Local Educational Agency
Medi-Cal Billing Option Program

Report to the Legislature, May 2011

Report Period April 2010 through May 2011

Director Toby Douglas
Department of Health Care Services

TABLE OF CONTENTS

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 (Ortiz, Chapter 655, Statutes of 2001), added Section 14115.8 to the Welfare and Institutions (W&I) Code to reduce the gap in per child recovery for Medicaid school-based reimbursements between California and the three states recovering the most per child from the federal government. SB 231 was reauthorized in Assembly Bill (AB) 1540 (Committee on Health, Chapter 298, Statutes of 2009).

Section 14115.8 requires the California Department of Health Care Services (DHCS) to amend California's Medicaid State Plan to accomplish various goals to enhance Medi-Cal services provided at school sites and access by students to those services.

Since SB 231 was originally chaptered into law, federal oversight of school-based programs by the Centers for Medicare and Medicaid Services (CMS) and its audit agency, the Office of the Inspector General (OIG), has significantly increased. OIG audits of Medicaid school-based programs in twenty-three states have identified millions of dollars in federal disallowances for services provided in schools. CMS and OIG continue to devote considerable resources toward fighting fraud, waste, and abuse involving all federal health care programs. The OIG work plan for federal fiscal year 2011 specifically identified Medicaid school-based services as a targeted area for compliance review. In addition to

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

compliance issues regarding inaccurate, inadequate or missing service documentation that resulted in significant unallowable payments identified by the OIG, "Free Care" and "Other Health Coverage" (OHC) requirements mandated by CMS during the summer of 2003 continue to impact the ability of schools to bill for health services that are provided to Medi-Cal eligible students[2].

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 (ARRA) of 2009, both CMS rules were placed on moratorium in State Fiscal Year (SFY) 2008-09; finally, CMS rescinded the Medicaid rules in June 2009. The ARRA of 2009 approved Federal Medical Assistance Percentage (FMAP) increases to all states and territories, effective October 2008 through June 2011. Increased FMAP rates have helped to generate increased LEA reimbursement for California's LEAs during the 2010-11 fiscal year. In addition, California's State Plan Amendment (SPA) 03-024 rate inflator requirement allowed DHCS to apply retroactive inflators to the interim reimbursement rates in 2009 and 2010, subsequently increasing reimbursement. The LEA Program is currently reimbursing LEA services at the SFY 2009-10 inflated reimbursement rates, although DHCS plans to implement rebased rates in SFY 2011-12 that will be retroactive to July 1, 2010.

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

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

LEA Medi-Cal reimbursement trends by SFY:

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)	$69.5 million	17%
SFY 2007-08 (1)	$81.2 million	36%
SFY 2008-09 (1)	$109.9 million	84%

Notes:
(1) Total Medi-Cal reimbursement is based on date of service and updated to reflect paid claims after error payment corrections were implemented for LEA services to correct previous claims processing errors that were incorrectly paid and denied. This amount includes claims paid at the "basic rate" and the increased reimbursement LEAs received due to the rate inflator.

After a lengthy review process by CMS, the first SPA prepared as a result of SB 231 was approved in March 2005 and systematically implemented on July 1, 2006. The SPA substantially increased both treatment and assessment reimbursement rates for a majority of LEA services provided to California's Medi-Cal eligible children in a school-based setting. DHCS and Hewlett Packard[3] (HP), collaborated during SFYs 2006-07, 2007-08 and 2008-09 to correct system errors that resulted after SPA implementation. System implementation errors have largely been corrected, although DHCS continues to work with HP to resolve minor technical coding issues in the claims processing system.

[3] Hewlett Packard was the DHCS fiscal intermediary during the reporting period contained in this report.

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

Due to the substantial work involving the Cost and Reimbursement Comparison Schedule (CRCS) implementation throughout 2010, research on new services was limited in early 2011. DHCS conducted preliminary research, reviewed other state school-based services provider manuals and interviewed other state Medicaid personnel regarding potential new services for California's LEA Program. Additional SPAs may be developed and submitted to CMS, along with the requisite and supportive analysis, studies, fieldwork, provider training, CMS negotiation and other due diligence required to continue to expand the LEA Program.

DHCS has also reviewed and is considering resubmitting SPA 05-010, which establishes equivalency for a credentialed speech language pathologist as a "speech pathologist" under the federal standard, for CMS review in SFY 2011-12. Once CMS reviews and approves the SPA equivalency language, 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. This equivalency will be implemented subject to the SPA and regulations approval process.

In addition, throughout 2010, DHCS continued to assist FI-COD and HP in identifying and resolving claims processing issues that resulted from technical claims processing system changes; revised the Medi-Cal Provider Manual sections specific to LEA services (LEA Provider Manual), as necessary; developed audit protocols in conjunction with DHCS Audits and Investigations (A&I); conducted LEA CRCS training; finalized, implemented and reviewed the first LEA CRCS form submission for the SFY 2006-07 and 2007-08 rate years; implemented the SFY 2008-09 CRCS form submission and intake process; and reviewed SFY 2007-08 cost expenditures to rebase interim reimbursement rates.

The work completed in 2010 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 Advisory Committee.

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[4]. 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 2001 and reauthorized in 2009.

SB 231 requires DHCS to accomplish various goals to enhance Medi-Cal services provided at school sites and access by students to those services. Specifically, SB 231 requires DHCS to:

- Amend the Medicaid state plan with respect to the LEA Program to ensure that schools are reimbursed for all eligible school-based services they provide that are not precluded by federal law;
- Examine methodologies to increase 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[5];

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

[5] 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. The rate study was completed in 2003.

- Consult regularly with CDE, representatives of urban, rural, large and small school districts, COE, the Local Education Consortium (LEC), LEAs and the LEA technical assistance project[6];
- 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 is 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, CDE, and LEAs;
- Develop and update written guidelines to LEAs regarding best practices to avoid audit exceptions, as needed;
- Establish and maintain a user 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.

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

Table 1: Annual Legislative Report Requirements

Report Section	Report Requirements
III	• An annual comparison of school-based Medicaid systems in comparable states. • A state-by-state comparison of school-based Medicaid total and per eligible child claims and federal revenues. The comparison shall include a review of the most recent two years for which completed data is available. • A summary of department activities and an explanation of how each activity contributed toward narrowing the gap between California's per eligible student federal fund recovery and the per student recovery of the top three states. • A listing of all school-based services, activities, and providers[7] approved for reimbursement by CMS in other state plans that are not yet approved for reimbursement in California's state plan and the service unit rates approved for reimbursement.
IV	• The official recommendations made to DHCS by the entities named in the legislation and the action taken by DHCS regarding each recommendation. The entities are CDE, representatives of urban, rural, large and small school districts, COEs, the LEC, LEAs, the LEA technical assistance project[8], 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.

[7] In this report, "providers" refer to allowable 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.

[8] 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, as long as 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 states and the federal government. In school-based programs, LEAs often fund the state share of Medicaid expenditures through a Certified Public Expenditure (CPE) program. Federal financial participation (FFP) 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. In SFY 2010-11, the OIG released two audit reports related to school-based health services in New Jersey and West Virginia. Twenty-three states have had audit reports issued on school-based health services since October 2001. These reports were part of a series in a multi-state initiative to review costs claimed for Medicaid school-based health services. Reported school-based health service findings have resulted in millions of dollars in alleged overpayments to schools, which 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;
- Non-compliance with the state plan;
- Inadequate and/or incorrect policy manuals;
- Inadequate third-party program administrators; and
- Lack of State-level oversight of federal guidelines.

Although the OIG has continued to focus on compliance issues surrounding school-based services, the federal government has provided a reprieve on proposed Medicaid funding cuts for school-based services. 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 also issued an interim final rule (CMS-2237-IFC with comment period) related

to case management services. In mid-2008 a moratorium was placed on CMS' ability to enforce the new rules. The passage of the ARRA of 2009 also extended the moratorium to June 30, 2009. In June 2009, CMS finally rescinded the rules.

As part of the ARRA of 2009, the federal government approved a 6.2 percent FMAP increase to all states and territories. Effective October 2008, the California FMAP increased from 50 percent to 61.59 percent, providing increased federal match funding for the LEA Program. The FMAP increase continued this enhanced rate based on a flat 6.2 percent increase for all states and an additional percentage point based on the state's increase in unemployment during the recession adjustment period, defined as October 1, 2008 through December 31, 2010. On August 5, 2010, President Obama signed HR 1586, which extended the ARRA FMAP increase through June 30, 2011. As a condition of receiving the additional federal funds during the extension period, the FMAP increases will gradually be lowered from 6.2 percent to 3.2 and 1.2 percent in the second and third quarters of the federal fiscal year, respectively. Since the LEA Program is a local-federal match program, we anticipate the extended enhanced FMAP will result in additional funding for LEA providers in California through the end of SFY 2010-11. Beginning SFY 2011-12, the California FMAP will resume at 50 percent.

