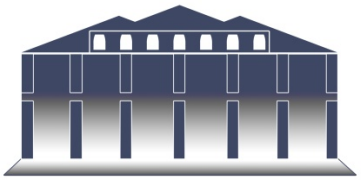
Minimal Evidence Found of Service Duplication for Students with Disabilities in Schools and Communities

Final Report to the Joint Legislative Program Evaluation Oversight Committee

Report Number 2018-12

December 10, 2018



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John W. Turcotte
Director

December 10, 2018

Senator Brent Jackson, Co-Chair, Joint Legislative Program Evaluation Oversight Committee
Representative Craig Horn, Co-Chair, Joint Legislative Program Evaluation Oversight Committee

North Carolina General Assembly
Legislative Building
16 West Jones Street
Raleigh, NC 27601

Honorable Co-Chairs:

The 2018 Work Plan of the Joint Legislative Program Evaluation Oversight Committee directed the Program Evaluation Division to examine how services for students with disabilities are determined and funded and whether duplication of Medicaid services occurs across school and community settings.

I am pleased to report that the Department of Health and Human Services and the Department of Public Instruction cooperated with us fully and were at all times courteous to our evaluators during the evaluation.

Sincerely,

John W. Turcotte
Director

Mandatory Evaluation Components

Report 2018-12: Minimal Evidence Found of Service Duplication for Students with Disabilities in Schools and Communities

N.C. Gen. § 120-36.14 requires the Program Evaluation Division to include certain components in each of its evaluation reports, unless exempted by the Joint Legislative Program Evaluation Oversight Committee. The table below fulfills this requirement and, when applicable, provides a reference to the page numbers(s) where the component is discussed in the report.

N.C. Gen. § 120-36.14 Specific Provision	Component	Program Evaluation Division Determination	Report Page
(b)(1)	Findings concerning the merits of the program or activity based on whether the program or activity		
(b)(1)(a)	Is efficient	**The delivery of services to students is not efficient, but improvements are underway.** The State requires evaluations to be conducted, eligibility determined, and placement completed within 90 days of receipt of a written referral. In Federal Fiscal Year 2015–16, local education agencies met the State's established timeframe 92% of the time. **North Carolina's performance on this indicator is worse than the national average of 98%.** Of the 3,371 referrals exceeding the 90-day period in North Carolina, local education agencies reported 56% of the delays were due to referral paperwork not being processed in a timely manner. The Department of Public Instruction plans to implement the Every Child Accountability and Tracking System (ECATS) in 2019. This new data system should bolster the efficiency of service delivery by improving workflow processes.	22, 41
(b)(1)(b)	Is effective	**Federal performance indicators suggest that services are effective and enable students with disabilities to achieve positive outcomes.** • Between 2007 and 2016, the four-year high school **graduation rate increased by 22%**. • Between 2007 and 2016, the **high school dropout rate decreased by 49%**. • From 2012 to 2016, the **percentage of students enrolled in higher education, enrolled in some other post-secondary education/training program, or employed within one year of departing high school increased by 24%**. **North Carolina's performance exceeded national performance in all of these areas.**	20-21, 40-41
(b)(1)(c)	Aligns with entity mission	DPI's Exceptional Children Division has a mission to ensure students with disabilities develop intellectually, physically, emotionally, and vocationally through the provision of an appropriate individualized education program in the least restrictive environment possible. **This mission aligns with the State Board of Education's mission** to lead and uphold a system of public education in North Carolina that guarantees every student in the state an opportunity to receive a sound basic education.	3

(b)(1)(d)	Operates in accordance with law	The U.S. Department of Education provides oversight to ensure states meet federal Individuals with Disabilities Education Act requirements. **In 2018, the U.S. Department of Education determined that North Carolina was among the 21 states that met requirements of the federal IDEA.**	19
(b)(1)(e)	Does not duplicate another program or activity	The State Board of Education has a duty to monitor local education agencies to determine compliance with the federal IDEA and state law. The State Board, through DPI's Exceptional Children Division, monitors the implementation of all LEAs' Exceptional Children Programs. **The Exceptional Children Division is the sole state entity responsible for monitoring LEAs in the provision of services for students with disabilities.**	3
(b)(1a)	Quantitative indicators used to determine whether the program or activity		
(b)(1a)(a)	Is efficient	The U.S. Department of Education requires each state to report annually on the timeliness of eligibility determinations. **The Program Evaluation Division's efficiency determination is based on Federal Indicator 11, which measures the percentage of children who were evaluated within the State's established timeframe.** North Carolina requires evaluations to be conducted, eligibility determined, and placement completed within 90 days of receipt of a written referral.	41
(b)(1a)(b)	Is effective	The U.S. Department of Education requires each state to report annually on student outcomes. **The Program Evaluation Division's effectiveness determination is based on several Federal Indicators:** • the percentage of youth with individualized education programs (IEPs) graduating from high school with a regular high school diploma within four years (Indicator 1), • the percentage of youth with IEPs dropping out of high school (Indicator 2), and • the percentage of youth who are no longer in secondary school, had IEPs in effect at the time they left school, and were enrolled in higher education or in some other postsecondary education or training program or were competitively employed in some other employment within one year of leaving high school (Indicator 14C).	40-41
(b)(1b)	Cost of the program or activity broken out by activities performed	In Fiscal Year 2016–17, LEAs spent an average of **$1,181 on direct medical services per Medicaid-enrolled student with an individualized education program**. During the same time period, LEAs spent an average of **$38 per Medicaid-enrolled student on Medicaid administrative activities**.	11, 35-39
(b)(2)	Recommendations for making the program or activity more efficient or effective	Recommendation 1 states the General Assembly should direct the Department of Public Instruction to establish methods for soliciting feedback from Exceptional Children Directors of local education agencies. This recommendation should improve the effectiveness of services for students with disabilities by improving the quality of technical assistance for local Exceptional Children Directors.	26-27
(b)(2a)	Recommendations for eliminating any duplication	The Program Evaluation Division **did not find evidence of duplication** in the provision of services for students with disabilities.	N/A
(b)(4)	Estimated costs or savings from implementing recommendations	Neither of the Program Evaluation Division's recommendations will require additional costs nor yield savings.	N/A

PROGRAM EVALUATION DIVISION
NORTH CAROLINA GENERAL ASSEMBLY

December 2018 Report No. 2018-12

Minimal Evidence Found of Service Duplication for Students with Disabilities in Schools and Communities

Summary

The Joint Legislative Program Evaluation Oversight Committee's 2018 Work Plan directed the Program Evaluation Division to examine how services for students with disabilities are determined and funded and whether duplication of Medicaid services occurs across school and community settings.

The Program Evaluation Division found minimal evidence that Medicaid-covered services are duplicated in school and community settings. A Program Evaluation Division analysis of 3.2 million Medicaid claims from Fiscal Year 2016–17 found only 0.4% of paid claims were potentially duplicated across settings. According to the Division of Health Benefits, all potentially duplicated claims are permissible under a federal law that ensures Medicaid-enrolled children receive medically necessary services.

Based on measures collected by the U.S. Department of Education, North Carolina complies with the Individuals with Disabilities Education Act and effectively provides services to students with disabilities; efficiency may be improved with the implementation of the Department of Public Instruction's (DPI) new special education services data system. In 2018, North Carolina was among 21 states to earn a federal determination of meeting IDEA requirements. The State is effective in getting students with disabilities into general classrooms and assisting them with achieving better outcomes. DPI's new Every Child Accountability and Tracking System should improve the efficiency of service delivery for services provided in schools. The Program Evaluation Division also found that DPI's Exceptional Children Division provides technical assistance to local education agencies (LEAs) but does not systematically measure the effectiveness of those efforts.

North Carolina's new health information exchange, NC HealthConnex, could improve service delivery coordination, but failure to meet the statutory connectivity deadline could negatively impact LEA funding. LEAs are at risk of losing state funding if they do not connect to NC HealthConnex by June 1, 2019.

Based on these findings, the General Assembly should

- direct DPI to establish methods for soliciting feedback from LEAs' Exceptional Children Directors and
- direct the Department of Information Technology, in conjunction with the Department of Health and Human Services and DPI, to determine the feasibility of and fiscal impact on LEAs in meeting mandatory NC HealthConnex connectivity requirements.

Purpose & Scope

The Joint Legislative Program Evaluation Oversight Committee's 2018 Work Plan directed the Program Evaluation Division to examine the provision of services for students with disabilities. Specifically, the evaluation examines how services are determined, sources of funding for services, and the extent to which duplication of Medicaid services occurs across school and community settings.

Three central research questions guided this evaluation:

1. How do students with disabilities receive services across school and community settings?
2. What are the funding mechanisms for providing services to students with disabilities in school settings?
3. To what extent are Medicaid services provided to students with disabilities being duplicated across settings?

The Program Evaluation Division collected data from several sources, including

- review of laws and policies guiding the provision of services for students with disabilities;
- review of policies and provider manuals guiding the provision of Medicaid-covered services;
- interviews and queries of Department of Health and Human Services, Division of Health Benefits (formerly the Division of Medical Assistance);
- an analysis of Medicaid claims data;
- interviews and queries of Department of Public Instruction, Exceptional Children Division;
- interviews of Exceptional Children Program Directors at 12 local school administrative units (commonly and hereafter in this report referred to as local education agencies);
- interviews with national and state association representatives; and
- an interview with the Exceptional Children's Assistance Center.

This evaluation focused on the provision of services for K-12 students with disabilities in traditional public schools, excluding pre-K and post-secondary students. Furthermore, the evaluation does not include students with disabilities in non-public educational settings.[1]

Appendix A shows summary statistics of students with disabilities in Fiscal Year 2016–17, including a statewide student profile, LEA expenditures and Medicaid participation, LEA funding for such services, and Medicaid claims and reimbursement.

[1] The Department of Administration's Non-Public Education Division governs non-public schools within the State.

Background

Federal and state law require that individuals with disabilities are provided with a free appropriate public education. Two federal laws have provisions specific to protecting the rights of students with disabilities.

- **Section 504.** Section 504 of the federal Rehabilitation Act of 1973 protects the civil rights of people with disabilities in programs that receive federal financial assistance. In general, Section 504 defines a disability as a physical or mental impairment that substantially limits one or more major life activities of an individual. Because public schools receive federal financial assistance, Section 504 prohibits discrimination against students with disabilities.
- **Individuals with Disabilities Education Act (IDEA).** The IDEA protects the rights of students with disabilities in public school settings. The purpose of the IDEA is to prepare students with disabilities for further education, employment, and independent living. The IDEA defines a child with a disability as one who has been evaluated as having a specific condition, such as autism, specific learning disabilities, or speech or language impairment.[2] Part B of the IDEA requires that all children between the ages of 3 and 21 are to be provided with a free appropriate public education.[3] The IDEA defines free appropriate public education as services being provided at public expense, under public supervision and direction, and without charge.

Similar to federal law, state law also requires full educational opportunities be provided to all students with disabilities residing in North Carolina.[4] State law permits the State Board of Education to set more stringent standards than those required by the IDEA, but at this time the State's requirements are the same as federal requirements.

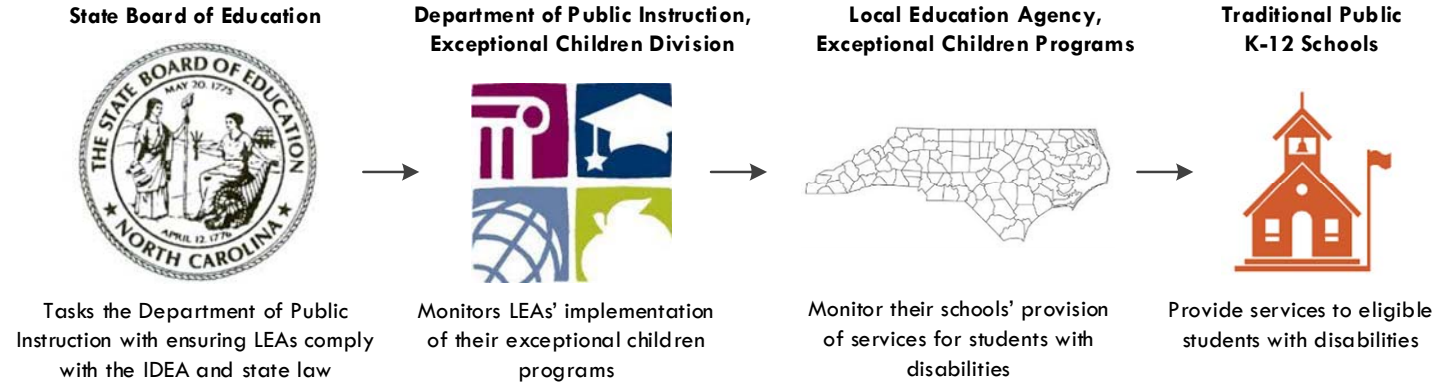
The State Board of Education sets rules to ensure IDEA requirements are met and tasks the Department of Public Instruction's Exceptional Children Division with overseeing local education agencies' provision of services for students with disabilities. The State Board has a duty to monitor local education agencies (LEAs) to determine their compliance with the IDEA and state law. The State Board, through the Department of Public Instruction's Exceptional Children Division, monitors the implementation of Exceptional Children programs that are administered by each individual LEA (see Exhibit 1). The Exceptional Children Division's mission is to ensure students with disabilities develop intellectually, physically, emotionally, and vocationally through the provision of an appropriate individualized education program in the least restrictive environment.

[2] Additional specific conditions include deaf-blindness, hearing impairment (including deafness), intellectual disability, multiple disabilities, orthopedic impairment, serious emotional disturbance, traumatic brain injury, visual impairment (including blindness), or another health impairment.

[3] According to IDEA's Child Find requirement, states must have policies and procedures in place to identify and evaluate children who need special education. Should a local school district fail to identify and evaluate a child with a disability, the district may be required to provide the student with compensatory education if the child is later determined to have needed services. A compensatory education is one-on-one special education designed to bring the student up to where he/she would have been if the district had identified the disability when it should have.

[4] N.C. Gen. Stat. § 115C-106.2.

Exhibit 1: DPI Monitors LEA Implementation of Exceptional Children Programs



Source: Program Evaluation Division based on information from the Department of Public Instruction.

