Local Educational Agency
Medi-Cal Billing Option Program

Report to the Legislature, May 2012

Report Period April 2011 through May 2012

Director Toby Douglas
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 (COEs) 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 (SB) 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).

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

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-five 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 fiscal year 2012 specifically identified Medicaid school-based services as a targeted area for compliance review. OIG will continue to review

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

Medicaid payments for school-based services in selected states to determine whether the health service costs claimed are reasonable. In addition to 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].

The American Recovery and Reinvestment Act (ARRA) of 2009 approved Federal Medical Assistance Percentage (FMAP) increases to all states and territories, effective October 2008 through June 2011. Increased FMAP rates 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 2011, subsequently increasing reimbursement. The LEA Program is currently reimbursing LEA services at the State Fiscal Year (SFY) 2010-11 reimbursement rates. DHCS plans to implement annual inflated rates during SFY 2012-13 that will be retroactive to July 1, 2011.

[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 third party 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 are listed below. The LEA Program reimbursement has more than doubled in the past five years and has grown by more than 100 percent since its authorization under SB 231.

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%
SFY 2009-10 (1)	$130.4 million	119%

Notes:
(1) Total Medi-Cal reimbursement is based on date of service and updated to reflect paid claims after erroneous payment corrections (EPCs) 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 been corrected, although DHCS continues to work with its fiscal intermediary,

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

Affiliated Computer Services, Inc. (ACS), the successor to HP, to resolve minor technical coding issues in the claims processing system.

On September 20, 2011, DHCS resubmitted SPA 05-010, which establishes equivalency for a credentialed speech-language pathologist as a "speech pathologist" under the federal standard, for CMS review. On December 16, 2011, CMS approved SPA 05-010, which allows speech-language pathology practitioners with preliminary or professional clear services credentials in speech-language pathology to provide services to Medi-Cal eligible children without supervision. 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 policy was implemented via a DHCS Policy and Procedure Letter (PPL #12-008) and updated in the relevant LEA Provider Manual sections.

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, provide LEA perspective and feedback, and have resulted in recommendations for new services and improvements to 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.

During 2011, DHCS conducted research, reviewed other state school-based services programs and interviewed other state Medicaid personnel regarding potential new services for California's LEA Program. Additional SPAs may be developed and submitted to CMS in 2012 and beyond, along with the requisite and supportive analysis, research, studies, fieldwork, provider training, CMS negotiation and other due diligence required to continue to successfully expand the LEA Program.

In addition, throughout 2011, DHCS continued to assist the fiscal intermediary in streamlining claims payments; identifying and resolving technical claims processing issues and system changes; and revised the Medi-Cal Provider Manual sections specific to LEA services (LEA Provider Manual), as necessary. During 2011, DHCS developed audit protocols; conducted separate LEA Cost and Reimbursement Comparison Schedule (CRCS) and annual LEA Program training sessions; audited the first LEA CRCS form submission from SFY 2006-07; implemented the SFY 2009-10 CRCS form submission and intake process; analyzed historic LEA costs to rebase interim reimbursement rates, and implemented those new rates in the paid claims system.

The work completed in 2011 has largely been due to the positive and on-going relationship between DHCS and the many officials of school districts, COEs, the California Department of Education (CDE) and professional associations representing LEA services who have participated in the LEA Advisory Committee.

I. INTRODUCTION

Within the LEA Program, California's school districts and COEs 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]. SB 231 was signed into law in 2001 and reauthorized in 2009, to reduce the estimated 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 DHCS 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 are reimbursed for all eligible school-based services 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[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, COEs, the Local Education Consortium (LEC) and LEAs;
- Consult with staff from Region IX of CMS, experts from the fields of both health and education, and state legislative staff;
- Undertake necessary activities to ensure that an LEA 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.

Table 1: Annual Legislative Report Requirements

Report Section	Report Requirements
III	• An annual comparison of school-based Medicaid systems in comparable states. • A state-by-state comparison of school-based Medicaid total and per eligible child claims and federal revenues. The comparison shall include a review of the most recent two years for which completed data is available. • A summary of department activities and an explanation of how each activity contributed toward narrowing the gap between California's per eligible student federal fund recovery and the per student recovery of the top three states. • A listing of all school-based services, activities, and providers[6] approved for reimbursement by CMS in other state plans that are not yet approved for reimbursement in California's state plan and the service unit rates approved for reimbursement.
IV	• The official recommendations made to 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[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 allowable practitioners who provide services to eligible students, and LEAs or LEA providers refer to school districts and COEs that have enrolled in the LEA Program.

[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, 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 the 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) 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. In SFY 2011-12, the OIG released three audit reports related to school-based health services in Colorado, Kansas and New Hampshire. Twenty-five 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;
- Improper billing of IEP services;
- Claims submitted for services provided by unqualified personnel;
- Inadequate referral and/or prescription for applicable services;
- Violation of Free Care requirements;
- Insufficient rate-setting methodologies;
- Non-compliance with respective State Plans;
- Inadequate and/or incorrect policy manuals;
- Inadequate third-party program administrators; and
- Lack of state-level oversight of federal guidelines.

The OIG continues to focus on compliance issues surrounding school-based services.

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 H.R. 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 were gradually 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, the extended enhanced FMAP resulted in additional funding for LEA providers in California through the end of SFY 2010-11, and the interim reimbursement rates were paid through the claims system. Effective SFY 2011-12, the California FMAP rate returned to 50 percent.

III. OTHER STATES' SCHOOL-BASED MEDICAID PROGRAMS

An 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) 2008-09, 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, Office of Management and Budget #1820-0043: "Children with Disabilities Receiving Special Education Under Part B of the Individuals with Disabilities Education Act," 2010.
Average salaries of instructional staff (classroom teachers, principals, supervisors, librarians, guidance and psychological personnel, and related instructional staff)	Rankings of the States 2011 and Estimates of School Statistics 2012, National Education Association (NEA), December 2011
Per capita personal income	Rankings of the States 2011 and Estimates of School Statistics 2012, NEA, December 2011

The number of Medicaid-eligible and IDEA eligible children provide a measure of the number of students that qualify for Medicaid school-based services. The average salaries of instructional staff and per-capita personal income provide a comparison of the cost of living 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 four states (Texas, Florida, Ohio, and Georgia) had greater numbers of Medicaid-eligible children than two of the selected comparable states (Pennsylvania and Michigan), they were not selected, since their cost of living measures were substantially lower than California.

In the past several years, many states have financed their school-based direct health service claiming programs using CPE programs, which are cost-settled on a retroactive basis. In these situations, providers must complete an annual cost report as part of the cost reconciliation process. In California, the standardized CRCS report, is submitted by LEAs and used to compare the interim Medi-Cal reimbursements received throughout the fiscal year to the estimated Medi-Cal costs to provide the health services. LEAs report the actual costs and annual hours worked for all qualified practitioners who provide and bill for LEA health-related reimbursable services, and the units of service and related Medi-Cal reimbursement for the appropriate fiscal year on the CRCS forms. Estimated costs are compared to Medi-Cal reimbursement to ensure that each LEA provider is not paid more than the costs of providing these services, which is a requirement within CPE programs. This reconciliation results in an amount owed to or from the LEA; underpayments are paid in a lump sum to LEAs while overpayments are withheld from future LEA reimbursement claims. As part of the cost reconciliation, the LEA providers certify that the public funds expended for LEA services provided are eligible for FFP. SFY 2009-10 was the fourth cost certification year and the CRCS was due by November 30, 2011. In order to assist LEAs in completing the Medi-Cal cost report, DHCS' fiscal intermediary worked to create an Interim Reimbursement and Units of Service (IRUS) Report in September 2011 for all LEAs who received Medi-Cal reimbursement during SFY 2009-10. This report summarized total units

and reimbursement information by LEA service and practitioner type and is available on the LEA Program website. In 2012, DHCS finished auditing 2006-07 CRCS reports and will continue their review of the SFYs 2007-08 and 2008-09 CRCS submissions.

