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Policy Considerations for California Following the 2014 Reversal of the Medicaid "Free Care Rule"

Erynne Jones, MPH and Tanya Schwartz, MPP, MSW

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Introduction

Health care reform is changing the way that health care services are delivered, with an increased emphasis on prevention and community-based solutions for improving health outcomes. Schools are uniquely positioned to contribute to these broader delivery system transformation efforts – they have regular access to children and are typically trusted by children and parents. This puts schools in a good position to provide health education, preventive and acute care, as well as follow-up and monitoring of chronic conditions. A recent change in federal Medicaid policy has opened the door for reimagining the role of schools in the broader health care delivery system. This brief describes the federal policy change and recommends implementation steps that would maximize the potential for schools to play a strong role in transforming health care delivery.

Background

Providing health services in schools has been shown to increase access to care and improve health outcomes.[1] This is particularly important for more than half of California's children (5.5 million) who are enrolled in Medi-Cal, California's Medicaid program.[2] Many of these children live in medically underserved communities with limited access to health care services. Despite the potential to improve health care access through schools, a federal policy known as the "free care rule" limited states' ability, until recently, to obtain federal Medicaid reimbursement for school-based health services provided to students enrolled in Medicaid. Under this policy, schools could not claim Medicaid reimbursement for services provided to students enrolled in Medicaid if those services were provided at no cost to non-Medicaid students (except for students enrolled in certain special education programs).[3] For example, schools that provided vision and hearing screening to all students free of charge could not obtain Medicaid reimbursement for the portion of those screenings that were provided to Medicaid enrollees.

Although the Centers for Medicare & Medicaid Services (CMS) provided guidance regarding the conditions under which schools could bill Medicaid for services provided to students outside of special education programs,[4] the administrative complexity of the policy was beyond the capacity of most schools. As a result, schools were limited in their ability to draw down federal Medicaid funding for the health services they delivered. Despite two lawsuits brought against CMS in which the courts determined that the free care rule had no basis in federal Medicaid statute, the policy remained in place for over a decade.

On December 15, 2014, CMS issued a letter to State Medicaid Directors that reversed the free care rule, officially permitting reimbursement for Medicaid-covered services provided to Medicaid enrollees, regardless of whether the service is also provided at no cost to other non-Medicaid populations.[5] The reversal removes a major barrier for schools to obtain federal Medicaid funding for student health services. The California Department of Health Care Services (DHCS, the state's Medicaid Agency) submitted a Medicaid State Plan Amendment (SPA) to CMS on September 30, 2015 to implement the new policy. The new policy represents an opportunity for schools in California to improve children's access to health services and to better integrate school health services with the broader health care delivery system.

This policy brief covers the following topics:

1) A brief history of the CMS free care rule;
2) Overview of how California schools obtain Medi-Cal reimbursement for health care services;
3) Implementation of the free care rule reversal in California; and
4) Recommendations for California policymakers to maximize the impact of the free care rule reversal on children's access to health care services.

A Brief History of the CMS Free Care Rule

Prior to 1997, schools were able to obtain federal reimbursement for health services provided to Medicaid-enrolled students, as long as **third party liability** requirements were met.[6] In 1997, CMS changed its interpretation with the publication of *Medicaid and School Health: A Technical Assistance Guide,* which established the "free care rule." Under this rule, Medicaid payment was not permitted for services that were available at no cost to non-Medicaid beneficiaries, with some exceptions. For schools, this meant that Medicaid could only be billed for services provided to Medicaid beneficiaries in cases where every non-Medicaid student's insurance plan was also billed, or if non-Medicaid students were charged for the cost of the services provided. Providers/schools were required to establish a fee schedule for the services they provided, determine whether third party coverage was available for every child served by the provider, and bill the third party for reimbursable services before billing Medicaid. Virtually no schools in California were able to meet these requirements and therefore, did not bill for many of the health services provided in schools.

Third Party Liability: Providers must pursue reimbursement from other sources (such as private health insurance) before Medicaid will pay for services provided to beneficiaries, since Medicaid is considered the "payor of last resort."

Individualized Education Program (IEP): A plan developed for students with disabilities ages 3 to 21 that outlines the special education and related services a child needs in order to obtain a free and appropriate education. Related services are defined in federal law as speech-language pathology and audiology services, interpreting services, psychological services, physical and occupational therapy, recreation, social work services, and school nurse services.