Before receiving services, students go through an identification and evaluation process. The IDEA defines the services for which students with disabilities may be eligible.

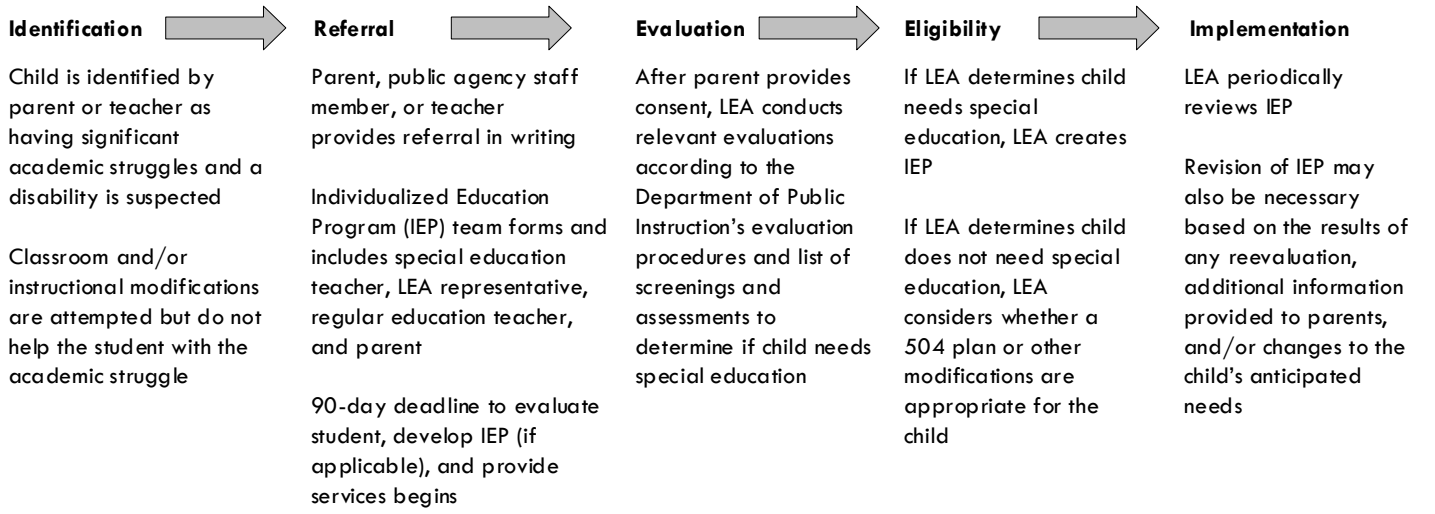
- **Special education.** This instruction is specifically designed to meet the unique needs of a child with a disability. Special education is meant to ensure access to the general curriculum so that a child can meet the educational standards that apply to all students.
- **Related services.** These services are necessary to allow students with disabilities to benefit from special education. The most common related services provided in schools include occupational therapy, physical therapy, and speech-language pathology and audiology services.[5] For example, a child with a disability who cannot be understood when speaking would need the related service of speech therapy, and a child who has poor motor skills and cannot write legibly would need the related service of occupational therapy. Considerations must be given to whether a related service will assist a child in meeting his/her educational goals.

The IDEA requires states to have policies and procedures to identify, refer, and evaluate students with disabilities. Exhibit 2 shows the process for making eligibility determinations in North Carolina. Upon suspicion that a disability may be interfering with a child's learning, the child first receives instructional or classroom-based adjustments. For example, a student who is easily distracted due to attention-related disabilities may be allowed to sit near the teacher, or a student with handwriting difficulty may be allowed to provide test answers orally rather than in writing. If these adjustments do not support improved learning outcomes, a parent, public agency staff member, or teacher can refer the child for an initial evaluation in writing. Once referred, the LEA has 90 days to evaluate the student and begin providing needed services.[6]

[5] Additional related services include counseling services (including rehabilitation counseling), early identification and assessment of disabilities in children, interpreting services, medical services for diagnostic and evaluation purposes, orientation and mobility services, psychological services, recreation (including therapeutic recreation), and transportation.

[6] Prior to the evaluation, the parent consents to the evaluation by signing a consent form.

Exhibit 2: Process for Determining Eligibility for Special Education



Source: Program Evaluation Division based on information from the Department of Public Instruction.

LEAs determine if a child is in need of special education by conducting initial individualized evaluations of the child's needs according to DPI's Policies Governing Services for Children with Disabilities, which includes the types of screenings and assessments required for each disability. LEAs must ensure assessments are administered by trained and knowledgeable personnel. LEAs must use more than one assessment tool to gather functional, developmental, and academic information during evaluation of a child.

- **If a student does not need special education, the LEA may create a 504 plan to document modifications.** Should an LEA determine a student does not meet IDEA eligibility, the LEA may consider whether the student meets eligibility requirements for a Section 504 Accommodation Plan. Although such students are not protected under the IDEA, they are protected by Section 504 of the Rehabilitation Act of 1973. In these situations, 504 plans are developed to ensure the needs of disabled children are met as adequately as those of their non-disabled peers. Essentially, 504 plans serve as a blueprint for specifying modifications to the learning environments of children outside the scope of the IDEA. For example, a student who uses a wheelchair may need special transportation to and from school, and a student with a hearing impairment may need a device that amplifies the teacher's voice in headphones.

  Although there are no standards for 504 plans, the plans are generally created by a team of people familiar with the child who understand the information obtained from evaluations and are knowledgeable about special education service options. Federal law does not require public schools to report the number of students with 504 plans. As a result, hereafter in this report, any reference to students with disabilities is limited to students with an individualized education program.

- **If a student needs special education, the LEA creates an individualized education program (IEP).** The IDEA requires each LEA to have an IEP for each disabled student within its district. IEPs are specific, written statements that stipulate the supports and educational goals for students with disabilities. IEPs provide measurable annual academic and functional goals and specify how progress will be measured towards meeting those goals. Specifically, the IEP provides a description of the special education and related services that are to be provided including the frequency, location, and duration of services.

  The IEP team must consider the strengths of the child, concerns of the parents for enhancing the child's education, results of performed evaluations, and the child's academic, developmental, and functional needs.[7] After an IEP has been implemented, LEAs must ensure its periodic review.[8] Revision of an IEP may also be necessary based on the results of any reevaluations, additional information provided to parents, and/or changes to the child's anticipated needs.

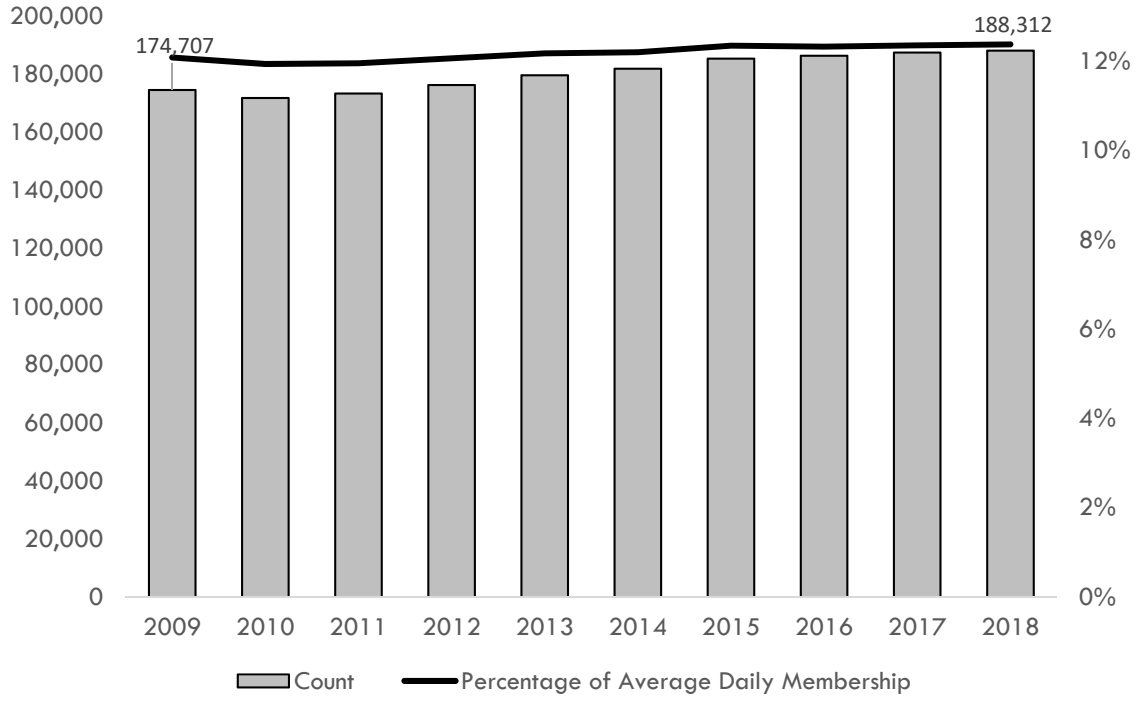
In April 2018, 12.4% of students attending North Carolina's public schools had an IEP, specifying their need for special education. Nationally, 13% of all public school students are designated as special education students under the IDEA. In North Carolina, the proportion of students with disabilities is similar. Students with disabilities have consistently represented approximately 12% of all students in traditional and charter public schools during the past decade (see Exhibit 3). The April 2018 headcount of students with disabilities in North Carolina was approximately 188,000 students.[9]

[7] The IEP team must include the parent(s) of the child, at least one regular education teacher of the child, at least one special education teacher of the child, a representative of the LEA, and an individual who can interpret the instructional implications of evaluation results. The team also may include the child with the disability (when appropriate) and other individuals at the discretion of the parent(s) or LEA, such as related services personnel.

[8] The IEP team must review an IEP no less frequently than annually to ascertain whether its stated annual goals are being achieved. If a lack of expected progress is noted, the IEP team revises the IEP.

[9] State law does not require non-public schools to provide headcounts of students with disabilities.

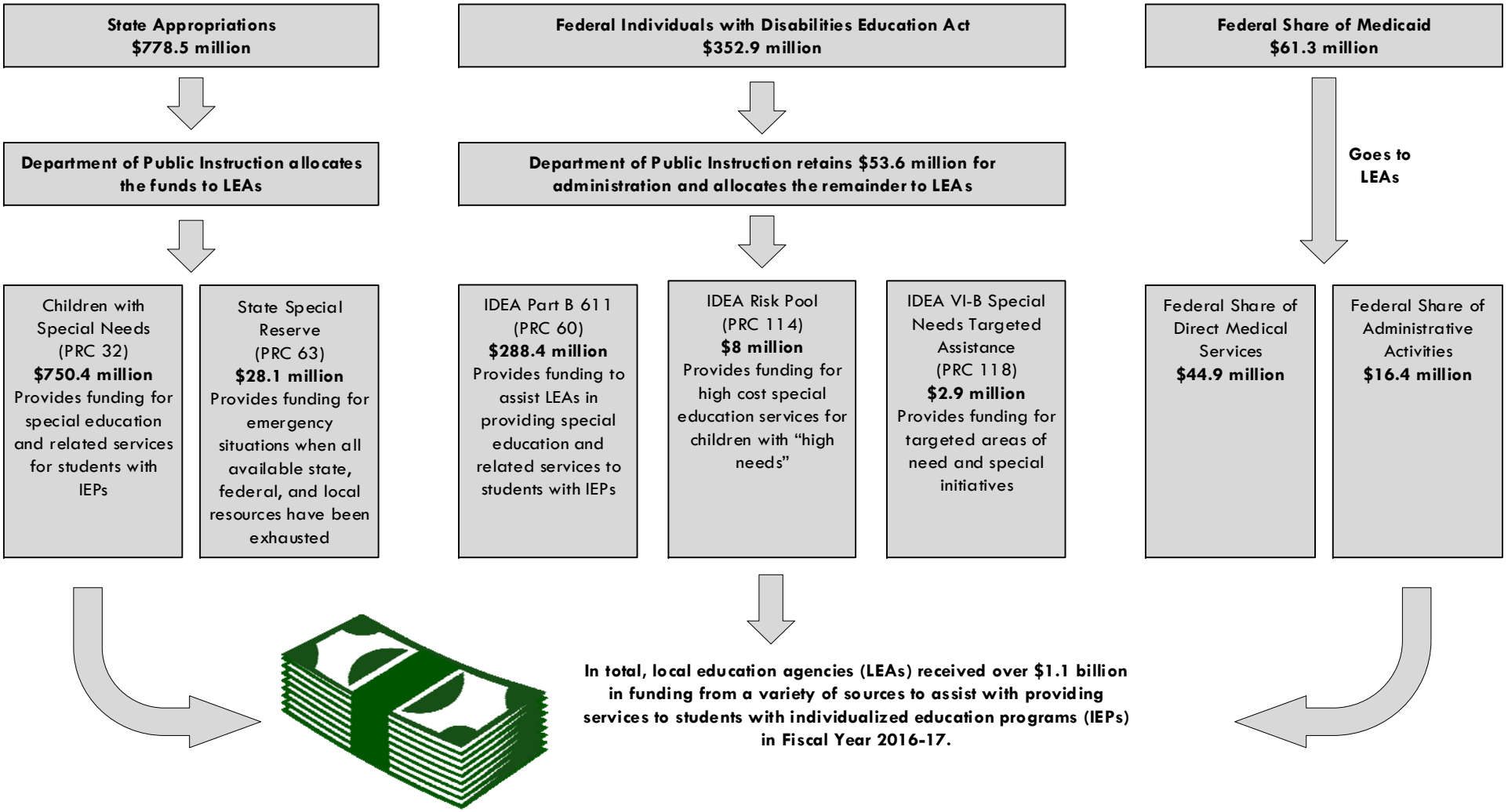
Exhibit 3: Proportion of Students with Individualized Education Programs in Traditional and Charter Schools Has Remained Stable during the Past Decade



Source: Program Evaluation Division based on the Department of Public Instruction's April 2009–2018 headcounts.

A combination of state education dollars and federal education and Medicaid dollars fund services for students with disabilities, mitigating how much local governments have to spend on special education and related services. The IDEA requires LEAs to meet the needs of students with disabilities regardless of an LEA's available resources. Exhibit 4 shows the funding sources for services for students with disabilities in Fiscal Year 2016–17.