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. However, Pennsylvania has a rate ceiling that is established by the Department of Public Welfare for each type of service.

New York submitted a SPA to change their reimbursement methodology from statewide rates to a CPE program, which is pending CMS approval. New York is currently transitioning to CPE requirements and will utilize a random moment time study (RMTS) to determine the average amount of time that school practitioners spend on Medicaid direct services and administrative activities. Effective SFY 2011-2012, schools that receive Medicaid payments for health services provided on and after October 1, 2011, will be required to operate under the CPE methodology. Schools will continue to submit fee-for-service Medicaid claims and will be reimbursed at interim rates. New York will initiate a cost settlement process after each school district, county and qualifying school entity has completed its quarterly RMTS and annual cost report. New York's Targeted Case Management (TCM) SPA was rescinded effective July 1, 2010. Medicaid reimbursement is available for TCM services provided before July 1, 2010, however claims must be submitted by April 30, 2012, in order to be reimbursed.

Pursuant to a CMS mandate, effective July 2008, Michigan developed a cost-based and provider specific cost reconciliation reimbursement methodology. CMS also requires Michigan school providers to submit procedure specific fee-for-service claims for all Medicaid allowable services. Although the claims do not generate any payment, CMS requires this in order to monitor the services provided, the eligibility of the recipient, and to provide an audit trail. Similar to New York, Michigan utilizes RMTS to determine the average amount of time spent on direct 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 based on prior year actual costs are reconciled on an annual basis to the current year costs (July 1 through June 30 of each year). Within six months after the close of each school fiscal year, school-based providers will review, certify and submit the necessary information to the state. The final settlement process begins within 18 to 20 months after the school fiscal year end. Michigan completed cost report submissions in November 2010 for the school year 2009-10. Michigan began their cost settlement process for 2009-10 in October 2011 and is in the process of completing reconciliations. The cost settlement process is expected to begin in May 2012 for the 2010-11 school year.

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

DHCS administered the ninth state survey beginning January 2012. DHCS contacted states to obtain updates to the information provided in the 2010 survey; states that did not participate in 2010 were given the opportunity to complete the 2012 survey. Follow-up contacts were made during Winter 2011 and Spring 2012 to states that did not respond to the survey. Some states indicated that they were unable to complete the survey on a timely basis due to a variety of reasons, such as unconfirmed reimbursement totals, program transition and overhaul, and internal data request issues; several states did not respond to multiple follow-ups. Twenty-seven of 49 states contacted returned the survey, however, six of those survey respondents did not provide Medicaid reimbursement figures. Four states that did not participate in 2009 and two states that had not participated in two or more previous DHCS surveys returned surveys in 2012.

Table 3 summarizes Medicaid reimbursement (federal share) for health services and administrative services for SFY 2009-10 and 2010-11 based on the survey. Several states did not have finalized data available for both SFYs. When data was provided, federal Medicaid reimbursement was divided by each state's FFP rate to estimate total claim dollars. Based on the federal changes in FMAP rates throughout SFY 2010-11, DHCS used

the Quarter 2 FFP for each individual state 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).

It is important to note that the original GAO report and DHCS surveying results cannot accurately compare direct billing option program dollars spent per Medicaid-eligible student among states. This is due to the inherent inability to split Medicaid-eligible students between direct claiming fee-for-service and administrative claiming programs. For those states that operate both programs, only the combined program dollars can be divided by the number of Medicaid-eligible students. As such, Table comparisons for those states (including California) that attempt to compare direct billing service dollars per eligible student are inadvertently impacted by the inclusion of administrative claiming program dollars. In addition, the FMAPs vary between states, which impact the average claim per Medicaid-eligible child. FMAPs range from 61.59 percent to 84.86 percent in FY 2009-10 and from 58.77 percent to 82.03 percent in FY 2010-11. Any state ranking interpretations made within these tables should consider this important caveat.

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 $211 in SFY 2009-10 and $76 in SFY 2010-11. Maryland's survey response indicated that they no longer have a Medicaid school-based administrative claiming program. As noted in Table 3, Nebraska had the highest average SFY 2009-10 claim of $786, while California's average claim was $159, a difference of $627. California's federal Medi-Cal reimbursement for direct billing option program services increased 19 percent between SFY 2009-10 and 2010-11. In addition, the federal revenues from administrative activities claimed in the California Medi-Cal Administrative Activities (MAA) (administrative claiming) program decreased from $158.8 in SFY 2009-10 to $101.6 million (year-to-date) in SFY 2010-11.

According to CMS', California had over 3.3 million Medicaid eligibles aged 6 to 20 in FFY 2008-09 (15 percent of the total U.S. school-aged Medicaid eligible population). In comparison, Nebraska, with the highest average claim per Medicaid-eligible child in Table 3, had approximately 103,200 school-aged Medicaid eligible population. As indicated in Table 3, California has the highest federal Medicaid reimbursement and total claims figures in both SFYs 2009-10 and 2010-11; however due to California's large Medicaid eligible population used in the Table 3 rankings, California's average claim per Medicaid-eligible child is substantially lower when compared to other states. Based on California's SFY 2009-10 paid claims reimbursement data, the number of actual LEA beneficiaries who received LEA Program services was 239,800 students. By utilizing the actual LEA beneficiary count and the total SFY 2009-10 reimbursement, the average reimbursement per beneficiary receiving LEA Program services in SFY 2009-10 is $544.

A comparison of the average claim in the April 2000 report published by the GAO to the SFY 2009-10 average claim per Medicaid-eligible child in Table 3 shows an increase in 24 of the 32 states that reported federal reimbursement (including California). The average claim decreased in eight states.

Table 3: Medicaid Reimbursement and Claims by State, Ranked by 2009-10 Average Claim Per Medicaid-Eligible Child

	SFY 2009-2010 [1]			SFY 2010-2011 [1]		
State	Federal Medicaid Reimbursement (000's)	Total Claims (000's)	Average Claim Per Medicaid-Eligible Child [2]	Federal Medicaid Reimbursement (000's)	Total Claims (000's)	Average Claim Per Medicaid-Eligible Child [2]
NEBRASKA	$ 41,346	$ 81,146	$ 786	$ 26,005	$ 50,530	$ 490
VERMONT	24,346	34,799	694	26,122	38,912	777
RHODE ISLAND	27,339	44,948	635	-	-	-
WEST VIRGINIA	48,341	58,207	423	50,540	62,994	458
PENNSYLVANIA	179,348	288,420	374	165,975	273,740	355
DELAWARE	13,266	21,473	346	12,060	19,594	316
MASSACHUSETTS	72,464	129,460	331	-	-	-
IOWA	36,819	50,749	287	-	-	-
MICHIGAN	144,856	202,995	257	128,501	180,846	229
ILLINOIS	148,283	262,083	253	166,147	300,545	290
NEW JERSEY	60,500	99,171	251	64,500	110,496	280
KANSAS	19,870	30,158	234	-	-	-
MARYLAND	39,139	73,326	211	15,575	26,502	76
MINNESOTA	34,041	55,270	194	-	-	-
WISCONSIN	37,049	58,658	178	33,782	50,462	153
MISSOURI	36,660	70,605	169	-	-	-
CALIFORNIA	289,259	529,431	159	248,120	452,511	136
FLORIDA [4]	76,664	146,955	132	16,281	25,121	23
ARKANSAS	26,231	40,240	131	-	-	-
MONTANA	4,468	6,626	123	-	-	-
VIRGINIA	18,600	33,946	85	-	-	-
KENTUCKY	15,389	27,919	82	9,516	15,878	46
COLORADO	10,438	17,320	80	1,052	2,105	10
LOUISIANA	29,084	37,078	73	29,486	37,840	75
MISSISSIPPI	8,987	17,974	71	1,783	3,566	14
NORTH CAROLINA	30,538	52,882	71	30,303	53,544	71
ARIZONA	25,560	36,405	68	31,553	44,863	84
OHIO	28,300	38,519	45	25,600	36,117	43
NEVADA	2,021	3,161	32	402	658	7
GEORGIA	16,148	21,542	26	-	-	-
OKLAHOMA	5,218	6,801	20	4,485	6,068	18
INDIANA	3,982	5,261	11	4,164	5,674	12
MAINE [3]	-	-	-	-	-	-
TENNESSEE [3]	-	-	-	-	-	-
WASHINGTON [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) 2008-09. (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 2009-2010 and/or SFY 2010-11.

