NO DOLLAR LEFT BEHIND

Leveraging Funding for Healthy Children and Healthy Schools

Consumers Union

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April 2006

Consumers Union

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EXECUTIVE SUMMARY

Schools throughout California seek creative ways to ensure the health of their students—some establish school-based health clinics, others work to ensure low-income students are enrolled in state-sponsored health insurance programs, and still others provide basic services and strive to meet the health needs of special populations. Millions of students around the state need to arrive at school healthy and ready to learn, so getting them health care is paramount. Since children spend most of their time in school, schools are a natural venue for improving health. Further, because state and federal laws require schools to provide certain health services to some categories of children, schools and districts have legal obligations they must meet.

The major health-related challenge schools face in the current fiscal climate is paying for the health services they provide children. Sustainable, ongoing funding sources are critical to any school strategy for improving children's health. Medicaid, the federal health insurance program for low-income individuals, can be a key funding stream for schools. Throughout the nation, and throughout California, Medicaid (called Medi-Cal in California) provides partial reimbursement to schools and districts for some health and related services provided to eligible students.

California could significantly increase the reimbursement it receives from the federal government for health services and related administrative services in schools. The California Endowment estimates that California schools could increase their billing by at least $86 million—1.5 times current revenue. If the programs were improved and more schools would participate, California could realize these dollars. In a time of shrinking budgets, leveraging this reimbursement is critical.

California gets federal dollars for health-related services and activities in schools through two distinct programs. Known in California as the **Medi-Cal LEA Program ("LEA Program")**, the first program garners federal Medicaid funds as reimbursement for **health services** provided to students such as health and mental health evaluation, physical therapy, certain nursing services and health assessments. The LEA Program has even more potential when coupled with another federal program that reimburses schools for **health-related administrative activities**, known in California as the **Medi-Cal Administrative Activities Program ("MAA Program")**.

While the amount California bills the federal government through the LEA Program has increased over the past five years, significant room for growth remains. Last year, only 45 percent of California school districts —500 of 1,100 districts—participated in the program. Even with less than half of all districts utilizing the LEA Program, California's schools billed for $91 million in services in 2003-2004. With additional districts participating, the state clearly could realize increased federal revenue.

School district participation in the MAA Program also can improve - only 42% of school districts claim MAA reimbursements. Many districts that claim MAA are large—their participation accounts for 70% of enrolled students. However, many non-participating districts are performing activities for which they could receive partial federal reimbursement and districts that are participating may not be optimizing their billing. While MAA reimbursement increased significantly from $15.3 million in 1999-2000 to $91 million in 2002-2003, the California State Auditor estimates that the state could have received at least $57 million more if more districts participated and if other districts maximized their billing.

In these tough fiscal times for California schools, the LEA and MAA programs afford a unique opportunity for schools to enhance student health and find funding to fulfill that goal. This report describes how the programs work from both a federal and a state perspective, addresses the challenges school districts face when billing under the programs, and offers recommendations for improvement. In compiling this report, in addition to reviewing written materials, we interviewed school officials throughout California and a number of education and health officials from other states. Consumers Union also convened a group of representatives from diverse districts around the state to discuss the LEA and MAA programs and how they could be improved. Our recommendations reflect the consensus view of the many individuals we interviewed, representing the spectrum of California communities.

RECOMMENDATIONS

■ **The California Department of Education should work in partnership with the Department of Health Services to administer the LEA and MAA programs**

California's Department of Education currently plays a minimal role in the administration of the MAA and LEA Programs—the Department of Health Services administers both programs. Schools are the Education Department's natural constituency and increasing that department's involvement could increase the visibility of both LEA and MAA billing, entice more schools to participate and help districts that already bill through the programs. The Department of Education could assume a number of responsibilities including "selling" the programs to non-participating districts and translating health information and regulations for participating districts, tracking system successes and challenges and troubleshooting for districts in their interactions with the Department of Health Services, and compiling information about how federal reimbursement dollars benefit school districts.

■ **The Department of Health Services and the Department of Education should improve communication with schools and districts**

The volume of information and the complexity of the Medicaid program require good communication and training. While the Department of Health Services has made improvements in this area, it must continue to ensure the information it provides is clear and consistent. The state should regularly update manuals and Web sites, conduct ongoing trainings and provide clear answers to district questions. DHS should establish an advisory group for the MAA Program as the agency did for the LEA Program.

■ **The Department of Health Services, working with the Department of Education, should actively monitor the MAA and LEA programs**

The state also should ensure it is sufficiently monitoring the LEA and MAA programs. In audits of school billing programs around the country, the federal government has called for improved state monitoring. In addition, the recent state audit of the MAA Program highlighted that DHS should improve monitoring and accountability by modifying its contracts to ensure school district participation, by developing performance outcomes and by enhancing reporting requirements.

DHS also should consider implementing a LEC selection process developed and executed regionally. An open regional selection process, combined with more choice, would likely improve the services school districts receive and, ultimately, result in lower costs and higher revenues for districts.

■ **DHS should continue to address the Third Party Liability issue and the free care requirement**

The "Third Party Liability" issue and the "free care requirement"—federal mandates enforced by the Centers for Medicare & Medicaid Services—present significant administrative and billing obstacles for districts. While DHS has taken concrete steps to address both of these issues, ongoing efforts could result in more dollars for California's schools.

■ **School districts should institutionalize the LEA and MAA programs**

The success of a district's billing program often is dependent upon a positive track record with the program and a supportive superintendent and a staff person who dedicates at least some portion of her time to maintaining a district-wide health services and administrative billing program. In addition to dedicated staff, districts can take a number of steps to institutionalize these programs, including getting support from their school board, disseminating information about how reimbursement dollars benefit the district and providing incentives to staff to participate in the programs.

■ **Districts should consider automation of billing processes**

Districts should consider automating billing processes, with assistance from and in concert with DHS and Department of Education. For example, the Los Angeles Unified School District (LAUSD) has automated

its billing processes, which we understand has made billing processes more efficient and effective. Although LAUSD is large, other districts could follow suit by borrowing specifications that are already developed and/or by banding together and forming consortia to develop and purchase automation software.

- **State legislators should ensure California is leveraging available federal dollars**

State legislators should monitor administration of the LEA and MAA programs and be proactive in pushing program improvements. Given budget shortfalls, capturing more federal dollars should be a priority for the California Legislature. Legislators could, for example, support a more active role for Department of Education and encourage (or mandate) collaboration between that department and DHS.

- **California's Congressional delegation should advocate federal policies that would create a favorable climate for California schools**

Because California's MAA and LEA programs are, in many ways, dependent on the federal government, California's Congressional delegation should be involved in improving the program. Senators and representatives should demand better information from CMS and advocate within the federal government for a strategy that helps schools participate in these programs and collect their share of federal dollars to which they are entitled.