Exhibit 4: Local Education Agencies Receive a Total of $1.1 Billion for Services for Students with Disabilities, Fiscal Year 2016–17



Notes: In addition to receiving the funding described above, some LEAs receive local funding to assist with the provision of services to students with IEPs. Medicaid services provided in schools are reimbursed using local funds with a federal match; the Division of Health Benefits does not use state funds to pay for any portion of these services. "High need" is defined as any special education and/or related service that is at least three times the per-pupil expenditure.

Source: Program Evaluation Division based on information from the Department of Public Instruction and Division of Health Benefits.

State Education Funds

The State provides the majority of funding for the provision of services to students with disabilities. In Fiscal Year 2016–17, the bulk of state appropriations for this purpose ($750.4 million) were allocated by DPI to LEAs on a formula basis. In Fiscal Year 2016–17, LEAs received an average base allocation of $4,093 per disabled child based on the previous April's headcount of students with disabilities, up to a maximum of 12.75% of the LEA's average daily membership. This cap means LEAs with disabled student populations greater than 12.75% receive less funding on a per-student basis.[10,11]

In Fiscal Year 2016–17, DPI received $28.1 million in state appropriations to fund the Special State Reserve program. In addition to their formula-based allocation, LEAs may apply to receive special state reserve funds

- to cover excess costs when a student with extraordinary needs enrolls in an LEA after available funds have been expended and budgets have been committed or
- to assist in serving students in approved developmental day centers and community residential centers.

Federal Education Funds

States receive federal funding to assist in the provision of services for students with disabilities. IDEA funding was originally intended to cover 40% of the costs of providing special education and related services, but funding has historically covered less than 20% of costs. Permitted expenditures include the salaries of special education teachers and costs associated with related services personnel such as speech therapists and psychologists. In Fiscal Year 2016–17, North Carolina received approximately $352.9 million in IDEA, Title VI, Part B funding, of which DPI retained $53.6 million for administration and distributed $299.3 million to LEAs.[12]

Federal Medicaid Funds

Unlike private insurance, Medicaid covers services that are provided in schools. For services provided under the IDEA, Medicaid is the primary payer and pays for eligible services before other federal and state funding sources. Since 1988, LEAs have been allowed to seek reimbursement from Medicaid for services provided to students under the IDEA. LEAs are not required to participate in Medicaid, but the available

[10] A 2016 report by the Program Evaluation Division entitled *Allotment-Specific and System-Level Issues Adversely Affect North Carolina's Distribution of K-12 Resources* found 62 LEAs had disabled student populations greater than the cap in Fiscal Year 2014–15 (which was 12.5% at that time) and, as a result, received less funding on a per-student basis. In addition, the allotment does not take into consideration that students with disabilities are not equally distributed across the State and that disabilities vary in severity and, as a result, some students cost more to serve.

[11] A 2017 report by North Carolina State University's Friday Institute for Educational Innovation entitled *Short- and Longer-Term Options for Modernizing State Exceptional Children Funding in North Carolina* recommended the State transition to a hybrid block/tiered reimbursement model to address the immediate fiscal needs of providing services to students with disabilities. The report recommended the hybrid model because of its responsiveness to changes in student population from year to year, its ability to reduce incentives for under-identifying students, and its ability to stabilize available funding at the LEA level.

[12] States receive a base amount equal to the amount they received for Federal Fiscal Year 1998–99 and additional funds based on the number of children with disabilities and the number of children living in poverty.

funding represents a significant means for LEAs to recoup spending for providing services to Medicaid-enrolled disabled children.[13]

At present, LEAs may bill Medicaid when the following conditions are met:

- a child is enrolled in Medicaid,
- the service is listed in an enrolled child's IEP,
- the State Medicaid Plan covers the service, and
- the LEA is an enrolled Medicaid provider.

Medicaid clinical policy dictates which services provided in schools are covered.[14] Recently, policy pertaining to covered school services was updated to include services outlined within a child's 504 plan. Although the policy has been updated and posted for public comment by the Division of Health Benefits, the amended policy will not go into effect until the U.S. Centers for Medicare and Medicaid Services has approved North Carolina's state plan amendment that references these changes. The Division of Health Benefits anticipates approval of the state plan amendment in early 2019. If the plan amendment receives federal approval, LEAs will then be allowed to bill Medicaid for covered services provided under a Medicaid-enrolled student's 504 plan.

As Medicaid providers, LEAs can seek reimbursement for both direct medical services and administrative activities.

- **Direct medical services.** The majority of LEAs claim Medicaid reimbursement for direct medical services on a fee-for-service basis. Generally, LEAs contract with a third-party vendor that submits direct medical service claims for reimbursement on their behalf to the Division of Health Benefits. In Fiscal Year 2016–17, 66.72% of direct medical services were federally funded. The Division of Health Benefits does not use state funds to pay for any portion of direct medical services. The non-federal match portion is met with local funds. North Carolina's Medicaid-participating LEAs were cumulatively reimbursed $44.9 million in Fiscal Year 2016–17 for the provision of direct medical services to students with disabilities.

- **Administrative activities.** LEAs also seek Medicaid funds for qualifying school-based administrative activities that are considered necessary for the proper and efficient administration of Medicaid. School-based administrative activities include outreach and enrollment activities related to assisting students who may not be Medicaid-enrolled; efforts that support the provision of Medicaid-eligible services; and activities such as care coordination, referrals, and transportation to and from school on a day a child receives a Medicaid-covered service. In Fiscal Year 2016–17, 50% of Medicaid school-based administrative activities were federally funded. North Carolina's Medicaid-participating LEAs were

[13] Ashe, Clay, Clinton City, Columbus, Dare, Elkin City, Hickory City, Hyde, Jones, Tyrrell, and Washington LEAs did not submit claims in Fiscal Year 2016–17. LEAs may choose not to participate in the Medicaid program if the challenges of providing documentation outweigh the benefits of securing reimbursement.

[14] Clinical Coverage Policy No. 10C Outpatient Specialized Therapies, Local Education Agencies (LEAs).

cumulatively reimbursed $16.4 million in Fiscal Year 2016–17 for Medicaid school-based administrative activities.

The Division of Health Benefits requires LEAs to submit annual cost reports that reconcile the actual cost of Medicaid-covered services with the amount reimbursed.[15] To substantiate the cost reports, LEAs must participate in random moment time studies that gauge the amount of time personnel spend on direct medical services.[16] In Fiscal Year 2016–17, LEAs spent $1,181 on direct medical services per Medicaid-enrolled student with an IEP and $38 on administrative activities per Medicaid-enrolled student (see Exhibit 5). See Appendix B and C for detailed cost report information for each reporting LEA.

Exhibit 5: On Average, LEAs Spend $1,181 on Direct Medical Services for Students with Disabilities, Fiscal Year 2016–17

	Number of Students	Total Cost	Cost Per Student	LEA Range of Cost Per Student
Direct medical services	56,736	$67,004,748	$1,181	$357 - $9,311
Administrative activities	860,274	$32,766,393	$38	$2 - $89

Notes: Direct medical services only include Medicaid-enrolled students with an Individualized Education Program (IEP), whereas administrative activities include all Medicaid-enrolled students because costs are not tracked separately for students who have IEPs and those who do not.

Source: Program Evaluation Division based on data from the Division of Health Benefits.

Local Funding

The non-federal Medicaid match (33.28%) for direct medical services is covered entirely by local funding. In Fiscal Year 2016–17, North Carolina's Medicaid-participating LEAs cumulatively spent $22 million on the provision of direct medical services for students with disabilities and $16.4 million on school-based administrative activities.

The amount of local funds available to supplement federal IDEA funding and state appropriations varies across LEAs and is a function of local tax bases. Because there are no dedicated federal or state funding streams for 504 plan services, LEAs pay for those services using local funds, unrestricted state education funds, or a combination of the two.

Because students with disabilities may be receiving services in multiple settings that are covered by multiple funding streams, the potential exists for duplication of services. Children with disabilities who receive services in school may have additional needs that must be addressed in a community setting. Medicaid is the only public funding source that covers services across school and community settings. For Medicaid-enrolled children, Medicaid covers a range of services provided by both schools

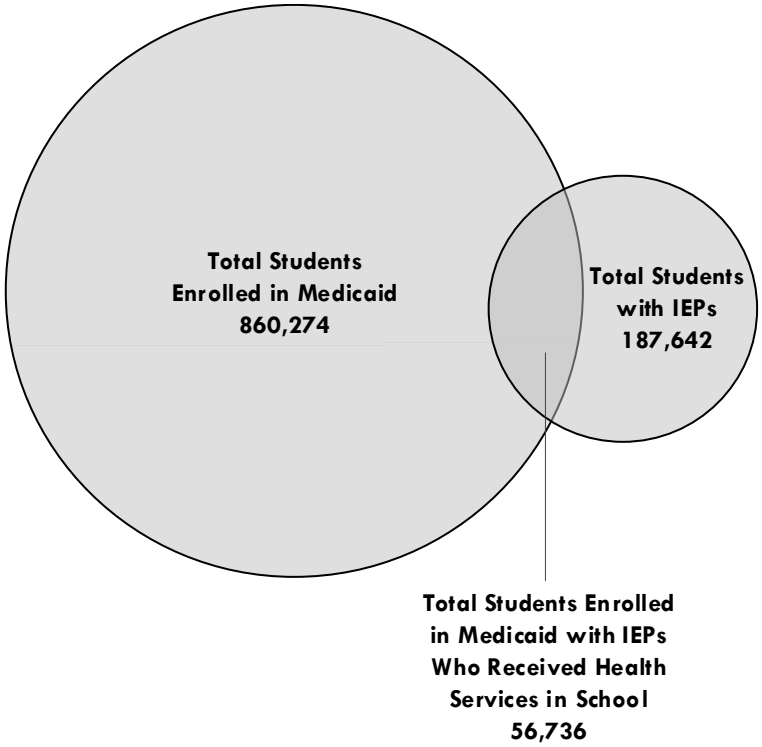
[15] The dollar amounts reported by LEAs in cost reports are certified public expenditures. Statutorily recognized as a Medicaid financing approach, certified public expenditures are certifications by LEAs that they have spent funds on items and services that are eligible for federal matching Medicaid funds. If the actual costs exceed the amount reimbursed, LEAs receive a settlement. However, if the amount LEAs initially receive exceeds costs, LEAs pay back the difference.

[16] A random moment time study is a federally approved, statistically valid sampling technique that produces accurate labor distribution results by determining what portion of the selected group of participants' workload is spent performing all work activities. The method polls participants on an individual basis at random time intervals over a given time period and totals the results to determine work effort for the entire population of participating staff during that same period.

and community-based providers. As shown in Exhibit 6, 56,736 students were enrolled in Medicaid, had IEPs, and received health services in school in Fiscal Year 2016–17. To ensure the proper use of Medicaid funding, it is important to examine whether the presence of service duplication exists across school and community settings.

Exhibit 6

Students Enrolled in Medicaid with IEPs May Receive Services in School and Community Settings



Source: Program Evaluation Division based on data from the Department of Public Instruction and Division of Health Benefits.

Findings

Finding 1. There is minimal evidence of duplication of Medicaid-covered services across school and community settings.

Students with disabilities receiving services in schools may also receive services from a variety of service providers in community settings, such as primary care providers, support and therapy providers, and mental health providers. If a lack of communication and coordination exists between service providers, gaps in services and duplication of services are more likely to occur, which can adversely affect the quality of services and increase overall costs.

Care coordination entails the organization of care among providers involved in the delivery of services and helps to ensure a patient's needs and preferences are met over time. With improved care coordination, recipients experience better outcomes as the efficacy of treatment is enhanced. In the provision of services for students with disabilities, care coordination between school and community providers can result in better alignment of services and help to prevent services from counteracting one another or being duplicated.

School and community providers both serve students with disabilities, yet their primary focuses may differ. For some children, the frequency or intensity of therapy received at school does not meet all of their needs. These children require services in both the school and community setting.

- **School setting.** When offered in school settings, services focus on helping students with disabilities benefit from their special education curriculum. In determining the need for services, an individualized education program (IEP) team only considers whether services will assist students with disabilities in meeting their educational goals.
- **Community setting.** When offered in clinical settings, services focus on addressing a medical condition or impairment. In determining the need for services, medical professionals use the diagnosis to determine which services are medically necessary. The focus of treatment in the community setting is broader than the school setting because it is aimed at realizing the full potential of the disabled child beyond simply meeting his or her educational goals.

Exhibit 7 illustrates the differences between the focus of therapy in school versus community settings. These differences may hinder coordination between school and community providers.

Exhibit 7: Focus of Therapy is Dependent on the Setting Where Services Are Provided

	School Setting	Community Setting
How is the need for services identified?	• Referral initiated by parent, public agency staff member, or teacher based on observed academic struggles	• Referral initiated by a doctor based on observed delay or diagnosis
Who decides the need for service?	• Individualized education program (IEP) team—including parents, student (if appropriate), educators, administrators, and school-based therapists—based on evaluation and classroom observation • Assessment considers *only* needs associated with special education	• Testing and clinical observation by licensed professional • Assessment considers *all* settings
Who decides the scope of services?	• IEP team determines the focus, frequency, and duration of therapy	• Medical team determines location, focus, frequency, and duration of therapy • Insurance coverage, doctor's orders, and transportation may be determining factors
How can services be changed?	• Changes to related services require a meeting of the IEP team to discuss and come to consensus	• Doctors can alter orders or therapist can change therapy plan, generally after discussing with parents
What is the focus of therapy?	• Therapy addresses access to special education and school environment • Therapy works towards independence and participation in the school setting	• Therapy addresses medical conditions and impairments • Therapy works towards realizing full potential in all settings
Where does therapy occur?	• On school grounds, bus, halls, playground, classroom, or lunchroom	• In the clinic, hospital, or home
Who pays for services?	• No cost to student or family because of federal requirement of free appropriate public education	• Fee-for-service payment by family, insurance company, or via governmental assistance
How are services documented?	• Documented in IEP using accessible, readable language guided by state and local policy reflecting best practice	• Dictated by insurance requirements and guidelines of the setting; emphasis on medical terminology and billing codes

Source: Program Evaluation Division based on information from the Department of Public Instruction.

