
Local Educational Agency Medi-Cal Billing Option Program

Report to the Legislature, May 2010

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EXECUTIVE SUMMARY

Schools nationwide play a critical role in providing health services to students, particularly those requiring special education services. For many schools, federal Medicaid reimbursements are a crucial source of revenues in providing necessary health services to students. Under the Local Educational Agency (LEA) Medi-Cal Billing Option Program (LEA Program), California's school districts and County Offices of Education (COE) are reimbursed by the federal government for health services provided to Medi-Cal eligible students. A report published by the United States General Accounting Office (GAO)¹ in April 2000 estimated that California ranked in the bottom quartile, with respect to the average claim per Medicaid-eligible child, of states with school-based Medicaid programs. Senate Bill 231 (SB 231) was signed into law in October 2001 to reduce the gap in per child recovery for Medicaid school-based reimbursements between California and the three states recovering the most per child from the federal government. SB 231 was reauthorized in Assembly Bill 1540 (AB 1540) in October 2009.

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

Since SB 231 was originally chaptered into law, federal oversight of school-based programs by the Centers for Medicare and Medicaid Services (CMS) and its audit agency, the Office of the Inspector General (OIG), has significantly increased. OIG audits of Medicaid school-based programs in twenty-three states have identified millions of dollars in federal disallowances for services provided in schools. "Free Care" and "Other Health Coverage"

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

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(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 students². In addition, the federal government continues to move towards a more restrictive stance in light of the on-going federal budget deficit. In December 2007, CMS published CMS-2287-F, the final rule to eliminate Medicaid reimbursement for school administration expenditures (administrative claiming) and costs related to transportation of school-age children between home and school. CMS also issued CMS-2237-IFC, an interim final rule related to case management services that clarifies when Medicaid will reimburse for case management activities. Subject to Obama Administration orders and the American Recovery and Reinvestment Act (ARRA) of 2009, both CMS rules were placed on moratorium in State Fiscal Year (SFY) 2008-09; finally, CMS rescinded the Medicaid rules in June 2009. Despite these developments, important progress towards accomplishing the goals of SB 231 continued in 2009.

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

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

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

Fiscal Year	Total Medi-Cal Reimbursement	Percentage Change from SFY 2000-01
SFY 2000-01	\$59.6 million	N/A
SFY 2001-02	\$67.9 million	14%
SFY 2002-03	\$92.2 million	55%
SFY 2003-04	\$90.9 million	53%
SFY 2004-05	\$63.9 million	7%
SFY 2005-06	\$63.6 million	7%
SFY 2006-07 ⁽¹⁾	\$69.5 million	17%
SFY 2007-08 ⁽²⁾	\$81.2 million	36%

Notes:

⁽¹⁾ SFY 2006-07 total Medi-Cal reimbursement is based on date of service and updated to reflect paid claims after Erroneous Payment Corrections (EPCs) were implemented in SFY 2007-08 and 2008-09 for LEA services to correct previous claims processing errors that were incorrectly paid and denied in SFY 2006-07. This amount includes claims paid at the “basic rate” and the increased reimbursement LEAs received due to the rate inflator.

⁽²⁾ SFY 2007-08 total Medi-Cal reimbursement is based on date of service and updated to reflect paid claims after EPCs were implemented in SFY 2007-08 and 2008-09 for LEA services to correct previous claims processing errors that were incorrectly paid and denied in SFY 2007-08. 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 State Plan Amendment (SPA) prepared as a result of SB 231 was approved in March 2005. This substantially increased both treatment and assessment reimbursement rates for most LEA practitioner services provided to California’s children in a school-based setting. New LEA assessment and treatment rates were systematically implemented on July 1, 2006. Subsequent to implementation, DHCS and the LEA Ad-Hoc Workgroup Advisory Committee (LEA Advisory Committee) identified substantial claims processing issues that had erroneously denied payment for legitimate LEA claims, as well as underpaid or overpaid LEAs for claims submitted since SFY 2006-07. DHCS, Fiscal Intermediary and Contracts Oversight Division (FI-COD) and Electronic Data Systems, now Hewlett Packard (HP), collaborated during SFYs 2006-07, 2007-08 and 2008-09 to correct the system errors. As of SFY 2009-10, HP has completed the necessary

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Erroneous Payment Corrections (EPCs) for all identified claims processing issues. After the claims processing issues were corrected, DHCS was able to apply retroactive inflators to the SPA 03-024 interim reimbursement rates, subsequently increasing reimbursement.

The LEA Advisory Committee was originally organized in early 2001. Regular LEA Advisory Committee meetings, currently conducted every other month, assist to identify barriers for both existing and potential LEA providers, and have resulted in recommended new services to be considered for 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 enhancements to the LEA Program website and other communication venues, in order to improve LEA provider communication and address relevant provider issues.

Due to the substantial work involving claims processing error fixes and Cost and Reimbursement Comparison Schedule (CRCS) implementation throughout 2009, research on new services has been postponed until 2010. DHCS re-submitted SPA 05-010 to CMS in September 2008 after the California Commission on Teacher Credentialing (CCTC) and the California Speech-Language Hearing Association (CSHA), with assistance from DHCS, established equivalency for a credentialed speech language pathologist as a “speech pathologist” under the federal standard. The California Attorney General (AG) opinion in 2006 concluded that State credentialing requirements were equivalent to federal standards. SPA 05-010 is currently on hold. Once CMS reviews the AG opinion and approves the SPA equivalency language, speech-language pathology practitioners with preliminary or professional clear services credentials in speech-language pathology will no longer require supervision when providing services to Medi-Cal eligible children. In addition, practitioners with professional clear services credentials in speech-language pathology will be qualified to provide supervision to other credentialed speech-language pathologists providing LEA services. This equivalency will be implemented subject to the SPA and regulations approval process.

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In addition, DHCS accomplished the following in 2009: assisted FI-COD and HP in identifying and resolving claims processing issues that resulted from technical claims processing system changes; revised the Medi-Cal Provider Manual sections specific to LEA services (LEA Provider Manual), as necessary; developed audit protocols in conjunction with DHCS Audits and Investigations (A&I); discussed Certified Public Expenditure (CPE) cost settlement requirements with CMS; conducted an LEA training videoconference and two CRCS webinar presentations; and finalized and implemented the first LEA CRCS form submission and review of submitted CRCS forms for the SFY 2006-07 and 2007-08 rate years.

Additional SPAs may be developed and submitted to CMS in 2010 and beyond, along with the requisite and supportive analysis, studies, fieldwork, provider training, CMS negotiation and other due diligence required to successfully expand the LEA Program.

The work completed in 2009 has largely been due to the positive and on-going relationship between DHCS and the many officials of school districts, COE, the California Department of Education (CDE) and professional associations representing LEA services who have participated in the LEA Advisory Committee.

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I. INTRODUCTION

Under the LEA Program, California's school districts and COE are reimbursed by the federal government for health services provided to Medi-Cal eligible students. The report published by the United States GAO in April 2000 estimated that California ranked in the bottom quartile, with respect to the average claim per Medicaid-eligible child, of states with school-based programs³. To reduce the gap in per child recovery for Medicaid school-based reimbursements between California and the three states recovering the most per child from the federal government, SB 231 was signed into law in October 2001 and reauthorized in AB 1540 in October 2009.

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

- Amend the Medicaid state plan with respect to the LEA Program to ensure that schools shall be reimbursed for all eligible school-based services that they provide that are not precluded by federal law;
- Examine methodologies for increasing school participation in the LEA Program;
- Simplify, to the extent possible, claiming processes for LEA Program billing;
- Eliminate and modify state plan and regulatory requirements that exceed federal requirements when they are unnecessary;
- Implement recommendations from the LEA Program rate study (LEA Rate Study) to the extent feasible and appropriate⁴;

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

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

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- Consult regularly with CDE, representatives of urban, rural, large and small school districts, and COE, the Local Education Consortium (LEC), LEAs and the LEA technical assistance project⁵;
- Consult with staff from Region IX of CMS, experts from the fields of both health and education, and state legislative staff;
- Undertake necessary activities to ensure that an LEA shall be reimbursed retroactively for the maximum period allowed by the federal government for any department change that results in an increase in reimbursement to LEAs;
- Encourage improved communications with the federal government, the CDE, and LEAs;
- Develop and update written guidelines to LEAs regarding best practices to avoid audit exceptions, as needed;
- Establish and maintain an LEA friendly interactive website; and
- File an annual report with the Legislature. The annual report requirements and corresponding sections in this report are summarized in Table 1 on the following page.

⁵ The LEA technical assistance project disbanded in 2002.