California has the opportunity to leverage more federal dollars for its most vulnerable children and to fill gaps in school funding with federal dollars to which schools are entitled. By undertaking a number of reforms, the state could encourage more schools to participate in the MAA and LEA programs and could make the program more user-friendly and efficient for districts already participating. The benefits are obvious—more dollars to fund valuable programs for California's children.

INTRODUCTION

Schools throughout California seek creative ways to ensure the health of their students—some establish school-based health clinics, others work to ensure low-income students are enrolled in state-sponsored health insurance programs, and still others provide basic services and strive to meet the health needs of special populations. Millions of students around the state need to arrive at school healthy and ready to learn, so getting them health care is paramount. Since children spend most of their time in school, schools are a natural venue for improving health. Further, because state and federal laws require schools to provide certain health services to some categories of children, schools and districts have legal obligations they must meet.

The major health-related challenge schools face in the current fiscal climate is paying for the health services they provide children. Sustainable, ongoing funding sources are critical to any school strategy for improving children's health. Medicaid, the federal health insurance program for low-income individuals, can be a key funding stream for schools. Throughout the nation, and throughout California, Medicaid (called Medi-Cal in California) provides partial reimbursement to schools and districts for some health and related services provided to eligible students.

California could significantly increase the reimbursement it receives from the federal government for health services and related administrative activities in schools. The California Endowment estimates that California schools could increase their billing by at least $86 million—1.5 times current revenue.[1] If the programs were improved and more schools would participate, California could realize these dollars. In a time of shrinking budgets, leveraging this reimbursement is critical.

California gets federal dollars for health-related services and activities in schools through two federal programs. Known in California as the **Medi-Cal LEA Program ("LEA Program")**, the first program garners federal Medicaid funds as reimbursement for **health services** provided to students such as health and mental health evaluation, physical therapy, certain nursing services and health assessments.[2] These services are provided and invoiced by Local Education Agencies (LEAs). Local Education Agencies include school districts, county offices of education, community colleges, and California State and University of California campuses.[3] For purposes of this report, we will refer to Local Education Agencies as "districts" or "school districts" since most billing through the LEA Program in the state is done by school districts.

While the amount California bills the federal government through the LEA Program has increased over the past five years, significant room for growth remains. Last year, only 45 percent of California school districts —500 of 1,100 districts—participated in the program. Even with less than half of all districts utilizing the LEA Program, California's schools billed for $91 million in services in 2003-2004. With additional districts participating, the state clearly could realize increased federal revenue.

The LEA Program has even more potential when coupled with another federal program that reimburses schools for **health-related administrative activities**, known in California as the **Medi-Cal Administrative Activities Program ("MAA Program")**. Through the MAA Program, the federal government reimburses school districts and counties for Medicaid-related administrative activities, such as health insurance outreach and enrollment activities. (This report focuses on school district billing through MAA, not MAA billing by counties.) School district participation in the MAA Program also can improve—only 42% of California school districts claim MAA reimbursements. Many districts that claim MAA are large—their participation accounts for 70% of enrolled students. However, many non-participating districts are performing activities for which they could receive partial federal reimbursement and districts that are participating may not be optimizing their billing. While MAA reimbursement increased dramatically from $15.3 million in 1999-2000 to $91 million in 2002-03, the California State Auditor estimates that the state could have received at least $57 million more in 2002-03 if more districts participated and if other districts maximized their billing.[4]

Although the LEA and MAA programs are distinct from each other, they are complementary: if a district maximizes billing for administrative activities through the MAA Program by conducting outreach and enrollment, it can ensure that all of its Medi-Cal eligible students are enrolled in the program. If the district then provides those students with health services that are billable through the LEA Program, it may be able to leverage additional dollars. While school districts do not have to participate in either program, when they participate in both they optimize federal reimbursement.

The administration of the MAA and LEA programs varies significantly among districts and schools. While the state has regulations governing billable services and reinvestment requirements, whether—and how—a district or school bills and reinvests the reimbursement revenue is largely dependent on staffing and school administration. Some districts have well-established processes and see 100% participation from their schools. Many more schools and districts choose not to participate at all or, when they do, find the administrative hurdles considerable. For these reasons, it is critical that the state take a leadership role both to encourage and facilitate participation.

In these tough fiscal times for California schools, the LEA and MAA programs afford a unique opportunity to advance the schools' desire to enhance student health and the funding to fulfill that goal. This report describes how the programs work from both a federal and a state perspective, addresses the challenges school

districts face when billing under the programs, and offers recommendations for improvement. In compiling this report, in addition to reviewing written materials, we interviewed school officials throughout California and a number of education and health officials from other states. Consumers Union also convened a group of representatives from diverse districts around the state to discuss the LEA and MAA programs and how they could be improved. Our recommendations reflect the consensus view of the many individuals we interviewed, representing the spectrum of California communities.


Hemera

THE MEDI-CAL LOCAL EDUCATION AGENCY (LEA) PROGRAM

PROGRAM BACKGROUND AND MECHANICS

THE FEDERAL FRAMEWORK

In 1989, Congress enabled school districts to claim federal funds for health services they provide to students enrolled in Medicaid. Districts can bill Medicaid for these services as long as the district becomes a Medicaid provider and meets requirements regarding licensure, certification and other federal mandates for the Medicaid program.

Federal reimbursement for health services originally focused on specific services available to all students enrolled in Medicaid. Over time, for a variety of reasons discussed below (see discussion of the "free care requirement"), most reimbursement has been for health services for children with special education needs. Congress ensured that Medicaid would pay for certain services provided by schools to children with disabilities and that Medicaid's financial responsibility would precede that of state education agencies.[5]

The requirement that Medicaid reimburse schools for health services provided to children enrolled in special education is related to Part B of the Individuals with Disabilities Education Act (IDEA) which authorizes federal funding to states so that children with disabilities receive a free appropriate education.[6] Under the law, school districts must prepare an Individualized Education Program (IEP) for each child eligible for special education services. An IEP is a written contract that, among other things, requires schools to provide "related services" necessary for disabled children to learn. Related services include developmental, corrective, and supportive services such as speech-language pathology, psychological services, physical and occupational therapy, counseling services and diagnostic/evaluative medical services.[7] According to federal law, reimbursement is available for those health services specified in a Medicaid-eligible child's IEP.[8]

The administration of state billing programs varies significantly. While federal law and regulation govern the program, each state has its own laws further delineating state-specific requirements for billing and for how

money received from Medicaid is "reinvested"—how states or localities spend the money they receive from the federal government. Also, the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers the Medicaid program, has divided the states into regions and each region operates somewhat differently.