Because of the potential for duplication, the Program Evaluation Division analyzed 3.2 million Medicaid claims for students with disabilities who received services in both school and community settings during Fiscal Year 2016–17. As shown in Exhibit 8, a total of 2.5 million claims for students with disabilities were paid in Fiscal Year 2016–17, totaling $227.4 million.

Exhibit 8: Description of Medicaid Reimbursed Services, Fiscal Year 2016–17

	School Setting	Community Setting	Total
Number of Medicaid claims paid for students with disabilities	649,199	1,841,250	2,490,449
Dollar value of Medicaid claims paid for students with disabilities	$25,072,156	$202,356,907	$227,429,063

Source: Program Evaluation Division based on information from the Division of Health Benefits.

The majority of Medicaid reimbursed claims in the school setting are for speech therapy followed by physical and occupational therapy (see Exhibit 9). In comparison, speech therapy, physical therapy, occupational

therapy, and psychological services only account for 24% of services provided in the community. The remainder of Medicaid reimbursed claims in the community setting are for pharmacy claims or different types of procedural, test-based services, such as ultrasounds, X-rays, and blood draws.

Exhibit 9

Speech Therapy is the Most Frequent Service Provided in the School Setting, Fiscal Year 2016–17

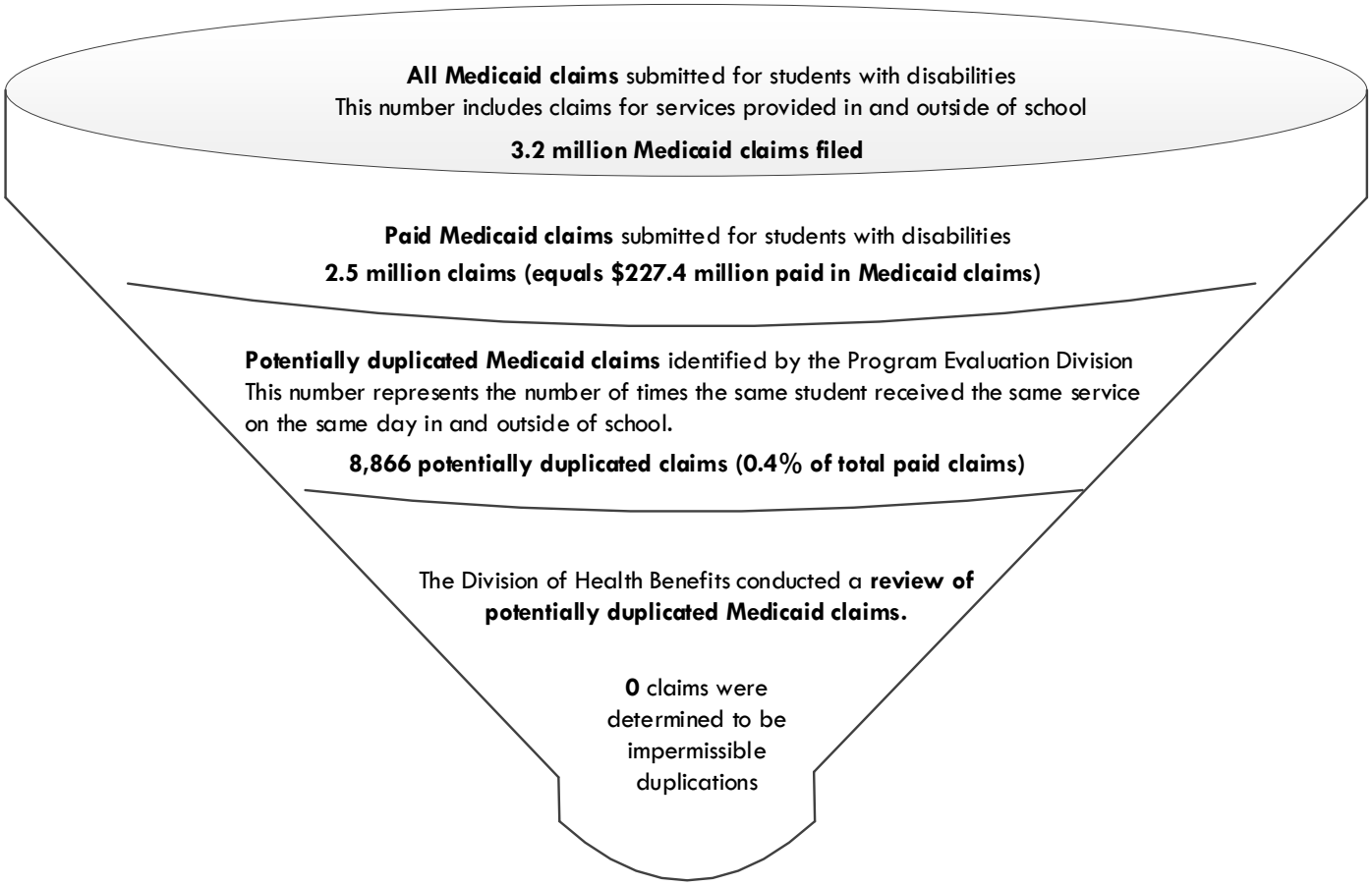
	School Setting	Community Setting
Speech therapy	71%	9%
Physical therapy	14%	6%
Occupational therapy	14%	6%
Psychological services	1%	3%

Source: Program Evaluation Division based on data from the Division of Health Benefits.

The Program Evaluation Division's analysis of Fiscal Year 2016–17 Medicaid claims data shows little evidence of duplication of services. Duplication was identified in the data when the same student (Medicaid ID number), received the same service (identified by Current Procedural Terminology code), on the same day, in a school setting and in a community setting (identified by National Provider Identification number).

Based on this methodology, the Program Evaluation Division found a potential 4,433 instances in which Medicaid paid for the same service on the same day in and outside of school (or 8,866 potentially duplicated claims), which represents 0.4% of the 2.5 million paid claims analyzed (see Exhibit 10). In terms of dollars, potential duplication accounts for $572,318 of the total $227.4 million in paid claims. The amounts paid out per student receiving duplicated services ranged from $1 to more than $500. The majority of identified duplicated services were for speech therapy (54.6%), followed by physical therapy (22.6%) and occupational therapy (22.6%).

Exhibit 10: Program Evaluation Division Identified 8,866 Potentially Duplicated Medicaid Claims, All of Which Are Permissible by Law, Fiscal Year 2016–17



Note: The Division of Health Benefits determined that all potentially duplicated claims were permissible because services (1) were coverable by Medicaid, (2) were provided to Medicaid-enrolled children, (3) met policy standards of medical necessity, and (4) were allowable in multiple locations on the same day under federal law.

Source: Program Evaluation Division based on data from the Division of Health Benefits.

Duplication of services may be appropriate if it is educationally and medically necessary to receive the same service in and outside of school. The Program Evaluation Division asked the Division of Health Benefits to review the 8,866 potentially duplicated claims.

- The Division of Health Benefits initially determined all but 70 instances identified by the Program Evaluation Division were permissible under federal law.[17] Although North Carolina state policy specifies that a provider cannot bill Medicaid twice for the same service provided on the same day, federal law supersedes state regulations. Section 1905(r) of the Social Security Act, entitled Early and Periodic Screening, Diagnostic and Treatment Services, requires that Medicaid-enrolled children receive any service

[17] Using the Division of Health Benefits's methodology, the Program Evaluation Division reassessed the 2.5 million paid Medicaid claims; looking only at students who did not have a billed service from a community provider, there were 775 instances that involved multiple same-day billings from an LEA. Of the 1,552 claims billed in these instances, the Division of Health Benefits determined all but 210 speech therapy claims were permissible under federal law. The Division of Heath Benefits is currently conducting an in-depth review of the 210 claims to determine whether impermissible duplication occurred.

coverable under the Act so long as the service is "medically necessary to correct or ameliorate" a diagnosed health condition.[18] Only a medical professional can truly determine if duplication of services is not appropriate, meaning the services a student received in school unnecessarily duplicated the services a student received outside of school or vice versa.

- The Division of Health Benefits conducted an in-depth review of the 70 instances when a student received either (1) a service in a community setting and at least two of that same service in a school setting that same day or (2) a service in a school setting and at least two of that same service in a community setting that same day.[19] The Division of Health Benefits consulted with its prior approval agent for speech, occupational, and physical therapy and determined those 70 instances met policy standards of medical necessity and were allowable in multiple locations on the same day under federal law.

Opportunities for duplication are minimized because of the multiple mechanisms North Carolina uses to comply with the U.S. Centers for Medicare and Medicaid Services's requirements for Medicaid services in general. Local education agencies (LEAs) are Medicaid providers and, like all Medicaid providers, are required to comply with rules and regulations as part of agreeing to participate in the Medicaid program. North Carolina employs several controls throughout the Medicaid reimbursement process to prevent fraud, waste, and abuse; the provision of unnecessary services; or the inappropriate use of Medicaid services available in the state plan.

- **LEAs are subject to provider enrollment requirements.** The North Carolina Division of Health Benefits approves LEAs as Medicaid providers. LEAs sign participation agreements including the False Claims Act attestation, which obligates them to adhere to state and federal laws prohibiting the submission of false claims. The provider enrollment requirements hold LEAs accountable on the front end of the Medicaid reimbursement process by informing them of the requirements they must follow including the requirement that they only provide medically necessary services.
- **Claims submitted by LEAs proceed through the claims adjudication process within NCTracks.** The North Carolina Department of Health and Human Services (DHHS) contracts with CSRA State and Local Solutions LLC to serve as the fiscal agent for Medicaid claims adjudication in the State. Like all Medicaid providers, LEAs submit claims for reimbursement in NCTracks, the State's multi-payer Medicaid Management Information System. NCTracks utilizes internal business processes for applying state Medicaid policies to identify duplication of services and calculate correct payment amounts to providers.

[18] 42 U.S. Code § 1396d.

[19] The 70 instances constituted a total of 210 claims of which 102 were for occupational therapy, 102 were for physical therapy, and 6 for speech therapy.

- **LEAs are subject to a cost settlement process.** At the end of each fiscal year, LEAs submit a cost report of certified public expenditures to the Division of Health Benefits. The cost settlement process ensures LEAs receive accurate reimbursement for services rendered and mitigates overpayment caused by duplicative payment.
- **LEAs are subject to audit by the Division of Health Benefits's Office of Compliance and Program Integrity.** Like all Medicaid providers, LEAs are subject to pre- and post-review audits by the Office of Compliance and Program Integrity. The office upholds both federal and state regulations related to Medicaid by investigating suspected fraud, waste, and abuse reported to it through external complaints or referrals and discovered through internal data analysis. Providers may receive a pre-payment review from the Office of Compliance and Program Integrity to ensure their claims meet federal and state law requirements and regulations and meet medically necessary criteria. A post-payment review includes an on-site visit from the Office of Compliance and Program Integrity, of which the provider may or may not receive prior notice. State audits serve as an enforcement mechanism, deterring providers from providing and claiming services unnecessarily. Within the past five years, no post-payment reviews have been triggered. Furthermore, no LEA has been terminated from the Medicaid program and referred for investigation.
- **LEAs are subject to audit by the U.S. Department of Health and Human Services's Office of Inspector General.** The U.S. DHHS Office of Inspector General conducts audits, investigations, and inspections in an effort to protect the integrity of DHHS programs in all states. Federal audits help ensure Medicaid payments are not duplicated or improperly claimed.[20]

Finding 2. Based on measures collected by the U.S. Department of Education, North Carolina complies with the Individuals with Disabilities Education Act and effectively provides services to students with disabilities; efficiency may be improved with the implementation of the Department of Public Instruction's new special education services data system.

The U.S. Department of Education's Office of Special Education Programs carries out administrative activities related to the Individuals with Disabilities Education Act (IDEA). The U.S. Department of Education monitors the North Carolina Department of Public Instruction's (DPI) Exceptional Children Division to ensure processes and procedures are in place to meet the State's obligation to monitor local education agency (LEA) compliance

[20] In 2016, the U.S. DHHS Office of Inspector General (OIG) found the Division of Health Benefits claimed almost $107.5 million in unallowable school-based administrative costs for federal fiscal years 2010 through 2012. NC DHHS and the Division of Health Benefits do not agree with OIG's finding. The U.S. Centers for Medicare and Medicaid Services continues to review North Carolina's response along with OIG's comments. As of October 16, 2018, the Division of Health Benefits has not received a request for repayment of any federal funds related to OIG's report.

with the IDEA. Exhibit 11 shows the eight primary ways the Exceptional Children Division monitors LEA compliance with the IDEA.

Exhibit 11: DPI Monitors LEAs in Eight Primary Ways

State Performance Plan and Annual Performance Reports	The State Performance Plan is updated at least every six years. Annual Performance Reports contain state performance data on student outcomes and compliance with IDEA requirements.
Policies, Practices, and Procedures	Historically, policies have been revised regularly with the latest revision occurring in March 2018.
Dispute Resolution System	DPI provides a formal means for dispute resolution that includes mediation, formal written complaints, and due process hearings regarding the identification, evaluation, and placement of students.
Data Collection	Data collection involves collection and verification, examination and analysis, and reporting. Data are used for decision making about program management or improvement.
Monitoring Activities	The North Carolina Continuous Improvement Focused Monitoring System includes LEA self-assessment, targeted on-site visits where systematic problems occur, focused monitoring of state priority areas, and program compliance review.
Improvement, Correction, Incentives, and Sanctions	LEAs must demonstrate they have addressed noncompliance and have made progress towards meeting performance targets. DPI recognizes high-performing LEAs and sanctions low-performing LEAs.
Targeted Technical Assistance	The Exceptional Children Division provides LEAs with targeted technical assistance to help improve student outcomes and compliance with IDEA requirements. Annual performance report indicators provide a better understanding of which LEAs are most in need of improvement.
Fiscal Monitoring	The Exceptional Children Division uses a three-tiered fiscal monitoring process. Monitoring includes a comparison review of LEA budgets versus expenditure reports, IDEA fiscal desk reviews, and IDEA fiscal monitoring on-site visits.

Source: Program Evaluation Division based on information from the Department of Public Instruction.