(4) Health service figures from Florida were compiled from the Florida Agency for Healthcare Administration website (http://ahca.myflorida.com/medicaid/childhealthservices/schools/index.shtml) where online Fee-for-Service School Certified Match Reimbursement Reports are updated quarterly

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 118 percent, growing from $59.6 million in SFY 2000-01 to $130.4 million in SFY 2009-10. Most 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:

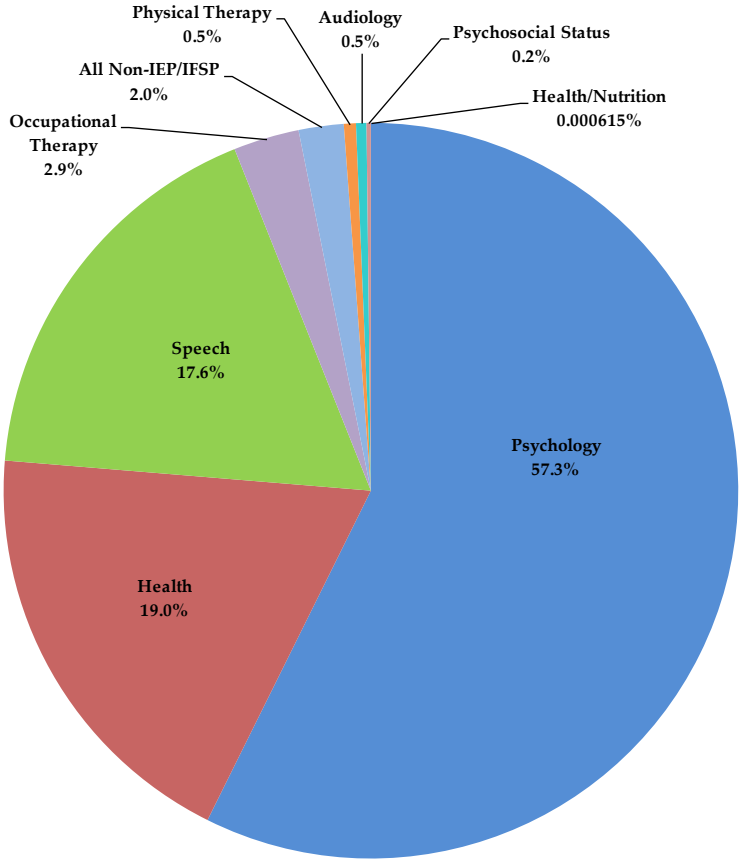
- Psychosocial Status;
- Health/Nutrition;
- Health Education and Anticipatory Guidance;
- Hearing;
- Vision; and
- Developmental.

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 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 2009-10



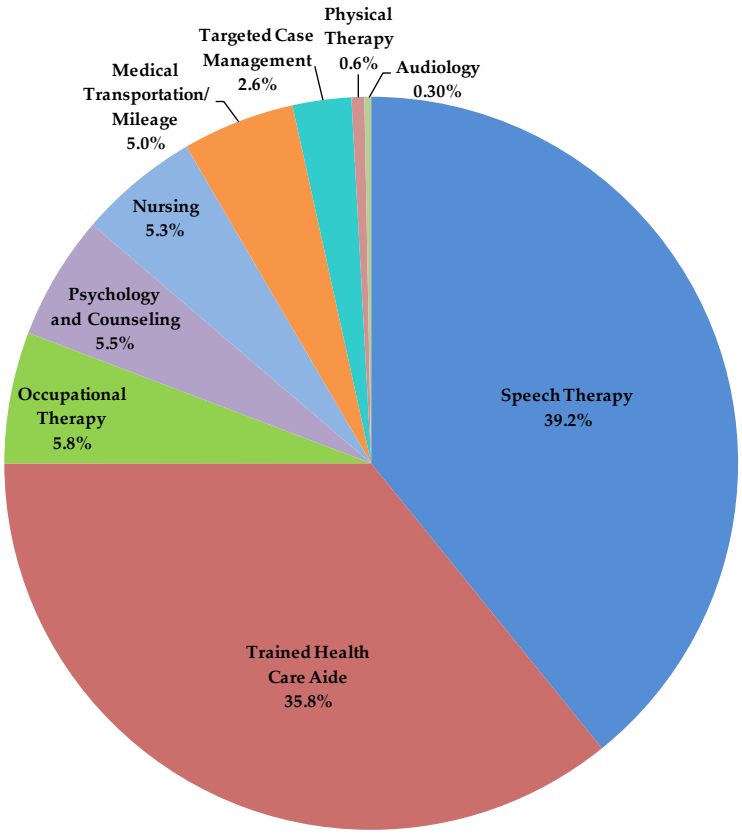
Note: Total LEA assessment service reimbursement for SFY 2009-10 was $26.49 million.

Figure 1 depicts each assessment type as a percentage of total assessment reimbursement for SFY 2009-10. As demonstrated in Figure 1, approximately 94 percent of assessment reimbursement is attributable to three IEP/IFSP assessment types: psychological, health and speech-language assessments. Although there were more LEA health assessment claims billed in SFY 2009-10, the majority of all LEA 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.[8] Over a third of assessment reimbursement is attributed to health and speech-language assessments at 19

[8] Psychological assessments were reimbursed at $439.92 for initial/triennial assessments and $146.64 for annual and amended assessments in SFY 2009-10.

percent and 17.6 percent, respectively. The remaining six assessment types, including all non-IEP/IFSP assessments account for only six percent of total assessment reimbursement in SFY 2009-10.