CALIFORNIA'S LEA PROGRAM

California established its LEA Program in 1993. The LEA Program is part of Medi-Cal, California's version of the federal Medicaid program, and is administered by California's Department of Health Services (DHS). School districts access funds through DHS—they do not receive reimbursement directly from the federal government. Under the California program, like in other states, districts can bill for certain health services provided to students and they will receive federal reimbursement via DHS. These dollars can then be "reinvested" in a variety of services for students (see below for more detail on California's reinvestment requirements).

Initially, the LEA Program was meant to provide sustainable funding for California's Healthy Start initiative, which was inaugurated in 1991. Healthy Start is a program to create and foster community-school partnerships to improve student learning and support families. Healthy Start services and activities include academic services such as dropout prevention programs, youth development programs such as tutoring, family support activities including case management, health and mental health care and employment assistance. The state requires that districts with Healthy Start programs enroll as Medi-Cal providers and bill through the LEA Program. Over time, especially as LEA billing has focused more in the special education arena, even districts without Healthy Start programs have begun to bill through the LEA Program. Despite this increase in participation, fewer than half of California's school districts currently participate.

California requires that all participating districts sign a "provider participation agreement." The agreement obliges districts to comply with relevant California laws and regulations and use qualified practitioners. It also lays out requirements for reinvestment of Medicaid dollars. Under California law, schools can bill for services such as health and mental health evaluation, nutritional assessment and education, vision and hearing assessment, medical transportation, nursing services, occupational therapy, physical therapy, mental health and counseling services, school health aide services, speech pathology services and audiology services.[9] State laws and regulations also govern how dollars can be reinvested (see below).

Almost all California districts that participate in the LEA Program use private vendors to do billing. Vendors may have a range of responsibilities in addition to processing the bills from districts and forwarding them to the state. Many vendors offer how-to manuals and conduct trainings. Opinions about vendors vary—many

districts find them invaluable. Others worry that vendors cost too much, do not have enough accountability, and may not always offer sound billing advice.

REINVESTMENT UNDER THE LEA PROGRAM

After a California school district has billed for health services, it receives money back from the federal government (through DHS) and can "reinvest" those dollars. While the federal government has numerous requirements regarding billing and provider requirements, it has little input to and oversight over the reinvestment process. Reinvestment requirements are determined state-by-state. In addition, most states retain some percentage of reimbursement dollars for administration, ranging from 1% to 85 percent.[10] In California, 1% goes to the state for administration. An additional 2 1/2%—not to exceed $1.5 million annually—is earmarked for the implementation of SB 231, a law that seeks to improve the LEA Program (see below).

California has a number of requirements governing reinvestment, but also affords latitude to localities. Districts must reinvest the funds in services specified in state statute.[11] These services can be health, mental health, social and academic support needs benefiting children and their families and may include immunizations, vision and hearing testing, dental services, physical exams, and parenting education. Reinvestment dollars also can go to academic support services, including tutoring, mentoring, and internships, provided that these grants supplement, not supplant, existing programs. In addition, dollars can fund counseling, nutrition services, and onsite Medi-Cal eligibility workers. While the law and regulations describe specific services, the state gives significant leeway to localities to make decisions regarding reinvestment.

The state requires that each participating district form a community collaborative to make decisions on the reinvestment of funds.[12] Many districts have used collaboratives formed under the Healthy Start program to meet this requirement. According to the state provider agreement and under state regulations, the collaborative must involve parents or guardians, teachers, and representatives from agencies that provide services to children in the community, civic and business leadership, the advocacy community, and current safety net and traditional health care providers. The structure of collaboratives varies—some are structured with by-laws and annual meetings, while others are more informal.

How LEA collaboratives spend their dollars varies widely and depends on the history and needs of the school district. Some districts only fund Healthy Start programs, while others annually fund the same staff position, such as a school nurse. Some districts use allocation formulas for distributing dollars while other districts take applications for grants. Finally, some districts only fund special education, since most LEA billing is done for children with special education needs, but this is not required by law.

RECENT DEVELOPMENTS IN CALIFORNIA'S LEA PROGRAM

In 2001, California legislators passed SB 231, a bill aimed at improving the LEA Program.[13] The law requires DHS to improve communication with the federal government, the California Department of Education and school districts. To this end, it mandates the establishment of a Web site for schools and districts. It also directs the department to increase school participation, requires DHS to modify state regulatory requirements that exceed federal requirements and to simplify the claiming process. The law also requires DHS to amend the state Medicaid plan to expand services to ensure that schools are reimbursed for all eligible services not precluded by federal requirements and requires the state to implement the results of a rate study conducted by Navigant Consulting (formerly Tucker Allen).

The law directs DHS to establish an advisory group, consisting of the Department of Education and representatives of various school districts and county offices of education. It also requires that DHS report annually to the legislature, beginning in 2002. The report must include a comparison of California's LEA Program with programs in similar states, a state-by-state comparison of revenues for the program, a summary of DHS activities, recommendations from the advisory committee and action taken as a result, and identification of barriers to LEA reimbursement. Funds to pay for the SB 231 requirements come from a percentage of the total amount billed by school districts (2 1/2 percent), up to $1.5 million annually.

DHS has made progress on a number of fronts mandated by SB 231. To implement the rate study and to expand billable services, DHS submitted a State Plan Amendment to CMS, which the federal government approved in 2005. The Amendment revises the billing rates for existing services and adds a new category of services. It also proposes changes to better reflect how schools actually deliver services. Implementation of the State Plan Amendment should increase billing possibilities for districts, in accordance with SB 231's direction.

On other fronts, the LEA Ad Hoc Advisory Committee required by SB 231 meets monthly and has representation from a variety of school districts throughout the state. The LEA Web site has been up and running since approximately 2001. Also, Navigant Consulting is updating the LEA Provider Manual—reorganizing topics, correcting erroneous information, and making changes to reflect the implementation of the recently approved State Plan Amendment. DHS has not yet submitted any report to the legislature, although this was required as required by SB 231 starting in 2002.

THE MEDI-CAL ADMINISTRATIVE ACTIVITIES (MAA) PROGRAM

PROGRAM BACKGROUND AND MECHANICS

THE FEDERAL FRAMEWORK

The federal government also partially reimburses school districts, counties and community-based organizations for administrative activities that support the Medicaid program. This report solely addresses school-based participation. In order for a state to participate, there must be an interagency agreement between the state Medicaid agency, the state department of education and/or school districts or local entities conducting the administrative activities. The state Medicaid agency submits claims to the federal government and reimbursement is routed back to the school districts through the state.