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Table 1: Annual Legislative Report Requirements

Report Section	Report Requirements
III	<ul style="list-style-type: none"> • 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 providers⁶ 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	<ul style="list-style-type: none"> • 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, and COE, the LEC, LEAs, the LEA technical assistance project⁷, staff from Region IX of CMS, experts from the fields of both health and education, and state legislative staff.
V	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 COE that have enrolled in the LEA Program.

⁷ The LEA technical assistance project disbanded in 2002.

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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 fund the state share of Medicaid expenditures through a 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

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- 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 2009-10, the OIG released four audit reports related to school-based health services in the states of Arizona, Missouri, New Jersey and West Virginia. The total number of states with audit reports issued on school-based health services since October 2001 has now increased to twenty-three. These reports were part of a series in a multi-state initiative to review costs claimed for Medicaid school-based health services. Reported school-based health service findings have resulted in millions of dollars in alleged overpayments to schools, which include:

- Insufficient documentation of services;
- Claims submitted for services provided by unqualified personnel;
- Inadequate referral and/or prescription for applicable services;
- Violation of Free Care requirements;
- Insufficient rate-setting methodologies;
- Non-compliance with the state plan;
- Inadequate and/or incorrect policy manuals;
- Inadequate third-party program administrators; and
- Lack of State-level oversight of federal guidelines.

In May 2003, CMS issued a final guide on Medicaid school-based administrative claiming. The guide clarified and consolidated requirements for administrative claiming. In addition, CMS noted in its distribution letter that the guide "...is one of several publications we are issuing on Medicaid claiming for school-based health programs. In the future, we propose to

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publish additional guidance on payment for specialized transportation, as well as an addendum to the 1997 guide, 'Medicaid and School Health: A Technical Assistance Guide'⁸, that will address such issues as IEP services, state plan requirements, documentation for services, and rate setting." CMS still has yet to publish additional guidance on these issues.

In December 2007, CMS issued a final rule (CMS-2287-F) eliminating Medicaid reimbursement for school administration expenditures (administrative claiming) and costs related to transportation of school-age children between home and school. CMS indicated in the final rule that these activities are not necessary for the proper and efficient administration of the Medicaid State Plan. In addition, CMS noted that transportation from home to school and back is not within the scope of the optional medical transportation benefit. In mid-2008 a moratorium was placed on CMS' ability to enforce the new rules. The February 13, 2009 passage of the ARRA of 2009 also extended the moratorium to June 30, 2009. In June 2009, CMS finally rescinded the rules.

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

As part of the ARRA of 2009, the federal government approved a 6.2 percent Federal Medical Assistance Percentage (FMAP) increase to all states and territories. Effective October 2008, the California FMAP increased from 50 percent to 61.59 percent which provides higher federal match funding for the LEA Program. The FMAP increase will continue at an increased 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, currently defined as October 1, 2008 through December 31,

⁸ This publication provides guidelines for school-based health services programs.

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2010. Currently, House Resolution (HR) 4213 proposes to allow the ARRA increased FMAP rates to continue for another six months through June 30, 2011. On May 28, 2010 the House of Representatives passed HR 4213 omitting the provision for extended enhanced FMAP. As of June 7, 2010, the US Senate is expected to vote on HR 4213 and is considering reinstating the extended enhanced FMAP provision. Since the LEA Program is a local-federal match program, the extended enhanced FMAP would result in additional funding for LEA providers in California.

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III. OTHER STATES' SCHOOL-BASED MEDICAID PROGRAMS

The annual survey of other states' school-based Medicaid programs was conducted to compare California's school-based programs to other states' programs. The responses obtained from the survey were supplemented by reviewing provider manuals and other sources of program information. In addition, a comparison of school-based Medicaid systems in comparable states was conducted using annual survey data.

School-Based Medicaid Systems in Comparable States

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

Table 2: Factors Considered in Selecting Comparable States

Factor	Source of Information
Number of Medicaid-eligible children aged 6 to 20	Medicaid Program Statistics, Federal Fiscal Year (FFY) 2006-07, CMS
Number of IDEA eligible children aged 3 to 21	U.S. Department of Education, Office of Special Education Programs Data Accountability Center (DAC), Data Analysis System (DANS), OMB #1820-0043: "Children with Disabilities Receiving Special Education Under Part B of the Individuals with Disabilities Education Act," 2006.
Average salaries of instructional staff (classroom teachers, principals, supervisors, librarians, guidance and psychological personnel, and related instructional staff)	Rankings of the States 2009 and Estimates of School Statistics 2010, National Education Association (NEA), December 2009
Per capita personal income	Rankings of the States 2009 and Estimates of School Statistics 2010, NEA, December 2009

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The number of Medicaid-eligible and IDEA eligible children provide a measure of the number of students that may be qualified for Medicaid school-based services. The average salaries of instructional staff and per-capita personal income provide a comparison of the cost of living between states. The ten states with the greatest number of Medicaid-eligible children aged 6 through 20 were identified. Each of these states was ranked from highest to lowest based on each of the four factors. From this analysis, four states were selected as comparable to California: New York, Illinois, Pennsylvania, and Michigan. Although three states (Texas, Florida, and Ohio) had greater numbers of Medicaid-eligible children than two of the selected comparable states (Pennsylvania and Michigan), they were not selected as comparable states, since their cost of living measures were substantially lower than California. In addition, Ohio's school-based services claiming program ended in June 2005; as of Spring 2009, Ohio is in the process of implementing their new SPA (approved by CMS August 2008 and retroactive to July 2005) and Medicaid School Program (MSP).

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

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

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appropriate fiscal year on the CRCS forms. Costs will be reconciled to Medi-Cal reimbursement to ensure that each LEA provider is not paid more than the costs of providing these services. The reconciliation results in a difference owed to or from the LEA; underpayments will be paid to LEAs and overpayments will be withheld from future LEA reimbursement. Finally, the LEA providers will certify that the public funds expended for LEA services provided are eligible for FFP. The first cost certification by LEAs for the SFY 2006-07 was scheduled to be due on November 30, 2007, however, the deadline was delayed until claims processing issues were resolved to ensure that accurate Medi-Cal reimbursement and units of service data is available for the reconciliation process. This delay subsequently postponed the SFY 2007-08 CRCS deadline as well. In Fall 2009, HP was able to furnish an Interim Reimbursement and Units of Service Report for SFY 2006-07 and 2007-08 to all LEAs who received Medi-Cal reimbursement in the respective fiscal years. This report summarizes total units and reimbursement information by LEA service and practitioner type. The revised submission deadline for the CRCS reports for SFY 2006-07 and 2007-08 was October 30, 2009. DHCS is currently working with LEAs to assist to identify errors that require LEA review and correction prior to DHCS accepting the CRCS as complete. The SFY 2008-09 CRCS will be due on November 30, 2010.

In comparison to California's LEA Program, the LEA-specific rates in Illinois and Pennsylvania are developed based on each provider's actual costs on an annual basis, and no reconciliation is made at fiscal year end. New York reimburses school providers based on statewide rates, and currently does not require annual cost reconciliation. Pursuant to a CMS mandate, Michigan has developed a fee-for-service rate methodology for its school-based services. Michigan's interim payments are calculated based on an estimated monthly reimbursement cost formula, which utilizes prior year costs plus any inflation or program changes. Interim monthly payments are reconciled on an annual basis to the current year costs (July 1 through June 30 of each year). Within 18 months after the school fiscal year end, Michigan

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will review, certify and finalize the Medicaid expenditure report which begins the final settlement process.

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

Administration of the seventh state survey began in January 2010. States were contacted to update information provided in the 2008 survey; states that did not participate in 2008 were given the opportunity to complete the current survey. Follow-up contacts were made during Winter 2010 to states that had not responded to the survey. Some states indicated that they were unable to complete the survey on a timely basis due to a variety of reasons, such as unconfirmed reimbursement totals and internal auditing issues; several states did not respond to follow-ups. 30 of 45 states contacted completed the survey, including three states that did not participate in 2008 and one state that had not participated in any previous DHCS survey. One of the survey respondents did not provide updated reimbursement figures for SFY 2007-08.

Table 3 summarizes Medicaid reimbursement (federal share) for health services and administrative services for SFY 2007-08⁹ and 2008-09. Several states did not have finalized data available for both SFYs. Federal Medicaid reimbursement was divided by each state's FFP rate to estimate total claim dollars. Total claim dollars were divided by the number of Medicaid-eligible children aged 6 through 20 to estimate the average claim amount per Medicaid-eligible child. Additional supportive information for Table 3 is provided in Appendices 1(a) and 1(b).

In the April 2000 GAO Report, Maryland had the highest average claim per Medicaid-eligible child of \$818¹⁰, while California's average claim was \$19, a difference of \$799. A comparison of the average claim in the April 2000 report published by the GAO to the SFY

⁹ A few states adjusted Medicaid reimbursement for SFY 2007-08 provided in their 2009 survey; the adjusted amounts are reflected in Table 3.