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) 2007-08, CMS
Number of IDEA eligible children aged 3 to 21	U.S. Department of Education, Office of Special Education Programs Data Accountability Center, Data Analysis System, OMB #1820-0043: "Children with Disabilities Receiving Special Education Under Part B of the Individuals with Disabilities Education Act," 2007.
Average salaries of instructional staff (classroom teachers, principals, supervisors, librarians, guidance and psychological personnel, and related instructional staff)	Rankings of the States 2010 and Estimates of School Statistics 2011, National Education Association (NEA), December 2010
Per capita personal income	Rankings of the States 2010 and Estimates of School Statistics 2011, NEA, December 2010

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 two of the selected comparable states (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 program underwent a major restructuring between 2005 and 2009, thereby limiting data that could be used in an analysis of comparable states. Ohio's previous school-based services claiming program ended in June 2005 and was re-implemented by October 2009 (approved by CMS August 2008 and retroactive to July 2005).

In the last several years, CMS has restructured many school-based direct health service claiming programs to CPE programs, which are effectively cost-settled on a retroactive basis. In these situations, providers annually complete a cost report as part of the cost reconciliation process. In California, the standardized cost report, known as the Medi-Cal 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, annual hours worked for all practitioners who provided health-related services, and the units and Medi-Cal reimbursement for the appropriate fiscal year on the CRCS forms. Costs will be compared to Medi-Cal reimbursement to ensure that each LEA provider is not paid more than the costs of providing these services. This reconciliation will result in an amount owed to or from the LEA; underpayments will be paid in a lump sum to LEAs while overpayments will be withheld from future LEA reimbursement. As part of the cost reconciliation, the LEA providers will certify that the public funds

expended for LEA services provided are eligible for FFP. The first two cost certifications for SFYs 2006-07 and 2007-08 for LEA Program participants were due by October 30, 2009. The SFY 2008-09 CRCS was due by November 30, 2010. In order to assist LEAs in completing the initial Medi-Cal cost reports, DHCS worked with HP to furnish an Interim Reimbursement and Units of Service (IRUS) Report in Fall 2009 for SFYs 2006-07 and 2007-08 to all LEAs who received Medi-Cal reimbursement during the two fiscal years. Additionally, an IRUS Report for SFY 2008-09 was provided in September 2010 to LEAs. This report summarizes total units and reimbursement information by LEA service and practitioner type.

In contrast 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 currently does not require annual cost reconciliation. Pursuant to a CMS mandate, Michigan has developed a fee-for-service rate methodology for its school-based services that contains a cost-reconciliation requirement. 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, Michigan will review, certify and finalize the Medicaid expenditure report which begins the final settlement process. Michigan completed cost report submission in November 2010 for school year 2009-10. The cost settlement process will begin in May 2011.

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

Administration of the eighth state survey began in January 2011. States were contacted to update information provided in the 2009 survey; states that did not participate in 2009 were given the opportunity to complete the current survey. Follow-up contacts were made during Winter and Spring 2011 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, program transition and overhaul, and internal data request issues; several states did not respond to follow-ups. 31 of 49 states contacted returned the survey, including six states that did not participate in 2009 and five states that had not participated in two or more previous DHCS surveys.

Table 3 summarizes Medicaid reimbursement (federal share) for health services and administrative services for SFY 2008-09 and 2009-10 collected by the State survey. Several states did not have finalized data available for both SFYs. In addition, six of the survey respondents did not provide reimbursement figures for SFY 2008-09 or SFY 2009-10 for reasons similar to those identified above. When data was provided, federal Medicaid reimbursement was multiplied by each state's FFP percentage 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).

In the April 2000 GAO Report, Maryland had the highest average claim per Medicaid-eligible child of $818, while California's average claim was $19, a difference of $799. Based on the state survey information collected, Maryland's calculated average claim per Medicaid-eligible child had decreased to $253 in SFY 2008-09 and $224 in SFY 2009-10. As noted in Table 3, Vermont had the highest average SFY 2008-09 claim of $737, while California's average claim was $118, a difference of $619. California's federal Medi-Cal reimbursement increased 35 percent between SFY 2007-08 and 2008-09. It is also significant that the federal revenues from administrative activities claimed in the California Medi-Cal Administrative Activities (MAA) Program continue to decrease from year to year, which contributed to the decrease in California's total expenditures per eligible child. The decline in reimbursement began in SFY 2006-07, going from $113.8 million to $111.2 million in SFY 2007-08; another significant decline occurred between SFYs 2008-09 and 2009-10 when MAA Program reimbursement fell from $101.3 to $90.9 million (year-to-date).

A comparison of the average claim in the April 2000 report published by the GAO to the SFY 2008-09 average claim per Medicaid-eligible child in Table 3 shows an increase in 27 of the 36 states that reported federal reimbursement (including California). The average claim decreased in nine states.

Table 3: Medicaid Reimbursement and Claims by State, Ranked by 2008-09 Average Claim Per Medicaid-Eligible Child

State		SFY 2008-2009 (1) Federal Medicaid Reimbursement (000's)	SFY 2008-2009 (1) Total Claims (000's)	SFY 2008-2009 (1) Average Claim Per Medicaid-Eligible Child (2)	SFY 2009-2010 (1) Federal Medicaid Reimbursement (000's)	SFY 2009-2010 (1) Total Claims (000's)	SFY 2009-2010 (1) Average Claim Per Medicaid-Eligible Child (2)
VERMONT		$ 24,005	$ 35,453	$ 737	$ 26,122	$ 37,338	$ 776
RHODE ISLAND		23,104	38,076	541	27,339	44,948	638
NEBRASKA		26,852	52,316	532	-	-	-
WEST VIRGINIA		42,234	52,497	394	48,341	58,207	436
MASSACHUSETTS		81,939	139,412	356	72,464	129,460	331
PENNSYLVANIA		152,300	253,311	342	170,850	274,430	370
KANSAS		22,219	36,287	298	19,870	30,158	248
UTAH		17,227	23,806	294	-	-	-
WISCONSIN		55,855	86,448	262	53,455	81,969	249
MARYLAND		43,796	82,853	253	39,139	73,326	224
ILLINOIS		133,361	239,439	247	148,283	262,083	271
IOWA		23,747	34,506	212	36,819	50,749	311
MICHIGAN		81,451	119,790	159	94,575	134,850	179
MINNESOTA		25,422	42,236	158	34,041	55,270	207
MONTANA		3,653	5,567	153	4,468	6,626	182
FLORIDA		75,666	146,114	151	79,515	151,170	156
ARKANSAS		24,785	37,864	121	26,231	40,240	129
ALABAMA		18,284	36,264	121	-	-	-
VIRGINIA		21,541	40,131	120	22,533	40,421	120
CALIFORNIA		211,173	380,994	118	220,323	391,919	122
NEW YORK		79,680	135,557	110	-	-	-
MISSOURI		18,635	35,135	87	36,660	70,605	175
NORTH CAROLINA		27,504	48,737	84	24,867	39,442	68
COLORADO		9,220	15,686	83	10,548	17,540	93
ARIZONA		26,161	37,156	78	25,560	36,405	76
NEW MEXICO		10,382	15,379	73	-	-	-
WASHINGTON		16,626	31,217	69	-	-	-
MISSISSIPPI		7,808	14,881	62	-	-	-
LOUISIANA		22,591	28,767	59	-	-	-
NEVADA		1,775	2,777	33	-	-	-
GEORGIA		12,137	16,527	28	16,148	21,542	37
KENTUCKY		4,375	6,184	20	15,389	27,919	91
OKLAHOMA		4,286	5,719	18	5,157	6,721	21
ALASKA		467	795	15	-	-	-
INDIANA		2,875	3,925	9	3,982	5,261	12
HAWAII		314	476	6	-	-	-
OHIO	3	-	-	-	-	-	-
TENNESSEE	3	-	-	-	-	-	-
WYOMING	3	-	-	-	-	-	-

(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) 2007-08. (Source: Medicaid Program Statistics, Centers for Medicare and Medicaid Services, http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/02_MSISData.asp

(3) This state did not have a school-based Medicaid health services program or administrative claiming program during SFY 2008-09.