Some administrative activities are associated with the provision of reimbursable medical services such as coordinating and monitoring health services and arranging for transportation in support of Medicaid-covered health services. Since most reimbursement for health services is for children with special education needs under the LEA Program, the administrative activities associated with health services are generally connected to children with disabilities.

The federal government also reimburses school districts for administrative activities to ensure that all eligible children are enrolled in Medicaid. These activities are not associated with a medical service and include performing outreach and enrollment for Medicaid, developing and distributing materials to inform individuals about the program, facilitating eligibility determinations, and general administration.[14]

Unlike billing for direct health services, when claiming reimbursement for administrative activities, districts do not bill for individual students. Instead, districts determine the amount of time school staff spends performing administrative activities by conducting "time surveys." For a specific time period, staff who perform potentially reimbursable activities record all of their activities (reimbursable or not). The time survey identifies and categorizes administrative activities and is the basis for determining reimbursement.[15] The federal

government discounts the reimbursement for certain activities, based on the number of Medicaid students in each district. Some activities are not discounted, including outreach and facilitating eligibility determinations.[16]

CALIFORNIA'S MAA PROGRAM

California established its current administrative activities billing program—the Medi-Cal Administrative Activities Program (MAA Program) in 1994 and updated it in 1998.[17] California also published an updated manual for the MAA Program in 2004. Like the LEA Program, MAA is administered by DHS, which has overall responsibility for the program.

To administer the school-based MAA Program, DHS contracts with eleven Local Educational Consortia (LECs) and twenty Local Governmental Agencies (LGAs) to work with school districts throughout the state. LECs can be school districts, community colleges and county offices of education.[18] LGAs are generally county departments of public health.[19] In 2002-2003, LGAs accounted for 24 percent of MAA invoices while LECs accounted for 76 percent.[20]

To maximize participation in the MAA Program, DHS provides technical assistance to LGAs and LECS.[21] DHS develops and conducts statewide trainings which cover time surveys, invoice preparation, and proper documentation. DHS also conducts site visits and observes LGA and LEC training. Participating LECs and LGAs pay a fee to DHS to help cover administrative costs incurred by the agency.

To bill for administrative activities, districts must contract with the LEC in their region or their local LGA. Districts pay their LEC or LGA an administrative fee, ranging from 3 percent to 10 percent of the district's reimbursement. LECs and LGAs provide a variety of services, including training district staff, overseeing the time survey process, preparation and submission of claiming plans, submission of invoices, and ensuring that districts comply with the MAA Program requirements.[22] Many LECs and LGAs contract with vendors to assist them in meeting the needs of districts.

In addition, many school districts contract with private vendors for help navigating the MAA process. In addition to the fees districts pay their LEC or LGA, some pay a private vendor an amount equal to 8 percent to 13 percent of their reimbursement. In total, some districts pay an amount equal to 20 percent of their MAA reimbursements for administrative costs.[23] Up to 50% of these costs are eligible for reimbursement under the MAA program, unless the fees are contingent upon reimbursement from Medicaid.[24]

Unlike in the LEA Program, no state requirements govern how districts can spend MAA Program reimbursement. Districts do not have to have a reinvestment plan nor does the reimbursement have be used for health-related activities. The fees can go to the districts' general funds, and they can spend it as they desire. However, districts can impose their own parameters on MAA funds, and some do so.

RECENT DEVELOPMENTS IN CALIFORNIA'S MAA PROGRAM

– 2005 Audit –

In 2004-2005, the California State Auditor audited the MAA Program, at the request of the Joint Legislative Audit Committee.[25] The Auditor found that while school district participation in MAA has increased significantly in recent years, California could have received at least $57 more for fiscal year 2002-03. Federal reimbursements increased from $15 million for 1999-2000 to $91 million for 2002-2003, but the majority of California's districts did not participate in the program and some participating districts did not maximize their reimbursements.

According to the audit, the reasons districts did not participate include a belief that the program would not be fiscally beneficial, a lack of awareness about the MAA Program, and time survey concerns.[26] District staff also said they didn't participate due to a lack of personnel to administer MAA, the complexity of MAA administration, and the delay in MAA reimbursement.

The Auditor found that DHS, LECs and LGAs have not done enough to help school districts fully participate in the program and invoice for all federally allowable costs. The audit stated that while LECs do limited outreach to non-participating school districts, they could improve their performance by targeting large school districts with high MAA reimbursement potential.[27] The audit also found that simplifying the MAA structure would increase its efficiency and enhance program oversight.

The Auditor found that DHS has not adequately monitored and evaluated the MAA Program by conducting site visits of LECs and LGAs and collecting data. Thus, DHS cannot easily determine total reimbursements through the MAA Program, the number of participating districts, the amount each district receives in reimbursements, or problem spots within the system. Finally, the audit found that LECs and LGAs are charging fees in excess of their administrative costs.

The Auditor made a number of specific recommendations to improve the MAA Program, and DHS agreed with the majority of the suggestions. On some of the recommendations, DHS expressed a belief that it lacks legislative authority. A number of the recommendations focus on LECs because the Auditor suggested that DHS eliminate LGAs from the school-based MAA Program.

The Auditor's major recommendations are summarized below:

■ DHS should require LECs to perform outreach activities to increase MAA participation. LECs should contact non-participating school districts with potential for high MAA reimbursements and work with participating school districts that are not maximizing their revenues. [DHS agreed that it should hold LECs accountable for maximizing reimbursement by modifying their contracts, developing appropriate performance measures and taking action when performance is unsatisfactory.]

■ DHS should improve monitoring of LECs and LGAs and assist in maximizing MAA reimbursement by conducting site visits and by improving data collection processes. [DHS stated that it is addressing these issues and will improve its data and analysis capabilities through the MAA Automation Project, currently underway.]

■ DHS should help districts bill for all reimbursable costs by issuing clear guidance on invoicing. In addition, it should develop policies to ensure that districts, LECs and LGAs avoid duplicate billing. [DHS agrees with this recommendation and states it will issue a policy letter to avoid duplicate billing.]

■ DHS should require LECs and LGAs to prepare annual reports that include participation statistics, outreach efforts and results, fees, and other performance information. [DHS agreed that LECs and LGAs should prepare annual reports and that the agency would compile and disseminate the information.]

■ DHS should develop policies on the appropriate level of fees charged by LECs and LGAs. [DHS does not believe it has authority to implement policies on fees and feels this issue should be handled at the local level.]

■ MAA would be more efficient if DHS required districts to use a vendor selected by their LEC in a competitive process. [While DHS agrees with the merits of this recommendation, the agency doesn't believe it has authority over districts' selections of vendors.]