¹⁰ Based on SFY 2004-05 data, Maryland had an average claim per Medicaid-eligible child of \$358. Maryland did not participate in the 2009 survey to update Medicaid reimbursement for health and administrative services.

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2007-08 average claim per Medicaid-eligible child in Table 3 shows an increase in 27 of the 38 states that reported federal reimbursement (including California). The average claim decreased in eleven states.

In the 2008-09 state survey, Vermont had the highest average SFY 2007-08 claim of \$760, while California's average claim was \$121, a difference of \$639. The decrease in California's average claim is likely due to several factors: LEAs continuing to comply with Free Care and OHC requirements mandated by CMS; strict billing procedures to eliminate certain billing practices for health services; and confusion related to the CMS moratoriums on elimination of transportation and Targeted Case Management services. In addition, it is significant that the federal revenues from administrative activities claimed in the California MAA Program decreased from \$113.8 million in SFY 2006-07 to \$111.2 million in SFY 2007-08 and \$70.9 million in SFY 2008-09. This substantially skewed the total expenditures per eligible child downward for FY 2008-09, when, in fact, the LEA Medi-Cal Billing Option Program expenditures increased from FY 2007-08 by 28 percent.

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

State	SFY 2007-2008 ⁽¹⁾			SFY 2008-2009 ⁽¹⁾		
	Federal Medicaid Reimbursement (000's)	Estimated Total Claim Dollars (000's)	Average Claim Per Medicaid-Eligible Child ⁽²⁾	Federal Medicaid Reimbursement (000's)	Estimated Total Claim Dollars (000's)	Average Claim Per Medicaid-Eligible Child ⁽²⁾
VERMONT	\$ 21,487	\$ 36,399	\$ 760	\$ 24,005	\$ 35,453	\$ 740
NEBRASKA	32,788	64,741	666	26,852	52,316	538
MASSACHUSETTS	³ 116,346	232,692	609	-	-	-
RHODE ISLAND	³ 20,778	39,986	547	-	-	-
DELAWARE	³ 15,088	30,175	536	-	-	-
WEST VIRGINIA	38,313	51,599	389	42,234	52,497	395
PENNSYLVANIA	141,629	265,890	372	152,300	253,311	355
IDAHO	³ 21,216	30,366	328	-	-	-
MICHIGAN	³ 133,882	236,340	322	-	-	-
UTAH	14,298	22,142	273	17,227	23,806	294
KANSAS	³ 18,224	31,812	261	-	-	-
ILLINOIS	117,757	235,514	257	133,361	239,439	261
NEW YORK	147,162	294,324	235	79,680	135,557	108
WISCONSIN	39,621	68,762	217	55,855	86,448	273
CONNECTICUT	19,020	38,040	208	21,790	36,202	198
MINNESOTA	³ 22,147	44,295	168	-	-	-
IOWA	15,154	24,548	153	23,747	34,506	215
OREGON	³ 12,465	24,930	151	-	-	-
VIRGINIA	24,543	49,086	149	21,541	40,131	122
ALASKA	4,010	7,994	149	467	795	15
MONTANA	3,099	5,204	140	3,514	5,288	143
FLORIDA	64,392	126,322	133	75,286	145,552	154
MISSOURI	26,497	51,434	128	24,541	46,946	117
CALIFORNIA	192,454	384,908	121	174,783	310,462	98
NORTH DAKOTA	³ 1,466	2,300	105	-	-	-
KENTUCKY	16,717	31,611	104	4,250	6,023	20
ARKANSAS	18,735	30,763	99	24,785	37,864	121
ARIZONA	26,730	43,966	97	26,161	37,156	82
COLORADO	8,921	17,842	96	9,220	15,686	84
ALABAMA	14,285	28,374	94	18,284	36,264	120
NORTH CAROLINA	25,630	46,675	83	27,504	48,737	87
NEW MEXICO	9,757	14,802	71	10,382	15,379	74
WASHINGTON	15,410	30,524	69	16,626	31,217	70
MISSISSIPPI	8,013	15,391	62	7,808	14,881	60
NEVADA	1,228	2,334	29	1,775	2,777	34
OKLAHOMA	4,048	6,033	19	4,286	5,719	18
HAWAII	326	577	8	314	476	6
INDIANA	1,202	1,978	5	2,227	3,041	7
GEORGIA	⁴ -	-	-	-	-	-
OHIO	⁴ -	-	-	-	-	-
TENNESSEE	⁴ -	-	-	-	-	-
WYOMING	⁴ -	-	-	-	-	-

(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) 2006-07.

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

(3) Federal reimbursement in SFY 2008-09 for this state's health services program and/or administrative claiming program was not available.

(4) This state did not have a school-based Medicaid health services program or administrative claiming program during SFY 2007-2008 or SFY 2008-09.

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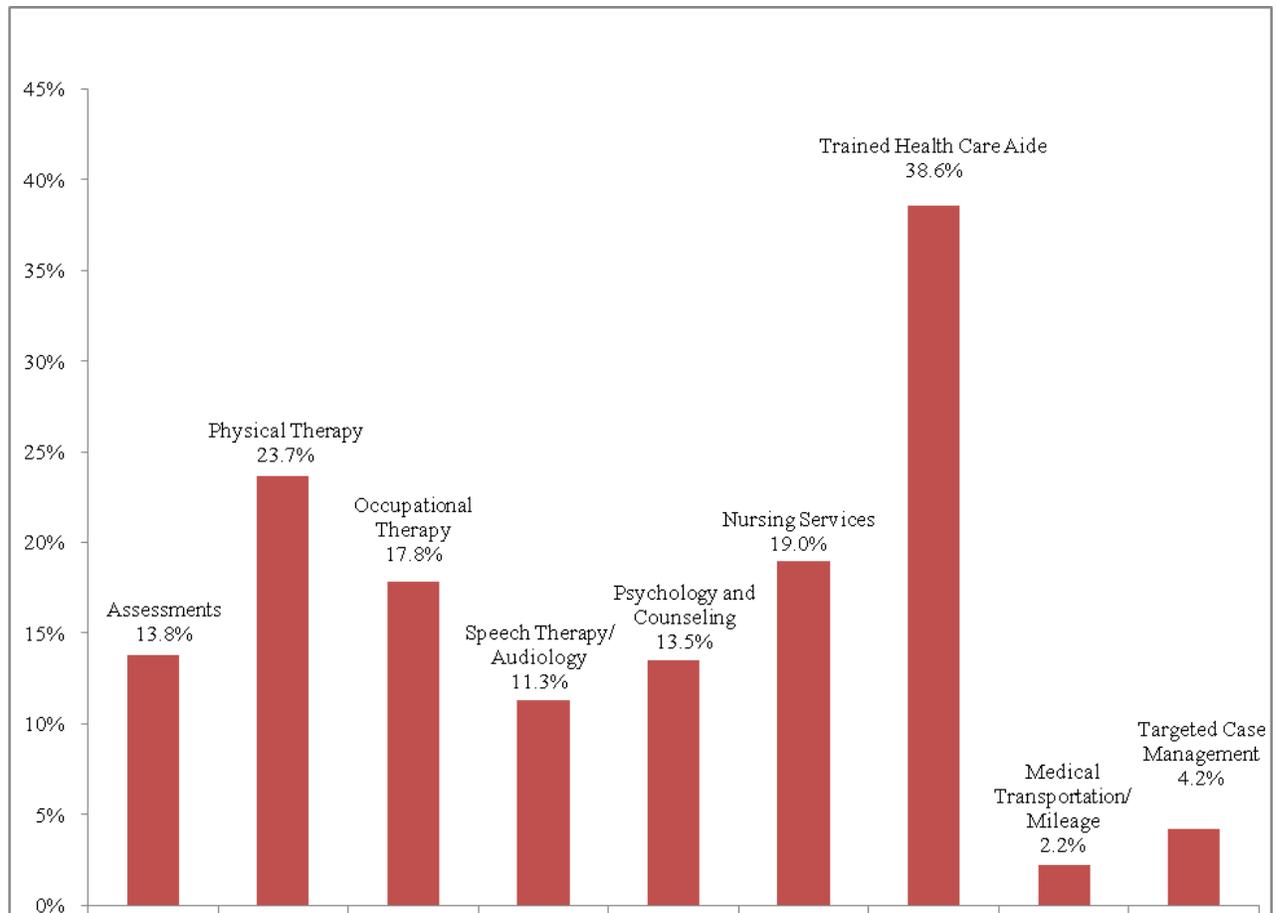
It should be noted that these survey results do not reflect any past, current or expected adjustments due to prior or on-going OIG or CMS investigations or audits in any state.