North Carolina was among 21 states to earn a federal determination of meeting IDEA requirements in 2018. The U.S. Department of Education has established 17 indicators that states are required to measure and report regarding their performance in educating students with disabilities. Appendix D shows how North Carolina's performance compares to overall national performance based on Federal Fiscal Year 2015–16 indicators. The U.S. Department of Education determined in June 2018 that North Carolina meets IDEA requirements based on its ability to

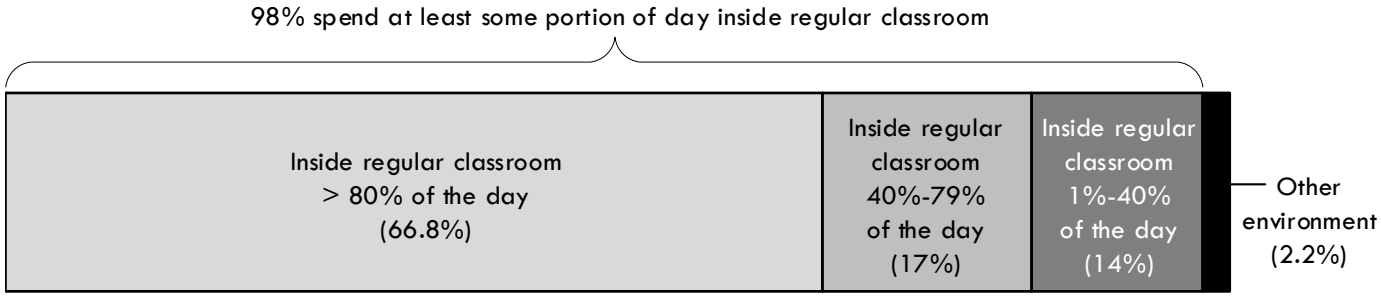
- report valid and reliable data,
- demonstrate corrective action for findings of noncompliance,
- ensure the timeliness of state complaint and due process hearing decisions, and
- achieve student-level results.

In addition, North Carolina has been effective in placing students with disabilities into regular classrooms and assisting them with achieving better outcomes. The IDEA requires schools to educate students with disabilities in the least restrictive environment possible.[21] Least restrictive

[21] A 2016 Program Evaluation Division report entitled *Meeting Current Standards for School Nurses Statewide May Cost Up to $79 Million Annually* discussed the impact that mainstreaming exceptional children has on the need for services in schools.

environment considerations help ensure students with disabilities are educated with their non-disabled peers in a regular educational environment.[22] During the past two decades, there has been an uptick nationally in the amount of time spent by students with disabilities in regular classrooms. As shown in Exhibit 12, in Federal Fiscal Year 2015–16, 98% of North Carolina students with disabilities spent at least some portion of their day inside a regular classroom, with most (66.8%) spending at least 80% of their day there.

Exhibit 12: Ninety-Eight Percent of Students with Disabilities Spend At Least Some Portion of the Day Inside a Regular Classroom, Federal Fiscal Year 2015–16



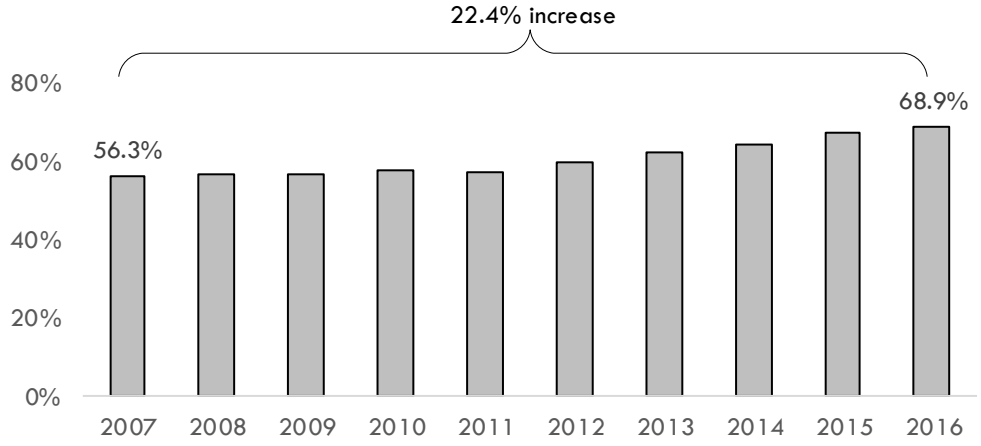
Source: Program Evaluation Division based on data from the U.S. Department of Education.

During the past decade, the State also has seen improvements in educational outcomes of students with disabilities. As shown in Exhibit 13, the percentage of students with IEPs graduating high school within four years increased by 22.4% between 2007 and 2016. During the same period, the high school dropout rate of students with IEPs declined by nearly half (49.1%). For students no longer in secondary school who had IEPs in effect at the time they left school, 24% more were either enrolled in higher education, enrolled in some other postsecondary education/training program, or were employed within one year of leaving high school in 2016 as compared to 2012.

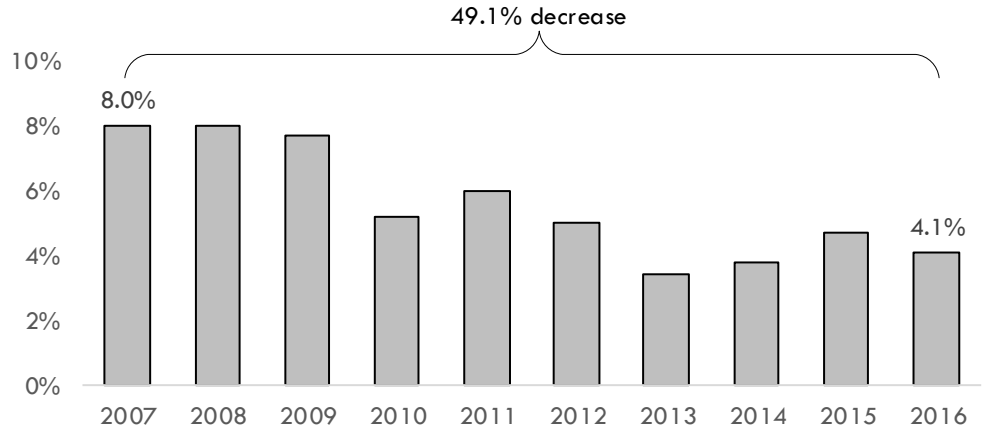
[22] A regular educational environment includes classrooms and other settings in schools such as lunchrooms and playgrounds in which children without disabilities participate.

Exhibit 13: Outcomes for North Carolina Students with Disabilities Have Improved in Recent Years

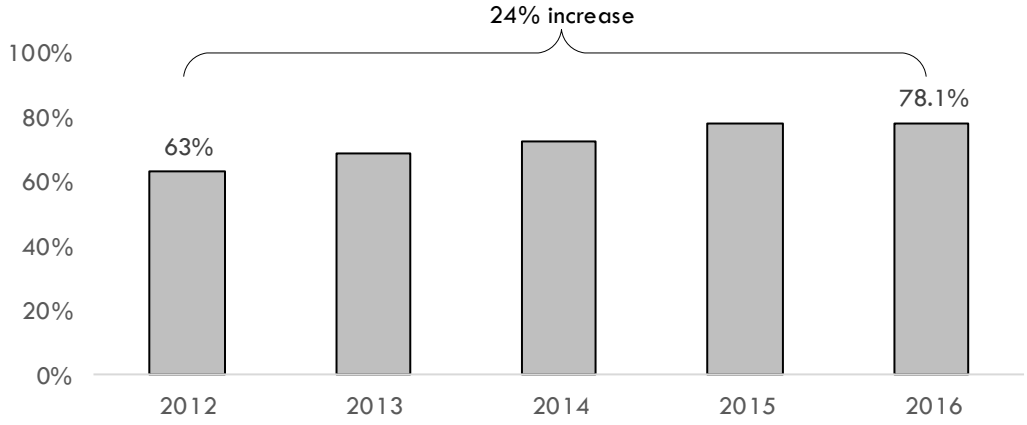
High School Graduation Rates for Students with Disabilities Increased



High School Dropout Rates for Students with Disabilities Decreased



Percentage of Students with Disabilities with Positive Post-School Outcomes Increased



Notes: Positive post-school outcomes are defined as either being enrolled in higher education, enrolled in some other post-secondary education/training program, or employed within one year of leaving high school.

Source: Program Evaluation Division based on data from the U.S. Department of Education.

LEAs' inability to process referral paperwork in a timely manner sometimes hinders the efficient delivery of services to students with disabilities, but DPI's new special education services data system should improve efficiency by improving workflow processes. The State requires evaluations to be conducted, eligibility determined, and placement completed within 90 days of receipt of a written referral. In Federal Fiscal Year 2015–16, LEAs met the State's established timeframe in 92% of instances in which parental consent to evaluate was received. North Carolina's performance on this indicator is worse than the national average of 98%. Of the 3,371 referrals exceeding the 90-day period, LEAs reported 56% of delays were due to referral paperwork not being processed in a timely manner.

The State's current special education data system, the Comprehensive Exceptional Children Accountability System (CECAS), was created in 2004 and is now obsolete because it does not meet the needs of LEAs. DPI does not require LEAs to use CECAS for maintaining student-level data. Currently, CECAS only contains detailed student-level service data for about half of the students with disabilities population in North Carolina's public schools because the State's largest LEAs have opted out of participation. The State's five largest LEAs, in addition to many others, have chosen instead to use independent data systems developed by third-party vendors.

In an effort to meet the needs of LEAs, DPI contracted with the Public Consulting Group, Inc. (PCG) in February 2017 to develop a new platform, the Every Child Accountability Tracking System (ECATS), which will assist all LEAs with collecting and maintaining data on students with disabilities.[23] The new system will cost the State $3.2 million annually for the first three years. DPI expects to roll out ECATS in 2019. As seen in Exhibit 14, ECATS will provide LEAs with three integrated modules that can be accessed from a single user interface.

[23] In North Carolina, LEAs may choose to submit Medicaid claims on their own or contract with a third party vendor for filing. PCG serves as a third-party Medicaid biller for many schools in North Carolina. PCG's Medicaid fee-for-service clients represent 68% of the State's Medicaid student population. Currently, PCG's contingency fee for Medicaid billing services is 15%, but the fee will go down to 13% when ECATS rolls out.

Exhibit 14: ECATS Will Provide Local Education Agencies with Three Modules

Module	Purpose	LEAs Required to Use	Cost to LEAs
Special Education	• Will serve as a case management and data analysis tool allowing for the efficient capturing of statewide data on students with disabilities • Will eliminate redundant data collection and reduce paperwork through virtual record keeping • Will include components that monitor IDEA compliance, track disputes pertaining to a student's free appropriate public education, and report on students receiving services paid with special funding	Yes	No cost for the base package but LEAs may choose to add on enhanced features at their expense
Medicaid Service Documentation	• Will provide LEAs with assistance in completing service documentation, allow for paperless record keeping, and provide enhanced reporting capabilities	No	No cost to LEAs
Multi-Tiered System of Support	• Will offer a means to collect and report on the instruction and interventions used to support students • Will include three components: the Early Warning System component is designed to help proactively identify students at risk, the Planning component will plan and monitor interventions, and the Insight Reporting component will analyze the effectiveness of interventions	LEAs will only be required to use the Early Warning System component	No cost for the base package but LEAs may choose to add on enhanced features at their expense

Notes: Although the Medicaid Service Documentation module will assist with ensuring services are documented for purposes of Medicaid claim reimbursement, users will not be able to submit claims directly as the module will not connect with NCTracks.

Source: Program Evaluation Division based on information from the Department of Public Instruction.

DPI anticipates the new system will prove beneficial to both the State and LEAs for the following reasons.

- **ECATS should provide cost savings.** Currently, LEAs either enter student-level data into CECAS or maintain student-level data in their own data system and must aggregate that data into CECAS to meet federal reporting requirements. Independent data systems are often managed by third-party vendors. Due to its sophistication, ECATS will eliminate the need for LEAs to retain independent data systems, resulting in cost savings to LEAs.
- **ECATS will provide uniform data.** ECATS will require users to enter uniform, comprehensive data on the services students receive. Uniformity in data collection across the state system will enable LEAs to analyze student data to improve efficiency and effectiveness.
- **ECATS will improve access to data.** With ECATS, LEAs will have access to data at the district, school, grade, classroom, and individual student level by disability, gender, and race. This level of access will ensure LEAs have all student files needed to continue appropriate services when a student transfers. By eliminating the need to transfer files from one LEA to another, there should be little interruption to services.

Finding 3. The Department of Public Instruction's Exceptional Children Division provides technical assistance to local education agencies but does not measure the effectiveness of those efforts.

Each LEA has an Exceptional Children Director, who is responsible for monitoring the provision of services for students with disabilities by the district's schools. The Program Evaluation Division interviewed 12 Exceptional Children Directors to better understand their role in the provision of services.[24] Directors reported several challenges of the position, such as the need to constantly shift funding around to meet students' needs, the complicated nature of IDEA and Medicaid regulations, and the shortage of qualified personnel available to provide specialty services.

Recognizing the challenges that LEAs face in administering their exceptional children programs, DPI provides several types of technical assistance to local districts. The Exceptional Children Division in the Department of Public Instruction (DPI) monitors each LEA's implementation of its exceptional children program. Five years ago, DPI made a concerted effort to assist LEA Exceptional Children Directors in meeting the demands of their positions by providing targeted and individualized technical assistance. At present, DPI offers the following types of technical assistance.

- **New Directors' Leadership Institute.** DPI designed the Institute for directors with less than two years of experience and for those in district-level leadership positions who might become directors in the future. The training includes eight two-day sessions spread over two years (up to 135 hours). The purpose of the training is to develop knowledge and skills in competency areas identified as essential to the role of director.
- **Annual conferences.** DPI hosts the Annual Conference on Exceptional Children for administrators, special education teachers, related service personnel, psychologists, regular education teachers, and parents/families. The one-and-a-half-day conference offers an opportunity to share and learn about innovations and practices intended to help students with disabilities achieve. DPI also hosts the March Institute, which is an annual three-day conference for Exceptional Children Directors and their direct staff. This Institute represents an opportunity to provide additional professional development on priority topics based on director input.
- **Regional consultants.** DPI has 23 regional consultant positions that provide professional services to LEAs regarding special education matters.[25] For example, consultants provide assistance with compliance and parent complaint follow-up; program planning, development, management, and evaluation; corrective action plan activities; and applications for Title VI-B Rural Education Achievement Program funding. In addition, regional

[24] The Program Evaluation Division interviewed directors from each of DPI's eight Exceptional Children regions.