■ DHS should eliminate LGAs from participating in the MAA process. [DHS disagreed with this recommendation because it believes school districts prefer having a choice between their LEC and their LGA and the agency doesn't want to eliminate local flexibility.]

Senate Bill 496

In the 2005 legislative session, Consumers Union and two California school districts sponsored a bill, SB 496 (Kuehl), to address some of the administrative problems with the MAA Program. The goal of the bill is to increase program accountability and efficiency while increasing the number of school districts claiming MAA reimbursement and helping districts maximize MAA billing. The bill successfully passed the Senate just as the Bureau of State Auditors released its audit of the MAA program. The bill was held in committee in order to consider incorporating relevant audit recommendations. SB 496 will continue through the Assembly during the 2006 legislative year.


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OVERARCHING CHALLENGES FOR THE MAA AND LEA PROGRAMS

Although the MAA and LEA Programs are distinct from each other, a number of common obstacles prevent California from maximizing revenues under both programs. These challenges, as well as opportunities to address them, are highlighted below.

FEDERAL ADMINISTRATIVE ISSUES

California, like many states, faces a number of challenges in seeking Medicaid reimbursement for school health services and administrative activities. States and schools around the country struggle to keep pace with complex and changing regulations and multiple interpretations of federal policy. A number of states report poor communication with CMS, insufficient guidance from the federal government and frustration with inconsistent messages. In 1999 and 2000, the General Accounting Office (GAO) issued reports and provided testimony citing lax federal oversight of payments to schools for health services and for administrative costs. While CMS has addressed some of the issues cited in the GAO reports, the complex nature of the program continues to present obstacles for districts that participate.

In addition to poor federal guidance, many state bureaucracies legitimately fear federal audits. The Office of the Inspector General of the federal Department of Health and Human Services (where CMS resides) has conducted numerous audits of school-based Medicaid billing programs, both for health services and administrative activities. Between 2002 and 2004, the OIG audited many states, including New York, Massachusetts, Oregon, New Jersey, Oklahoma, Washington and Wisconsin. The audits address improper reimbursement of certain services and administrative activities, inadequate monitoring and insufficient documentation.[28] The OIG often recommends improved state monitoring, training and technical assistance and generally imposes financial penalties.

In addition to inconsistent federal guidance and a fear of audits, two components of the Medicaid school-billing program present significant challenges for all participating states –Third Party Liability (TPL) and the "free care requirement." These two issues create significant administrative challenges for districts and signif-

icantly limit the amount of reimbursement districts can receive. Every individual interviewed—whether in California or in another state—stated that these two issues presented major obstacles to an efficient and effective billing program.

While TPL and the free care requirement present significant obstacles for health services billing, they also affect school districts' ability to invoice for administrative activities. As noted, districts cannot bill for administrative activities associated with non-reimbursable health services. However, the TPL and free care requirements do not affect school districts' ability to bill for administrative activities such as outreach and enrollment that are not associated with specific health services.

The administrative burdens of Third Party Liability and the free care requirement mean that districts lose thousands of dollars in potential federal reimbursement. Many districts are providing covered services to Medicaid-eligible children, but unless they meet the onerous requirements set out by CMS to satisfy TPL and the free care requirement, they cannot bill for those services. If the federal government worked with states to address these two issues, school districts throughout the country would have more clarity on how to administer their health and administrative billing programs and would be able to maximize reimbursement for health services and administrative activities to benefit children.

THIRD PARTY LIABILITY

Third Party Liability (TPL) refers to the legal obligation of certain health care payers, such as private health insurance, to pay the medical claims of Medicaid beneficiaries before Medicaid pays these claims.[29] This means that as a Medicaid provider, a district is required to bill a private health insurer *before* billing Medicaid. This situation arises, for example, when a Medicaid-enrolled child also has partial coverage under a parent's private insurance policy. If the child has reached the lifetime limit with the private insurer, the insurer would deny the claim. As long as the child is eligible for Medicaid and Medicaid covers the service, once the private insurer has been billed and has denied payment, the school district can bill Medicaid.

The TPL requirement, as currently administered, creates an unnecessary and significant administrative burden for school billing programs. In seeking reimbursement before billing Medicaid, schools and districts are subjected to significant delays, costs and administrative burdens of sending letters to parents of students enrolled in Medicaid asking for permission to bill private insurance, verifying information about third-party insurers, and accumulating denial letters. The return on investment is low for two reasons: the number of students who receive Medicaid with third party insurance is low and, even when there is additional insurance, many private insurers deny payment for school-based services.

Federal law permits a more efficient and effective way for school districts to seek TPL reimbursement.[30] For certain services, Medicaid providers can seek third-party reimbursement *after* billing Medicaid, under a "pay and chase" method. In September 2005, CMS denied a request from California to allow it to bill third party insurers using the pay and chase method for certain services. Given the denial, current California law still stands and requires that prior to submitting a claim to DHS, providers must first seek payment from any private or public health insurance coverage to which the Medi-Cal eligible child is entitled.[31]

THE FREE CARE REQUIREMENT

The "free care requirement," outlined in a CMS technical assistance guide but not in regulation or statute, precludes Medicaid from paying for the costs of services and activities which are available to all students without charge. For example, if a school offers routine vision and hearing screenings to all students free of charge, the school cannot bill Medicaid for those services provided to students enrolled in Medicaid nor can it bill for any administrative activities associated with the services. The only way districts can bill for these services is to meet three requirements. The provider (district/school) must: 1) establish a fee for each service it wants to bill for; 2) collect third party insurance information from *all* children served (both Medicaid and non-Medicaid students) and 3) bill other responsible third party insurers for *all* children (both Medicaid and non-Medicaid students) who have third party insurance.[32]

Services provided under the Individuals with Disabilities Education Act (IDEA) are exempt from the free care requirement.[33] The free care requirement is the reason that most districts only bill for services provided to students with special education needs, as specified in their Individualized Education Programs (IEPs).

In the last several years, CMS has outlined and enforced administrative requirements regarding "free care." Many states, California included, have significantly reduced their billing to the federal government because the free care requirements are too cumbersome to meet. For example, California districts were billing Medicaid for vision and hearing screening services for Medi-Cal eligible students that are provided to other students free of charge. In the past few years, the majority of districts have discontinued that billing because of the administrative burden associated with the "free care" provision. Thus, even though districts are providing health services to children enrolled in Medicaid, they are not reimbursed for those costs because they cannot meet the administrative requirements established by CMS.