Summary of Departmental Activities

Since the passage of SB 231, Medi-Cal reimbursement in the LEA Program has increased by 36 percent, growing from \$59.6 million in SFY 2000-01 to \$81.2 million in SFY 2007-08. LEA services may be classified into nine service types: assessments; physical therapy; occupational therapy; speech therapy and audiology; psychology and counseling; nursing services; trained health care aide; medical transportation and mileage; and Targeted Case Management (TCM). As indicated in Figure 1, percentage increases in service type reimbursement between SFYs 2006-07 and 2007-08 vary from an increase of 2.2 percent (medical transportation/mileage) to an increase of 38.6 percent (trained health care aide services). The lower percent increase in TCM likely reflects changes in billing due to the CMS interim final rule (CMS-2237-IFC with comment period) regarding targeted case management that was rescinded as of June 2009.

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Figure 1: Percentage Change In Reimbursement By Service Type, SFYs 2006-07 Through 2007-08



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

- **Resolution of Claims Processing Issues**

FI-COD and HP implemented the HIPAA-compliant national codes on July 1, 2006, contributing to updated reimbursement rates and policy changes related to modifiers, qualified practitioner types, maximum units of services and general utilization controls for the LEA Program. Much focus during SFY 2007-08 and 2008-09 was related to the continued resolution of claims processing errors that occurred post-implementation of SPA 03-024. Claims processing issues were identified by DHCS,

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the LEA Advisory Committee, FI-COD and HP. DHCS has worked extensively to resolve multiple claims processing issues after implementation of the new national codes. Billing system issues resulted in LEA claims being erroneously overpaid, underpaid or denied. Many of the issues were related to the complexity of system coding required to distinguish the multiple procedure code and modifier combinations. Each procedure code and modifier combination distinguishes the specific LEA service type, rendering practitioner, reimbursement rate and utilization control. As of March 2009, all of the identified issues have been corrected in the claims processing system. Throughout 2008 and 2009, HP implemented various EPCs that automatically reprocessed LEA claims and adjusted LEA reimbursements to the appropriate payment amount.

- **Rate Inflatons**

As specified in SPA 03-024, DHCS is required to annually adjust LEA reimbursement rates for IEP/IFSP assessments and treatment services, and non-IEP/IFSP assessments and treatment services using the Implicit Price Deflator, which is published by the U.S. Department of Commerce. As of SFY 2008-09, the LEA Program rates had not been adjusted from the originally implemented SFY 2003-04 rates due to the on-going claims processing issues. Reimbursement rates were inflated and implemented in the claims processing system for SFY 2006-07 and 2007-08 in May 2009. SFY 2006-07 rates were inflated by 17.3 percent from the original SFY 2003-04 rates. The SFY 2006-07 rates were subsequently inflated an additional 5.88 percent for SFY 2007-08 rates. These SFY 2007-08 rates were inflated by 3.04 percent for SFY 2008-09, and implemented in August 2009. In April 2010, HP implemented SFY 2009-10 rates (increasing SFY 2008-09 rates by 0.9 percent). These rates are the current reimbursement rates LEAs receive until DHCS either implements SFY 2010-11 inflation, or rebases the original rates.

- **Cost and Reimbursement Comparison Schedule**

The original CRCS submission date was November 30, 2007 for the SFY 2006-07 CRCS and November 30, 2008 for SFY 2007-08. As noted, DHCS has delayed the SFY 2006-07 and SFY 2007-08 CRCS deadlines to determine an efficient way to

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summarize and provide accurate reimbursement and units of service information to each LEA for inclusion on the CRCS. In Fall 2009 HP furnished an Interim Reimbursement and Units of Service Report for SFYs 2006-07 and 2007-08 to all LEAs. DHCS revised the submission deadline for SFY 2006-07 and 2007-08 CRCS reports to October 30, 2009. DHCS communicated the new CRCS due date to LEAs via the LEA Program website and a CDE Special Education Local Area Plan (SELPA) directors e-mail distribution. During the current year, DHCS has reviewed submitted LEA CRCS forms for accuracy, validation and completeness through a CRCS import application, resulting in acceptances or rejections. DHCS sent letters to LEAs notifying them of specific CRCS errors that may require further revisions in order for the CRCS to be accepted by DHCS prior to A&I reconciliation. DHCS has provided LEAs with CRCS re-submission deadlines of April 23, 2010 and June 21, 2010 in order to allow LEAs to finalize their CRCS form corrections. DHCS also provided LEA CRCS submission process and technical assistance webinar trainings in March and May 2010. DHCS is evaluating penalty policies for LEAs who are non-compliant with CRCS submission requirements.

- **LEA Advisory Committee**

Members of the LEA Advisory Committee represent large, medium, and small school districts, COE, professional associations representing LEA services, DHCS, and the CDE. Meetings are held every other month and provide a forum for Workgroup members to identify relevant issues and make recommendations for changes to the LEA Program. The LEA Advisory Committee has been instrumental in identifying claims processing issues, assisting with LEA Program training, and providing input on the operational aspect of LEA Program policies within the school-based setting for specific LEA services, which has resulted in updates to the LEA Program. In SFY 2009-10, the bi-monthly workgroup meetings were re-tooled to more closely follow the structure outlined in SB 231.

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

California's LEA Program provides many of the same "core" services that exist in other states' school-based programs. However, there are additional services that are allowable in other state programs, which are not currently reimbursable in California's LEA Program. In order to gather information on these services and qualified practitioners, we have relied on numerous sources, including responses from the state survey, updated reviews of relevant provider manuals and Medicaid state plans, and interviews with other states' program personnel. These services are listed below:

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

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

Addition of these benefits requires submission of a new State Plan Amendment to CMS. The pros and cons of such a submission are routinely discussed during the Ad-Hoc Workgroup meetings. In addition, the Workgroup developed a number of sub-committees during SFY 2009-10, including a New Services sub-committee. This sub-committee is currently providing guidance and opinions to the larger Workgroup and DHCS.

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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
<ul style="list-style-type: none">• Update the LEA Provider Manual to improve the organization and content of the policy information, as necessary.	<ul style="list-style-type: none">• 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 2009 to ensure clarity on LEA policy implemented as a result of SPA 03-024. 2009 LEA Provider Manual updates and revisions included updating DHCS contact information, updating the LEA maximum allowable rates and LEA claim submission examples due to inflation rate updates, clarification of nurse credentialing requirements and updating IEP/IFSP assessment and non-IEP/IFSP service utilization controls to reflect the new fiscal year policy.• Continued revisions to the LEA Provider Manual will be published in 2010, as necessary.

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Recommendation	Action Taken/To Be Taken
<ul style="list-style-type: none"> Implement LEA Rate Study recommendations related to assessments conducted to determine a student's eligibility for services under IDEA¹¹ and treatment services. 	<ul style="list-style-type: none"> On July 1, 2006, DHCS implemented the LEA Rate Study, SPA 03-024 recommendations, and the HIPAA-mandated conversion to national billing codes. Since that date, DHCS identified errors in the claims processing system, which have caused certain claims to be inadvertently denied or paid incorrectly. In 2008 and 2009, DHCS, FI-COD and HP continued to hold bi-weekly meetings to discuss and resolve claiming errors. Considerable time and effort was expended clarifying and responding to paid claims issues raised by the LEA Advisory Committee, FI-COD and HP regarding review protocols, utilization controls, and inaccurate reimbursement for LEA services. In addition, Medi-Cal Safety Net Financing worked closely with FI-COD and HP, as well as the LEA Advisory Committee to test system implementation fixes to confirm that the claims processing system would correct system errors. As of March 2009, DHCS, FI-COD and HP successfully implemented system updates for all of the original issues identified. The first EPC implemented in December 2007 and subsequent EPCs throughout 2007, 2008 and 2009 re-processed claims and adjusted LEA payments for claims mistakenly overpaid, underpaid or denied. Continued collaboration with FI-COD and HP will be ongoing in 2010 to monitor the claims processing system to ensure that the LEA Program is continuing to process claims appropriately.

¹¹ Schools are mandated by the IDEA to provide appropriate educational services to all children with disabilities. School-based health services reimbursed by the LEA Program are primarily provided to students with disabilities receiving special education services through an IEP or IFSP. The LEA Program also provides reimbursement for health services, such as nursing care, rendered to general education students, provided the LEA meet the Free Care and OHC requirements.