[25] Of the 23 positions, 18 were filled at the time of this report, and DPI reported it is attempting to fill the remaining 5 positions.

consultants keep abreast of current trends in special education and make LEAs aware of any such developments.

- **Regional director meetings.** DPI's regional consultants plan and coordinate four quarterly one-day regional meetings for Exceptional Children Directors. The purpose of these meetings is to share information on upcoming requirements and events and to provide professional development. In addition, directors have the opportunity to network, collaborate, problem solve, and brainstorm with directors of like-sized districts within their region.
- **Webinars.** DPI offers hour-long webinars every other month for Exceptional Children Directors. Webinars cover informational updates, clarification around recent memorandums, and hot topics. LEAs have the opportunity to submit questions in advance, which are covered during the question and answer portion. Webinars are posted to DPI's website for on-demand access by LEAs.

DPI collects feedback and input regularly but does not distribute a formalized survey to collect customer satisfaction data to determine the effectiveness of its technical assistance efforts. Anecdotally, LEA Exceptional Children Directors reported satisfaction with the support they receive from DPI. For example, directors felt the New Directors' Leadership Institute was a valuable and helpful resource. One stated, "The Institute was great. It definitely opened my eyes to how we are supposed to be doing things." However, directors' reactions to regional consultants varied, with some reporting positive experiences and others reporting negative experiences. In addition, more than half of the directors interviewed mentioned the need for a formal mentorship program.

DPI does not systematically seek nor gauge feedback from LEA Exceptional Children Directors on its technical assistance efforts. Customer satisfaction surveys are an important diagnostic tool for assessing satisfaction with services provided to internal or external customers. For example, the U.S. Office of Personnel Management has designed a customer satisfaction survey that measures nine service quality dimensions: access, courtesy, knowledge, timeliness, reliability, choice, tangibles, recovery, and quality. Customer satisfaction data from LEA Exceptional Children Directors could inform DPI about which technical assistance efforts are most beneficial and could reveal shortcomings of or inconsistencies across other efforts. Having this type of performance data could help DPI improve the quality and effectiveness of its services.

Finding 4. North Carolina's new health information exchange, NC HealthConnex, could improve service delivery coordination, but failure by local education agencies to meet the statutory connectivity deadline could negatively impact their funding.

A health information exchange is a secure electronic network that gives healthcare providers the ability to access and share patient information. Health information exchanges are designed to improve healthcare quality, enhance patient safety, improve health outcomes, and reduce overall healthcare costs.

In 2015, the General Assembly passed the Statewide Health Information Exchange Act, and appropriated up to $1.4 million for establishing a successor health information exchange network.[26] The North Carolina Health Information Exchange Authority oversees and administers NC HealthConnex, the State's designated health information exchange.[27] NC HealthConnex is a secure electronic network that facilitates communication between healthcare providers by enabling them to share information electronically.

Local education agencies are at risk of losing state funding if they do not connect to NC HealthConnex by June 1, 2019. All healthcare providers, excluding local management entities/managed care organizations, who receive state funds for the provision of healthcare services must connect to NC HealthConnex by June 1, 2019 in order to continue receiving state funds for healthcare services. LEAs receive state funds for providing healthcare services. In Fiscal Year 2018–19, the State initially allocated $14 million to LEAs for healthcare services. According to law, LEAs that are not connected by June 1, 2019 would stop receiving state funds for healthcare services.

To connect to NC HealthConnex, providers must meet minimal technology requirements. In July 2018, the Department of Information Technology published a study on the feasibility of various provider types connecting to NC HealthConnex. The study recognized that certain healthcare providers (e.g., speech, language, and hearing service providers, occupational therapists, physical therapists) may not have electronic health records and noted the costs of health information technology are significant. The study did not examine the impact on LEAs of procuring necessary technology and therefore did not include implementation cost estimates for LEAs.

The Program Evaluation Division asked Health Information Exchange Authority officials how NC HealthConnex requirements would affect LEAs in their role as Medicaid providers. These officials were unaware that LEAs are subject to the connectivity requirements. The Program Evaluation Division then asked officials from DPI's Exceptional Children Division about the impact of connectivity requirements on LEAs. These officials also were unaware of NC HealthConnex and its requirements. To date, there has been no indication that Health Information Exchange Authority officials have engaged the Exceptional Children Division or LEAs.

[26] N.C. Gen. Stat. § 90-414.

[27] The Authority is housed within the Department of Information Technology's Government Data Analytics Center.

Recommendations

Recommendation 1. The General Assembly should direct the Department of Public Instruction to establish methods for soliciting feedback from Exceptional Children Directors of local education agencies.

As discussed in Finding 3, the Department of Public Instruction (DPI) provides several types of technical assistance to local education agency (LEA) Exceptional Children Directors in order to assist directors in meeting the demands of their positions. Anecdotally, directors reported satisfaction with the support they receive from DPI. However, interviews with directors revealed varying degrees of satisfaction with regional consultants and a perceived need for a formal mentorship program. Customer satisfaction data could inform DPI about which technical assistance efforts are most effective and which efforts need improvement.

The General Assembly should direct DPI to establish methods for soliciting feedback on each of its technical assistance efforts: the New Directors' Leadership Institute, annual conferences, regional consultants, regional director meetings, and webinars. DPI should consider seeking feedback in the form of customer satisfaction surveys. The methods for soliciting feedback should be incorporated into DPI's Exceptional Children Division policies and procedures. DPI should report to the Joint Legislative Education Oversight Committee by December 15, 2019 on its efforts to seek systematic feedback from LEA Exceptional Children Directors.

Recommendation 2. The General Assembly should direct the Department of Information Technology, in conjunction with the Departments of Health and Human Services and Public Instruction, to determine the feasibility of and fiscal impact on local education agencies in meeting mandatory NC HealthConnex connectivity requirements.

As discussed in Finding 4, LEAs must connect to NC HealthConnex by June 1, 2019. LEAs not connected to NC HealthConnex by that date will stop receiving state funds for healthcare services. As of October 2018, Health Information Exchange Authority officials had failed to consider the impact of the statutory connectivity requirement on LEAs. Furthermore, officials of the Department of Public Instruction's Exceptional Children Division were unaware of NC HealthConnex.

The General Assembly should direct the Department of Information Technology, in conjunction with the Departments of Health and Human Services and Public Instruction, to determine the feasibility of and fiscal impact on LEAs in meeting NC HealthConnex's connectivity requirements. The Department of Information Technology should report to the Joint Legislative Oversight Committee on Health and Human Services, Joint Legislative Oversight Committee on Information Technology, Joint Legislative Program Evaluation Oversight Committee, and Fiscal Research Division by April 15, 2019. Based on the report, LEAs may need additional time and resources to meet connectivity requirements.

Appendices

Appendix A: Summary Statistics of Students with Disabilities, Fiscal Year 2016–17

Appendix B: LEA Medicaid Cost Report Details, Fiscal Year 2016–17

Appendix C: Per Student Costs for Medicaid Direct Medical Services and Administrative Activities by LEA, Fiscal Year 2016–17

Appendix D: North Carolina Annual Performance Report Indicators, Federal Fiscal Year 2015–16

Agency Responses

A draft of this report was submitted to the Department of Health and Human Services and the Department of Public Instruction for review. Their responses are provided following the appendices.

A draft of Finding 4 and Recommendation 2 regarding NC HealthConnex was submitted to the Department of Information Technology for review. Its response to these sections of the report is provided following the appendices.

Program Evaluation Division Contact and Acknowledgments

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Appendix A: Summary Statistics of Students with Disabilities, Fiscal Year 2016–17

Statewide Student Profile	
Number of students with disabilities with an individualized education program (IEP) attending North Carolina traditional and charter schools	187,642
Percentage of students with disabilities with an IEP attending North Carolina traditional and charter schools based on average daily membership	12.4%
Number of students with an IEP receiving health/treatment services in schools	99,383
Number of Medicaid-enrolled students with an IEP receiving health/treatment services in school	56,736
Percentage of students with an IEP receiving health/treatment services in school who are Medicaid-enrolled	57.1%

LEA Expenditures and Medicaid Participation	
Number of local education agencies (LEAs) in North Carolina	115
Number of LEAs participating in Medicaid fee-for-service claiming	102
Total LEA expenditures for providing direct medical services covered by the Individuals with Disabilities Education Act (IDEA) to Medicaid-enrolled students with disabilities	$67 million
Direct medical service costs per Medicaid-enrolled student with an IEP	$1,181
Federal share for direct medical services	66.72%
Number of LEAs participating in Medicaid school-based administrative activities	112
Total LEA expenditures for Medicaid school-based administrative activities	$32.8 million
Federal share for school-based administrative activities	50%

Funding to LEAs	
Total state appropriations to LEAs for the provision of services for students with disabilities	$778.5 million
Average base state appropriation per disabled student (PRC 32)	$4,093
Federal IDEA funding for LEAs (traditional K-12 students)	$299.3 million
Total federal Medicaid reimbursement to LEAs for expenditures	$61.3 million
Total local funds used to meet Medicaid match requirements	$38.4 million

Medicaid Claims Reimbursement	
Total number of Medicaid claims paid for students with disabilities	2,490,449
Number of Medicaid claims paid for students with disabilities receiving services in a community setting	1,841,250
Number of Medicaid claims paid for students with disabilities receiving services in a school setting	649,199
Percentage of school-based claims paid that were for speech therapy services	71%

Source: Program Evaluation Division based on information from the Department of Public Instruction and Division of Health Benefits.

Appendix B: LEA Medicaid Cost Report Details, Fiscal Year 2016–17

School District	Medicaid Students			IEP Students			Direct Medical Services		Administrative Activities	
	Medicaid-Enrolled Students	Total Students	Proportion of Medicaid-Enrolled to Total	Medicaid-Enrolled IEP Students Receiving Health Services	Total IEP Students Receiving Health Services	Proportion of Medicaid-Enrolled IEP to Total IEP	Federal Share (66.72%)	Local Share (33.28%)	Federal Share (50%)	Local Share (50%)
Alamance-Burlington	13,980	24,246	57.70%	1,100	1,949	56.40%	$950,473	$474,097	$365,721	$365,721
Alexander County	2,816	4,888	57.60%	250	412	60.70%	$263,173	$118,944	$82,924	$82,924
Alleghany County	966	1,317	73.30%	107	148	72.30%	$114,381	$57,054	$40,368	$40,368
Anson County	2,849	3,333	85.50%	304	356	85.40%	$283,375	$141,347	$89,852	$89,852
Asheboro City	2,737	4,603	59.50%	242	340	71.20%	$214,149	$106,817	$74,668	$74,667
Asheville City	16,637	30,481	54.60%	193	298	64.80%	$167,992	$83,794	$64,716	$64,716
Avery County	1,165	2,143	54.40%	155	252	61.50%	$61,552	$30,702	$22,972	$22,973
Beaufort County	4,751	7,084	67.10%	325	462	70.30%	$122,644	$61,175	$35,382	$35,382
Bertie County	2,053	2,503	82.00%	171	215	79.50%	$126,077	$62,888	$27,446	$27,446
Bladen County	3,529	4,668	75.60%	177	235	75.30%	$244,777	$122,095	$69,781	$69,781
Brunswick County	8,983	12,409	72.40%	562	874	64.30%	$488,652	$243,740	$129,376	$129,376
Buncombe County	16,637	30,481	54.60%	1,248	2,019	61.80%	$826,343	$412,180	$345,320	$345,320
Burke County	7,974	12,325	64.70%	928	1,394	66.60%	$607,183	$302,479	$261,555	$261,554
Cabarrus County	15,930	40,080	39.70%	944	2,317	40.70%	$720,949	$359,610	$280,854	$280,854
Caldwell County	7,655	11,716	65.30%	626	882	71.00%	$653,699	$254,567	$213,873	$213,873
Camden County	438	1,826	24.00%	61	148	41.20%	$68,843	$34,339	$9,787	$9,787
Carteret County	4,191	8,377	50.00%	270	448	60.30%	$373,333	$168,032	$125,038	$125,038
Caswell County	2,068	2,631	78.60%	146	193	75.60%	$157,589	$78,605	$40,152	$40,152
Catawba County	8,851	16,307	54.30%	565	989	57.10%	$535,118	$266,917	$198,934	$198,934
Charlotte-Mecklenburg	84,479	159,472	53.00%	3,782	7,979	47.40%	$3,255,923	$1,624,057	$1,333,165	$1,333,165
Chatham County	4,056	9,811	41.30%	292	578	50.50%	$293,427	$134,715	$97,528	$97,528
Cherokee County	2,344	3,467	67.60%	170	236	72.00%	$169,963	$84,778	$46,387	$46,387
Cleveland County	10,741	14,662	73.30%	979	1,328	73.70%	$616,655	$307,588	$288,680	$288,680