Figure 2: Percentage of Total LEA Treatments by Treatment Type, SFY 2009-10

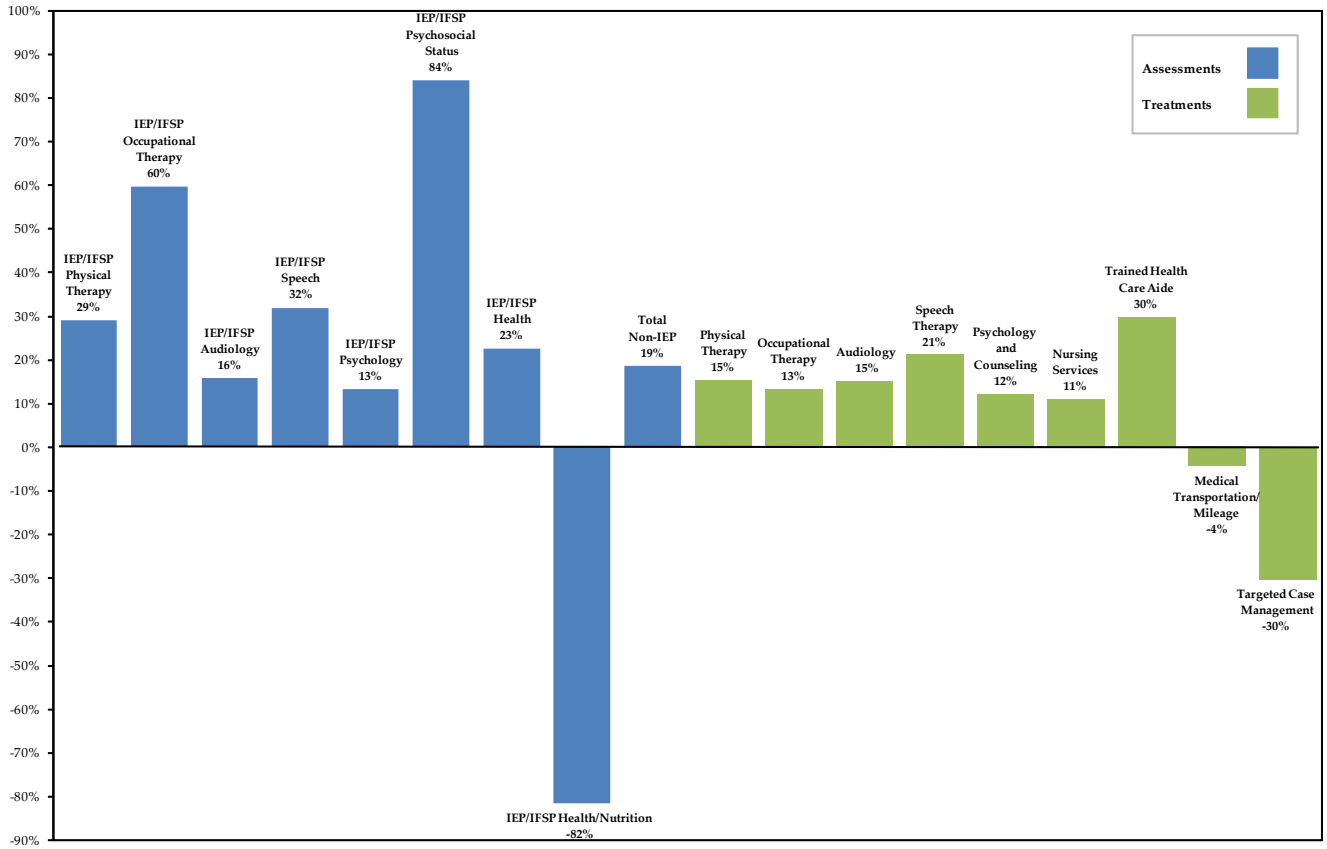


Note: Total LEA treatment, transportation/mileage and TCM service reimbursement for SFY 2009-10 was $103.94 million. Less than one percent of total treatment, transportation/mileage and TCM reimbursement is attributable to non-IEP/IFSP services.

Figure 2 demonstrates each treatment type as a percentage of total treatment reimbursement for SFY 2009-10. Two-thirds of treatment service reimbursement are attributed to speech therapy and trained health care aide services. The remaining seven treatment service types account for the final third of treatment service reimbursement in SFY 2009-10.

As demonstrated in the following Figure 3, all but three LEA services experienced an increase in reimbursement between SFYs 2008-09 and 2009-10. Percentage increases vary from 11 percent for nursing treatment to 84 percent for IEP/IFSP psychosocial status assessments, with most services increasing at least 12 percent between SFY 2008-09 and 2009-10. Although the decrease in IEP/IFSP health/nutrition assessments is large (82 percent), this type of assessment is not billed frequently. In SFY 2008-09, there were 83 claims submitted for $886 in reimbursement, compared to 15 claims reimbursed at $163 in SFY 2009-10. IEP/IFSP health/nutrition assessments are only provided by licensed physicians; only a few LEA providers have licensed physicians available to provide services. The decrease in TCM may be due to LEAs claiming TCM under the MAA program, as there are less stringent documentation requirements. The LEA Program requires that providers retain a service plan, document case management activities, and record student and/or family progress. In addition, since TCM rates were not updated 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 they are included in a future SPA. Similar to TCM, transportation and mileage rates were not updated in SPA 03-024, and have not increased.

Figure 3: Percentage Change In Reimbursement By Service Type, SFYs 2008-09 Through 2009-10



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:

- **Rate Inflators and Rate Rebasing**

  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 addition, DHCS is required to rebase LEA reimbursement rates for IEP/IFSP assessments and treatment services and non-IEP/IFSP assessments and treatment services periodically. DHCS reviewed and analyzed the as-submitted SFY 2007-08 CRCS costs to rebase interim reimbursement rates. The majority of the LEA practitioner's costs per hour have

increased. In August 2011, DHCS' fiscal intermediary implemented the SFY 2010-11 rebased rates. These rates are the current reimbursement rates LEAs receive until DHCS implements the SFY 2011-12 reimbursement rates at a future date. In April 2012, DHCS submitted the SFY 2011-12 inflated reimbursement rate table to its fiscal intermediary for implementation. These rates are expected to be implemented soon.

- **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 impacted LEA reimbursement beginning in SFY 2008-09, since the federal government financed more than California's traditional 50 percent of Medicaid reimbursement. The increased FMAP was extended beyond the original date of December 2010, and then decreased incrementally per quarter until June 2011 when the 50 percent FMAP resumed for SFY 2011-12. DHCS' fiscal intermediary retroactively implemented the rate table in August 2011 to adjust for the FMAP decrease impacting the January 2011 through June 2011 period.

- **SB 231 Withhold**

  As a requirement of SB 231, 2.5 percent is withheld from LEA claims to fund activities mandated in W&I Code, Section 14115.8. Effective from July 2011 through December 2011, DHCS did not collect the 2.5 percent on LEA paid claims, effectively increasing LEA reimbursement during this time frame. In January 2012, DHCS reinstated the 2.5 percent withhold on paid claims after the SFY 2011-12 reimbursement met the mandated baseline of $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 suggest 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. Beginning in 2012, the LEA Advisory Committee meetings were reformatted to include collaborative working sessions. The members break into smaller groups to brainstorm challenges and barriers; utilize participants' combined expertise to provide guidance to DHCS; and suggest planning and solutions to LEA issues. In addition, DHCS and the LEA Advisory Committee co-chairs have met in the intervening months between Workgroup Ad Hoc bi-monthly meetings to discuss Workgroup planning and issues, as appropriate.

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

- 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 services beyond transportation in a wheelchair van or litter van.
- Telehealth

Detailed information, including 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 LEA Advisory Committee meetings. DHCS continues to evaluate 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 the LEA Provider Manual throughout 2011 to ensure clarity on LEA policy. The 2011 LEA Provider Manual updates and revisions included updating: Provider Participation Agreement/Annual Report (PPA/AR) requirements, speech-language equivalency practitioner and supervision requirements, maximum allowable rates, clarifying withholds applied to LEA claims, and IEP/IFSP assessment service limitations. • Pending the implementation of SFY 2011-12 interim rates in the claims processing system, DHCS will update the LEA maximum allowable rates and LEA claim submission examples to reflect the new rates. • Continued revisions to the LEA Provider Manual will be published in 2012, as necessary. DHCS will also re-evaluate the content and organization of the LEA Provider Manual sections.
• Monitor LEA claims processing system to ensure claims are reimbursed according to LEA Program policy.	• Continued collaboration with ACS will be on-going in 2012 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 2011, DHCS continued to modify and organize the LEA Program content to ensure that LEA Program information is readily accessible. DHCS added a "Getting Started" link that provides new school districts general program information and information on how to enroll in the LEA Program. In addition, DHCS has started to issue provider PPLs and post them on the website. • The 2011 LEA website maintenance activities included posting the following documents: LEA Advisory Committee meeting minutes; PPA/AR forms; LEA Frequently Asked Questions (FAQs); increased maximum allowable reimbursement rate charts reflecting inflation increases; May 2011 Annual Legislative Report; LEA Program training announcements and presentation materials, and other LEA policy clarification and training. • CRCS-related information was also posted on the website and included the SFY 2009-10 CRCS forms, CRCS submission and deadline requirements, IRUS reports, and CRCS training, announcements and subsequent training materials. DHCS also created a new LEA Program CRCS website with additional CRCS information, announcements, FAQs and links to CRCS trainings. • 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, to reflect changes recommended by the LEA Advisory Committee and increase communication to the LEA provider community regarding LEA Program billing and policy information.