Individualized Family Service Plan (IFSP): A written plan that outlines early intervention services for children under age three. At age three, children on an IFSP often transition into an IEP.

The 1997 guidance provided two exceptions to these rules based on statutory protections for certain populations under the Social Security Act. The exceptions included: 1) Medicaid services covered through an **Individualized Education Program (IEP)** or **Individualized Family Service Plan (IFSP);**[7] and 2) health services provided under the Maternal and Child Health Services Block Grant.[8] Because the free care rule requirements for claiming reimbursement for services provided to students who did not meet these two exceptions were administratively complex and burdensome, most schools only pursued Medicaid reimbursement for students with disabilities who were served through an IEP.[9]

Since the release of the 1997 guidance, both the State of Oklahoma[10] and the City of San Francisco[11] successfully challenged the free care rule in court, arguing that the policy was not based in federal statute. However, the free care rule continued to be applied to school districts nationwide, in large part due to a lack of technical guidance and confusion over whether the lawsuits meant that federal Medicaid reimbursement would be permitted for services provided to all Medicaid enrollees across the country or whether only schools in Oklahoma and San Francisco could qualify for federal reimbursement.

The long-awaited letter to State Medicaid Directors was released in December 2014, formally overturning the 1997 guidance and permitting federal reimbursement for covered services provided to all Medicaid-enrolled students. In order to implement the new policy, states must review their Medicaid state plans to determine under which circumstances schools are currently allowed to bill for services provided to Medicaid-enrolled students. States that had incorporated the free care rule into their Medicaid state plan will need to submit a SPA to CMS with the new policy approach.

School-Based Health Centers: In California, there are currently 243 school-based health centers (SBHCs) that provide various combinations of primary care, mental health, and dental services. SBHCs are run by federally qualified health centers (FQHCs), school districts, and county health departments. The free care rule reversal will impact SBHCs run by school districts by increasing opportunities for Medi-Cal billing. It can also strengthen SBHCs that are run by outside medical providers (e.g., FQHCs, county health departments) by enabling the school district to be an active partner by, for example, hiring more school nurses to coordinate health services with the SBHC.

Overview of How California Schools Obtain Medi-Cal Reimbursement for Health Care Services

School health services in California are provided by Local Education Agencies (LEAs), which are "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."[12] LEAs provide and pay for health services for Medi-Cal-enrolled students through the LEA Medi-Cal Billing Option Program, and they are reimbursed for the administrative activities associated with providing services through the School-based Medi-Cal Administrative Activities (SMAA) program.

LEA Medi-Cal Billing Options Program

Established in 1993, the LEA Medi-Cal Billing Option Program traditionally used a fee-for-service model to obtain reimbursement for Medi-Cal covered services (with a 50 percent federal matching rate).[13] Most LEAs do not have the capacity to conduct the billing process in-house, and therefore contract with a vendor to assist with billing and claims submissions. Since there are no strict requirements for how LEAs must structure their billing process, LEAs use a variety of different models for billing, including:

1) Working with a vendor to process and send claims;
2) Processing the claims completely in-house; and
3) Using a hybrid model in which a vendor conducts parts of the process and in-house LEA staff coordinate with providers.

DHCS has emphasized that while LEAs may be working closely with a vendor to submit Medi-Cal claims, the LEA should contact DHCS (rather than the vendor) with any questions related to billing, payment inquiries, and/or policy changes, since LEAs are ultimately liable for any mistakes in the claim submissions.

LEAs must reinvest the federal reimbursement for Medi-Cal services into support services that supplement, but do not supplant, existing school resources.[14] These support services include:

- Health care services such as immunizations, vision and hearing services, dental services, physical exams, or prenatal care;
- Mental health services such as primary prevention and crisis intervention, assessments, or training for teachers to recognize mental health problems;
- Substance use prevention and treatment;
- Education and support programs for families;
- Academic support services such as tutoring or mentoring;
- Counseling services such as family counseling, suicide prevention, or targeted services for children experiencing community violence;
- Nutrition services;
- Youth development programs such as mentoring or career placement;
- Case management services; and
- Onsite Medi-Cal eligibility workers.[15]

These support services can either be provided directly by the LEA or contracted for through another entity, such as a non-profit organization or county agency. The LEA Medi-Cal Billing Option Program tracks how reimbursement funds were used through an Annual Report process.[16]

School-based Medi-Cal Administrative Activities (SMAA)