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Recommendation	Action Taken/To Be Taken
<ul style="list-style-type: none"> • Develop and maintain an interactive LEA Program website. 	<ul style="list-style-type: none"> • In 2009, DHCS continued to modify and organize the LEA Program content to ensure that LEA Program information is readily accessible • 2009 LEA website maintenance activities included posting: LEA Advisory Committee meeting summaries; Annual Report forms; updated LEA Frequently Asked Questions (FAQs); SFY 2006-07 and 2007-08 paid claims data reports and reimbursement trends; increased maximum allowable reimbursement rate charts reflecting inflation increases, and other LEA policy clarification. • During 2009, a claims processing issues matrix was maintained on the LEA Program website containing a summary of identified issues and status of resolution. This matrix was updated periodically as claim issues were resolved and included system implementation and EPC dates. The EPC letters that were sent to impacted LEA providers were also posted on the LEA Program website. As of 2010, all major identified claims processing issues had been corrected and documentation materials were moved to an archived section of the LEA Program website. • LEA Program policy and CRCS training, announcements and subsequent training materials were posted on the website, including March 2009 LEA Program training videoconference materials, updated CRCS forms, instructions, sample CRCS and submission deadlines, a March 2010 CRCS submission process webinar presentation and FAQs, and a May 2010 CRCS technical assistance webinar presentation and materials. • DHCS continued to maintain an electronic mailing list that LEA personnel may subscribe to and automatically receive e-mail notifications when new or updated information has been posted on the LEA Program website. In addition, an LEA Contact Form was developed to assist program information, correspondence, and required documents flow to the appropriate LEA contact. • DHCS will continue to update the website, reflecting changes recommended by the LEA Advisory Committee and increasing communication to the LEA provider community regarding LEA Program billing and policy information.

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Recommendation	Action Taken/To Be Taken
<ul style="list-style-type: none"> Establish equivalency for credentialed speech-language pathologists. 	<ul style="list-style-type: none"> DHCS originally submitted a SPA in 2005 to remove supervision requirements for credentialed speech-language practitioners. The SPA was placed on hold because CMS required an equivalency ruling from the California Attorney General. AB 2837, chaptered in September 2006, successfully created three types of credentialed speech-language practitioners: 1) practitioners with a preliminary services credential in speech-language pathology, 2) practitioners with a professional clear services credential in speech-language pathology, and 3) practitioners with a valid credential issued by CCTC on or before January 1, 2007. This established new educational and work requirements that are equivalent to federal standards for two of the three credentialed speech-language pathologists. The California AG issued an opinion in November 2006 stating that the California credentialing requirements for speech-language pathologists with preliminary or professional clear services credentials in speech-language pathology, defined in Education Code, Section 44265.3(a), are equivalent to the federal credentialing requirements. DHCS re-submitted the SPA and responded to CMS' request for additional information in September 2008. CMS will not review the speech-language equivalency SPA until the LEA Program is fully compliant with the current SPA 03-024. Ultimately, after CMS SPA approval, speech-language pathology practitioners with preliminary or professional clear services credentials in speech-language pathology will no longer require supervision when providing services to Medi-Cal eligible children. In addition, practitioners with professional clear services credentials in speech-language pathology will be qualified to provide supervision to other credentialed speech-language pathologists providing LEA services.

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Recommendation	Action Taken/To Be Taken
<ul style="list-style-type: none"> Provide LEA trainings to the LEA provider community. 	<ul style="list-style-type: none"> In March 2010, DHCS conducted a CRCS submission process training webinar to provide LEAs with updated information on the CRCS submission process, requirements and deadlines for SFY 2006-07 and 2007-08 CRCS forms. In May 2010, DHCS conducted a CRCS technical assistance webinar with the following training areas: overview of LEA CRCS resources; CRCS forms and flow of calculations between worksheets and how they interrelate; common CRCS rejections and errors and how to identify and address them on the CRCS; review of CRCS process and upcoming deadlines; and future SFY 2008-09 CRCS submission. A&I Financial Audits Branch also participated in the training and providing an overview of their role in the CRCS submission and reconciliation process, explained the various levels of audits that may be conducted, and provided a timeline of the reconciliation process.
<ul style="list-style-type: none"> Improve communications regarding policy issues (to the extent allowed by Executive Order S-2-03) and status of SB 231 implementation with LEA providers. 	<ul style="list-style-type: none"> DHCS continues to prepare LEA Advisory Committee Meeting Summaries, containing information regarding items discussed during the bi-monthly Workgroup meetings. The meeting summaries are posted on the LEA Program website. DHCS continues to disseminate information to LEA providers via the LEA Program website, including current status of claims processing issues, EPC letters to providers, FAQs, and information on the CRCS reporting requirement deadline. DHCS has worked with CDE to post important LEA Program information on the CDE website and utilize CDE's e-mail distribution to school superintendents to increase dissemination of program information to LEA providers. DHCS has requested CDE send e-mails to school Superintendents regarding CRCS deadline reminders and LEA Program training announcements. DHCS will continue to utilize CDE to further communicate with LEAs in 2010.

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Recommendation	Action Taken/To Be Taken
<ul style="list-style-type: none"> Update the statewide LEA provider contact list. 	<ul style="list-style-type: none"> The statewide LEA provider contact list was updated with e-mail addresses and contact names from the March 2009 videoconference training. DHCS will update the provider contact list with the March 2010 and May 2010 CRCS webinar trainings as well. This list will be further updated with information from future training sessions. DHCS developed an LEA Contact Information Form available on the LEA Program website so that participants can complete the form to ensure program information, correspondence, and required documents are directed to the appropriate LEA contact. The statewide LEA provider contact list was used to disseminate information and announce the March 2010 and May 2010 LEA Program training webinars. The LEA contacts identified from submitted CRCS forms have been collected and used to disseminate CRCS related information via e-mail.
<ul style="list-style-type: none"> Provide quarterly status reports describing how SB 231 funds are spent. 	<ul style="list-style-type: none"> The contractor that assists DHCS in implementing the provisions of SB 231 continues to prepare monthly status reports of actual and projected activities. Reports detailing activities DHCS conducted in 2009 were provided at the LEA Advisory Committee meetings on a periodic basis.
<ul style="list-style-type: none"> Submit SPAs and subsequent updates to CMS on a timely basis. 	<ul style="list-style-type: none"> DHCS will continue to work towards submission of future SPAs within a reasonable time frame, as appropriate, based on CMS' policy direction and temperament.

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Recommendation	Action Taken/To Be Taken
<ul style="list-style-type: none"> Conduct meetings with Medi-Cal Safety Net Financing, A&I and LEA providers regarding audit procedures. 	<ul style="list-style-type: none"> In 2010, DHCS intends to continue to support and foster communication between A&I Medical Review Branch and the LEA Advisory Committee through meetings and training in order to improve A&I's understanding of differences between medical documentation and educational documentation in a school-setting and assist to determine what is sufficient and adequate documentation standards for LEAs to support LEA Medi-Cal services. DHCS also intends to foster communication between A&I Financial Audits Branch and the LEA Advisory Committee to assist auditors to develop appropriate CRCS audit procedures and the reconciliation process.
<ul style="list-style-type: none"> Update interim reimbursement rates for LEA services per allowances in SPA 03-024. 	<ul style="list-style-type: none"> DHCS worked in 2009 to apply an approved inflation adjustment to the current interim reimbursement rates for LEA services. As part of the requirements specified in SPA 03-024, DHCS is required to annually adjust LEA reimbursement rates for IEP/IFSP assessments and treatment services, and non-IEP/IFSP assessments and treatment services using the Implicit Price Deflator, which is published by the U.S. Department of Commerce. As of SFY 2008-09, the LEA Program rates had not been adjusted from the originally implemented SFY 2003-04 rates due to the on-going claims processing issues. Throughout 2009, rates were retroactively inflated for SFYs 2006-07 and 2007-08 in May 2009 and SFY 2008-09 in August 2009. In April 2010, rates were retroactively inflated for SFY 2009-10 and updated by HP in the claims processing system. DHCS intends to begin the process of rebasing the interim reimbursement rates pursuant to SPA 03-024 in 2010, once adequate CRCS data is available.

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Recommendation	Action Taken/To Be Taken
<ul style="list-style-type: none"> • Determine CRCS submission deadline for SFY 2008-09, notify LEA providers. 	<ul style="list-style-type: none"> • DHCS announced the SFY 2008-09 CRCS submission deadline of November 30, 2010 during the May 2010 CRCS webinar. • DHCS is in process of amending the CRCS forms to accommodate the two FMAP percentages that were applied during SFY 2008-09 due to the ARRA enhanced FMAP rate. • DHCS will provide instructions and guidance and update current training materials to align with any CRCS form revisions for SFY 2008-09. • LEA providers will be notified via regular channels of communication of any further updates regarding the CRCS submission deadlines. This includes the LEA Program website, SELPA e-mail distribution, and LEA contact lists. • SPA 03-024 states that CRCS forms shall be due no later than November 30, following the end of the SFY; however, LEAs are allowed to submit claims up to 12-months from the date of service, to allow for claims “run-out.” Medi-Cal Interim Reimbursement and Units of Service reports cannot be generated until 12 months following the final date of service for the appropriate SFY.