The state of Oklahoma filed an administrative challenge of the federal free care requirement. Stemming from a federal audit and a disallowance of almost $2 million dollars in Medicaid funds received by the state of Oklahoma, that state argued that the free care requirement does not have the force of law. The Departmental Appeals Board of the federal Department of Health and Human Services agreed and found that that the "free

care principle" outlined in a CMS 1997 manual "Medicaid and School Health: A Technical Assistance Guide," was not an interpretation of any provision of the Social Security Act nor of any regulation implementing federal law. The Board found that Oklahoma was only required to seek third-party reimbursement for the cost of certain services provided to Medicaid-eligible students (meeting the Third Party Liability requirement). The state was not required to seek reimbursement for services provided to students *who are not eligible for Medicaid*, as CMS has contended in its 1997 manual. The Board essentially concluded that the free-care requirement, as applied to specific services Oklahoma was providing to students, did not apply.[34]

The impact of the Oklahoma decision is unclear. While the ruling applies only to the facts in the Oklahoma case, it could have broader applicability. While a number of states are hoping that the decision will set a precedent that minimizes the impact of the free care requirement on school billing practices, CMS may attempt to codify the requirement. In any event, states will have to directly address this issue with CMS—either through legal action or negotiation—to overcome the chilling effect of the free care requirement.

CALIFORNIA'S ADMINISTRATIVE ISSUES

In addition to the issues presented by federal administration of the Medicaid school billing programs, interviews with school personnel throughout California revealed impediments within California's LEA and MAA system. A number of these challenges are similar to those faced by other states. More than half of California's school districts don't participate in the MAA or LEA Programs. While it is probably not worth the investment for some small districts to participate, there are many that could benefit from reimbursement dollars. Interviews with school officials and the conclusions of the California Auditor identify multiple obstacles to participating in the programs, including a significant administrative burden, a lack of clear and consistent communication with the state, low school awareness about the program and its mechanics, and a school district belief that participation would not be fiscally beneficial.

ROOM FOR IMPROVEMENT: RECOMMENDATIONS

A number of concrete state reforms could address low participation and obstacles for districts already participating. Interviews with California stakeholders and officials from other states identified key components of successful state health service and administrative billing programs. While MAA and LEA are distinct, the characteristics of a good state-billing program are the same for both:

■ Clear and consistent communication between the state and districts. Good communication is essential to ensure districts understand program parameters and procedures. Strategies include regular trainings, ongoing technical assistance, clear provider manuals and up-to-date Web sites.

■ Strong collaboration between the state's health and education agencies. In many states, the education agency takes a lead role in administering the program, although the state's health agency must be involved since it is the conduit to CMS. Education and health are different arenas and cultural and administrative differences between these two fields can impede the effectiveness of the billing program. Creating and clarifying appropriate roles for each agency is key.

■ Structures for monitoring school billing and reinvestment to ensure schools are operating within the boundaries established by state and federal law. Effective monitoring could ameliorate concerns about audits.

■ For stability and effectiveness, state and school district should support institutionalizing the billing programs so they are part of the regular business of school health programs. With the billing system firmly in place, districts can draw on a fairly stable source of funding for health care for vulnerable children.

Taking these components into account, stakeholders in California can take a number of concrete steps to realize a high quality Medicaid billing system that garners the maximum in federal funding. Recommendations for improving the program are outlined below.

RECOMMENDATIONS

The California Department of Education should work in partnership with the Department of Health Services to administer the LEA and MAA programs

California's Department of Education currently plays a minimal role in the administration of the MAA and LEA Programs—the Department of Health Services administers both programs. Schools are the Department of Education's natural constituency and increasing that department's involvement could increase the visibility of both LEA and MAA billing, entice more schools to participate and help districts that already bill through the programs. The Department of Education could assume a number of responsibilities:

- "Sell" the LEA and MAA programs to non-participating districts as well as translate health information and regulations for participating districts. The Department could take the lead in writing user-friendly best practices manuals.

- Compile anecdotal information about how federal reimbursement dollars benefit districts.

- Collect information from districts and provide analysis and reports detailing the successes of the LEA and MAA programs and identifying needed systemic reforms.

- Troubleshoot for districts in their interactions with DHS.

- In the case of the LEA Program, the Department could work with districts to improve the reinvestment process. Reinvestment decisions should remain in the hands of local collaboratives, but the Department could collect and distribute case studies about reinvestment processes and decisions.[35] The Department also could field and respond to district concerns about their local LEA reinvestment process.

- For the MAA Program, the Department of Education could respond to district concerns about their LEC or LGA and work with DHS to improve any problems encountered by districts.

Many states have their education agency take the lead for all or part of their school Medicaid billing program and a number of states employ interagency agreements or Memoranda of Understanding (MOUs) between the education and health agencies. In Indiana, as part of their LEA program, the education department provides assistance to the health department with research, budget preparation, and financial reporting, and works on policy discussions on behalf of schools.[36] In Texas, the Department of Health has jurisdiction over rate setting and billing for health services, while the Education Department is responsible for communicating with school districts and answering questions about IEPs. The two Texas agencies conduct joint trainings for districts and for vendors and share monitoring responsibilities.

As many states have done, the California Department of Education could create a staff position to manage the LEA and MAA programs. This position could be funded through LEA and MAA dollars or with federal funds available through Part B of IDEA (as other states, such as Iowa, do).
DHS must remain involved in both programs, given its administration of the Medi-Cal program and federal requirements. The agency has significant knowledge of Medicaid and, as the state health agency, is the conduit to the federal government.

DHS should improve communication with schools and districts

The volume of information and the complexity of the Medicaid program require good communication and training. The state must improve communication with school districts and ensure the information it provides is clear and consistent.

- The state should regularly update manuals and Web sites, conduct ongoing trainings and provide clear answers to district questions. While DHS has taken steps in this area, specifically through the LEA Web site and the LEA advisory group, almost all individuals interviewed expressed frustration over a lack of clarity and consistency of information in both the MAA and LEA programs. To maximize participation in these programs, districts must have a place to go, a number to call, and a state employee to rely on for accurate and efficient answers to questions.

- DHS should establish an advisory group for MAA as the agency did for the LEA Program. A variety of school districts are represented on the group and its work has proven to be a helpful vehicle in improving the LEA Program. While both LECs and LGAs have committees that communicate with DHS, the agency should have a mechanism to hear directly from school districts.

- The state should consider reinstituting an effort akin to the LEA technical assistance project that the state established in 1998, but has since expired. Such a project could focus on both MAA and LEA and would involve outreach to all schools, building the cost/benefit argument, training and manuals to explain rules on billing, guidance for choosing a vendor and tools for self-auditing.

- Because there are information gaps, many districts rely on their vendors for information. However, DHS does not communicate with vendors so the information loop is not complete, efficient, or effective. The state might consider a vendor training or conference to ensure that information is consistent.