The School-based Medi-Cal Administrative Activities (SMAA) program provides federal funding for staff time spent on certain Medi-Cal-related activities that are not reimbursable through the LEA Medi-Cal Billing Options Program. These activities include outreach, referrals, arranging for non-emergency transportation, targeted case management coordination, and program planning. Payment is based on a Random Moment Time Survey (RMTS) methodology, which estimates the proportion of staff time spent on these activities. Federal reimbursement through SMAA can be used to pay for staff salaries, benefits, and other program costs. While SMAA is not affected by the reversal of the free care rule, issues with federal deferral of payment to California schools and challenges with state oversight of the program have left schools wary of expanding their role in delivering and claiming payment for health services.[17]

Implementation of the Free Care Rule Reversal in California

On September 30, 2015, California submitted a state plan amendment (SPA) to CMS to permit LEAs to qualify for Medi-Cal reimbursement for covered services provided to all students in Medi-Cal, regardless of whether the services are part of an IEP. The proposed SPA also adds new services and additional types of providers that would qualify for reimbursement under the LEA Medi-Cal Billing Option Program and revises the payment methodology from fee-for-service to the RMTS methodology used in the SMAA program to streamline the administrative process for both programs.

Table 1 (below) outlines the assessment and treatment services, as well as the practitioners that currently qualify for federal reimbursement under the LEA Medi-Cal Billing Option Program and highlights the additional services and providers that will be added upon approval of the proposed SPA for all Medi-Cal enrollees. In addition to these services and practitioners, DHCS initially planned to include interpreter services, dental screening services, specialized assessments, and some behavioral health services. However, these services were removed from the SPA to avoid duplication of Medi-Cal services available through other Medi-Cal programs.

DHCS staff are using a variety of strategies to communicate the proposed changes to LEAs as they negotiate the SPA with CMS, receive feedback from stakeholders, and develop resources to help LEAs understand the process for obtaining federal reimbursement. DHCS currently hosts an open ad hoc work group every four to six weeks to discuss program changes, sends out informational e-mails, maintains a website with tools and resources, and hosts in-person trainings and webinars to help LEAs understand the LEA Medi-Cal Billing Option Program process.

Once the SPA is approved by CMS, DHCS will need to provide technical assistance and guidance to LEAs to implement the new policy. DHCS will also need to update the LEA Program Provider Manual in collaboration with a review subgroup composed of LEA representatives. DHCS has instructed LEAs to continue using current billing guidelines and practices until further technical guidance is released on the new policy.

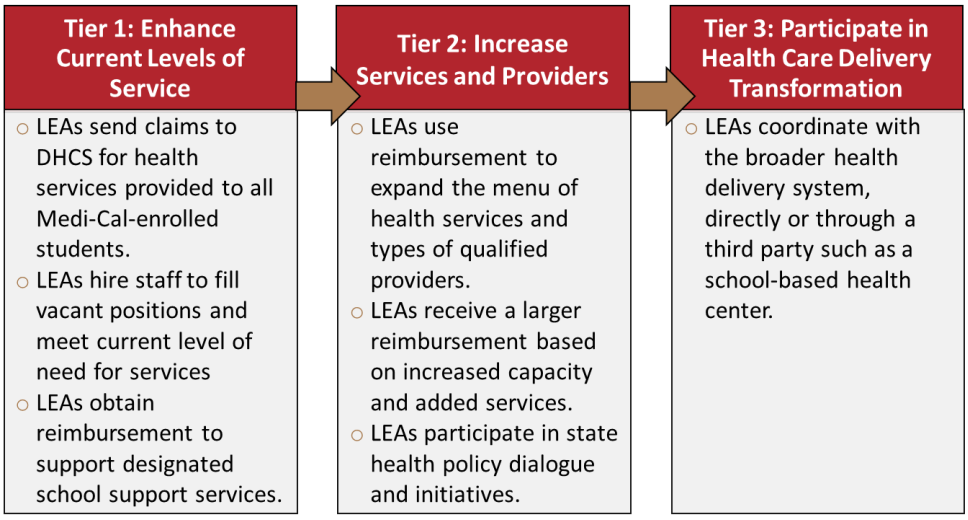
Table 1: LEA Medi-Cal Billing Option Program Qualified Services and Practitioners Prior to 2015[18] and Proposed SPA Additions		
	Pre-2015 Qualified Services and Practitioners*	**Proposed Additional Services and Practitioners for All Medi-Cal Enrollees**
Assessments	IEP/IFSP only • Psychological • Psychosocial Status • Health • Health/Nutrition • Audiological • Speech-Language • Physical Therapy • Occupational Therapy Non IEP/IFSP • Psychosocial Status • Health/Nutrition • Health Education and Anticipatory Guidance • Hearing • Vision • Developmental	• Respiratory Therapy • Orientation and Mobility Assessment
Treatments	IEP/IFSP only • Targeted Case Management Non IEP/IFSP • Physical Therapy • Occupational Therapy • Individual/Group Speech Therapy • Audiology • Individual/Group Psychology and Counseling • Nursing Services • School Health Care Aide Services • Medical transportation	• Personal Care Services • Orientation and Mobility Services • Respiratory Therapy