Recommendation	Action Taken/To Be Taken
• Provide LEA Program trainings to the LEA provider community.	• DHCS prepared and sent an LEA training survey to gauge interest in specific training topics for the October 2011 training. This helped DHCS incorporate high priority training topics, as determined by the responses from the training survey. • DHCS conducted an annual LEA Program policy training webinar in October 2011. This training provided LEAs with general information on LEA Program policy and procedures, including revised LEA provider participation requirements; LEA provider billing requirements; reimbursable LEA services; practitioner qualifications; Free Care and OHC requirements; and updates on the CRCS. The webinar was recorded and the training presentation is available on the LEA Program website. • DHCS conducted a webinar training in May 2012 specifically to present updated information regarding the completion of the PPA/AR. Over 300 participants were included in the training, and the FAQS that were generated will soon be answered and posted on the LEA Program website. • DHCS is planning another annual LEA Program training webinar in Fall 2012 to update providers on any LEA Program policy changes.
• Provide LEA CRCS trainings to the LEA provider community.	• In May and June 2011, DHCS conducted three CRCS live trainings (Los Angeles, San Diego and Sacramento), which focused on the following training subjects: 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 was recorded and made available on the LEA Program website. • In Fall 2012, DHCS intends to dedicate a portion of the annual LEA Program training webinar to update LEA providers on the SFY 2010-11 CRCS submission requirements and SFY 2009-10 resubmission process.

Recommendation	Action Taken/To Be Taken
• Improve communications regarding policy issues with LEA providers.	• DHCS continues to prepare LEA Advisory Committee meeting minutes, containing information regarding items discussed during the bi-monthly meetings. The meeting minutes are posted on the LEA Program website. • DHCS continues 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 continues to work 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 this channel to further communicate with LEAs in 2012. • In 2012, DHCS will continue to write PPLs to LEAs in the LEA Program. DHCS will utilize PPLs as a formal notification process to disseminate guidance, information and instruction to the LEAs participating in the LEA Program. These will be sent out to LEA contacts and made available on the LEA Program website. DHCS issued the first PPL regarding Standardized Account Code Structure (SACS) Resource Code 5640 in March 2012. In April 2012, DHCS also issued a PPL regarding the speech-language equivalency SPA.
• 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 CRCS and LEA Program webinar trainings, the LEA PPA/AR, LEA Contact Information Form, and SFY 2008-09 contacts identified in submitted CRCS forms. This list will be further updated and maintained by DHCS with contact information from future training sessions and SFY 2009-10 CRCS information.
• Submit SPAs and subsequent updates to CMS.	• DHCS will continue to work towards submission of future SPAs within a reasonable time frame, as appropriate, subject to CMS policy and timelines.

Recommendation	Action Taken/To Be Taken
• Conduct meetings between DHCS and LEA providers regarding audit procedures.	• In 2012, DHCS intends to continue to support and foster communication with 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 adequate documentation guidance for LEAs that will support billing for LEA Medi-Cal services. • In 2011, DHCS auditors developed appropriate CRCS audit procedures for the reconciliation process. The goal was 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. DHCS attends the LEA Advisory Committee meetings and provides status updates regarding the CRCS updates, audit procedures and review process.
• Update interim reimbursement rates for LEA services per allowances in SPA 03-024.	• In 2011, DHCS finalized rebasing the interim reimbursement rates pursuant to SPA 03-024. DHCS reviewed and analyzed SFY 2007-08 CRCS cost data submitted by LEAs. The LEA Program reimbursement rates have been rebased and inflated to the SFY 2010-11 rate year. These interim rates were implemented August 19, 2011. Rebased rates will be implemented retroactively to SFY 2010-11. The increased reimbursement from the rebased rates will offset the reduced FMAP rates for January through June 2011. DHCS is awaiting the EPC implementation to retroactively adjust for claims with dates of service from July 1, 2010 to August 19, 2011. • In April 2012, DHCS applied an approved inflation adjustment to the SFY 2010-11 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 2012, DHCS will work with ACS to implement the new rate table.

Recommendation	Action Taken/To Be Taken
• Review SB 231 2.5 percent withhold, one percent administrative withhold and Audits and Investigations (A&I) one percent 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. • Beginning September 2011, LEAs started to incur an additional one percent withhold to fund the auditor positions required by A&I to staff the workload for the CRCS reconciliation. The annual amount of the one percent withhold is not to exceed $650,000. The one percent fee is subtracted from the total reimbursement amount on the Medi-Cal RAD. The A&I withhold was intended to be effective July 1, 2011, however, DHCS did not retroactively collect the A&I one percent withhold on claims submitted between July 2011 and September 2011. DHCS monitored and tracked the one percent funding and stopped this withhold in April 2012. • DHCS tracked the LEA Program reimbursement until the total reimbursement exceeded the baseline amount of approximately $60 million, and then initiated the 2.5 percent SB 231 withhold. LEAs were not charged the 2.5 percent SB 231 withhold for the first half of SFY 2011-12. Beginning January 2012, 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. • During 2011 and 2012, DHCS worked extensively with HP/ACS to implement a System Development Notice to automate the collection and stoppage of withholds applied to LEA claims, EPCs and cost settlement. However, due to budgeting constraints and the transition takeover from HP to ACS, DHCS determined that automating the process was not cost-effective. DHCS will continue to monitor and track the withholds and submit policy memos to start and stop the withhold collections manually.

Recommendation	Action Taken/To Be Taken
• Review SB 231 2.5 percent withhold, one percent administrative withhold and A&I one percent withhold applied to cost settlement and EPCs.	• The one percent administrative withhold is not exempt from the CRCS cost settlement and EPC process. However, the SB 231 2.5 percent withhold and A&I one percent withhold should not be applied to the CRCS cost settlement and EPC process. DHCS is currently working with ACS to ensure that the appropriate withholds will not be applied to future cost settlements and EPCs.
• Review of CRCS forms submitted by LEAs and final cost settlements.	• DHCS created a CRCS import application to process and review submitted CRCS reports. The import application reviews CRCS submissions and checks for accuracy, validation and completeness. In 2011, DHCS continued to review and update the import application and the CRCS reports generated for SFYs 2006-07 through 2008-09. These reports assist DHCS in their audit and review. DHCS spent considerable time finalizing the import application, importing the CRCS files and preparing the application to transfer to DHCS. • In 2011 and 2012, DHCS auditors finished conducting pilot audits at targeted LEA school districts to review LEA accounting and financial records to substantiate information submitted on the CRCS. The auditors completed minimal audits on all SFY 2006-07 CRCS submissions in early 2012. DHCS sent CRCS 15-day letters to LEAs in March and April 2012. At the conclusion of the audits, DHCS will issue audit reports to LEAs. DHCS notified LEAs of their audit results via audit reports in May 2012. DHCS will continue to review and finalize reconciliations for SFYs 2007-08 and 2008-09 CRCS submissions in 2012.