DHS, working with the Department of Education, should actively monitor the MAA and LEA programs

The state should ensure it is sufficiently monitoring the LEA and MAA programs. The recent state audit of the MAA Program highlighted that DHS should improve monitoring and accountability by modifying its contracts with LECs and LGAs to ensure that they are maximizing district participation, by developing performance outcome standards, and by enhancing reporting requirements. DHS has taken a number of steps

in this direction, especially with regard to the MAA Program. It submitted and received approval for budget changes that fund additional staff to monitor the MAA Program. DHS also agreed with many of the Auditor's recommendations to improve its oversight of the MAA Program and, hopefully, will implement the suggestions in the near future.

DHS should ensure that the MAA Program is accessible to participating districts. As the audit highlighted, DHS does not have a selection process for their contracts with LECs and LGAs. In effect these regional administrators have been granted permanent tenure. Though in most circumstances the LECs and LGAs successfully serve as intermediaries between the districts and DHS, accountability requires some process by which participating districts can notify DHS of any concerns they encounter with their regional administrator. Such a process would likely improve the services school districts receive and, ultimately, result in lower costs and higher revenues for districts.

■ DHS should continue to address the Third Party Liability issue and the free care requirement

Everyone interviewed agreed that the Third Party Liability (TPL) issue and the free care requirement present significant administrative and billing obstacles for districts. While these issues directly affect the LEA Program, they also hinder administrative billing.

DHS has taken concrete steps to address both of these issues. To help schools meet the TPL requirement, the state surveyed insurers about whether they would pay for certain billable services provided by school and has posted the results on the LEA Web site. DHS also requested a waiver from CMS of the TPL and free care requirement, pointing to the Oklahoma decision (see above). In September 2005, CMS denied the waiver request. Still, the state may want to consider other steps to address these two issues. While the impact of the Oklahoma decision is unclear, it provides an opportunity for states to address one of the biggest obstacles in the Medicaid billing program for schools. Efforts in this area could result in more dollars for California's schools.

■ School districts should institutionalize the LEA and MAA programs

The success of a district's billing program (both for MAA and LEA) often is dependent upon a positive track record with the program and a supportive superintendent or other administration official and a staff person who dedicates at least some portion of her time to maintaining a district-wide health services and administrative billing program. Staff can be a liaison to the providers that do the billing, a convener of the reinvestment collaborative (in the case of the LEA Program) and a champion for the benefits of billing. The districts that are most successful in the LEA and MAA programs have one or two staff working on Medi-Cal reimbursement and generally have the support of a superintendent or other administrator.

- School boards should consider passing a supportive resolution and creating a permanent staff position to manage the LEA and MAA programs.

- District administration could include information about the LEA and MAA programs in staff training and could incorporate the programs into the district's business plan.

- District staff should be informed about how revenue generated through the LEA and MAA programs benefit their district. While this may be challenging, especially with MAA dollars since there are no requirements about how districts spend their reimbursements, staff should know how the work they do in these programs benefits students.

- Districts also should consider providing incentives to staff to participate in these programs. DHS and the Department of Education could assist in these efforts by collecting and disseminating best practices for encouraging staff participation.

- Districts should consider working together to improve the MAA and LEA programs. Over the past two years, Consumers Union has convened a group of school districts from around the state and found their insights invaluable. Building on that effort, a larger group of more than twenty-five districts recently formed the California MAA Coalition to make certain that California's students reap the full benefit of the MAA Program. The group seeks to improve the MAA Program by providing input to and asking for accountability from the state and the entities with which it contracts.

Districts should consider automation of billing processes

Districts should consider automating billing processes, with assistance from and in concert with DHS and Department of Education. For example, the Los Angeles Unified School District (LAUSD) has automated its billing processes, which we understand has made billing processes more efficient and effective. Although LAUSD is large, other districts could follow suit by borrowing specifications that are already developed and/or by banding together and forming consortia to develop and purchase automation software.

State legislators should ensure California is leveraging available federal dollars

State legislators should monitor administration of the LEA and MAA programs and be proactive in pushing program improvements. Given budget shortfalls, capturing more federal dollars should be a priority for the California Legislature. Legislators could, for example, support a more active role for Department of Education and encourage (or mandate) collaboration between that department and DHS. The recent audit of the MAA Program noted that legislative support would be helpful as DHS seeks to improve the program.

California's Congressional delegation should advocate federal policies that would create a favorable climate for California schools

Because California's MAA and LEA programs are, in many ways, dependent on the federal government, California's Congressional delegation should be involved in improving the program. Senators and representatives should demand better information from CMS and advocate within the federal government for rea-

sonable administrative interpretation (e.g. of the third party liability requirement) and for a strategy that helps schools participate in these programs and collect the share of federal dollars to which they are entitled. Given the federal deficit, the federal government will likely seek to reduce payments to states, not increase them. This is even more reason for the delegation to be involved. While the state needs to be realistic about the federal government's willingness and cooperation to provide more dollars, it should not shy away from aggressively seeking reimbursement to which schools are entitled.

The state's delegation also should monitor the federal audit process. While it is appropriate for the federal government to perform audits on states and districts, the federal government must meet its end of the bargain and ensure that states have clear and consistent information about the federal standards against which they will be audited.


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CONCLUSION

California has the opportunity to leverage more federal dollars for its most vulnerable children and to fill gaps in school funding with federal dollars to which schools are entitled. Through the concrete recommendations discussed above, the state could encourage more schools to participate in the MAA and LEA programs and could make the program more user-friendly and efficient for districts already participating. The benefits are obvious—more dollars to fund valuable programs for California's children.

NOTES

1 Health Management Associates, prepared for The California Endowment, *Revenue Maximization Strategies: Final Report*, December 2004.

2 Cal. Wel. & Inst. Code §14132.06(f).

3 A Local Education Agency (LEA) is defined as "the governing body of any school district or community college district, the county office of education, a state special school, a California State University Campus, or a University of California campus." Cal. Welfare and Institutions Code §14132.06(h).

4 California State Auditor, *Department of Health Services: Participation in the School-Based Medi-Cal Administrative Activities Program Has Increased, but School Districts Are Still Losing Millions Each Year in Federal Reimbursements*, August 2005.

5 42 U.S.C. §1396b(c).

6 20 U.S.C. §1400(d)(1)(A).

7 20 U.S.C. §1401(22).

8 42 U.S.C. §1396b(c).

9 Cal. Wel. & Inst. Code §14132.06(f).

10 U.S. General Accounting Office, *Medicaid in Schools: Poor Oversight and Improper Payments Compromise Potential Benefit*, testimony before the Committee on Finance, U.S. Senate, 106th Cong., (2000), retrieved from www.gao.gov/archive/2000/h60087T.pdf.