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

Summary of Departmental Activities

Since the passage of SB 231, Medi-Cal reimbursement in the LEA Program has increased by 84 percent, growing from $59.6 million in SFY 2000-01 to $109.9 million in SFY 2008-09. LEA services may be classified into two main categories: assessments and treatments. In addition, services can be further defined as those that are provided pursuant to an IEP or IFSP, versus those that are provided to the "general" non-IEP/IFSP population. The following eight IEP/IFSP assessment types exist in the LEA Program:

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

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

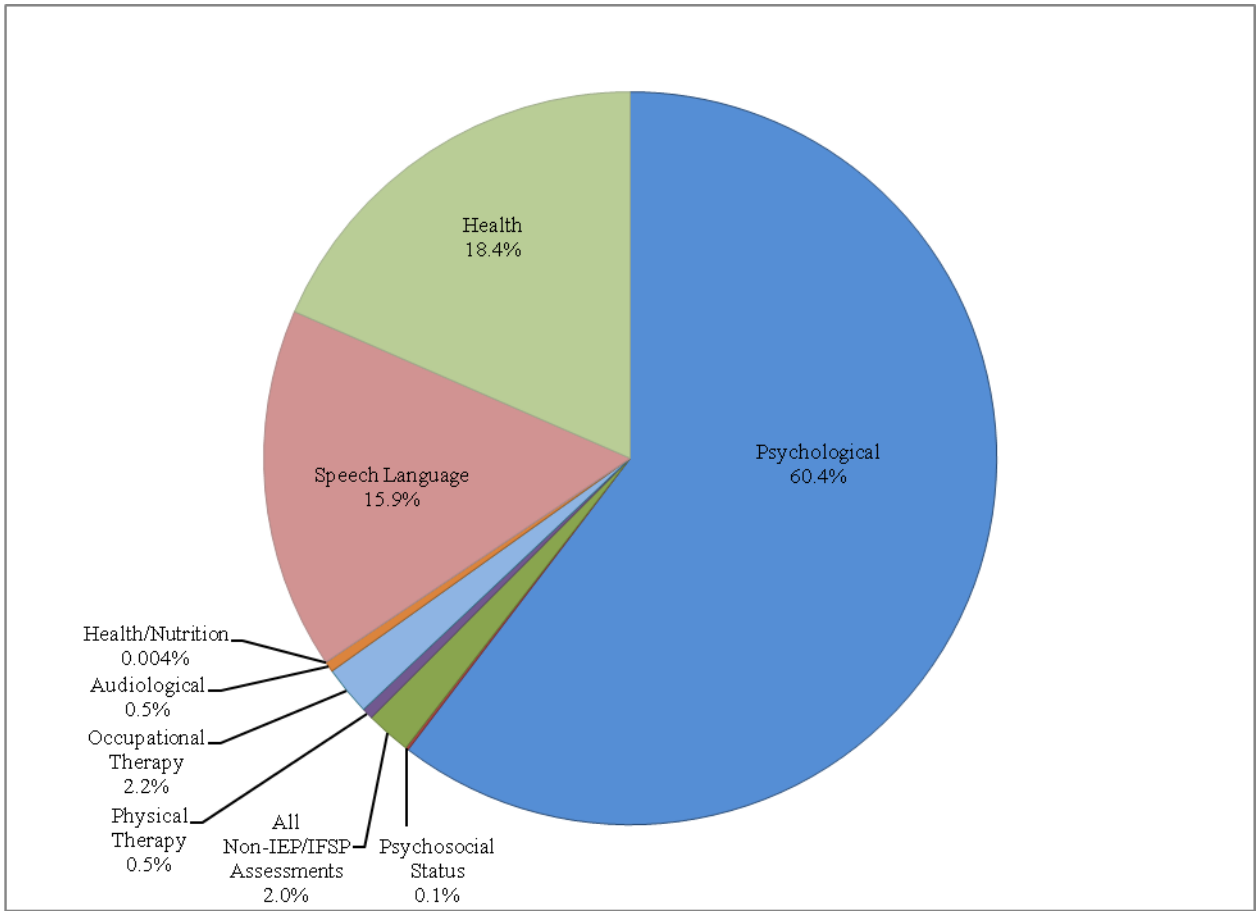
- Psychosocial Status;
- Health/Nutrition;
- Health Education and Anticipatory Guidance;
- Hearing;
- Vision; and
- Developmental.

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

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

In addition, medical transportation/mileage and Targeted Case Management (TCM) services are classified as treatment services; however, TCM is only a covered service for the IEP/IFSP student population.

Figure 1: Percentage of Total LEA Assessments by Assessment Type, SFY 2008-09



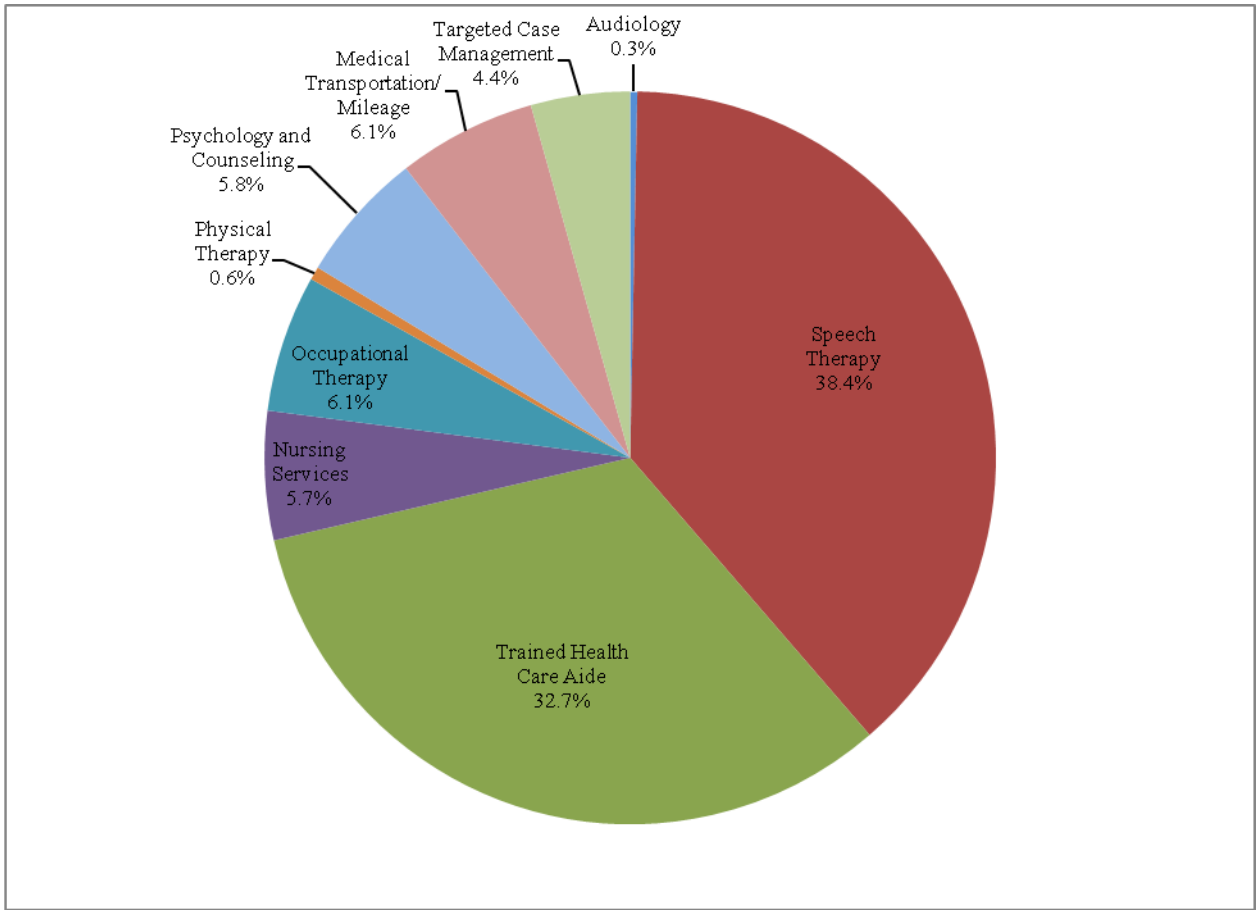
Note: Total LEA assessment service reimbursement for SFY 2008-09 was $22.21 million.

Figure 1 depicts each assessment type as a percentage of total assessment reimbursement for SFY 2008-09. As indicated in Figure 1, approximately 95 percent of assessment reimbursement is attributable to three IEP/IFSP assessment types: psychological, health and speech-language assessments. Further, over 60 percent of all assessment reimbursement is attributable to psychological assessments. Psychological assessments have the highest reimbursement rates among assessment types and are provided by licensed psychologists, licensed educational psychologists and credentialed school psychologists.[9] Over a third of assessment reimbursement is attributed to health and speech-language assessments at 18.4 percent and 15.9 percent, respectively. The

[9] Psychological assessments are reimbursed at $439.92 for initial/triennial assessments and $146.64 for annual and amended assessments.

remaining six assessment types, including all non-IEP/IFSP assessments account for only five percent of total assessment reimbursement in SFY 2008-09.