Recommendation	Action Taken/To Be Taken
• Review the LEA AR and provide assistance and guidance to LEA providers.	• LEAs are required to submit an AR each year. The AR 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 2010-11 LEA AR, DHCS combined the AR document with the LEA PPA. Originally, LEAs were only required to complete the PPA when the LEA first enrolled as an LEA provider and subsequently submitted an AR. All LEAs will now be required to review the contract requirements to participate in the LEA Program and sign the PPA with the State and complete the AR annually. DHCS also created a flow chart and check list to help LEAs understand roles and responsibilities of LEAs, CDE and DHCS. • In 2011, DHCS and the LEA Advisory Committee reviewed the information requested in the AR and CRCS to determine if the AR can be modified to remove duplicative information. DHCS also reviewed the California Code of Regulations to determine if information could be removed; however at this time, DHCS cannot remove information from the AR because the California Code of Regulations specifies the AR requirements. DHCS has made revisions to simplify the reporting requirements by removing unnecessary attachments and clarified instructions for SFY 2011-12. • DHCS conducted a webinar training in May 2012 to provide guidance, clarification and information to LEA providers to assist in the completion of the PPA/AR and changes to the forms. DHCS announced that its review of the California Code of Regulations (22 CCR § 51270) showed that LEAs must submit a Certification of State Matching Funds on or before October 10, annually with an extension period to November 30, annually.

Recommendation	Action Taken/To Be Taken
• Review SFY 2009-10 CRCS report and instructions to determine the reporting requirements and make changes, as necessary.	• DHCS made changes to the SFY 2009-10 CRCS forms to clarify instructions and ensure reporting consistency across all LEAs. After subsequent review of SFY 2009-10 CRCS instructions, reporting requirements, and sample SFY 2009-10 CRCS forms and corresponding SFY 2008-09 CRCS submissions by LEAs, DHCS identified two reporting issues: 1) The SFY 2009-10 CRCS excluded federal revenues from LEA practitioner expenditures; however, LEAs reported all practitioner full-time equivalents (FTEs) and hours (regardless of whether or not they were federally funded). This diluted the percentage of time estimates for practitioners and understated costs on the CRCS, if the LEA had federally funded expenditures and FTEs. 2) The SFY 2009-10 CRCS instructions specified that LEAs were to report "all qualified practitioners employed by the LEA, regardless of whether or not they provided LEA services to Medi-Cal beneficiaries". The definition of "all qualified" was subject to interpretation. DHCS updated and clarified the instructions to reflect that LEAs should report federally funded FTEs (or portion of FTEs) if their time is not dedicated to the federal program; and report expenditures, FTEs and hours for all qualified district employed practitioners billing LEA reimbursable services in the LEA Medi-Cal Billing Option Program. • DHCS is allowing LEAs the option of resubmitting the SFY 2009-10 CRCS with updated reporting requirements by November 30, 2012, if LEAs determine that the reporting differences related to the two issues are significant to the net overpayment/underpayment. LEAs are not required to resubmit their SFY 2009-10 report. Information was sent to LEA CRCS contacts, using CDE's email distribution lists, posted on the LEA website and announced during the May 2012 training webinar. Regardless of whether or not the LEA opts to resubmit a SFY 2009-10 CRCS, all LEAs must maintain supporting documentation for the information reported on the CRCS form for at least three years from the date of CRCS submission/resubmission. • DHCS will update the CRCS forms for SFY 2010-11 with the same reporting instructions and also to accommodate the three FMAP percentages that were applied during SFY 2010-11 due to the ARRA enhanced FMAP rate.

Recommendation	Action Taken/To Be Taken
• Determine penalty process for LEAs that do not submit CRCS forms timely.	• DHCS implemented penalty policies for LEAs who are non-compliant with CRCS submission requirements for SFY 2009-10 CRCS submissions. DHCS is implementing an initial 20 percent withhold penalty on claims payments, and ultimately LEA Program termination, if LEAs do not submit mandatory annual CRCS forms. • DHCS created a list of LEA CRCS submissions for SFYs 2006-07 through 2009-10. The document is posted on the website so LEAs can verify DHCS received their CRCS forms.
• Identify non-compliant LEAs that have not submitted the annual PPA/AR.	• DHCS identified and reviewed all the submitted PPA/ARs and contacted LEAs if information was incomplete, missing and/or incorrect. In addition, DHCS prepared a list of LEAs that did not submit a PPA/AR, as required, and contacted these LEAs. • DHCS is providing technical assistance to these LEAs to ensure they properly complete and submit their PPA/ARs as required.
• Produce LEA reimbursement reports and post on the LEA website	• In 2011, DHCS was working with ACS to determine the feasibility of providing LEA reimbursement reports to assist LEAs to track reimbursement by procedure code/modifier combinations. The goal is to post the reimbursement reports on the LEA website and allow LEAs to access and download the information online. In 2012, DHCS will continue working with ACS to produce LEA reimbursement reports.

V. ONE-YEAR TIMETABLE FOR STATE PLAN AMENDMENTS

The first SPA after SB 231 was originally submitted to CMS in June 2003, re-submitted in December 2004, and finally approved in March 2005. In October 2010, CMS issued a State Medicaid Director letter which revised the SPA review process and outlined the new procedures for SPA processing to ensure efficiency. In December 2011, CMS approved the speech-language equivalency SPA.

In 2012, DHCS intends to set up a meeting with CMS to discuss other potential new services to expand the LEA Program reimbursable services. Discussions will include the types of new services, qualified practitioners and how to develop interim reimbursement rates. Based on the discussions with CMS, DHCS will prioritize the new services and determine the best approach to open the current SPA to add services.

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 recommended that DHCS not submit the SPA based on expected upcoming CMS regulation changes to school-based reimbursement and services.	• On hold

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 2011, 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.	• DHCS maintains a list of potential LEA services to expand the LEA Program. The list was compiled in collaboration with the LEA Advisory Committee and is being considered and reviewed by DHCS. In addition, DHCS must determine the necessary means to implement specific new services, if a new SPA is required and how to develop interim reimbursement rates. In 2012, DHCS plans to set up a meeting with CMS to discuss adding new service to the LEA Program. • In 2011, DHCS conducted other state interviews to obtain information regarding services offered, practitioner qualifications, reimbursement methodologies and CMS SPA experiences. In addition, DHCS conducted a few interviews with California LEAs to discuss specialized assessments. DHCS will continue to research 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. • In 2012, DHCS will also research school-based and general Medicaid telemedicine and telehealth standards and determine how to implement standards for non-face-to-face LEA services. DHCS will also work with the LEA Advisory Committee and other LEAs to define services, practitioners, supervision and documentation requirements, as necessary.

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 (AG). AB 2837 (Baca, Chapter 581, Statute 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 resubmitted the speech-language equivalency SPA to CMS in September 2011 and it was approved in December 2011. With the approval of 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. Speech-language pathology practitioners with a clinical or rehabilitative services credential in language, speech and hearing or older credential still require supervision in order to bill the LEA Program. • In April 2012, DHCS published PPL #12-008 and updated the LEA Provider Manual with the necessary changes. The PPL and LEA Provider Manual are available on the LEA Program website.

Barriers	Actions Taken /To Be Taken
• Enrollment requirements may hinder new school districts and COEs from enrolling in the LEA Program.	• In 2011, DHCS compared the CDE list of California school districts to the LEA Program participants to identify school districts that are currently not participating in the LEA Program. In addition, DHCS sent out a survey to LEAs to identify if the LEA is part of a billing consortium. The survey helped to identify school districts that are providing LEA services, but billing under another LEA's National Provider Identifier. DHCS has identified 407 non-participating school districts and obtained a list of school superintendent contact information from CDE so DHCS can reach out to these school districts. • In 2012, DHCS will continue to analyze the non-participating school districts by identifying the special education population. DHCS may also identify the school districts participating in the school-based administrative activities program, but not in the LEA Program. • In 2012, DHCS will begin to target non-participating school districts and provide outreach for school districts and COEs that are not claiming Medi-Cal reimbursement. • In addition, DHCS has started analyzing LEA Program reimbursement to determine under-participating LEAs. Outreach may be conducted for those LEAs enrolled in the LEA Program that receive limited reimbursement. Under-participating LEAs may consider expanding the scope of services provided to Medi-Cal eligible students. Additional analyses will be conducted in 2012 to determine which LEAs to target.