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Recommendation	Action Taken/To Be Taken
<ul style="list-style-type: none"> Revise the CP-O-888 Report provided monthly to LEAs by HP. 	<ul style="list-style-type: none"> Each month, LEAs that submit claims receive a service and reimbursement report from HP. The report lists the number of services rendered, dollar amounts reimbursed and procedure codes paid by month, quarter-to-date and year-to-date on a fiscal year basis. Currently, the report does not recognize multiple LEA modifiers that were implemented on July 1, 2006, and is not useful for LEAs to reconcile claims. HP system modifications and an SDN would be required in order for HP to generate the report with multiple modifiers; DHCS submitted the SDN to HP in 2009. It was determined that the required system changes as part of the SDN would not be cost efficient. As a more cost effective method, DHCS will request an Interim Reimbursement and Units of Service report to be generated quarterly (similar to that used for the CRCS with reimbursement and number of services by procedure code and modifier combination) on a date of service and date of payment basis. These quarterly reports will be mailed to LEAs. After it is determined that the quarterly Interim Reimbursement and Units of Service report process has been running effectively, DHCS will terminate the CP-O-888 report process and mailings to LEAs.
<ul style="list-style-type: none"> Review SB 231 2.5 percent withhold and one percent administrative withhold applied to all claims. 	<ul style="list-style-type: none"> A one percent administrative fee is levied against LEA claims for claims processing and related costs and an additional 2.5 percent to fund activities mandated by SB 231. The annual amount of the 2.5 percent withhold is not to exceed \$1.5 million. The fees are subtracted from the total reimbursement amount on the Medi-Cal Remittance Advice Details (RAD) with RAD code 795 for the one percent withhold and code 798 for the 2.5 percent withhold. DHCS prepared the necessary policy letter for HP to stop the SB 231 2.5 percent withhold for SFY 2009-10, once the \$1.5 million cap was collected. In 2010, DHCS will continue to explore alternative methods to collect the SB 231 funding withhold proportionately across LEA Program participants. DHCS expects to implement the new process during 2010.

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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. The delays were associated with the CMS approval process. In addition, the LEA Program worked with CMS in 2009 to become fully compliant with the requirements of SPA 03-024. We acknowledge the following SPA submissions:

Table 5: Timetable for Proposed State Plan Amendments

Service Description	Estimated Submission Date
<ul style="list-style-type: none"> • TCM services: These services include IEP review services performed by a case manager to coordinate the development of an IEP/IFSP and attendance at meetings by health service providers to write and develop the IEP/IFSP. In September 2004, DHCS submitted proposed language for a SPA to expand TCM services in the LEA Program. CMS convinced DHCS not to submit the SPA based on expected upcoming CMS regulation changes to school-based reimbursement and services. 	<ul style="list-style-type: none"> • On hold
<ul style="list-style-type: none"> • Speech-language equivalency: The SPA to remove supervision requirements for credentialed speech-language pathologists was originally submitted to CMS in Summer 2005 and re-submitted by DHCS in September 2008. CMS required a letter of equivalency from the AG, as noted in Section IV. DHCS has subsequently established that the requirements for credentialed speech-language pathologists with preliminary or professional clear services credentials in speech-language pathology are equivalent to federal standards. CMS will not review the speech-language equivalency SPA until the LEA Program is fully compliant with the current SPA 03-024. 	<ul style="list-style-type: none"> • On hold

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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 2009, as well as the actions that have been and will be taken by DHCS.

Table 6: Barriers to Reimbursement

Barriers	Actions Taken /To Be Taken
<ul style="list-style-type: none"> Certain health and mental health services and services provided by assistants are provided by LEAs but are not currently reimbursable in the LEA Program. 	<ul style="list-style-type: none"> The LEA Advisory Committee compiled a list of potential LEA services to expand the LEA Program. Potential new services will be considered and reviewed by DHCS. In addition, DHCS must determine the necessary means to implement specific new services and if a new SPA is required. Research on behavioral intervention services, personal care services and therapy assistants was originally conducted in 2007. In 2010, DHCS will continue and update the research on these services and consider expanding the scope of reimbursable services for LEAs. A cost survey may be designed in SFY 2010-11 to collect information from a sample of LEAs employing practitioners providing behavioral services, dieticians, physicians, and other practitioners to obtain rates for these practitioners. SPAs to expand services may be submitted to CMS, as discussed in Section V.

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Barriers	Actions Taken /To Be Taken
<ul style="list-style-type: none"> Enrollment requirements may hinder new school districts and COE from enrolling in the LEA Program. 	<ul style="list-style-type: none"> In SFY 2010-11, DHCS will determine which LEAs are not currently enrolled in the LEA Program and potentially target those LEAs to provide a general orientation for school districts and COEs that are not claiming for Medi-Cal reimbursement for services they currently render. Orientations may include information on the necessary steps to become a participating provider, guidance on how to enroll and annual requirements, and an overview of billing policies and procedures. In addition, DHCS outreach may be conducted for LEAs enrolled in the LEA Program, but who are not optimizing Medi-Cal reimbursement for services they render to students.
<ul style="list-style-type: none"> LEA Program billing policies and procedures have not always been consistently documented. 	<ul style="list-style-type: none"> Training sessions for LEA providers were conducted in March 2009 to inform LEAs of current billing policies and procedures and LEA Program changes, including A&I audit findings and documentation requirements. The reorganization, content revision and ongoing updates of the LEA Provider Manual, as described in Section IV, has further helped to clarify LEA Program billing policies and procedures. FAQs are posted on the LEA Program website to assist providers with common questions regarding billing and program policies. FAQs are periodically reviewed and updated to reflect current LEA Program policy, as well as add new FAQs based on questions submitted from LEA providers. FAQs were developed and updated based on the March 2009 training questions. 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.

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Barriers	Actions Taken /To Be Taken
<ul style="list-style-type: none"> Post SPA implementation claims processing issues have been identified and have resulted in LEA claims being incorrectly paid or denied. 	<ul style="list-style-type: none"> Medi-Cal Safety Net Financing continually conducted bi-weekly meetings and worked closely with FI-COD and HP to resolve the claims processing issues identified after the SDN was implemented in July 2006. Throughout 2008, DHCS clarified LEA Program billing policies and requirements for HP to alter system design, provided example claims to test system changes, and reviewed test results to ensure LEA claims were processing properly prior to implementation of system changes. DHCS determined appropriate timelines to resolve the claims processing errors through EPCs for LEAs impacted by the claiming errors. The first EPC was implemented in December 2007 and additional EPCs were implemented in 2007, 2008 and completed in 2009 to adjust LEA payments for inadvertently denied or incorrectly paid claims.
<ul style="list-style-type: none"> IEP/IFSP assessment utilization control changes 	<ul style="list-style-type: none"> IEP/IFSP initial/triennial and annual assessments and corresponding utilization controls are intended to follow the school year. Since the school year generally aligns with the state fiscal year, the LEA Program originally requested that the utilization controls be conducted on a state fiscal year basis, rather than a "rolling months" basis. However, FI-COD and HP could not implement a fiscal year utilization control at the time the original SPA implementation and HIPAA changes occurred in July 2006. DHCS submitted an SDN in 2009 to repeal the "rolling months" utilization controls for IEP/IFSP assessments and non-IEP/IFSP services and replace them with utilization controls that will operate on a fiscal year basis. In addition, the SDN requested a utilization control change related to IEP/IFSP amended assessments, which provides additional reimbursement for these services to LEA providers. The new amended assessment utilization control allows for an amended assessment every 30 days (per beneficiary per LEA provider per service type), rather than every three months. These changes were implemented in September 2009, with an effective date of July 1, 2009. An EPC was submitted to retroactively pay claims under the new fiscal year utilization control between the policy effective date and implementation date.