Figure 2: Percentage of Total LEA Treatments by Treatment Type, SFY 2008-09



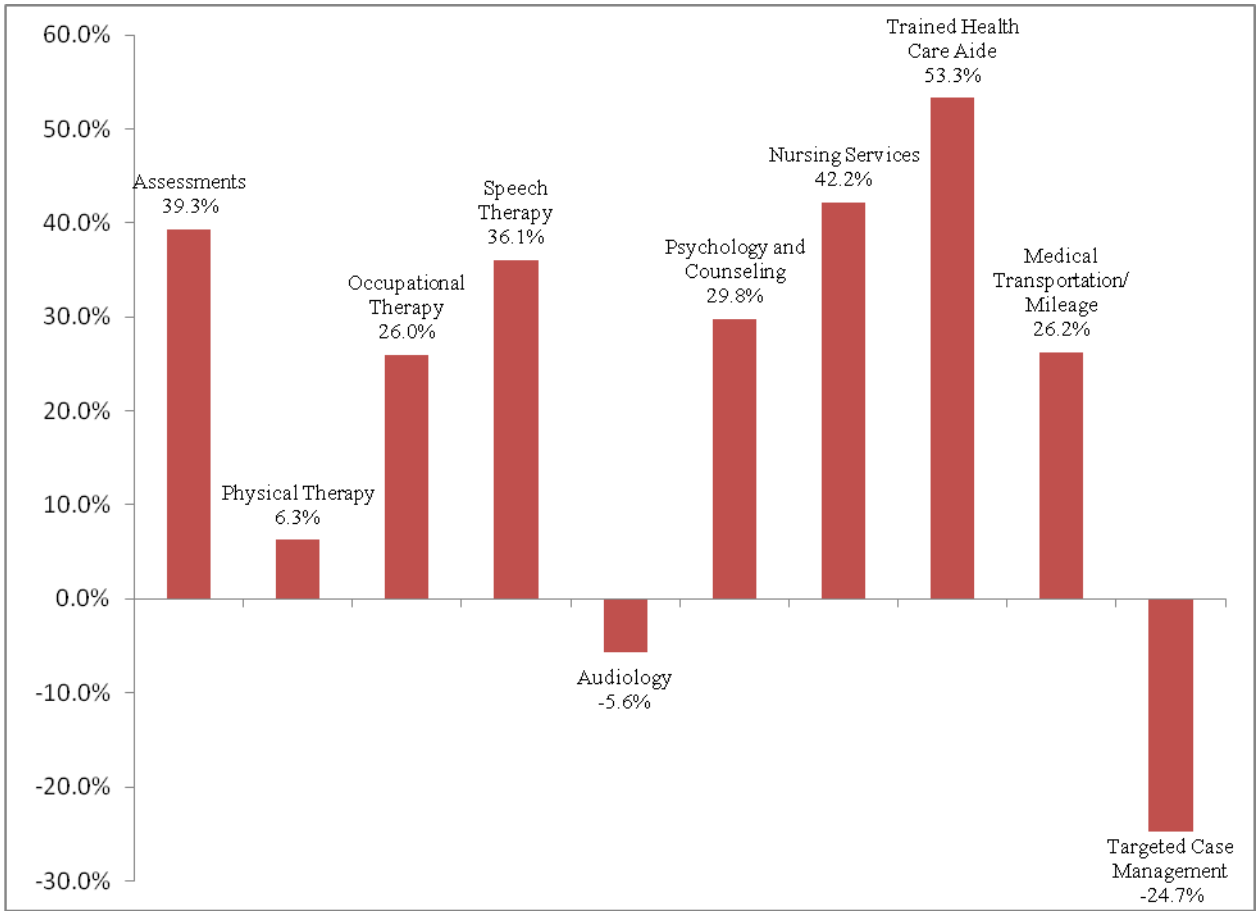
Note: Total LEA treatment, transportation/mileage and TCM service reimbursement for SFY 2008-09 was $87.67 million. Less than one percent of total treatment reimbursement is attributable to non-IEP/IFSP services.

Figure 2 depicts each treatment type as a percentage of total treatment reimbursement for SFY 2008-09. Over two-thirds of treatment service reimbursement are attributed to speech therapy and trained health care aide services. Although the percent of total speech therapy treatment units and reimbursement have remained relatively constant between SFY 2006-07 and 2008-09, trained health care aide services have increased during this time. Trained health care aide reimbursement grew from 19 percent of total reimbursement in SFY 2006-

07 to 26 percent in SFY 2008-09; similarly, units grew from 38 percent of total units in SFY 2006-07 to 47 percent in SFY 2008-09. Since the percent of total reimbursement attributed to nursing services remained constant over this time period, the increase in trained health care aide services may be partially attributable to the higher costs for LEAs to employ or contract with registered credentialed nurses, licensed registered nurses, certified public health nurses or certified nurse practitioners to provide nursing treatment services. Between SFYs 2006-07 and 2008-09, trained health care aide services also had a higher number of 15-minute treatment units per claim than nursing services. During SFY 2008-09, trained health care aide services also had a higher number of 15-minute treatment units per claim than nursing services. On average, LEAs bill approximately eleven 15-minute units of trained health care aide services per claim (representing 2.75 hours of service) versus eight 15-minute units of trained health care aide services per claim in SFY 2006-07 (representing two hours of service). In contrast, over this time period, LEAs continued to bill an average of approximately four 15-minute units of nursing services per claim (representing one hour of service). The remaining seven treatment service types account for the final third of treatment service reimbursement in SFY 2008-09.

As indicated in the following Figure 3, all but two LEA services experienced an increase in reimbursement between SFYs 2007-08 and 2008-09. Percentage increases vary from 6.3 percent for physical therapy treatment to 53.3 percent for trained health care aide services, with most services increasing at least 25 percent between SFY 2007-08 and 2008-09. The decrease in TCM may reflect changes in billing due to the CMS interim final rule (CMS-2237-IFC with comment period) regarding targeted case management that was rescinded as of June 2009. In addition, since TCM rates were not impacted by SPA 03-024, they have remained static for many years. The historic TCM rates are not subject to annual rate inflation and will remain at the current levels unless a new SPA is submitted to CMS. The decrease in audiology treatment services may be due to a decrease in audiologists providing LEA services because of the additional licensing requirements from the California Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board. Audiology applicants graduating after January 1, 2008 must now hold a Doctorate in Audiology.

Figure 3: Percentage Change In Reimbursement By Service Type, SFYs 2007-08 Through 2008-09



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

- **Rate Inflators**

  As specified in SPA 03-024, DHCS is required to annually adjust LEA reimbursement rates for assessment and treatment services using the Implicit Price Deflator, which is published by the U.S. Department of Commerce. In April 2010, HP implemented SFY 2009-10 rates, increasing SFY 2008-09 rates by 0.9 percent. These rates are the current reimbursement rates LEAs receive until DHCS implements the rebased reimbursement rates at a future date.

- **FMAP ARRA Adjustments**

  Effective October 1, 2008, the federal government approved FMAP increases to help support state Medicaid programs during the economic downturn. The FMAP increase directly impacted LEA reimbursement beginning in SFY 2008-09, since the federal government financed more than California's traditional fifty percent of Medicaid reimbursement. The increased FMAP was extended beyond the original date of December 2010, and will decrease incrementally per quarter until June 2011 when the 50 percent FMAP will resume for SFY 2011-12.

- **SB 231 Withhold**

  As a requirement of SB 231, 2.5 percent is withheld from LEA claims to fund activities mandated in W&I, Section 14115.8. Effective from July 2010 to January 2011, DHCS did not collect the 2.5 percent on LEA paid claims, effectively increasing LEA reimbursement during this time frame. In January 2011, DHCS reinstated the 2.5 percent withhold on paid claims after the SFY 2010-11 reimbursement met the baseline of approximately $60 million in total LEA Program reimbursement.

- **LEA Advisory Committee**

  Members of the LEA Advisory Committee represent large, medium, and small school districts, COEs, professional associations representing LEA services, DHCS, and CDE. Meetings are held every other month and provide a forum for LEA Advisory Committee members to identify relevant issues and make recommendations for changes to the LEA Program. The emphasis of the meeting is to strategize various goals and activities aimed at expanding and enhancing the Medi-Cal services provided on school sites and access by students to these services, while increasing federal reimbursement to LEAs for the cost of providing these services. The LEA Advisory Committee has been instrumental in identifying claims processing issues, assisting with LEA Program training, 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. In SFY 2009-10, the bi-monthly workgroup meetings were reformatted to more closely follow the structure outlined in

SB 231. The LEA Advisory Committee also formed sub-committees to specifically address increasing communication between DHCS and LEAs, LEA training, and expanding new services.

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, the services indicated below are services that are allowable in other state programs, but are not currently reimbursable in California's LEA Program. In order to gather information on these services and qualified practitioners, we have relied on numerous sources, including responses from the state survey, updated reviews of relevant provider manuals and Medicaid state plans, and interviews with other state Medicaid program personnel.

- 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.

Addition of these benefits requires submission of a new SPA to CMS. The pros and cons of such a submission are routinely discussed during the Ad-Hoc Workgroup meetings. The New Services sub-committee is currently providing guidance and opinions to the larger Workgroup and DHCS regarding the extent and timing of adding new services to the LEA Program.

IV. OFFICIAL RECOMMENDATIONS MADE TO DHCS

Official recommendations are made to DHCS during LEA Advisory Committee 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 practitioners that have not been added to the state plan or included in a proposed SPA are noted in Section V.