Barriers	Actions Taken /To Be Taken
• 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 (LEA Program and CRCS) posted on the LEA Program website. • 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.
• Claims processing issues have been identified and have resulted in LEA claims being incorrectly paid or denied.	• DHCS worked closely with HP/ACS to resolve outstanding claims processing issues. Throughout 2011, DHCS monitored and researched claims processing issues and clarified LEA Program billing policies and requirements for HP/ACS to alter system design to ensure LEA claims were processing properly prior to implementation of system changes. • DHCS determined that the scope of LEA claims billed with procedure codes 92551 and 92552 (non-IEP/IFSP hearing assessments) and IEP/IFSP services modifiers (TM or TL) is immaterial and therefore no claims processing updates will be necessary. DHCS will annually review the claims billed with procedure codes 92551 and 92552 to ensure that that the scope is limited.

Barriers	Actions Taken /To Be Taken
• IEP/IFSP assessment utilization controls are denying legitimate claims.	• LEAs received denials for IEP/IFSP assessment claims with RAD Codes 9921 and 9922. DHCS and HP/ACS 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 September 2011, HP/ACS implemented the necessary changes to the claims processing system to ensure that claims were not erroneously denied. DHCS has planned to implement an EPC to retroactively pay claims between the policy effective date (July 1, 2009) and system implementation date. Due to the transition from HP and ACS, no EPCs have been implemented since ACS' assumption of operations in October 2011. DHCS has submitted early claims placeholders with CMS to ensure that LEAs will be reimbursed for claims with dates of service over the two year claiming limit. • In 2012, DHCS will review the EPC criteria to ensure that RAD Codes 9921and 9922 denials are reprocessed correctly to reimburse legitimate claims and deny improper claims.
• Revise state regulations to be no more restrictive than federal requirements.	• In 2012, DHCS will review the previous work conducted on the development of a proposed regulation package. DHCS will propose revisions to existing State regulations that are required to implement the LEA Rate Study. The regulations will be consistent with SPA 03-024 and SPA 05-010 requirements, existing federal law and regulations, and existing State law. DHCS will discuss a timeline and priorities with Office of Regulations to restart work on the proposed regulations package.

Barriers	Actions Taken /To Be Taken
• Clarify SACS Resource Code 5640 (Medi-Cal Billing Option).	• In 2011, DHCS had discussions with CDE regarding Resource Code 5640. DHCS does not consider LEA Program reimbursement to be restricted federal funds. However, as specified in Education Code, Section 8804(g), LEAs must continue to adhere to the reinvestment requirements for federal funds received through the LEA Program to supplement services for school children and their families. • In March 2012, DHCS issued PPL #12-006 to notify LEAs that SACS Resource Code 5640 revenues are not considered federal income for the purpose of the LEA Program. Effective for the SFY 2009-10 CRCS, LEAs may include allowable expenses funded by Resource Code 5640. • The SFY 2009-10 CRCS instructions were updated to reflect that expenditures classified under Resource Code 5640 are not considered to be restricted federal funds and may be included on the CRCS form.
• AB 114 (Committee on Budget, Chapter 43, Statutes of 2011) eliminated funding for mental health services provided through county mental health agencies.	• In June 2011, AB 114 was signed into law, which ended the state mandate on county mental health agencies to provide mental health services to students with disabilities. As a result, school districts are now solely responsible for ensuring that students with disabilities receive special education and related mental health services in accordance with IDEA. CDE formed a transition workgroup to assist in the transition of mental health services that were provided under AB 3632 (W. Brown, Chapter 1747, Statutes of 1984) to related services under IDEA; evaluate the mental health services; and identify other potential funding sources available. DHCS joined the transition workgroup and assisted to prepare and present LEA Program information to the workgroup. CDE created LEA Program overview handouts and guidance that is posted on their website for potential providers. In 2012, DHCS and CDE will continue to discuss and evaluate mental health services that were provided by county mental health agencies.

Barriers	Actions Taken /To Be Taken
• Authorized signers for electronic claims submission are restricted.	• The LEA Advisory Committee identified an issue regarding the electronic claims submission and who is qualified as the authorized signor. Electronic claims submissions were being held up in the claims processing system or denied. ACS and DHCS' Provider Enrollment Division (PED) discussed the issue and subsequently compiled an expanded list of the various LEA personnel classifications that are qualified as authorized signers. In addition, DHCS also established acceptable classifications based on functional equivalents. ACS has been instructed to implement the list of authorized signers and their equivalents.
• LEA tape match and data release requirements must meet Health Insurance Portability and Accountability Act (HIPAA) requirements.	• Due to HIPAA restrictions, DHCS has been working with its Information Technology Services Division to ensure that the LEA eligibility tape match system effectively produces student eligibility for LEA providers and is HIPAA compliant. In 2012, DHCS will continue working to finalize necessary modifications to the LEA tape match fields and notify LEAs of the changes.

Barriers	Actions Taken /To Be Taken
• CMS Rule 6028 requires practitioners to obtain a National Provider identification (NPI).	• A new CMS rule requires that all ordering, referring and prescribing physicians and other professionals providing Medicaid services must enroll as a Medi-Cal provider and obtain an NPI. Practitioners that only provide services and do not bill Medi-Cal directly (and do not order, refer or prescribe services) are not required to enroll as a provider and obtain an NPI. The targeted date for full implementation of CMS Rule 6028 is January 1, 2013. • In March 2012, DHCS held a Provider Community Stakeholders Session hosted by PED. This was a preliminary informational session that allowed for questions and answers regarding the CMS Rule 6028. • DHCS will continue to work with PED to determine the requirements and impact for LEAs. Additionally, DHCS will work with the LEA Advisory Committee to identify potential barriers to access of care due to CMS Rule 6028. In 2012, DHCS may develop waiver language to exempt LEAs from this requirement since the LEA is the provider and the rendering practitioners work under the LEA's NPI.
• Transition to version 5010 electronic file format and impact on LEAs.	• In January 2009, the Secretary of the federal Department of Health and Human Services published the final rule for Accredited Standards Committee (ASC) X12 version 5010. This is the next HIPAA standard to regulate electronic transmissions of health care transactions. This was supposed to be implemented January 1, 2012, but there have been subsequent delays to implementation and LEAs are currently still allowed to bill on the ASC X12N 4010A1 forms. The projected due date for compliance with version 5010 is June 25, 2012. • DHCS will continue to monitor the federal implementation requirements and notify LEAs about the required deadlines in order to be compliant.

