.78% | 3,217 | - | 3,217 | 4,611 | - | 4,611 |
| INDIANA | 62.69% | 1,677 | 151 | 1,828 | 2,675 | 302 | 2,976 |
| SOUTH DAKOTA [5] | 60.03% | - | - | - | - | - | - |
| MINNESOTA [5] | 50.00% | - | - | - | - | - | - |
| SOUTH CAROLINA [5] | 69.79% | - | - | - | - | - | - |
| GEORGIA [6] | 63.10% | - | - | - | - | - | - |
| OHIO [6] | 60.79% | - | - | - | - | - | - |
| TENNESSEE [6] | 63.71% | - | - | - | - | - | - |
| WYOMING [6] | 50.00% | - | - | - | - | - | - |

(1) The Federal Medical Assistance Percentage (FMAP) for each state was obtained from the Federal Register, published on November 30, 2006.
(2) Calculated as Medicaid reimbursement (federal share) divided by each state's FMAP.
(3) Calculated as Medicaid reimbursement (federal share) divided by 50%.
(4) California SFY 2007-08 Federal Medicaid reimbursement and total claims include incorrectly paid and denied LEA claims due to EDS claims processing issues. The preliminary amounts include some positive and negative adjustments for corrected claims processing issues during the SFY.
(5) Total federal reimbursement for this state's health services program and/or administrative claiming program was not available for SFY 2007-08.
(6) This state did not have a school-based Medicaid health services program or administrative claiming program in effect during SFY 2006-07 or SFY 2007-08.

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

| Service | Qualified Provider(s) | Example Rates |
|---|---|---|
| **Behavioral services provided by a behavioral aide**<br>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**<br>A paraprofessional working under the direction of a mental health professional. | **Iowa:** $10.20 per 15-minute increment.<br>$4.95 per group session<br>**Minnesota:** Based on each school district's cost of providing service. |
| **Behavioral services provided by a certified behavioral analyst or certified associate behavioral analyst**<br>Behavioral services include behavioral evaluations and functional assessments, analytic interpretation of assessment results, and design and delivery of treatments and intervention methods. | **Certified behavior analyst**<br>A person with a bachelor's or master's degree who meets state requirements for a certified behavioral analyst. A person with a bachelor's degree must work under the supervision of a certified behavioral analyst with a master's degree.<br>**Certified associate behavioral analyst**<br>A person with a bachelor degree or higher who meets state requirements for a certified associate behavioral analyst and who works under supervision of a certified behavioral analyst with a master's degree. | **Florida:** Certified behavior analyst, $8.00 per 15-minute increment.<br>Certified behavior analyst (bachelor's level), $6.70 per 15-minute increment.<br>Certified associate behavior analyst, $6.70 per 15-minute increment. |
| **Behavioral services provided by an intern**<br>Behavioral services include testing, assessment and evaluation that appraise cognitive, developmental, emotional, and social functioning; therapy and counseling, and crises assistance. | **Psychologist intern, Social worker intern**<br>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.<br>Social worker, $8.97 per 15-minute increment.<br>**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**<br>Dental assessment services include a dental oral exam using a mouth mirror and explorer to identify abnormalities, such as abscess, growth or lesion, traumatic injury and periodontal problems. Dental health education includes one-on-one teaching of awareness, prevention and education, including awareness of teeth and dental hygiene techniques. | **Dental hygienist**<br>A person who is a licensed dental hygienist. | **Delaware:** $40.04 per 15-minute increment. |
| **Durable medical equipment and assistive technology devices**<br>Purchase or rental of medically necessary and appropriate assistive devices such as augmentative communication devices, crouch screen voice synthesizers, prone standers, corner chairs, wheelchairs, crutches, walkers, auditory trainers, and suctioning machines. The equipment is for the exclusive use of the child and is the property of the child. | **Not applicable** | **Illinois:** Medically necessary equipment may be claimed up to a total of $1,000 per day based on the cost of the equipment.<br>**Minnesota:** Based on purchase price, rental costs or costs of repairs. |
| **IEP review services**<br>Coordination and management of the activities leading up to and including the writing of the IEP or IFSP, including convening and conducting the meeting to write the IEP or IFSP. | **Case manager**<br>A person who has a bachelor's degree with a major in special education, social services, psychology, or related field; or a registered nurse. | **West Virginia:**<br>Initial or Triennial: $703.66<br>Annual: $171.97 |

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

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

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

| Service | Qualified Provider(s) | Example Rates |
|---|---|---|
| **Personal Care Services**<br>Services and support furnished to an individual to assist in accomplishing activities of daily living (eating, toileting, grooming, dressing, bathing, transferring, mobility, and positioning); health related functions through hands-on assistance, supervision, and cuing; and redirection and intervention for behavior, including observation. | **Health aide, Personal care assistant**<br>A paraprofessional supervised by a qualified health care professional. | **Arizona:** $4.30 per 15-minute increment.<br>**Michigan:** Based on each school district's cost of providing service from prior year.<br>**Virginia:** Based on estimated costs for services furnished in 15-minute increments.<br>**West Virginia:**<br>Full-day students: $192.68<br>Partial-day students: $96.34 |
| **Physical therapy services provided by a physical therapy assistant**<br>Services rendered to a child to develop, improve or restore neuromuscular or sensory-motor function, relieve pain, or control postural deviations to attain maximum performance. | **Physical therapy assistant**<br>A person who meets state requirements for a physical therapy assistant and works under the direction of a qualified physical therapist.<br>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.<br>**Florida:** $13.58 per 15-minute increment. |
| **Respiratory therapy services**<br>Respiratory therapy services assist a child who has breathing or other cardiopulmonary disorders. Procedures include, but are not limited to, the assessment and therapeutic use of the following: medical gases (excluding anesthetic gases); aerosols, humidification, environmental control systems; ventilator support; and maintenance and care of natural and artificial airways. | **Licensed respiratory therapist**<br>A person who meets state requirements as a licensed respiratory therapist. | **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**<br>Services rendered to a child to treat speech and language disorders of verbal and written language, articulation, voice, fluency, phonology, and mastication. | **Speech-language pathology assistant**<br>A person who meets state requirements for a speech-language pathology assistant and works under the direction of a qualified speech pathologist. | Most states do not have separate rates for speech therapy services provided by speech pathologists and speech-language pathology assistants. The rate listed below applies to speech-language pathology assistants only.<br>**Florida:** $13.58 per 15-minute increment. |
| **Specialized transportation**<br>Transportation in a vehicle adapted to serve the needs of the disabled to and from school when the child receives a Medicaid-covered service in school and when transportation is specifically listed in the IEP or IFSP as a required service. Transportation from the school to a provider in the community also may be billed to Medicaid. (Transportation for students that require a litter van or wheelchair van is currently reimbursable in the LEA Program.) | **Not Applicable** | **Michigan:** Based on each school district's cost of providing service from prior year.<br>**New York:** $12.23 – 32.25 per day.<br>In Michigan and New York, providers may not bill separately for an attendant. |