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

Recommendation	Action Taken/To Be Taken
• 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 and revise the LEA Provider Manual throughout 2010 to ensure clarity on LEA policy, including updating DHCS contact information and e-mail addresses and clarifying LEA document retention requirements. • When the rebased rates are implemented in the claims processing system, DHCS will update the LEA maximum allowable rates to reflect the rebased reimbursement rates and LEA claim submission examples. • Continued revisions to the LEA Provider Manual will be published in 2011, as necessary.
• Monitor LEA claims processing system to ensure claims are reimbursed according to LEA Program policy.	• Continued collaboration with FI-COD and HP (and its successor, Affiliated Computer Services) will be on-going in 2011 to monitor the claims processing system to ensure that the LEA Program is continuing to process claims appropriately.

Recommendation	Action Taken/To Be Taken
• Develop and maintain an interactive LEA Program website.	• In 2010, DHCS continued to modify and organize LEA Program content to ensure that LEA Program information is readily accessible. • 2010 LEA website maintenance activities included posting the following documents: LEA Advisory Committee meeting summaries; Annual Report forms; updated LEA Frequently Asked Questions (FAQs); SFY 2008-09 paid claims data reports and reimbursement trends; increased maximum allowable reimbursement rate charts reflecting inflation increases, and other LEA policy clarification. Cost and Reimbursement Comparison Schedule (CRCS)related information was also posted on the website and included the SFY 2008-09 CRCS forms, CRCS submission and deadline requirements, and CRCS training, announcements and subsequent training materials. • DHCS continued to maintain an electronic mailing list that LEA personnel may subscribe to and automatically receive e-mail notifications when new or updated information has been posted on the LEA Program website. • DHCS will continue to update the website, reflecting changes recommended by the LEA Advisory Committee and increasing communication to the LEA provider community regarding LEA Program billing and policy information.
• Provide LEA Program trainings to the LEA provider community.	• DHCS will conduct an annual LEA Program policy training webinar in Fall 2011. This training is intended to provide LEAs with general information on LEA Program policy and procedures, including LEA provider participation requirements; LEA provider billing requirements; reimbursable LEA services; practitioner qualifications; and Free Care and OHC requirements.

Recommendation	Action Taken/To Be Taken
• Provide LEA CRCS trainings to the LEA provider community.	• In May and June 2011, DHCS A&I Financial Audits Branch (FAB) conducted three CRCS live trainings (Los Angeles, San Diego and Sacramento) focused on the following training areas: CRCS submission process; overview of the audit process and experience; CRCS documentation used to support the information reported on CRCS forms; and Medi-Cal billing review. The Sacramento training will be recorded as a webinar and will be available on the LEA Program website for LEAs to access at any time.
• Improve communications regarding policy issues (to the extent allowed by Executive Order S-2-03) and status of SB 231 implementation with LEA providers.	• DHCS continues to prepare LEA Advisory Committee Meeting Summaries, containing information regarding items discussed during the bi-monthly Workgroup meetings. The meeting summaries are posted on the LEA Program website. • In 2011, DHCS continued to disseminate information to LEA providers via the LEA Program website, including FAQs, information on the CRCS reporting requirement deadline and other policy information. • DHCS has worked with CDE to utilize CDE's e-mail distribution to school superintendents to increase dissemination of program information to LEA providers. DHCS will continue to utilize CDE to further communicate with LEAs in 2011. • With the assistance of the Communications sub-committee, DHCS is working to increase LEA provider communications through the County Office Finance Subcommittee to increase awareness on CRCS information, Special Education Local Plan Area (SELPA) directors, and the California County Superintendents Education Services Association. DHCS will continue collaborating with the Communications sub-committee to disseminate information through various channels.

Recommendation	Action Taken/To Be Taken
• Update the statewide LEA provider contact list.	• The statewide master LEA provider contact list was compiled and updated with e-mail addresses and contact names from the March 2010 and May 2010 CRCS webinar trainings, the LEA Annual Report, LEA Contact Information Form, and SFYs 2006-07 and 2007-08 contacts identified in submitted CRCS forms. This list will be further updated and maintained by DHCS with contact information from future training sessions.
• 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 2010 were provided at the LEA Advisory Committee meetings on a periodic basis.
• Submit SPAs and subsequent updates to CMS.	• DHCS will continue to work towards submission of future SPAs within a reasonable time frame, as appropriate, based on CMS' policy direction.
• Conduct meetings with Medi-Cal Safety Net Financing, A&I and LEA providers regarding audit procedures.	• In 2011, DHCS intends to continue to support and foster communication between A&I Medical Review Branch and the LEA Advisory Committee through meetings and training. The goal is to improve understanding of differences between medical documentation and educational documentation in a school-based setting, and to develop sufficient and adequate documentation standards for LEAs that will support billing for LEA Medi-Cal services. • In 2010, DHCS initiated communication between A&I FAB and the LEA Advisory Committee to assist auditors to develop appropriate CRCS audit procedures for the reconciliation process. The goal is to provide auditors insight on how LEAs account for costs and revenues internally within schools and to provide LEAs with guidance on how to support expenditure information reported on their CRCS. A&I FAB attends the LEA Advisory Committee meetings and provides status updates regarding the CRCS audit procedures and review process.

Recommendation	Action Taken/To Be Taken
• Update interim reimbursement rates for LEA services per allowances in SPA 03-024.	• Throughout 2009 and 2010, DHCS applied an approved inflation adjustment to the current interim reimbursement rates for LEA services. As part of the requirements specified in SPA 03-024, DHCS is required to annually adjust LEA reimbursement rates for assessments and treatment services using the Implicit Price Deflator, which is published by the U.S. Department of Commerce. • In 2011, DHCS began the process of rebasing the interim reimbursement rates pursuant to SPA 03-024. DHCS reviewed and analyzed SFY 2007-08 CRCS cost data submitted by LEAs. LEA Program reimbursement rates have been rebased and inflated to the SFY 2010-11 rate year. LEAs are currently reimbursed at the SFY 2009-10 reimbursement rates and will continue receiving those rates until the rebased rates are implemented in the claims processing system. Rebased rates will be implemented retroactively to SFY 2010-11 when the ARRA FMAP adjustments have been finalized. The increased reimbursement from the rebased rates will offset the reduced FMAP rates for January through June 2011.
• Determine penalty process for LEAs that do not submit CRCS forms timely.	• DHCS A&I is evaluating penalty policies for LEAs who are non-compliant with CRCS submission requirements. DHCS is considering an initial 20 percent withhold penalty on claims payments, and ultimately LEA Program termination, if LEAs do not submit mandatory annual CRCS forms. DHCS will finalize penalty policies and implement withholds, as necessary.

Recommendation	Action Taken/To Be Taken
• Determine CRCS submission deadline for SFY 2008-09 and notify LEA providers.	• DHCS originally announced the SFY 2008-09 CRCS submission deadline of November 30, 2010 during the May 2010 CRCS webinar. LEA providers were also notified via regular channels of communication, including the LEA Program website, SELPA e-mail distribution, and LEA contact lists. • DHCS amended the CRCS forms to accommodate the two FMAP percentages that were applied during SFY 2008-09 due to the ARRA enhanced FMAP rate. DHCS also provided instructions and guidance and updated current training materials to align with any CRCS form revisions for SFY 2008-09 and posted them on the LEA Program website. LEA IRUS Reports were generated twelve months following the final date of service for SFY 2008-09. DHCS provided LEAs with IRUS Reports in September 2010.
• Review 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, as well as an additional 2.5 percent to fund activities mandated by SB 231. The annual amount of the 2.5 percent withhold is not to exceed $1.5 million. The fees are subtracted from the total reimbursement amount on the Medi-Cal Remittance Advice Details (RAD) with RAD code 795 denoting the one percent withhold and RAD code 798 denoting the 2.5 percent withhold. • In 2010, DHCS explored alternative methods to collect the SB 231 funding withhold proportionately across LEA Program participants; however, DHCS determined that it would not be feasible to collect proportionate withhold funding from LEAs. • LEAs were not charged the 2.5 percent SB 231 withhold for the first half of SFY 2010-11. Beginning January 2011, DHCS reinstated the 2.5 percent withhold on paid claims. DHCS will monitor and track the 2.5 percent funding and subsequently turn off the withhold when the total amount reaches $1.5 million or at the end of the fiscal year, whichever comes first. In the future, DHCS will continue to track the LEA Program reimbursement until the total reimbursement exceeds the baseline amount of approximately $60 million, then initiate the withholding process for the fiscal year.