11 Cal. Ed. Code §8804(g).

12 Cal. Ed. Code §8806.

13 Although SB 231 was scheduled to sunset in January 2006, in the 2005-2006 legislative session, the legislature extended the bill's provisions until January 2010.

14 *Id.* at 4.

15 *Id.* at 8.

16 *Id.* at 12.

17 The state established the new MAA Program in 1994 as part of a settlement with federal auditors who had disallowed $335 million in reimbursement claimed through the MAA Program's predecessor, the Medi-Cal Administrative Claiming (MAC) Program. The disallowance resulted from limited state oversight, a lack of documentation and claiming inaccuracies. As a result of the settlement, the state also separated the MAC Program from its Targeted Case Management (TCM) Program. TCM is another program through which the state can be reimbursed by the federal government. This report does not discuss the TCM Program, which DHS also administers.

18 Cal. Wel. & Inst. Code §14132.47(q)(1). *See also* California Department of Health Services, *California School-Based Medi-Cal Administrative Activities Manual,* July 2004 at 3-4.

19 Cal. Wel & Inst. Code §14132.47(o). A local governmental agency can be "a county, chartered city, Native American Indian tribe, tribal organization, or subgroup of a Native American Indian tribe or tribal organization."

20 California State Auditor, *Department of Health Services: Participation in the School-Based Medi-Cal Administrative Activities Program Has Increased, but School Districts Are Still Losing Millions Each Year in Federal Reimbursements*, August 2005 at 7.

21 Cal. Wel. & Inst. Code §14132.47(x).

22 Cal. Wel. & Inst. Code §14132.47(r).

23 California State Auditor Report at 41.

24 California Department of Health Services, *California School-Based Medi-Cal Administrative Activities Manual,* July 2004 at 4-3.

25 As a result of a bill introduced in the 2003 legislative session (AB 2270, sponsored by Consumers Union and introduced by Assembly Member Wilma Chan), the Audit Committee asked the Bureau of State Audits to examine the MAA Program and specifically focus on DHS' relationship with CMS; DHS guidelines for LECs and districts and its relationship with those entities; the process by which DHS selects, monitors and evaluates LECs and LGAs; how DHS establishes payment rates; and the effectiveness of LGAs and LECs in administering MAA and ensuring maximum participation by school districts. The Committee also asked the Auditor to conduct a survey of school districts regarding their participation in the program.

26 California State Auditor Report at 20.

27 Because the Auditor recommended the elimination of LGAs from the MAA process, it framed many of its findings and recommendations for improvement on LECs.

28 Health and Human Services Office of Inspector General, *Semiannual Reports*: October 2003-March 2004 at 11-13; April-September 2003 at 7-9; April -September 2002 at 9. Retrieved from www.oig.hhs.gov/reading/semiannual.html.

29 42 U.S.C. §1396(a)(25).

30 *Id.*

31 Cal. Wel. and Inst. Code §14023.7.

32 Centers for Medicare & Medicaid Services, *Medicaid School-based Administrative Claiming Guide* at 20.

33 *Id.*

34 *Oklahoma Health Care Authority*, Department of Health and Human Services, Departmental Appeals Board, Appellate Division, DAB No. 1924, June 14, 2004. Denial of Request for Reconsideration, Ruling No. 2005-1, January 25, 2005.

35 While districts are required to submit an annual report about reinvestment, the form is brief without providing substantive information. The Department could ensure the state utilizes these reports in a meaningful way.

36 Indiana Department of Education, Indiana Family and Social Services Administration & Indiana State Budget Agency, *Medicaid Billing Guidebook,* August 17, 2004 at 3-2-2.

APPENDICES

APPENDIX A

GLOSSARY

Center for Medicare & Medicaid Services (CMS): CMS is the federal agency that oversees the Medicaid program, as well as Medicare, the State Children's Health Insurance Program (SCHIP) and other health-related programs.

Free Care: The "free care requirement," as interpreted by CMS, precludes Medicaid from paying for the costs of health services and activities which are provided free to all students by a school district.

Individualized Education Program (IEP): An agreement written by a team of education professionals, with input from parents, describing a student's level of functioning, necessary special education and related services, annual goals and benchmarks and decisions relating to a child's care.

Individuals with Disabilities Education Act (IDEA): The federal law that entitles children with disabilities to a free and appropriate education which emphasizes special education and related services designed to meet their needs. The law protects the rights of children with disabilities and their parents, assists states and localities in providing for the education of children with disabilities and authorizes federal funding.

Local Education Agency (LEA): The governing body of any school district or community college district, the county office of education, a state special school, a California State University Campus, or a University of California campus.

LEA Collaborative: A group established pursuant to state law that makes decisions about the reinvestment of funds available through the Medi-Cal Health Services Billing Program. California's Education Code requires these collaboratives to include parents or guardians, teachers, and representatives from agencies that provide services to children in the community, civic and business leadership, the advocacy community, and current safety net and traditional health care providers.

Local Educational Consortium (LEC): A LEC is an LEA that coordinates the MAA Program services for one specific region. Each LEC represents one of the 11 service regions of the California County Superintendents Educational Services Association (CCSESA). School districts currently must go through their respective region's LEC or their county's Local Governmental Agency (LGA) to claim reimbursement through the MAA Program.

Local Governmental Agency (LGA): Generally a local public health office or county agency that oversees the MAA Program for its county. An LGA can be a county, chartered city, Native American Indian tribe, tribal organization, or subgroup of a Native American Indian tribe or tribal organization.

Medi-Cal Administrative Activities Program (MAA): A program that provides partial federal reimbursement to school districts that perform health-related administrative activities including providing information to families, referring them to covered services and helping enroll children in state-sponsored health insurance programs.

Medi-Cal LEA Program (LEA Program): A program that allows school districts to draw down federal Medicaid funds as reimbursement for health services provided to students such as health and mental health evaluation, nutrition education, physical therapy, certain nursing services and vision and hearing assessment.

Medicaid: A federal program under Title XIX of the Social Security Act that provides health care coverage to low-income families and individuals and aged, blind and disabled persons and is jointly funded by federal and state governments. Medi-Cal is California's Medicaid program and is administered by the Department of Health Services (DHS).

State Plan: Each state must provide a plan to CMS that outlines its Medicaid eligibility standards, provider requirements, payment methods and health benefit packages. To alter their plans, states may submit a State Plan Amendment or SPA. CMS must review and approve state plans and amendments.

Third Party Liability: Refers to the legal obligations of third parties (individuals, insurers or other programs) to pay all or a part of the medical claims of Medicaid beneficiaries before Medicaid pays these claims.

APPENDIX B

We are grateful to the people who gave their input to and feedback on this report. We have listed them below.

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