School District	Medicaid Students			IEP Students			Direct Medical Services		Administrative Activities	
	Medicaid-Enrolled Students	Total Students	Proportion of Medicaid-Enrolled to Total	Medicaid-Enrolled IEP Students Receiving Health Services	Total IEP Students Receiving Health Services	Proportion of Medicaid-Enrolled IEP to Total IEP	Federal Share (66.72%)	Local Share (33.28%)	Federal Share (50%)	Local Share (50%)
Craven County	7,583	13,876	54.60%	456	852	53.50%	$481,653	$240,249	$158,313	$158,312
Cumberland County	32,248	51,003	63.20%	1,825	2,887	63.20%	$1,370,365	$616,260	$462,566	$462,566
Currituck County	1,142	3,995	28.60%	76	144	52.80%	$169,345	$84,469	$23,033	$23,033
Davidson County	13,581	24,061	56.40%	814	1,409	57.80%	$679,603	$338,987	$203,153	$203,153
Davie County	2,830	6,195	45.70%	242	437	55.40%	$283,513	$134,599	$97,648	$97,648
Duplin County	6,502	9,572	67.90%	275	420	65.50%	$230,320	$114,883	$72,707	$72,707
Durham County	22,964	32,907	69.80%	1,358	2,885	47.10%	$1,172,102	$584,646	$478,951	$478,951
Edenton-Chowan County	1,299	2,028	64.10%	88	116	75.90%	$132,020	$58,560	$46,974	$46,974
Edgecombe County	6,923	7,613	91.00%	359	438	82.00%	$186,734	$93,143	$116,360	$116,360
Elizabeth City/Pasquotank	3,562	5,860	60.80%	280	436	64.20%	$237,367	$118,399	$66,178	$66,178
Franklin County	5,568	8,613	64.60%	303	472	64.20%	$277,873	$138,603	$111,797	$111,797
Gaston County	19,336	33,765	57.30%	1,329	2,158	61.60%	$1,136,193	$566,734	$461,445	$461,445
Gates County	788	1,594	49.40%	81	128	63.30%	$68,503	$34,169	$14,987	$14,987
Graham County	854	1,162	73.50%	59	89	66.30%	$124,608	$62,155	$29,407	$29,407
Granville County	4,302	7,667	56.10%	263	494	53.20%	$148,585	$74,115	$58,317	$58,317
Greene County	2,302	3,100	74.30%	127	169	75.10%	$129,966	$64,826	$19,847	$19,847
Guilford County	47,744	77,498	61.60%	3,583	6,315	56.70%	$2,426,795	$1,210,488	$990,521	$990,521
Halifax County	2,490	2,825	88.10%	161	194	83.00%	$87,976	$43,882	$38,565	$38,565
Harnett County	11,040	20,357	54.20%	822	1,494	55.00%	$574,823	$286,723	$190,549	$190,549
Haywood County	4,685	7,083	66.10%	439	668	65.70%	$320,767	$159,999	$128,708	$128,708
Henderson County	7,202	13,609	52.90%	417	777	53.70%	$367,265	$183,192	$165,156	$165,156
Hertford County	2,529	2,862	88.40%	115	137	83.90%	$161,691	$75,958	$28,318	$28,318
Hoke County	5,887	8,355	70.50%	361	637	56.70%	$132,114	$65,899	$85,614	$85,614
Iredell-Statesville	11,199	20,300	55.20%	689	1,404	49.10%	$494,204	$246,509	$171,474	$171,474

School District	Medicaid Students			IEP Students			Direct Medical Services		Administrative Activities	
	Medicaid-Enrolled Students	Total Students	Proportion of Medicaid-Enrolled to Total	Medicaid-Enrolled IEP Students Receiving Health Services	Total IEP Students Receiving Health Services	Proportion of Medicaid-Enrolled IEP to Total IEP	Federal Share (66.72%)	Local Share (33.28%)	Federal Share (50%)	Local Share (50%)
Jackson County	2,872	3,949	72.70%	188	282	66.70%	$190,512	$95,027	$86,328	$86,328
Johnston County	17,326	34,964	49.60%	1,365	2,695	50.60%	$742,887	$370,553	$267,416	$267,416
Kannapolis City	15,930	40,080	39.70%	148	249	59.40%	$170,215	$84,904	$48,850	$48,850
Lee County	6,284	9,948	63.20%	439	766	57.30%	$441,800	$220,370	$123,142	$123,142
Lenoir County	6,772	8,873	76.30%	308	422	73.00%	$212,578	$106,034	$127,355	$127,355
Lexington City	1,645	2,995	54.90%	236	293	80.50%	$177,648	$88,612	$39,069	$39,069
Lincoln County	5,932	11,340	52.30%	393	736	53.40%	$290,997	$145,139	$100,409	$100,409
Macon County	2,681	4,303	62.30%	344	517	66.50%	$172,791	$86,188	$53,691	$53,691
Madison County	1,545	2,295	67.30%	100	163	61.30%	$35,337	$17,626	$1,816	$1,816
Martin County	2,381	3,558	66.90%	216	300	72.00%	$262,169	$130,769	$80,279	$80,279
McDowell County	4,107	6,107	67.30%	251	385	65.20%	$276,571	$137,954	$104,274	$104,273
Mitchell County	1,152	1,823	63.20%	134	206	65.00%	$42,879	$21,388	$16,891	$16,891
Montgomery County	2,880	3,848	74.80%	169	250	67.60%	$160,484	$80,050	$85,644	$85,644
Moore County	5,895	13,321	44.30%	426	821	51.90%	$525,651	$262,195	$230,496	$230,496
Mooresville	2,161	6,017	35.90%	173	356	48.60%	$150,792	$75,215	$19,619	$19,619
Mount Airy City	1,315	2,311	56.90%	72	104	69.20%	$81,656	$40,730	$19,049	$19,049
Nash-Rocky Mount	9,369	16,418	57.10%	657	963	68.20%	$539,507	$269,107	$131,447	$131,447
New Hanover Co.	13,697	26,953	50.80%	2,547	4,424	57.60%	$979,028	$488,340	$416,135	$416,135
Newton-Conover City	1,636	3,015	54.30%	134	206	65.00%	$101,831	$50,793	$50,364	$50,364
Northampton County	2,175	2,984	72.90%	174	208	83.70%	$138,716	$64,648	$39,066	$39,066
Onslow County	12,612	25,936	48.60%	897	1,708	52.50%	$1,043,992	$510,512	$379,281	$379,281
Orange County	6,199	20,124	30.80%	258	619	41.70%	$309,931	$154,594	$88,126	$88,127
Pender County	4,786	9,154	52.30%	360	627	57.40%	$318,475	$158,855	$102,072	$102,072
Perquimans County	1,047	1,637	64.00%	126	171	73.70%	$104,087	$50,907	$30,724	$30,724

School District	Medicaid Students			IEP Students			Direct Medical Services		Administrative Activities	
	Medicaid-Enrolled Students	Total Students	Proportion of Medicaid-Enrolled to Total	Medicaid-Enrolled IEP Students Receiving Health Services	Total IEP Students Receiving Health Services	Proportion of Medicaid-Enrolled IEP to Total IEP	Federal Share (66.72%)	Local Share (33.28%)	Federal Share (50%)	Local Share (50%)
Person County	3,189	5,586	57.10%	237	341	69.50%	$227,781	$113,618	$61,995	$61,995
Pitt County	15,295	23,888	64.00%	1,059	1,610	65.80%	$595,567	$280,245	$219,091	$219,091
Polk County	1,272	2,158	58.90%	86	140	61.40%	$112,348	$56,039	$44,369	$44,369
Randolph County	10,676	17,956	59.50%	721	1,085	66.50%	$419,834	$205,066	$130,165	$130,165
Richmond County	6,103	7,233	84.40%	430	587	73.30%	$271,060	$124,463	$107,971	$107,970
Roanoke Rapids	2,539	2,879	88.20%	125	180	69.40%	$132,032	$64,335	$74,089	$74,089
Robeson County	20,159	23,200	86.90%	2,049	2,613	78.40%	$488,394	$243,611	$25,997	$25,997
Rockingham Co.	8,224	12,445	66.10%	832	1,234	67.40%	$675,673	$337,026	$258,926	$258,926
Rowan-Salisbury	13,475	19,053	70.70%	817	1,257	65.00%	$543,725	$271,211	$200,249	$200,249
Rutherford County	5,841	9,646	60.60%	494	672	73.50%	$458,671	$228,785	$150,788	$150,788
Sampson County	5,615	8,292	67.70%	20	29	69.00%	$124,250	$61,976	$21,640	$21,640
Scotland County	4,974	5,688	87.40%	485	640	75.80%	$422,775	$210,880	$209,974	$209,974
Stanly County	4,673	8,762	53.30%	369	640	57.70%	$287,523	$143,417	$84,753	$84,753
Stokes County	3,241	5,896	55.00%	512	821	62.40%	$354,905	$177,027	$103,555	$103,555
Surry County	4,540	7,984	56.90%	373	553	67.50%	$329,084	$164,148	$126,651	$126,651
Swain County	1,597	2,094	76.30%	86	134	64.20%	$117,340	$58,529	$60,841	$60,840
Thomasville City	13,581	24,061	56.40%	174	213	81.70%	$91,794	$45,787	$28,583	$28,583
Transylvania County	2,315	3,690	62.70%	180	254	70.90%	$192,373	$95,956	$41,913	$41,913
Union County	14,087	43,529	32.40%	1,028	2,394	42.90%	$1,261,431	$629,203	$265,341	$265,341
Vance County	6,371	7,439	85.60%	178	224	79.50%	$254,710	$127,049	$114,574	$114,574
Wake County	56,595	169,630	33.40%	3,235	8,141	39.70%	$3,370,519	$1,681,218	$1,200,467	$1,200,467
Warren County	1,917	2,319	82.70%	175	228	76.80%	$92,069	$45,924	$54,403	$54,403
Watauga County	1,565	4,564	34.30%	288	546	52.70%	$272,204	$135,775	$69,704	$69,705
Wayne County	13,688	18,321	74.70%	638	1,192	53.50%	$264,496	$131,931	$214,152	$214,152
Weldon City	770	873	88.20%	66	85	77.60%	$59,345	$29,601	$19,639	$19,639

School District	Medicaid Students			IEP Students			Direct Medical Services		Administrative Activities	
	Medicaid-Enrolled Students	Total Students	Proportion of Medicaid-Enrolled to Total	Medicaid-Enrolled IEP Students Receiving Health Services	Total IEP Students Receiving Health Services	Proportion of Medicaid-Enrolled IEP to Total IEP	Federal Share (66.72%)	Local Share (33.28%)	Federal Share (50%)	Local Share (50%)
Whiteville City	2,357	3,043	77.50%	78	108	72.20%	$121,679	$45,099	$2,219	$2,219
Wilkes County	5,824	9,538	61.10%	595	862	69.00%	$504,558	$249,731	$179,187	$179,187
Wilson County	9,071	13,249	68.50%	401	584	68.70%	$387,922	$193,496	$159,188	$159,188
Winston-Salem/Forsyth County	33,411	56,784	58.80%	2,397	4,712	50.90%	$1,893,008	$944,234	$954,669	$954,669
Yadkin County	3,086	5,262	58.60%	257	424	60.60%	$302,356	$109,259	$58,669	$58,669
Yancey County	1,434	2,145	66.90%	117	197	59.40%	$100,759	$50,258	$32,826	$32,826
Statewide	**860,274**	**1,563,890**	**55.00%**	**56,736**	**99,383**	**57.10%**	**$44,911,374**	**$22,093,374**	**$16,383,198**	**$16,383,195**

Notes: IEP stands for individualized education program. Direct medical services only include Medicaid-enrolled students with an IEP, whereas administrative activities include all Medicaid-enrolled students because costs are not tracked separately for students who have IEPs and those students who do not. The federal and local share amounts for administrative services reflect all LEA Medicaid Administrative Claiming that has been reviewed by the Provider Audit section of the Division of Health Benefits's NC Medicaid office and submitted to the Program Evaluation Division as of October 19, 2018.

Source: Program Evaluation Division based on data from the Division of Health Benefits.

Appendix C: Per Student Costs for Medicaid Direct Medical Services and Administrative Activities by LEA, Fiscal Year 2016–17

School District	Direct Medical Services			Administrative Activities		
	Medicaid-Enrolled IEP Students	Federal and Local Share of Direct Medical Services	Per Student Cost	Medicaid-Enrolled Students	Federal and Local Share of Administrative Activities	Per Medicaid Student Cost
Alamance-Burlington	1,100	$1,424,570	$1,295	13,980	$731,442	$52
Alexander County	250	$382,117	$1,528	2,816	$165,849	$59
Alleghany County	107	$171,435	$1,602	966	$80,736	$84
Anson County	304	$424,722	$1,397	2,849	$179,703	$63
Asheboro City	242	$320,966	$1,326	2,737	$149,335	$55
Asheville City	193	$251,786	$1,305	16,637	$129,433	$8
Avery County	155	$92,254	$595	1,165	$45,945	$39
Beaufort County	325	$183,819	$566	4,751	$70,764	$15
Bertie County	171	$188,965	$1,105	2,053	$54,893	$27
Bladen County	177	$366,872	$2,073	3,529	$139,563	$40
Brunswick County	562	$732,392	$1,303	8,983	$258,752	$29
Buncombe County	1,248	$1,238,523	$992	16,637	$690,640	$42
Burke County	928	$909,662	$980	7,974	$523,109	$66
Cabarrus County	944	$1,080,559	$1,145	15,930	$561,708	$35
Caldwell County	626	$908,266	$1,451	7,655	$427,746	$56
Camden County	61	$103,182	$1,692	438	$19,575	$45
Carteret County	270	$541,365	$2,005	4,191	$250,076	$60
Caswell County	146	$236,194	$1,618	2,068	$80,304	$39
Catawba County	565	$802,035	$1,420	8,851	$397,868	$45
Charlotte-Mecklenburg	3,782	$4,879,980	$1,290	84,479	$2,666,329	$32
Chatham County	292	$428,142	$1,466	4,056	$195,055	$48
Cherokee County	170	$254,741	$1,498	2,344	$92,775	$40
Cleveland County	979	$924,243	$944	10,741	$577,360	$54
Craven County	456	$721,902	$1,583	7,583	$316,626	$42