	Pre-2015 Qualified Services and Practitioners*	Proposed Additional Services and Practitioners for All Medi-Cal Enrollees
Qualifying Rendering Providers	• Licensed registered nurse • Certified nurse practitioner • Licensed vocational nurse • Trained health care aide • Licensed physician/psychiatrist • Licensed optometrist • Licensed clinical social worker • Credentialed school social worker • Licensed psychologist • Licensed educational psychologist • Credentialed school psychologist • Licensed marriage and family therapist • Credentialed school counselor • Licensed physical therapist • Registered occupational therapist • Licensed speech-language pathologist • Speech-language pathologist • Licensed audiologist • Audiologist • Registered school audiometrist • Program specialist • Licensed physician assistant • Registered dietitian	• Personal care assistant • Registered speech-language pathology assistant • Licensed physical therapy assistant • Licensed occupational therapy assistant • Orientation and mobility specialist • Licensed respiratory therapist • Registered marriage and family therapist intern • Registered associate clinical social worker

*Note: Under the proposed SPA, targeted case management services would continue to qualify for federal reimbursement only for students with an IEP/IFSP.

Looking Forward: Recommendations for California Policymakers

The free care rule reversal sets the stage for California and other states to have a broader policy conversation about the role schools can play in supporting the health of school-aged children. Once the proposed SPA is approved by CMS, LEAs will primarily focus on implementing the new policy and meeting the current level of need (Tier 1). DHCS can help ease implementation of the Medi-Cal Billing Option Program changes for LEAs by creating a streamlined process, providing technical assistance, and creating opportunities for dialogue. This would enable LEA staff to focus their attention on thoughtfully investing the federal funding to expand school support services and providers (Tier 2). Ultimately, there is an opportunity for health care and education leaders to work together to better integrate school health services into health care delivery transformation (Tier 3).



There are a number of implementation issues that state policymakers will need to address as they expand qualified school health services and practitioners. In order to fully understand these issues, interviews were conducted with key stakeholders during the summer and fall of 2015, including California state staff from DHCS and The California Department of Education (CDE), CMS, LEA representatives, school health providers, managed care plans, vendors, trade associations, advocates, and national health policy leaders. Based on these interviews, this report makes the following recommendations:

(1) Request a federal waiver of the third-party liability requirements;
(2) Strengthen the role of CDE in the LEA Medi-Cal Billing Option Program;
(3) Improve communication between DHCS and vendors on program policy and procedures;
(4) Address data sharing issues; and
(5) Develop and promote models for integrating school health services into the health care delivery system.

Recommendation 1: Request a federal waiver of the third-party liability requirements

Federal Medicaid regulations require states to take reasonable measures to pursue claims from legally liable third parties, such as private insurance plans.[19] Medicaid enrollees are required to cooperate with state agencies to identify third party resources and providers are required to bill legally liable third parties prior to billing Medicaid. It is estimated that only 8.4 percent of children enrolled in Medicaid nationwide are also covered by private insurance.[20] In the school setting, this situation may arise when a child is enrolled in Medicaid and also covered as a dependent under their parent's private insurance coverage.

In California, LEAs are required to confirm that the health services they provide to Medi-Cal beneficiaries are not covered by another insurance carrier before they can be reimbursed by Medi-Cal. In order to do this, LEAs must first send letters to parents of students requesting permission to bill their private insurance, send the claim to the student's private insurer, obtain a letter of denial from that insurance plan, and maintain a record of the denial before billing the Medi-Cal program. Because there were no requirements for managed care plans to respond to the claim with a denial, LEAs have struggled to obtain the documentation required to claim reimbursement from the Medi-Cal program.