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Barriers	Actions Taken /To Be Taken
<ul style="list-style-type: none"> Seven percent interest charged on all outstanding debts established by HP. 	<ul style="list-style-type: none"> Due to the claims processing issues, LEAs were originally overpaid for LEA services conducted in SFY 2006-07. After the first EPC was implemented in December 2007, several LEAs had an accounts receivable balance (overpayment). DHCS was notified that according to Welfare and Institutions Code, Sections 14170-14178, seven percent interest would be charged on all outstanding debts owed to the State and would be automatically applied 60 days after LEA notification of the outstanding debt. DHCS Office of Legal Services (OLS) determined that LEAs are exempt from the seven percent interest rate penalties on outstanding overpayments resulting from claims processing issues. LEAs received their refunds on the interest accrued on overpayments in October 2008; however, the one percent administrative and 2.5 percent SB 231 withholds were applied to the refund in error. DHCS, FI-COD and HP are working to correct this issue and refund LEAs their full interest amount during June 2010.
<ul style="list-style-type: none"> SB 231 2.5 percent withhold and one percent administrative withhold applied to all claims, including claims reprocessed during EPCs. 	<ul style="list-style-type: none"> LEA claims are subject to the SB 231 2.5 percent and one percent administrative withholds. Due to the claims processing issues, the first EPC implemented in December 2007 left several LEAs with an overpayment, as described above. For LEAs with overpayments, an account receivable was set up with 100 percent of the claims reimbursement amount; 100 percent of future LEA claims reimbursement is withheld until the LEA's account receivable has a zero balance. The 3.5 percent withhold will not be applied until the account receivable has been cleared and then will be applied at the time the LEA has a positive claims payout. For underpayments, the 3.5 percent will be applied at the time of the check write. DHCS, FI-COD and HP are working to correct this issue and refund LEAs any withhold amount held on reprocessed claims during June 2010.

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Barriers	Actions Taken /To Be Taken
<ul style="list-style-type: none"> Eligibility Data Match is missing the Beneficiary Identification Card (BIC) numbers for some students and LEAs can no longer use Social Security Numbers (SSNs) on Medi-Cal claims. 	<ul style="list-style-type: none"> Providers may no longer bill Medi-Cal using a beneficiary's SSN and must bill using the recipient's Medi-Cal identification number from the Beneficiary Identification Card (BIC). LEAs submitting Medi-Cal claims using a beneficiary's SSN will deny with RAD Code 0046 "SSN not permitted for billing Medi-Cal". Potential reimbursable services for eligible students are being denied because BIC numbers are not available on the Eligibility Data Match. DHCS recommends that LEAs leave the BIC number blank when the BIC is not provided on the LEA Eligibility Data Match or request the student's BIC based on the date of service. LEAs can reprocess the claims after the 30-day waiting period for BIC numbers or contact their county office for a temporary County Identification Number (CIN). In addition, there is an eligibility gateway and students may be given an initial BIC number, however there is a three-month period to determine if the student is Medi-Cal eligible.
<ul style="list-style-type: none"> Denial of optional services to beneficiaries age 21 and older (RAD Code 9909) 	<ul style="list-style-type: none"> Some LEA claims have been denying with Remittance Advice Detail (RAD) Code 9909 "Optional service not payable on date of service" for beneficiaries age 21 and older for services that are allowable under the LEA Medi-Cal Billing Option Program. Recently, a number of optional benefits were excluded from the Medi-Cal program for beneficiaries age 21 and older, but should exclude the LEA Program. DHCS is working with FI-COD and HP to determine the cause of these denials, and a possible solution.

VII. APPENDICES

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

SFY 2007 - 2008							
State	FMAP ⁽¹⁾	Federal Reimbursement (Federal Share)			Calculated Claim Dollars		
		Health (000's)	Administrative (000's)	Total (000's)	Health (000's) ⁽²⁾	Administrative (000's) ⁽³⁾	Total (000's)
VERMONT	59.03%	\$ 21,487	\$ -	\$ 21,487	\$ 36,399	\$ -	\$ 36,399
NEBRASKA	58.02%	3,026	29,763	32,788	5,215	59,526	64,741
MASSACHUSETTS	⁴ 50.00%	58,661	57,685	116,346	117,322	115,370	232,692
RHODE ISLAND	⁴ 52.51%	16,408	4,369	20,778	31,248	8,738	39,986
DELAWARE	⁴ 50.00%	15,088	-	15,088	30,175	-	30,175
WEST VIRGINIA	74.25%	38,313	-	38,313	51,599	-	51,599
PENNSYLVANIA	54.08%	115,107	26,522	141,629	212,846	53,044	265,890
IDAHO	⁴ 69.87%	21,216	-	21,216	30,366	-	30,366
MICHIGAN	⁴ 58.10%	112,703	21,179	133,882	193,981	42,359	236,340
UTAH	71.63%	10,688	3,610	14,298	14,921	7,220	22,142
KANSAS	⁴ 59.43%	14,605	3,618	18,224	24,575	7,237	31,812
ILLINOIS	50.00%	53,462	64,295	117,757	106,924	128,590	235,514
NEW YORK	50.00%	147,162	-	147,162	294,324	-	294,324
WISCONSIN	57.62%	39,621	-	39,621	68,762	-	68,762
CONNECTICUT	50.00%	19,020	-	19,020	38,040	-	38,040
MINNESOTA	50.00%	22,147	-	22,147	44,295	-	44,295
IOWA	61.73%	15,154	-	15,154	24,548	-	24,548
OREGON	60.86%	-	12,465	12,465	-	24,930	24,930
VIRGINIA	50.00%	14,523	10,020	24,543	29,047	20,040	49,086
ALASKA	52.48%	273	3,737	4,010	519	7,475	7,994
MONTANA	68.53%	1,837	1,262	3,099	2,680	2,523	5,204
FLORIDA	56.83%	10,243	54,149	64,392	18,024	108,298	126,322
MISSOURI	62.42%	3,923	22,574	26,497	6,285	45,149	51,434
CALIFORNIA	50.00%	81,241	111,213	192,454	162,482	222,426	384,908
NORTH DAKOTA	⁴ 63.75%	1,466	-	1,466	2,300	-	2,300
KENTUCKY	69.78%	3,217	13,500	16,717	4,611	27,000	31,611
ARKANSAS	72.94%	10,662	8,073	18,735	14,617	16,146	30,763
ARIZONA	66.20%	19,400	7,331	26,730	29,305	14,662	43,966
COLORADO	50.00%	8,921	-	8,921	17,842	-	17,842
ALABAMA	67.62%	376	13,909	14,285	556	27,818	28,374
NORTH CAROLINA	64.05%	10,454	15,177	25,630	16,321	30,354	46,675
NEW MEXICO	71.04%	7,955	1,802	9,757	11,197	3,605	14,802
WASHINGTON	51.52%	5,021	10,389	15,410	9,746	20,778	30,524
MISSISSIPPI	76.29%	920	7,093	8,013	1,206	14,186	15,391
NEVADA	52.64%	1,228	-	1,228	2,334	-	2,334
OKLAHOMA	67.10%	4,048	-	4,048	6,033	-	6,033
HAWAII	56.50%	326	-	326	577	-	577
INDIANA	62.69%	1,051	151	1,202	1,677	302	1,978
GEORGIA	⁵ 63.10%	-	-	-	-	-	-
OHIO	⁵ 60.79%	-	-	-	-	-	-
TENNESSEE	⁵ 63.71%	-	-	-	-	-	-
WYOMING	⁵ 50.00%	-	-	-	-	-	-

(1) The Federal Medical Assistance Percentage (FMAP) for each state was obtained from the Federal Register, published on November 30, 2006.

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

(3) Calculated for this analysis as Medicaid reimbursement (federal share) divided by 50% for each state's administrative amount reported.

(4) Total federal reimbursement for this state's health services program and/or administrative claiming program was obtained from the 2008 state survey.

(5) These states did not have a school-based Medicaid health services program or administrative claiming program in effect during SFY 2007-08 or SFY 2008-09.