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) 2009 - 2010

		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)
NEBRASKA	68.76%	$ 2,833	$ 38,513	$ 41,346	$ 4,121	$ 77,025	$ 81,146
VERMONT	69.96%	24,346	-	24,346	34,799	-	34,799
RHODE ISLAND	63.92%	22,339	5,000	27,339	34,948	9,999	44,948
WEST VIRGINIA	83.05%	48,341	-	48,341	58,207	-	58,207
PENNSYLVANIA	65.85%	145,982	33,366	179,348	221,689	66,731	288,420
DELAWARE	61.78%	13,266	-	13,266	21,473	-	21,473
MASSACHUSETTS	61.59%	41,100	31,364	72,464	66,732	62,728	129,460
IOWA	72.55%	36,819	-	36,819	50,749	-	50,749
MICHIGAN	73.27%	136,523	8,333	144,856	186,329	16,666	202,995
ILLINOIS	61.88%	89,808	58,476	148,283	145,132	116,951	262,083
NEW JERSEY	61.59%	58,000	2,500	60,500	94,171	5,000	99,171
KANSAS	69.68%	16,962	2,907	19,870	24,343	5,815	30,158
MARYLAND	61.59%	13,159	25,980	39,139	21,365	51,961	73,326
MINNESOTA	61.59%	34,041	-	34,041	55,270	-	55,270
WISCONSIN	70.63%	26,430	10,619	37,049	37,420	21,238	58,658
MISSOURI	74.43%	4,137	32,523	36,660	5,559	65,046	70,605
CALIFORNIA	61.59%	130,427	158,832	289,259	211,766	317,664	529,431
FLORIDA [5]	67.64%	12,217	64,447	76,664	18,062	128,894	146,955
ARKANSAS	81.18%	15,912	10,320	26,231	19,601	20,639	40,240
MONTANA	77.99%	3,218	1,250	4,468	4,126	2,499	6,626
VIRGINIA	61.59%	8,645	9,955	18,600	14,036	19,910	33,946
KENTUCKY	80.14%	3,800	11,589	15,389	4,742	23,178	27,919
COLORADO	61.59%	9,447	991	10,438	15,339	1,981	17,320
LOUISIANA	81.48%	27,293	1,791	29,084	33,497	3,581	37,078
MISSISSIPPI	84.86%	-	8,987	8,987	-	17,974	17,974
NORTH CAROLINA	74.98%	12,297	18,241	30,538	16,400	36,482	52,882
ARIZONA	75.93%	21,544	4,016	25,560	28,374	8,031	36,405
OHIO	73.47%	28,300	-	28,300	38,519	-	38,519
NEVADA	63.93%	2,021	-	2,021	3,161	-	3,161
GEORGIA	74.96%	16,148	-	16,148	21,542	-	21,542
OKLAHOMA	76.73%	5,218	-	5,218	6,801	-	6,801
INDIANA	75.69%	3,982	-	3,982	5,261	-	5,261
MAINE [4]	74.86%	-	-	-	-	-	-
TENNESSEE [4]	75.37%	-	-	-	-	-	-
WASHINGTON [4]	62.94%	-	-	-	-	-	-
WYOMING [4]	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) This state did not have a school-based Medicaid health services program or administrative claiming program in effect during SFY 2009-10 and/or SFY 2010-11.

(5) Health service figures from Florida were compiled from the Florida Agency for Healthcare Administration website (http://ahca.myflorida.com/medicaid/childhealthservices/schools/index.shtml) where online Fee-for-Service School Certified Match Reimbursement Reports are updated quarterly

Appendix 1(b): Medicaid Reimbursement And Claims By State
Ranked By Average Claim Per Medicaid-Eligible Child, State Fiscal Year (SFY) 2009-2010

			SFY 2010 - 2011					
			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)
NEBRASKA		65.84%	$ 3,073	$ 22,931	$ 26,005	$ 4,668	$ 45,863	$ 50,530
VERMONT		67.13%	26,122	-	26,122	38,912	-	38,912
RHODE ISLAND	4	61.39%	-	-	-	-	-	-
WEST VIRGINIA		80.23%	50,540	-	50,540	62,994	-	62,994
PENNSYLVANIA		63.76%	134,865	31,110	165,975	211,519	62,220	273,740
DELAWARE		61.55%	12,060	-	12,060	19,594	-	19,594
MASSACHUSETTS	4	58.77%	-	-	-	-	-	-
IOWA	4	69.68%	-	-	-	-	-	-
MICHIGAN		72.74%	121,803	6,698	128,501	167,450	13,397	180,846
ILLINOIS		59.05%	103,581	62,566	166,147	175,413	125,132	300,545
NEW JERSEY		58.77%	62,000	2,500	64,500	105,496	5,000	110,496
KANSAS	4	66.81%	-	-	-	-	-	-
MARYLAND		58.77%	15,575	-	15,575	26,502	-	26,502
MINNESOTA	4	58.77%	-	-	-	-	-	-
WISCONSIN		67.80%	32,569	1,212	33,782	48,037	2,424	50,462
MISSOURI	4	71.61%	-	-	-	-	-	-
CALIFORNIA		58.77%	146,516	101,604	248,120	249,304	203,208	452,511
FLORIDA	6	64.81%	16,281	-	16,281	25,121	-	25,121
ARKANSAS	4	78.30%	-	-	-	-	-	-
MONTANA	4	75.17%	-	-	-	-	-	-
VIRGINIA	4	58.77%	-	-	-	-	-	-
KENTUCKY		77.78%	4,414	5,102	9,516	5,675	10,203	15,878
COLORADO		58.77%	-	1,052	1,052	-	2,105	2,105
LOUISIANA		78.65%	29,007	479	29,486	36,881	959	37,840
MISSISSIPPI		82.03%	-	1,783	1,783	-	3,566	3,566
NORTH CAROLINA		72.16%	11,499	18,804	30,303	15,936	37,608	53,544
ARIZONA		73.10%	28,866	2,687	31,553	39,488	5,374	44,863
OHIO		70.88%	25,600	-	25,600	36,117	-	36,117
NEVADA		61.10%	402	-	402	658	-	658
GEORGIA	4	72.33%	-	-	-	-	-	-
OKLAHOMA		73.90%	4,485	-	4,485	6,068	-	6,068
INDIANA		73.39%	4,164	-	4,164	5,674	-	5,674
MAINE	5	72.03%	-	-	-	-	-	-
TENNESSEE	5	72.79%	-	-	-	-	-	-
WASHINGTON	5	60.11%	-	-	-	-	-	-
WYOMING	5	58.77%	-	-	-	-	-	-

(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 June 3, 2011.

(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 2010-11.

(5) This state did not have a school-based Medicaid health services program or administrative claiming program in effect during SFY 2009-10 and/or SFY 2010-11.

(6) Health service figures from Florida were compiled from the Florida Agency for Healthcare Administration website (http://ahca.myflorida.com/medicaid/childhealthservices/schools/index.shtml) where online Fee-for-Service School Certified Match Reimbursement Reports are updated quarterly

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

Service	Qualified Provider(s)	Example Rates
Behavioral services provided by a behavioral aide Behavioral aide services prevent or correct maladaptive behavior on the part of the child. The interventions are used to change specific behaviors. A behavioral plan is designed by a mental health professional and carried out by behavioral aides. The plan provides a description of the behavior to be addressed and positive or negative incentives to encourage appropriate behavior.	**Mental health behavioral aide** A paraprofessional working under the direction of a mental health professional.	**Iowa:** $10.20 per 15-minute increment $4.95 per group session **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: $4.95 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.	**Licensed Dentist** A person who is a licensed dentist. **Dental hygienist** A person who is a licensed dental hygienist.	**Oklahoma:** Dentist, $22.06 **Delaware:** Dental Hygienist, $15.57 for 0-29 minutes; $31.14 for 30-44 minutes; $46.71 for 45-59 minutes; $62.29 for over 60 minutes
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:** $3.97 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.
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:** $3.50 per 15-minute increment.

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

Service	Qualified Provider(s)	Example Rates
Services for children with speech and language disorders provided by a speech-language pathology assistant Services rendered to a child to treat speech and language disorders of verbal and written language, articulation, voice, fluency, phonology, and mastication.	**Speech-language pathology assistant** A person who meets state requirements for a speech-language pathology assistant and works under the direction of a qualified speech pathologist.	Most states do not have separate rates for speech therapy services provided by speech pathologists and speech-language pathology assistants. The rate listed below applies to speech-language pathology assistants only. **Florida:** Individual: $13.58 per 15-minute increment. Group: $2.60 per 15-minute increment.
Specialized transportation Transportation in a vehicle adapted to serve the needs of the disabled to and from school when the child receives a Medicaid-covered service in school and when transportation is specifically listed in the IEP or IFSP as a required service. Transportation from the school to a provider in the community also may be billed to Medicaid. (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:** School rate: $7.92 – $21.69 per day based on county. Pre-school rate: $14.21 – $36.50 per day based on county. In Michigan and New York, providers may not bill separately for an attendant.