California could resolve this issue by requesting a third party liability waiver from CMS. California had a third party liability waiver in place prior to 1997, but was unable to renew the waiver after CMS instituted the free care rule. However, CMS recently affirmed that the third party liability waiver is once again an option that states may pursue.[21] In order to do this, states must demonstrate in writing that the collection of third party liability information for school health services is not cost-effective (such as showing that the costs to collect third party liability information are greater than the amount of funds that would be recovered) and can submit the waiver of third party liability for some or all school-based services. CMS Guidance on the waiver of third party liability is available at 42 CFR 433.138(l) and 433.139(e), and in the State Medicaid Manual at 3904.2. State waiver requests may be submitted through the CMS Regional Office in their area.

Advocates in California have also sought to address the third party liability issue through the passage of Senate Bill 276 (Wolk) in 2015, which permits LEAs to bill Medi-Cal if the managed care plan fails to issue a denial letter within 45 days of the claim submission.[22] However, the authority to allow reimbursement due to a non-response of third party liability coverage is subject to CMS approval and has not been decided upon to date.

Recommendation 2: Strengthen the role of the California Department of Education in the LEA Medi-Cal Billing Option Program

The disciplines of education and health care have historically operated in separate siloes. In the education field, health services have traditionally been viewed as a method of ensuring that students are able to pursue their education, but not as part of the overarching mission of school districts. In the health care field, the role of school-based health centers is often included in conversations on health care delivery system transformation and improving

population health, but school health services provided by LEAs are usually absent from these discussions.

CDE currently plays a minimal role in the LEA Medi-Cal billing process, which is primarily overseen and administered by DHCS. However, CDE is familiar with the regulatory policies and responsibilities that schools must adhere to, which can help with ensuring that information is disseminated to the right individuals and communicated to target the broader education field. If given the proper tools, resources, and authority, CDE could play a much larger role in helping school districts implement the policies proposed in the SPA and consider possibilities for expanding and improving the delivery of services.

Recommendation 3: Improve communication between DHCS and vendors on program policy and procedures

The majority of LEAs in California depend on a vendor to submit claims for Medi-Cal reimbursement. While some LEAs report having strong working relationships with their vendors, others do not and have cited a lack of a direct line of communication between DHCS and vendors as a major problem. While schools are ultimately liable for compliance with the Medi-Cal program, many use vendors as a source of information to supplement the resources provided by DHCS.

Ensuring that vendors have accurate and timely information from DHCS, including information on important policy and regulatory changes, would enable them to help LEAs understand and meet state requirements to participate in the program. Additionally, acknowledging the role that vendors play in many LEA programs could help the state develop additional resources to empower LEAs as they improve their billing infrastructure, such as sample contract language and resources to assist LEAs in selecting a vendor or bringing their billing infrastructure in-house.

Recommendation 4: Address data sharing issues

Information sharing across sectors is critical to integrating school health services into the broader health care delivery system. Receiving data on school-based health services would benefit managed care plans and primary care providers by giving them a more complete picture of the health services their patients receive. Better communication between schools and health care providers could improve monitoring of chronic conditions, facilitate follow-up after acute visits, and reduce duplication of services. However, there are significant barriers that prevent data sharing. Schools and health care providers operate under different privacy laws and use different data systems to track health-related services.

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule prescribes standards for how patient medical information can be used, accessed, and shared. Under this rule, health care providers that transmit patient information electronically to health plans and other providers must abide by strict privacy safeguards. Generally, health care providers cannot share protected health information without a signed authorization form, but

there are some exceptions, such as sharing information with other providers for the purpose of diagnosing and/or treating a patient.[24]

Education agencies that receive federal funding from the U.S. Department of Education, including public schools, are subject to the Family Educational Rights and Privacy Act (FERPA). FERPA pertains to privacy around educational records, including student health information maintained by the school, and requires parental consent for the release of information until the child is 18 years of age.[25] Under FERPA privacy protections, parental consent is necessary for LEAs to transmit Medi-Cal claims to bill a health plan for services or for a school nurse to communicate to a primary care provider, for example, that a student had four asthma attacks in the last week.