Recommendation	Action Taken/To Be Taken
• DHCS A&I to develop CRCS audit procedures to be shared with LEA providers.	• A&I FAB developed a pilot audit program with the goal of reviewing CRCS information to gain a better understanding of how LEAs operate, bill for LEA services, and maintain financial documentation to support services rendered to Medi-Cal eligible students. A&I FAB conducted LEA site visits at Sacramento City USD and Santa Barbara COE and reviewed LEA accounting and financial records to substantiate information submitted on the CRCS. A&I may continue to conduct additional pilot audits with other LEAs in 2011. • A&I will host three trainings in May and June 2011 to LEA providers with the goal of providing information about the CRCS audit process, findings and documentation.
• Correct IRUS Report initial treatment service units on submitted CRCS forms.	• During the A&I pilot audits, DHCS identified a global CRCS issue impacting the IRUS Reports generated by HP for SFYs 2006-07, 2007-08 and 2008-09. The IRUS Reports contain overstated units of service for initial treatment services (psychology and counseling, speech therapy, audiology, physical therapy and occupational therapy). The units of service information on the IRUS Report sums the total units billed (1, 2, or 3) instead of singularly reporting the total number of initial treatment service claims reimbursed. LEAs were not required to correct and resubmit CRCS forms to DHCS. Instead, DHCS corrected this issue internally for each LEA and a resulting audit adjustment will be made by A&I during the cost reconciliation process. • DHCS worked with HP and finalized the corrections to the reported units of service values for initial treatment services. DHCS posted an informational summary report on the LEA Program website that identifies the correct claim counts for initial treatment services by LEA by date of service. This report is available for SFYs 2006-07 and 2007-08. DHCS will also post the SFY 2008-09 informational summary report for initial treatment service claim counts on the LEA Program website in 2011.

Recommendation	Action Taken/To Be Taken
• Hire new A&I auditor positions to handle the CRCS reconciliation process.	• LEAs will incur an additional one percent withhold to fund the 14 new auditor positions required to staff the workload on the CRCS reconciliation. The one percent withhold will be limited to $650,000 per fiscal year and any unused funds will be returned to the LEAs. A&I has interviewed to fill the positions, however, due to a statewide hiring freeze the positions have remained vacant. In late April 2011, DHCS A&I received an exemption from the statewide hiring freeze and will be able to secure auditor positions for the CRCS reconciliation. • DHCS will continue working with HP to implement the necessary changes in the paid claims processing system to collect the one percent withhold.
• Provide LEA Annual Report assistance and guidance to LEA providers.	• LEAs are required to submit an Annual Report by October 30th of each year. The Annual Report requires LEAs to list collaborative members, report expenditures and activities for the prior year and anticipate service priorities for the current fiscal year. For the SFY 2009-10 LEA Annual Report, DHCS reformatted the document into Excel so LEA providers can fill out the form electronically and have fields auto-calculate, as appropriate. • DHCS and the LEA Advisory Committee will review the information requested in the Annual Report and CRCS to determine if the Annual Report can be modified to remove duplicative information. Additionally, DHCS will research the feasibility of combining the Annual Report and CRCS forms. DHCS will determine if additional guidance and information can be provided to LEA providers to assist in the completion of the Annual Report.

V. ONE-YEAR TIMETABLE FOR STATE PLAN AMENDMENTS

The first SPA after SB 231 was originally submitted to CMS in June 2003, was re-submitted in December 2004, and finally approved in March 2005. Delays were associated with the CMS approval process. In October 2010, CMS issued a State Medicaid Director letter which revises the SPA review process and outlines the new procedures for SPA processing to ensure efficiency. DHCS is hopeful that the improved process will reduce the time between SPA submission and approval, and simplify the implementation process.

Table 5: Timetable for Proposed State Plan Amendments

Service Description	Estimated Submission Date
• TCM services: These services include IEP review services performed by a case manager to coordinate the development of an IEP/IFSP and attendance at meetings by health service providers to write and develop the IEP/IFSP. In September 2004, DHCS submitted proposed language for a SPA to expand TCM services in the LEA Program. CMS convinced DHCS not to submit the SPA based on expected upcoming CMS regulation changes to school-based reimbursement and services.	• On hold
• Speech-language equivalency: 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 VI. 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. CMS would not review the speech-language equivalency SPA until the LEA Program was fully compliant with the current SPA 03-024.	• DHCS will resubmit SPA 05-010 with the required Attorney General (AG) equivalency opinion in SFY 2011-12.

VI. BARRIERS TO REIMBURSEMENT

Barriers to reimbursement continue to be identified and acted upon through discussions with LEA Advisory Committee members. Table 6 describes the barriers to reimbursement identified in 2010, as well as the actions that have been and will be taken by DHCS to remove these barriers.

Table 6: Barriers to Reimbursement

Barriers	Actions Taken /To Be Taken
• Certain health and mental health services and services provided by assistants are provided by LEAs but are not currently reimbursable in the LEA Program.	• The LEA Advisory Committee compiled a list of potential LEA services to expand the LEA Program. Potential new services are being considered and reviewed by DHCS. In addition, DHCS must determine the necessary means to implement specific new services and if a new SPA is required. • In 2011, DHCS began to review other states' school-based Medicaid programs with regard to the list of LEA services compiled by the LEA Advisory Committee. DHCS began targeted interviews with ten states (Connecticut, Georgia, Iowa, Kansas, Kentucky, Maryland, Minnesota, Ohio, Rhode Island and West Virginia) to obtain information regarding services offered, practitioner qualifications, reimbursement methodologies and CMS SPA experiences. DHCS will continue to update the research on services such as behavioral intervention services, personal care services, and services provided by therapy assistants, as they consider expanding the scope of reimbursable services for LEAs in California. • A cost survey may be designed in SFY 2011-12 to collect information from a sample of LEAs employing practitioners such as behavioral aides, dieticians, physicians and therapy assistants, in order to obtain rate development information.

Barriers	Actions 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 (Baca, Chapter 581, Statutes of 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 California Commission on Teacher Credentialing on or before January 1, 2007. This tiered structure 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. DHCS is considering resubmitting the speech-language equivalency SPA since the LEA Program is compliant with the current SPA 03-024. 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. DHCS plans to resubmit the SPA in SFY 2011-12.

Barriers	Actions Taken /To Be Taken
• Enrollment requirements may hinder new school districts and COE from enrolling in the LEA Program.	• In SFY 2011-12, DHCS will determine which LEAs are not currently enrolled in the LEA Program and potentially target those LEAs to provide a general orientation for school districts and COEs that are not claiming Medi-Cal reimbursement. Orientations may include information on the necessary steps to become a participating provider, including guidance on how to enroll, annual reporting requirements, and an overview of billing policies and procedures. • In addition, DHCS outreach may be conducted for LEAs enrolled in the LEA Program, but receive limited reimbursement and may consider expanding the scope of services provided to Medi-Cal eligible students.
• LEA Program billing policies and procedures have not always been consistently documented.	• FAQs are posted on the LEA Program website to assist providers with common questions regarding billing and program policies. FAQs are intended to clarify policy in the LEA Provider Manual. FAQs are periodically reviewed and updated to reflect current LEA Program policy. DHCS intends to consolidate FAQs posted on the LEA Program website and review the information to determine if additional policy language can be added to the LEA Provider Manual. • DHCS actively monitors and responds to an LEA Program specific e-mail address where LEA providers can e-mail specific questions regarding policy and billing requirements.

Barriers	Actions Taken /To Be Taken
• Claims processing issues have been identified and have resulted in LEA claims being incorrectly paid or denied.	• Medi-Cal Safety Net Financing conducted meetings and worked closely with FI-COD and HP to resolve outstanding claims processing issues. Throughout 2010, DHCS monitored and researched claims processing issues, clarified LEA Program billing policies and requirements for HP to alter system design, provided example claims to test system changes, and reviewed test results to ensure LEA claims were processing properly prior to implementation of system changes. • LEA claims billed with procedure codes 92551 and 92551 (non-IEP/IFSP hearing assessments) and IEP/IFSP services modifiers (TM or TL) are invalid procedure code/modifier combinations that are erroneously being paid. DHCS is working with HP to update the claims processing system to limit payment to procedure codes 92551 and 92552 with only the appropriate modifiers. • DHCS will continue working with HP to implement policy to deny payment for any LEA claim beyond two years from the date of service to ensure federal compliance.
• IEP/IFSP assessment utilization control changes	• LEAs have received recent denials for IEP/IFSP assessment claims with RAD Code 9921. DHCS and HP researched these claims and determined that the claims processing system is not allowing back to back annual IEP/IFSP assessments. LEAs may bill an annual assessment every year (per beneficiary per LEA provider per service type) that an initial/triennial assessment is not reimbursed. In 2011, DHCS will work with HP (and its successor, Affiliated Computer Services) to implement the necessary changes to the claims processing system and implement an EPC to retroactively pay claims between the policy effective date and system implementation date.

Barriers	Actions Taken /To Be Taken
• Seven percent interest charged on all outstanding debts established by HP.	• Due to the claims processing issues, LEAs were originally overpaid for LEA services conducted in SFY 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 W&I, Sections 14170-14178, 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 Office of Legal Services determined that LEAs are exempt from the 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. In June 2010, DHCS, FI-COD and HP identified all LEAs that were charged interest on outstanding account receivable balances and refunded LEAs their full interest amount.
• 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. In these cases, 100 percent of future LEA claims reimbursement was 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. In June 2010, DHCS, FI-COD and HP identified all LEAs that were impacted and refunded LEAs their withhold amounts.