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

SFY 2008 - 2009							
State	FMAP ⁽¹⁾	Federal Reimbursement (Federal Share)			Calculated Claim Dollars		
		Health (000's)	Administrative (000's)	Total (000's)	Health (000's) ⁽²⁾	Administrative (000's) ⁽³⁾	Total (000's)
VERMONT	67.71%	\$ 24,005	\$ -	\$ 24,005	\$ 35,453	\$ -	\$ 35,453
NEBRASKA	65.74%	2,899	23,953	26,852	4,409	47,907	52,316
MASSACHUSETTS	⁴ 58.78%	-	-	-	-	-	-
RHODE ISLAND	⁴ 63.89%	-	-	-	-	-	-
DELAWARE	⁴ 60.19%	-	-	-	-	-	-
WEST VIRGINIA	80.45%	42,234	-	42,234	52,497	-	52,497
PENNSYLVANIA	63.05%	123,900	28,400	152,300	196,511	56,800	253,311
IDAHO	⁴ 78.37%	-	-	-	-	-	-
MICHIGAN	⁴ 69.58%	-	-	-	-	-	-
UTAH	77.83%	14,889	2,338	17,227	19,130	4,676	23,806
KANSAS	⁴ 66.28%	-	-	-	-	-	-
ILLINOIS	60.48%	78,722	54,639	133,361	130,162	109,277	239,439
NEW YORK	58.78%	79,680	-	79,680	135,557	-	135,557
WISCONSIN	65.58%	53,166	2,688	55,855	81,071	5,377	86,448
CONNECTICUT	60.19%	21,790	-	21,790	36,202	-	36,202
MINNESOTA	60.19%	-	-	-	-	-	-
IOWA	68.82%	23,747	-	23,747	34,506	-	34,506
OREGON	⁴ 71.58%	-	-	-	-	-	-
VIRGINIA	58.78%	9,877	11,664	21,541	16,803	23,328	40,131
ALASKA	58.68%	467	-	467	795	-	795
MONTANA	76.29%	2,524	990	3,514	3,308	1,980	5,288
FLORIDA	67.64%	9,625	65,661	75,286	14,230	131,322	145,552
MISSOURI	71.24%	3,580	20,960	24,541	5,026	41,921	46,946
CALIFORNIA	61.59%	103,904	70,879	174,783	168,703	141,759	310,462
NORTH DAKOTA	⁴ 69.95%	-	-	-	-	-	-
KENTUCKY	77.80%	3,465	785	4,250	4,453	1,570	6,023
ARKANSAS	79.14%	15,896	8,889	24,785	20,086	17,778	37,864
ARIZONA	75.01%	22,744	3,417	26,161	30,321	6,835	37,156
COLORADO	58.78%	9,220	-	9,220	15,686	-	15,686
ALABAMA	76.64%	438	17,847	18,284	571	35,693	36,264
NORTH CAROLINA	73.55%	9,793	17,711	27,504	13,315	35,422	48,737
NEW MEXICO	77.24%	7,635	2,747	10,382	9,885	5,494	15,379
WASHINGTON	60.22%	5,993	10,633	16,626	9,952	21,265	31,217
MISSISSIPPI	83.62%	915	6,893	7,808	1,094	13,786	14,881
NEVADA	63.93%	1,775	-	1,775	2,777	-	2,777
OKLAHOMA	74.94%	4,286	-	4,286	5,719	-	5,719
HAWAII	66.13%	314	-	314	476	-	476
INDIANA	73.23%	2,227	-	2,227	3,041	-	3,041
GEORGIA	⁵ 73.44%	-	-	-	-	-	-
OHIO	⁵ 70.25%	-	-	-	-	-	-
TENNESSEE	⁵ 73.25%	-	-	-	-	-	-
WYOMING	⁵ 56.20%	-	-	-	-	-	-

(1) The Federal Medical Assistance Percentage (FMAP) adjusted for the American Recovery and Reinvestment Act (ARRA) for each state was obtained from the Federal Register, published on August 4, 2009.

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

(3) Calculated for this analysis as Medicaid reimbursement (federal share) divided by 50% for each state's administrative amount reported, to accommodate inter-state comparisons of dollars per child.

(4) Total federal reimbursement for these states' health services programs and/or administrative claiming programs were not available for SFY 2008-09.

(5) These states did not have a school-based Medicaid health services program or administrative claiming program in effect during SFY 2007-08 or SFY 2008-09.

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

Service	Qualified Provider(s)	Example Rates
<p>Behavioral services provided by a behavioral aide</p> <p>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.</p>	<p>Mental health behavioral aide</p> <p>A paraprofessional working under the direction of a mental health professional.</p>	<p>Iowa: \$10.20 per 15-minute increment.⁽¹⁾</p> <p>\$4.95 per group session ⁽¹⁾</p> <p>Minnesota: Based on each school district's cost of providing service.</p>
<p>Behavioral services provided by a certified behavioral analyst or certified associate behavioral analyst</p> <p>Behavioral services include behavioral evaluations and functional assessments, analytic interpretation of assessment results, and design and delivery of treatments and intervention methods.</p>	<p>Certified behavior analyst</p> <p>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.</p> <p>Certified associate behavioral analyst</p> <p>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.</p>	<p>Florida: Certified behavior analyst, \$8.00 per 15-minute increment.</p> <p>Certified behavior analyst (bachelor's level), \$6.70 per 15-minute increment.</p> <p>Certified associate behavior analyst, \$6.70 per 15-minute increment.</p>
<p>Behavioral services provided by an intern</p> <p>Behavioral services include testing, assessment and evaluation that appraise cognitive, developmental, emotional, and social functioning; therapy and counseling, and crises assistance.</p>	<p>Psychologist intern, Social worker intern</p> <p>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.</p>	<p>Florida: Psychologist, \$9.66 per 15-minute increment.</p> <p>Social worker, \$8.97 per 15-minute increment.</p> <p>Illinois: Based on each school district's cost of providing service.</p>

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

Service	Qualified Provider(s)	Example Rates
<p>Dental assessment and health education provided under Early and Periodic Screening, Diagnostic and Treatment services</p> <p>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.</p>	<p>Dental hygienist</p> <p>A person who is a licensed dental hygienist.</p>	<p>Delaware: \$40.04 per 15-minute increment. ⁽¹⁾</p>
<p>Durable medical equipment and assistive technology devices</p> <p>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.</p>	<p>Not applicable</p>	<p>Illinois: Medically necessary equipment may be claimed up to a total of \$1,000 per day based on the cost of the equipment.</p> <p>Minnesota: Based on purchase price, rental costs or costs of repairs.</p>
<p>IEP review services</p> <p>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.</p>	<p>Case manager</p> <p>A person who has a bachelor's degree with a major in special education, social services, psychology, or related field; or a registered nurse.</p>	<p>West Virginia:</p> <p>Initial or Triennial: \$703.66</p> <p>Annual: \$171.97</p>

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

Service	Qualified Provider(s)	Example Rates
<p>Interpreter services</p> <p>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.</p>	<p>Interpreter</p> <p>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.</p> <p>Sign language: A person with a bachelor's degree or higher who has graduated with a valid certification from a recognized interpreters' evaluation program.</p>	<p>Minnesota: Based on each school district's cost of providing service.</p> <p>Pennsylvania: Based on each school district's cost of providing service.</p>
<p>Occupational therapy services provided by an occupational therapy assistant</p> <p>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.</p>	<p>Occupational therapy assistant</p> <p>A person who meets state requirements as an occupational therapy assistant and works under the direction of a qualified occupational therapist.</p>	<p>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.</p> <p>Florida:</p> <p>Individual: \$13.58 per 15-minute increment.</p> <p>Group: \$2.60 per 15-minute increment.</p>

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

Service	Qualified Provider(s)	Example Rates
<p>Orientation and mobility services</p> <p>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.</p>	<p>Orientation and mobility provider</p> <ul style="list-style-type: none"> - 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. 	<p>Michigan: Based on each school district's cost of providing service from prior year.</p>

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

Service	Qualified Provider(s)	Example Rates
<p>Personal Care Services</p> <p>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.</p>	<p>Health aide, Personal care assistant</p> <p>A paraprofessional supervised by a qualified health care professional.</p>	<p>Arizona: \$4.50 per 15-minute increment.</p> <p>Michigan: Based on each school district's cost of providing service from prior year.</p> <p>Virginia: Based on estimated costs for services furnished in 15-minute increments.</p> <p>West Virginia:</p> <p style="padding-left: 20px;">Full-day students: \$192.68</p> <p style="padding-left: 20px;">Partial-day students: \$96.34</p>
<p>Physical therapy services provided by a physical therapy assistant</p> <p>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.</p>	<p>Physical therapy assistant</p> <p>A person who meets state requirements for a physical therapy assistant and works under the direction of a qualified physical therapist.</p> <p>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.</p>	<p>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.</p> <p>Florida:</p> <p style="padding-left: 20px;">Individual: \$13.58 per 15-minute increment.</p> <p style="padding-left: 20px;">Group: \$2.60 per 15-minute increment.</p>

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

Service	Qualified Provider(s)	Example Rates
<p>Respiratory therapy services</p> <p>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.</p>	<p>Licensed respiratory therapist</p> <p>A person who meets state requirements as a licensed respiratory therapist.</p>	<p>Kentucky: \$3.75 per 15-minute increment. ⁽¹⁾</p>
<p>Services for children with speech and language disorders provided by a speech-language pathology assistant</p> <p>Services rendered to a child to treat speech and language disorders of verbal and written language, articulation, voice, fluency, phonology, and mastication.</p>	<p>Speech-language pathology assistant</p> <p>A person who meets state requirements for a speech-language pathology assistant and works under the direction of a qualified speech pathologist.</p>	<p>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.</p> <p>Florida:</p> <p>Individual: \$13.58 per 15-minute increment.</p> <p>Group: \$2.60 per 15-minute increment.</p>
<p>Specialized transportation</p> <p>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.)</p>	<p>Not Applicable</p>	<p>Michigan: Based on each school district's cost of providing service from prior year.</p> <p>New York: \$12.23 – 32.25 per day.</p> <p>In Michigan and New York, providers may not bill separately for an attendant.</p>

Note (1): This service was confirmed for this state; however rates are no longer available on the school-based website as of SFY 2009-10. Rates were confirmed in SFY 2008-09.