A second obstacle to effectively sharing health information between schools and the broader health care system is the inability to share data across systems. Many health care providers outside of the school setting have adopted electronic health records (EHRs) certified by CMS and the Office of the National Coordinator for Health Information Technology (ONC) to document and track patient health information. School districts, on the other hand, use a range of methods to track educational data and health services. The vendor selected by school districts, as well as the staff and financial resources available to schools, greatly impacts their ability to document and bill for health services. Currently, these tracking methods are not compatible with EHR technology used by health care providers outside of schools, making communication between schools and the larger health care system challenging.

Because information sharing is critical for incorporating school health services into broader health care delivery systems, data sharing under HIPAA and FERPA must be addressed. This could include improved guidance from the state on interpretation of federal law or on strategies for working within the law to obtain parental consent. It could also include participation in efforts to change FERPA so that health care information held by LEAs falls under HIPAA. In addition, the state could play a leadership role in encouraging pilot programs to share data across the different information systems used by LEAs and health care providers.

Recommendation 5: Develop and promote models for integrating school health services into the health care delivery system

Health reform at the state and national levels is catalyzing many changes in how care is delivered and financed. Managed care organizations have drastically transformed their service delivery networks to include new types of organizations that are essential to improving patient health outcomes, including county mental health departments, community clinics, and housing services. Schools have the potential to deliver a number of health care services in an accessible and cost-effective manner, including:

- Schoolwide screenings for communicable diseases, obesity, mental health conditions, vision, hearing and dental issues.
- Health education and support groups for both children and parents.

- Follow up with students who were recently discharged from the hospital or treated for an acute condition.
- Monitoring of chronic conditions and medication management.

However, many LEA providers, such as school nurses and speech pathologists, have not been traditionally recognized as Medi-Cal managed care providers, making coordination between school health services and managed care plans extremely challenging.

DHCS should facilitate opportunities for LEAs to participate in the broader delivery system transformation, using successes from pilot programs and local initiatives to guide larger system transformation efforts. CMS, California, and other states, are implementing innovative and comprehensive approaches to care delivery and financing through engaging patients, providing services in locations where people can be reached, and promoting prevention. The role of schools is largely absent from this dialogue around health system transformation. However, the free care rule reversal increases the capacity of schools to deliver reimbursable health services, and therefore is an opportunity to conceptualize a role for schools in major health system reforms, including the Health Homes for Patients with Complex Needs (California's Section 2703 Demonstration),[26] Accountable Communities for Health,[27] and the Whole Person Care Pilots.[28]

Case Study in School-Based Chronic Care Management: In early 2013, a pilot program was implemented between Kern Family Health Care, the local initiative for Medi-Cal managed care, and the Bakersfield City School District to improve asthma management for students. The program focused on activities to reduce asthma-related emergency room usage and hospitalization, including initial and follow up home visits, classroom education, and individual education. Based on the initial success of the program, Kern Family Health Care is exploring the possibility of adding programs focused on nutrition education and obesity prevention.[23] Strategies similar to those used in Kern could be applied to other regions to help schools play a larger role in managing chronic diseases and capture the impact of their involvement on health outcomes, which ultimately impact academic achievement.

Conclusion

As California expands the availability of Medi-Cal reimbursement for school health services through the LEA Medi-Cal Billing Option Program, ensuring that schools have the resources, information, and capacity to participate in the program in a meaningful way is an essential component of enabling schools to be active partners in moving the state towards the goals of the Triple Aim. California is using this opportunity to not only implement the free care reversal, but to redesign the current billing program to expand the types of providers and services that are reimbursable in an effort to increase access to onsite school health services. Once the state's SPA is approved, ongoing communication with stakeholders to identify implementation challenges will help to ensure that they are addressed in real time. Most importantly, the state has an unprecedented opportunity to use this policy change to first restore, then expand, the health services provided by school districts. In doing so, there is further opportunity to create a more effective alignment between school-based services and the care that children receive through health plans and health care providers.

As states work to create models that allow for schools to align with other state and national health reform efforts, sharing best practices and lessons learned with CMS and other states will help schools and state Medicaid agencies to take full advantage of this new opportunity and improve the health and well-being of children nationwide.

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Endnotes

[1] For a compilation of research on the impact of student access to health services and improved attendance, see National Collaborative on Education and Health. (September 2015). Leading Health Conditions Impacting Student Attendance. Available at http://www.attendanceworks.org/wordpress/wp-content/uploads/2011/10/School-Health-Chart-for-CA_Sept9_draft.docx.