Barriers	Actions Taken /To Be Taken
• Denial of optional services to beneficiaries age 21 and older (RAD Code 9909)	• Some LEA claims have been denying with RAD Code 9909 "Optional service not payable on date of service" for beneficiaries age 21 and older for services that are allowable under the LEA Medi-Cal Billing Option Program. On July 1, 2009, a number of optional benefits were excluded from the Medi-Cal program for beneficiaries age 21 and older. DHCS worked with FI-COD and HP and determined that LEA services should be exempt from the age limitations when the service is part of an IEP. The claims processing system changes were implemented October 2010 and an EPC to retroactively pay claims erroneously denied with RAD Code 9909 was implemented in January 2011. LEA claims are no longer denying with RAD Code 9909 for beneficiaries age 21 and older.
• 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. In April 2011, DHCS wrote a letter to CDE requesting clarification on the LEA Program reimbursement funding restrictions. DHCS will work with CDE to determine how LEAs can use the federal monies received from LEA services.

VII. APPENDICES

Appendix 1 – Medicaid Reimbursement and Claims by State

Appendix 2 – Other State's School-Based Services and Providers

Appendix 1(a): Medicaid Reimbursement And Claims By State
Ranked By Average Claim Per Medicaid-Eligible Child, State Fiscal Year (SFY) 2008 - 2009

		SFY 2008 - 2009					
		Federal Reimbursement (Federal Share)			Calculated Claim Dollars		
State	FMAP [1]	Health (000's)	Administrative (000's)	Total (000's)	Health (000's) [2]	Administrative (000's) [3]	Total (000's)
VERMONT	67.71%	$ 24,005	$ -	$ 24,005	$ 35,453	$ -	$ 35,453
RHODE ISLAND	63.89%	18,703	4,401	23,104	29,273	8,803	38,076
NEBRASKA [4]	65.74%	2,899	23,953	26,852	4,409	47,907	52,316
WEST VIRGINIA	80.45%	42,234	-	42,234	52,497	-	52,497
MASSACHUSETTS	58.78%	81,900	39	81,939	139,333	79	139,412
PENNSYLVANIA	63.05%	123,900	28,400	152,300	196,511	56,800	253,311
KANSAS	66.28%	16,592	5,627	22,219	25,033	11,254	36,287
UTAH [4]	77.83%	14,889	2,338	17,227	19,130	4,676	23,806
WISCONSIN [4]	65.58%	53,166	2,688	55,855	81,071	5,377	86,448
MARYLAND	58.78%	15,860	27,935	43,796	26,983	55,870	82,853
ILLINOIS [4]	60.48%	78,722	54,639	133,361	130,162	109,277	239,439
IOWA	68.82%	23,747	-	23,747	34,506	-	34,506
MICHIGAN	69.58%	76,601	4,849	81,451	110,091	9,699	119,790
MINNESOTA	60.19%	25,422	-	25,422	42,236	-	42,236
MONTANA	76.29%	2,524	1,129	3,653	3,308	2,259	5,567
FLORIDA	67.64%	10,005	65,661	75,666	14,791	131,322	146,114
ARKANSAS	79.14%	15,896	8,889	24,785	20,086	17,778	37,864
ALABAMA [4]	76.64%	438	17,847	18,284	571	35,693	36,264
VIRGINIA	58.78%	9,877	11,664	21,541	16,803	23,328	40,131
CALIFORNIA	61.59%	109,872	101,300	211,173	178,393	202,601	380,994
NEW YORK [4]	58.78%	79,680	-	79,680	135,557	-	135,557
MISSOURI	71.24%	3,580	15,055	18,635	5,026	30,110	35,135
NORTH CAROLINA	73.55%	9,793	17,711	27,504	13,315	35,422	48,737
COLORADO	58.78%	9,220	-	9,220	15,686	-	15,686
ARIZONA	75.01%	22,744	3,417	26,161	30,321	6,835	37,156
NEW MEXICO [4]	77.24%	7,635	2,747	10,382	9,885	5,494	15,379
WASHINGTON [4]	60.22%	5,993	10,633	16,626	9,952	21,265	31,217
MISSISSIPPI [4]	83.62%	915	6,893	7,808	1,094	13,786	14,881
LOUISIANA	80.01%	21,882	709	22,591	27,349	1,418	28,767
NEVADA [4]	63.93%	1,775	-	1,775	2,777	-	2,777
GEORGIA	73.44%	12,137	-	12,137	16,527	-	16,527
KENTUCKY	77.80%	3,590	785	4,375	4,614	1,570	6,184
OKLAHOMA [4]	74.94%	4,286	-	4,286	5,719	-	5,719
ALASKA [4]	58.68%	467	-	467	795	-	795
INDIANA	73.23%	2,875	-	2,875	3,925	-	3,925
HAWAII [4]	66.13%	314	-	314	476	-	476
OHIO [5]	70.25%	-	-	-	-	-	-
TENNESSEE [5]	73.25%	-	-	-	-	-	-
WYOMING [5]	56.20%	-	-	-	-	-	-

(1) The Federal Medical Assistance Percentage (FMAP) adjusted for the American Recovery and Reinvestment Act (ARRA) for each state was obtained from the Federal Register, published published on April 21, 2009.

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

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

(4) Total federal reimbursement for this state's health services program and/or administrative claiming program was obtained from the 2009 state survey.

(5) This state did not have a school-based Medicaid health services program or administrative claiming program in effect during SFY 2008-09 and/or SFY 2009-10.

Appendix 1(b): Medicaid Reimbursement And Claims By State
Ranked By Average Claim Per Medicaid-Eligible Child, State Fiscal Year (SFY) 2008 - 2009

		SFY 2009 - 2010					
		Federal Reimbursement (Federal Share)			Calculated Claim Dollars		
State	FMAP [1]	Health (000's)	Administrative (000's)	Total (000's)	Health (000's) [2]	Administrative (000's) [3]	Total (000's)
VERMONT	69.96%	$ 26,122	$ -	$ 26,122	$ 37,338	$ -	$ 37,338
RHODE ISLAND	63.92%	22,339	5,000	27,339	34,948	9,999	44,948
NEBRASKA [4]	68.76%	-	-	-	-	-	-
WEST VIRGINIA	83.05%	48,341	-	48,341	58,207	-	58,207
MASSACHUSETTS	61.59%	41,100	31,364	72,464	66,732	62,728	129,460
PENNSYLVANIA	65.85%	139,739	31,111	170,850	212,208	62,222	274,430
KANSAS	69.68%	16,962	2,907	19,870	24,343	5,815	30,158
UTAH [4]	80.78%	-	-	-	-	-	-
WISCONSIN	70.63%	42,694	10,761	53,455	60,447	21,521	81,969
MARYLAND	61.59%	13,159	25,980	39,139	21,365	51,961	73,326
ILLINOIS	61.88%	89,808	58,476	148,283	145,132	116,951	262,083
IOWA	72.55%	36,819	-	36,819	50,749	-	50,749
MICHIGAN	73.27%	85,488	9,087	94,575	116,675	18,175	134,850
MINNESOTA	61.59%	34,041	-	34,041	55,270	-	55,270
MONTANA	77.99%	3,218	1,250	4,468	4,126	2,499	6,626
FLORIDA	67.64%	15,068	64,447	79,515	22,277	128,894	151,170
ARKANSAS	81.18%	15,912	10,320	26,231	19,601	20,639	40,240
ALABAMA [4]	77.53%	-	-	-	-	-	-
VIRGINIA	61.59%	12,344	10,189	22,533	20,042	20,378	40,421
CALIFORNIA	61.59%	129,471	90,853	220,323	210,214	181,706	391,919
NEW YORK [4]	61.59%	-	-	-	-	-	-
MISSOURI	74.43%	4,137	32,523	36,660	5,559	65,046	70,605
NORTH CAROLINA	74.98%	15,445	9,421	24,867	20,599	18,843	39,442
COLORADO	61.59%	9,447	1,101	10,548	15,339	2,202	17,540
ARIZONA	75.93%	21,544	4,016	25,560	28,374	8,031	36,405
NEW MEXICO [4]	80.49%	-	-	-	-	-	-
WASHINGTON [4]	62.94%	-	-	-	-	-	-
MISSISSIPPI [4]	84.86%	-	-	-	-	-	-
LOUISIANA [4]	81.48%	-	-	-	-	-	-
NEVADA [4]	63.93%	-	-	-	-	-	-
GEORGIA	74.96%	16,148	-	16,148	21,542	-	21,542
KENTUCKY	80.14%	3,800	11,589	15,389	4,742	23,178	27,919
OKLAHOMA	76.73%	5,157	-	5,157	6,721	-	6,721
ALASKA [4]	62.46%	-	-	-	-	-	-
INDIANA	75.69%	3,982	-	3,982	5,261	-	5,261
HAWAII [4]	67.35%	-	-	-	-	-	-
OHIO [5]	73.47%	-	-	-	-	-	-
TENNESSEE [5]	75.37%	-	-	-	-	-	-
WYOMING [5]	61.59%	-	-	-	-	-	-

(1) The Federal Medical Assistance Percentage (FMAP) adjusted for the American Recovery and Reinvestment Act (ARRA) for each state was obtained from the Federal Register, published on April 30, 2010.

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

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

(4) Total federal reimbursement for this state's health services program and/or administrative claiming program was not available for SFY 2009-10.

(5) This state did not have a school-based Medicaid health services program or administrative claiming program in effect during SFY 2008-09 and/or SFY 2009-10.

DRAFT

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

Service	Qualified Provider(s)	Example Rates
Behavioral services provided by a behavioral aide Behavioral aide services prevent or correct maladaptive behavior on the part of the child. The interventions are used to change specific behaviors. A behavioral plan is designed by a mental health professional and carried out by behavioral aides. The plan provides a description of the behavior to be addressed and positive or negative incentives to encourage appropriate behavior.	**Mental health behavioral aide** A paraprofessional working under the direction of a mental health professional.	**Iowa:** Based on each school district's cost of providing service. **Minnesota:** Based on each school district's cost of providing service.
Behavioral services provided by a certified behavioral analyst or certified associate behavioral analyst Behavioral services include behavioral evaluations and functional assessments, analytic interpretation of assessment results, and design and delivery of treatments and intervention methods.	**Certified behavior analyst** A person with a bachelor's or master's degree who meets state requirements for a certified behavioral analyst. A person with a bachelor's degree must work under the supervision of a certified behavioral analyst with a master's degree. **Certified associate behavioral analyst** A person with a bachelor degree or higher who meets state requirements for a certified associate behavioral analyst and who works under supervision of a certified behavioral analyst with a master's degree.	**Florida:** Certified behavior analyst, Individual: $8.00 per 15-minute increment Group: $4.00 per 15-minute increment Certified behavior analyst (bachelor's level), Individual: $6.70 per 15-minute increment Group: $3.35 per 15-minute increment Certified associate behavior analyst, Individual: $6.70 per 15-minute increment Group: $3.35 per 15-minute increment

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

Service	Qualified Provider(s)	Example Rates
Behavioral services provided by an intern Behavioral services include testing, assessment and evaluation that appraise cognitive, developmental, emotional, and social functioning; therapy and counseling, and crises assistance.	**Psychologist intern, Social worker intern** A psychologist or social worker with a master's degree or higher obtaining the required work experience for licensure and working under the supervision of a qualified provider.	**Florida:** Psychologist, Individual: $9.66 per 15-minute increment Group: $4.25 per 15-minute increment Social worker, Individual: $8.97 per 15-minute increment. Group: $4.25 per 15-minute increment **Illinois:** Based on each school district's cost of providing service.
Dental assessment and health education provided under Early and Periodic Screening, Diagnostic and Treatment services Dental assessment services include a dental oral exam using a mouth mirror and explorer to identify abnormalities, such as abscess, growth or lesion, traumatic injury and periodontal problems. Dental health education includes one-on-one teaching of awareness, prevention and education, including awareness of teeth and dental hygiene techniques.	**Dental hygienist** A person who is a licensed dental hygienist.	**Delaware:** $40.04 per 15-minute increment. (1)
Durable medical equipment and assistive technology devices Purchase or rental of medically necessary and appropriate assistive devices such as augmentative communication devices, crouch screen voice synthesizers, prone standers, corner chairs, wheelchairs, crutches, walkers, auditory trainers, and suctioning machines. The equipment is for the exclusive use of the child and is the property of the child.	**Not applicable**	**Illinois:** Medically necessary equipment may be claimed up to a total of $1,000 per day based on the cost of the equipment. **Minnesota:** Based on purchase price, rental costs or costs of repairs.

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

Service	Qualified Provider(s)	Example Rates
IEP review services Coordination and management of the activities leading up to and including the writing of the IEP or IFSP, including convening and conducting the meeting to write the IEP or IFSP.	**Case manager** A person who has a bachelor's degree with a major in special education, social services, psychology, or related field; or a registered nurse.	**West Virginia:** Initial or Triennial: $703.66 Annual: $171.97
Interpreter services Interpretive services rendered to a child who requires an interpreter to communicate with the professional or paraprofessional providing the child with a health-related service. Services include oral language interpretation for children with limited English proficiency or sign language interpretation for children who are deaf or hard of hearing. Services must be provided in conjunction with another Medicaid service.	**Interpreter** Oral language: A person who speaks the language understood by the child and who is employed by or has a contract with the school district to provide oral language interpreter services. Sign language: A person with a bachelor's degree or higher who has graduated with a valid certification from a recognized interpreters' evaluation program.	**Minnesota:** Based on each school district's cost of providing service. **Pennsylvania:** Based on each school district's cost of providing service.
Occupational therapy services provided by an occupational therapy assistant Services rendered to a child to develop, improve, or restore functional abilities related to self-help skills, adaptive behavior and sensory, motor, postural development, and emotional deficits that have been limited by a physical injury, illness, or other dysfunctional condition.	**Occupational therapy assistant** A person who meets state requirements as an occupational therapy assistant and works under the direction of a qualified occupational therapist.	Most states do not have separate rates for occupational therapy services provided by occupational therapists and occupational therapy assistants. The rate listed below applies to occupational therapy assistants only. **Florida:** Individual: $13.58 per 15-minute increment. Group: $2.60 per 15-minute increment.

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

Service	Qualified Provider(s)	Example Rates
Orientation and mobility services Evaluation and training designed to correct or alleviate movement deficiencies created by a loss or lack of vision in order to enhance the child's ability to function safely, efficiently and purposefully in a variety of environments.	**Orientation and mobility provider** - Orientation and mobility specialist certified by the Association for the Education and Rehabilitation of the Blind and Visually Impaired; the Academy for Certification of Vision Rehabilitation and Education Professionals; or the National Blindness Professional Certification Board - Teacher of special education with approval as teacher of the visually impaired; or - Assistive technology consultant with a master's degree in special education or speech pathology.	**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 Services and support furnished to an individual to assist in accomplishing activities of daily living (eating, toileting, grooming, dressing, bathing, transferring, mobility, and positioning); health related functions through hands-on assistance, supervision, and cuing; and redirection and intervention for behavior, including observation.	**Health aide, Personal care assistant** A paraprofessional supervised by a qualified health care professional.	**Arizona:** $4.30 per 15-minute increment. **Michigan:** Based on each school district's cost of providing service from prior year. **Virginia:** Based on estimated costs for services furnished in 15-minute increments. **West Virginia:** Full-day students: $192.68 Partial-day students: $96.34
Physical therapy services provided by a physical therapy assistant Services rendered to a child to develop, improve or restore neuromuscular or sensory-motor function, relieve pain, or control postural deviations to attain maximum performance.	**Physical therapy assistant** A person who meets state requirements for a physical therapy assistant and works under the direction of a qualified physical therapist. One state allows a physical education teacher or an adaptive physical education teacher to bill for services as a paraprofessional if the services are prescribed and supervised by a licensed physical therapist.	Most states do not have separate rates for physical therapy services provided by physical therapists and physical therapy assistants. The rate listed below applies to physical therapy assistants only. **Florida:** Individual: $13.58 per 15-minute increment. Group: $2.60 per 15-minute increment.

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

Service	Qualified Provider(s)	Example Rates
Respiratory therapy services Respiratory therapy services assist a child who has breathing or other cardiopulmonary disorders. Procedures include, but are not limited to, the assessment and therapeutic use of the following: medical gases (excluding anesthetic gases); aerosols, humidification, environmental control systems; ventilator support; and maintenance and care of natural and artificial airways.	**Licensed respiratory therapist** A person who meets state requirements as a licensed respiratory therapist.	**Kentucky:** $3.75 per 15-minute increment. [(1)]
Services for children with speech and language disorders provided by a speech-language pathology assistant Services rendered to a child to treat speech and language disorders of verbal and written language, articulation, voice, fluency, phonology, and mastication.	**Speech-language pathology assistant** A person who meets state requirements for a speech-language pathology assistant and works under the direction of a qualified speech pathologist.	Most states do not have separate rates for speech therapy services provided by speech pathologists and speech-language pathology assistants. The rate listed below applies to speech-language pathology assistants only. **Florida:** Individual: $13.58 per 15-minute increment. Group: $2.60 per 15-minute increment.

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

Service	Qualified Provider(s)	Example Rates
Specialized transportation Transportation in a vehicle adapted to serve the needs of the disabled to and from school when the child receives a Medicaid-covered service in school and when transportation is specifically listed in the IEP or IFSP as a required service. Transportation from the school to a provider in the community also may be billed to Medicaid. (Reimbursable transportation is currently restricted to students that require a litter van or wheelchair van, in California's LEA Program.)	**Not Applicable**	**Michigan:** Based on each school district's cost of providing service from prior year. **New York:** $12.23 – 32.25 per day. In Michigan and New York, providers may not bill separately for an attendant.

Note (1): This service was confirmed for this state; however rates are no longer available on the school-based website as of SFY 2010-11. Rates were confirmed in SFY 2008-09.