[2] Department of Health Care Services. (November 3, 2015). Medi-Cal Children's Health Dashboard (Draft). Figure 1. Available at http://www.dhcs.ca.gov/services/Documents/November_MCHAP_Dashboard_Draft.pdf

[3] Health Care Financing Administration. (August 1997). *Medicaid and School Health: A Technical Assistance Guide.* Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/School_Based_User_Guide.pdf.

[4] Schools could only bill Medicaid for general education students under free care if they met all of the following requirements: 1) a fee schedule is established for each service that the school is billing for; 2) third party insurance information is collected from all children served (including Medicaid and non-Medicaid students); and 3) all third party insurance carriers are billed prior to Medicaid for all children (both Medicaid and non-Medicaid students). See Health Care Financing Administration. (August 1997). Exceptions to the Free Care Rule in *Medicaid and School Health: A Technical Assistance Guide.* Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/School_Based_User_Guide.pdf.

[5] Centers for Medicare and Medicaid Services. (December 15, 2014). Medicaid Payment for Services Provided without Charge (Free Care). *State Medicaid Director Letter# 14-006.* Available at http://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf.

[6] Under Title XIX of the Social Security Act Section 1902(a)(17)(B).

[7] Pursuant to the Individuals with Disabilities Act (IDEA).

[8] Health Care Financing Administration. (August 1997). Exceptions to the Free Care Rule in *Medicaid and School Health: A Technical Assistance Guide.* Available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/School_Based_User_Guide.pdf.

[9] While the free care rule includes exceptions for IEPs and IFSPs, IFSPs are only available through age 2, while IEPs are used for children ages 3-21.

[10] Department Appeals Board (DAB) Ruling: Oklahoma Health Care Authority and Free Care, U.S. Department of Health and Human Services (HHS), June 14, 2004.

[11] San Francisco Unified School District v. State of California (2009) Superior Court of California Case No. CPF-0905094999. Verified Petition for Writ of Mandamus and Verified Complaint for Declaratory and Injunctive Relief.

[12] California School-Based Health Alliance. (December 2013). About School-Based Health Centers Factsheet: Overview of School-Based Health Centers with Map. Available at http://cshca.wpengine.netdna-cdn.com/wp-content/uploads/2014/04/CASBHCs-Map-Overview-2014.pdf.

[13] California Welfare and Institutions Code §14132.06.

[14] California Welfare and Institutions Code §14132.06(c).

[15] California Education Code §8804(g).

[16] A sample Annual Report can be viewed at http://www.dhcs.ca.gov/provgovpart/Documents/ACLSS/LEA/PPA%20AR/Annual_Report_SAMPLE.pdf.

[17] For an overview of challenges and recommendations pertaining to the SMAA program, see the California Auditor's Report 2014-130. (April 10, 2015). *California Department of Health Care Services: It Should Improve Its Administration and Oversight of School-Based Medi-Cal Programs.* Available at https://www.bsa.ca.gov/pdfs/reports/2014-130.pdf

[18] Department of Health Care Services. (2012). *Report to the Legislature: Local Educational Agency Medi-Cal Billing Option Program.* Available at http://www.dhcs.ca.gov/provgovpart/Documents/ACLSS/LEA/LEA%20Legislative%20Reports/LEA%20Medi-Cal%20Billing%20Option%20April%202011%20through%20May%202012.pdf.

[19] Social Security Act §1902(a)(25).

[20] Government Accountability Office Report. (January 2015). *GAO-15-208 Medicaid Third Party Liability*. Available at http://www.gao.gov/assets/670/668134.pdf.

[21] Email communications with CMS staff, November 15, 2015.

[22] Senate Bill 276 (Wolk); Statutes of 2015.

[23] California School-Based Health Alliance. (2015). Managing Asthma in Schools: Health Plan & School District Partnership. Available at https://www.schoolhealthcenters.org/wp-content/uploads/2015/05/P3-Case-Study_Asthma-Management_Kern-County_FINAL.pdf.

[24] 45 C.F.R. § 164.502 and Cal. Civ. Code § 56.10(c)(1)

[25] 34 CFR §99.30.

[26] For information on the Health Homes for Patients with Complex Needs program, visit http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx.

[27] For information on the Accountable Communities for Health program, visit http://www.chhs.ca.gov/PRI/Pages/ResourcesforACHsReportFINAL.pdf.

[28] For information on the Whole Person Care Pilots through the 1115 Waiver, visit http://www.dhcs.ca.gov/provgovpart/Pages/WaiverRenewal.aspx.