School District	Direct Medical Services			Administrative Activities		
	Medicaid-Enrolled IEP Students	Federal and Local Share of Direct Medical Services	Per Student Cost	Medicaid-Enrolled Students	Federal and Local Share of Administrative Activities	Per Medicaid Student Cost
Cumberland County	1,825	$1,986,625	$1,089	32,248	$925,131	$29
Currituck County	76	$253,814	$3,340	1,142	$46,066	$40
Davidson County	814	$1,018,590	$1,251	13,581	$406,306	$30
Davie County	242	$418,112	$1,728	2,830	$195,295	$69
Duplin County	275	$345,203	$1,255	6,502	$145,413	$22
Durham County	1,358	$1,756,748	$1,294	22,964	$957,903	$42
Edenton-Chowan County	88	$190,580	$2,166	1,299	$93,948	$72
Edgecombe County	359	$279,877	$780	6,923	$232,720	$34
Elizabeth City/Pasquotank	280	$355,766	$1,271	3,562	$132,357	$37
Franklin County	303	$416,476	$1,375	5,568	$223,593	$40
Gaston County	1,329	$1,702,927	$1,281	19,336	$922,890	$48
Gates County	81	$102,672	$1,268	788	$29,974	$38
Graham County	59	$186,763	$3,165	854	$58,813	$69
Granville County	263	$222,700	$847	4,302	$116,635	$27
Greene County	127	$194,792	$1,534	2,302	$39,693	$17
Guilford County	3,583	$3,637,283	$1,015	47,744	$1,981,042	$41
Halifax County	161	$131,858	$819	2,490	$77,131	$31
Harnett County	822	$861,546	$1,048	11,040	$381,098	$35
Haywood County	439	$480,766	$1,095	4,685	$257,417	$55
Henderson County	417	$550,457	$1,320	7,202	$330,312	$46
Hertford County	115	$237,649	$2,067	2,529	$56,635	$22
Hoke County	361	$198,013	$549	5,887	$171,229	$29
Iredell-Statesville	689	$740,713	$1,075	11,199	$342,949	$31
Jackson County	188	$285,539	$1,519	2,872	$172,655	$60
Johnston County	1,365	$1,113,440	$816	17,326	$534,832	$31

School District	Direct Medical Services			Administrative Activities		
	Medicaid-Enrolled IEP Students	Federal and Local Share of Direct Medical Services	Per Student Cost	Medicaid-Enrolled Students	Federal and Local Share of Administrative Activities	Per Medicaid Student Cost
Kannapolis City	148	$255,119	$1,724	15,930	$97,699	$6
Lee County	439	$662,170	$1,508	6,284	$246,283	$39
Lenoir County	308	$318,612	$1,034	6,772	$254,710	$38
Lexington City	236	$266,260	$1,128	1,645	$78,137	$47
Lincoln County	393	$436,136	$1,110	5,932	$200,817	$34
Macon County	344	$258,979	$753	2,681	$107,383	$40
Madison County	100	$52,963	$530	1,545	$3,631	$2
Martin County	216	$392,938	$1,819	2,381	$160,557	$67
McDowell County	251	$414,525	$1,651	4,107	$208,547	$51
Mitchell County	134	$64,267	$480	1,152	$33,782	$29
Montgomery County	169	$240,534	$1,423	2,880	$171,288	$59
Moore County	426	$787,846	$1,849	5,895	$460,993	$78
Mooresville	173	$226,007	$1,306	2,161	$39,237	$18
Mount Airy City	72	$122,386	$1,700	1,315	$38,097	$29
Nash-Rocky Mount	657	$808,614	$1,231	9,369	$262,894	$28
New Hanover County	2,547	$1,467,368	$576	13,697	$832,270	$61
Newton-Conover City	134	$152,624	$1,139	1,636	$100,728	$62
Northampton County	174	$203,364	$1,169	2,175	$78,132	$36
Onslow County	897	$1,554,504	$1,733	12,612	$758,562	$60
Orange County	258	$464,525	$1,800	6,199	$176,253	$28
Pender County	360	$477,330	$1,326	4,786	$204,144	$43
Perquimans County	126	$154,994	$1,230	1,047	$61,448	$59
Person County	237	$341,399	$1,441	3,189	$123,989	$39
Pitt County	1,059	$875,812	$827	15,295	$438,181	$29
Polk County	86	$168,387	$1,958	1,272	$88,739	$70

School District	Direct Medical Services			Administrative Activities		
	Medicaid-Enrolled IEP Students	Federal and Local Share of Direct Medical Services	Per Student Cost	Medicaid-Enrolled Students	Federal and Local Share of Administrative Activities	Per Medicaid Student Cost
Randolph County	721	$624,900	$867	10,676	$260,330	$24
Richmond County	430	$395,523	$920	6,103	$215,941	$35
Roanoke Rapids	125	$196,367	$1,571	2,539	$148,178	$58
Robeson County	2,049	$732,005	$357	20,159	$51,995	$3
Rockingham County	832	$1,012,699	$1,217	8,224	$517,852	$63
Rowan-Salisbury	817	$814,936	$997	13,475	$400,499	$30
Rutherford County	494	$687,456	$1,392	5,841	$301,576	$52
Sampson County	20	$186,226	$9,311	5,615	$43,281	$8
Scotland County	485	$633,655	$1,307	4,974	$419,948	$84
Stanly County	369	$430,940	$1,168	4,673	$169,506	$36
Stokes County	512	$531,932	$1,039	3,241	$207,110	$64
Surry County	373	$493,232	$1,322	4,540	$253,301	$56
Swain County	86	$175,869	$2,045	1,597	$121,681	$76
Thomasville City	174	$137,581	$791	13,581	$57,166	$4
Transylvania County	180	$288,329	$1,602	2,315	$83,827	$36
Union County	1,028	$1,890,634	$1,839	14,087	$530,682	$38
Vance County	178	$381,759	$2,145	6,371	$229,148	$36
Wake County	3,235	$5,051,737	$1,562	56,595	$2,400,933	$42
Warren County	175	$137,993	$789	1,917	$108,806	$57
Watauga County	288	$407,979	$1,417	1,565	$139,409	$89
Wayne County	638	$396,427	$621	13,688	$428,303	$31
Weldon City	66	$88,946	$1,348	770	$39,278	$51
Whiteville City	78	$166,778	$2,138	2,357	$4,438	$2
Wilkes County	595	$754,289	$1,268	5,824	$358,375	$62
Wilson County	401	$581,418	$1,450	9,071	$318,377	$35

School District	Direct Medical Services			Administrative Activities		
	Medicaid-Enrolled IEP Students	Federal and Local Share of Direct Medical Services	Per Student Cost	Medicaid-Enrolled Students	Federal and Local Share of Administrative Activities	Per Medicaid Student Cost
Winston-Salem/Forsyth County	2,397	$2,837,242	$1,184	33,411	$1,909,338	$57
Yadkin County	257	$411,615	$1,602	3,086	$117,339	$38
Yancey County	117	$151,017	$1,291	1,434	$65,652	$46
Statewide	**56,736**	**$67,004,748**	**$1,181**	**860,274**	**$32,766,393**	**$38**

Notes: IEP stands for individualized education program. Direct medical services only include Medicaid-enrolled students with an IEP, whereas administrative activities include all Medicaid-enrolled students because costs are not tracked separately for students who have IEPs and those students who do not. The federal and local share amounts for administrative services reflect all LEA Medicaid Administrative Claiming that had been reviewed by the Provider Audit section of the Division of Health Benefits's NC Medicaid office and submitted to the Program Evaluation Division as of October 19, 2018.

Source: Program Evaluation Division based on data from the Division of Health Benefits.

Appendix D: North Carolina Annual Performance Report Indicators, Federal Fiscal Year 2015–16

Indicator No.	Indicator	Measurement	NC	National
1	Graduation rate	Percentage of youth with individualized education programs (IEPs) graduating from high school with a regular high school diploma within four years	68.9%	65.4%
2	Dropout Rate	Percentage of youth with IEPs dropping out of high school	4.1%	3.7%
3B	Reading Assessment Participation	Participation rate of children with IEPs on statewide reading assessments	99.1%	94.6%
3B	Math Assessment Participation	Participation rate of children with IEPs on statewide math assessments	99.0%	94.8%
3C	Reading Proficiency	Proficiency rate for children with IEPs scoring at or above proficient against grade level and alternate academic achievement standards for reading (as measured by statewide reading assessments)	14.1%	20.6%
3C	Math Proficiency	Proficiency rate for children with IEPs scoring at or above proficient against grade level and alternate academic achievement standards for math (as measured by statewide reading assessments)	14.6%	19.2%
4A	Suspension and Expulsion	Percentage of districts that have a significant discrepancy in the rate of suspensions and expulsions of greater than 10 days in a school year for children with IEPs	0.0%	A direct comparison is not appropriate as states use a variety of methods to calculate.
5A	Least Restrictive Education Environment	Percentage of children with IEPs aged 6 through 21 who remain inside the regular classroom 80% or more of the day	66.8%	65.5%
5B	Least Restrictive Education Environment	Percentage of children with IEPs aged 6 through 21 who remain inside the regular classroom less than 40% of the day	14.0%	10.8%
5C	Least Restrictive Education Environment	Percentage of children with IEPs aged 6 through 21 placed in separate schools, residential facilities, or with homebound/hospital placements	1.8%	2.9%
8	Parent Involvement	Percentage of parents with a child receiving special education services who report that schools facilitated parent involvement as a means of improving services and results for children with disabilities	43.4%	76.0%
9	Disproportionate Representation Due to Inappropriate Identification	Percentage of districts with disproportionate representation of racial and ethnic groups in special education and related services that is the result of inappropriate identification	0.0%	A direct comparison is not appropriate as states use a variety of methods to calculate.

Indicator No.	Indicator	Measurement	NC	National
10	Disproportionate Representation Due to Inappropriate Identification	Percentage of districts with disproportionate representation of racial and ethnic groups in specific disability categories that is the result of inappropriate identification	0.0%	A direct comparison is not appropriate as states use a variety of methods to calculate.
11	Timely Initial Evaluations (Child Find)	Percentage of children who were evaluated within the state's established timeframe	92.0%	97.6%
13	Secondary Transition	Percentage of youth aged 16 and above with an IEP that includes appropriate measurable postsecondary goals that are annually updated and based upon an age appropriate transition assessment.	85.4%	91.0%
14A	Post-School Outcomes	Percentage of youth who are no longer in secondary school, had IEPs in effect at the time they left school, and were enrolled in higher education within one year of leaving high school	27.3%	26.3%*
14B	Post-School Outcomes	Percentage of youth who are no longer in secondary school, had IEPs in effect at the time they left school, and were enrolled in higher education or competitively employed within one year of leaving high school	62.5%	62.3%*
14C	Post-School Outcomes	Percentage of youth who are no longer in secondary school, had IEPs in effect at the time they left school, and were either enrolled in higher education, enrolled in some other postsecondary education/training program, or were employed within one year of leaving high school	78.1%	77.6%*
15	Dispute Resolution	Percentage of hearing requests that went to resolution sessions that were resolved through resolution session settlement agreements	38.5%	52.0%
16	Dispute Resolution	Percentage of mediations held that resulted in mediation agreements	79.0%	73.0%
17	State Systematic Improvement Plan	The State Performance Plan/Annual Performance Report includes a State Systemic Improvement Plan (SSIP) that is a comprehensive, ambitious, yet achievable multi-year plan for improving results for children with disabilities.	Yes	-

Notes: Values represent national averages except those marked with an asterisk (*), which represent national median values. Indicators 6, 7, and 12 have been excluded from this table as they pertain to preschool-aged children.

Source: Program Evaluation Division based on data from the U.S. Department of Education.

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Benefits

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
DAVE RICHARD • Deputy Secretary, NC Medicaid

Nov. 15, 2018

John W, Turcotte, Director
Program Evaluation Division, NC General Assembly
Legislative Office Building, Suite 100
300 North Salisbury Street
Raleigh, NC 27603-5925

Dear Mr. Turcotte:

This letter serves as the formal response from the Department of Health of Human Services (DHHS) regarding the Program Evaluation Division (PED) Preliminary Report dated October 24, 2018. Thank you and your team for evaluating this aspect of the Medicaid program. These services provide necessary care to Medicaid enrolled students and we must ensure compliance with federal and state requirements.

PRELIMINARY FINDINGS

The preliminary report found minimal evidence of service duplication for students with disabilities in schools and communities. PED analyzed 3.2 million Medicaid claims from Fiscal year 2016-2017 of which 2.5 million claims were submitted for students with disabilities. PED identified potentially duplicated services in the data when the same student received the same service on the same day in a school setting and in an outside setting. A total of 8,866 claims representing 0.4% of total paid claims had potentially duplicated services. Medicaid reviewed this subset and initially verified all but 70 claims identified in this subset were permissible under federal law. Medicaid continued the review of the remaining paid claims.

On November 5th PED delivered another, smaller, subset of claims from the original sample representing claims paid for services delivered in a school setting only. A total of 62 claims were received representing Physical Therapy (PT) services. Another 62 claims were received representing Occupational Therapy (OT) services. And a total of 210 claims identified received Speech Therapy (ST) services. This smaller subset of claims in the school setting only appear to be identical and likely that the two visits billed on the same day represents different therapies provided.

DHHS RESPONSE:

When Medicaid reimbursable services are provided in the school setting, these services are driven by an Individualized Education Plan (IEP). IEP goals are tightly constructed to support the special education student to benefit from his/her curriculum. These goals and their ordered therapeutic interventions are targeted to regain or acquire skills necessary to accomplish curriculum goals. IEP plans are frequently updated and changed based on documented progress in the context of a student's school day.

Children receiving OT, PT and ST services in community settings are accomplishing treatment plan goals which focus on the broader context of their "24/7" activities of daily living. These goals include family communication, interactions with helpers, strangers and others in the broad transactional environment of their daily social milieu.
They may include development of skills needed for future employment and independent living. These community based settings are provided after an EPSDT medical necessity review and, though necessarily *complementary* to those being delivered within the IEP, they are neither a *repetition* or *duplication* of IEP services.

After further review of the original claims, 70 outstanding claims indicated either a multiple same-day bill from the school system *or* multiple same-day billing from a community based setting. The services were delivered to children with complex diagnoses reflecting significant and ongoing developmental challenges. Medicaid continued its review of the remaining claims to determine if any duplicated services occurred. On review, we found that the CPT codes billed on the same day by the providers in this cohort were for different therapies (PT and OT). PT/OT CPT codes are generic and represent different interventions despite use of the same code. **Therefore, the claims do not indicate a billing for duplicative services. DHHS confirms that the 70 paid claims were reflective of unduplicated, medically necessary services, and were appropriately billed and delivered.**

In the additional subset of claims in the school setting only, the OT and PT claims appear to be identical. It is likely that the two visits billed on the same day represents two different therapies. Both OT and PT can bill the same CPT code, e.g. 97110 (Therapeutic Exercise) while addressing different problems. Only sampling these claims for documentation of rendering provider will set aside the concern with confidence.

Medicaid initiated the sampling of documentation associated with the 210 claims for the school setting only; however, this review will not be completed by the timeframe given by PED. The students' medical records are needed to verify if the student presented with different problems/diagnoses and as a result, received different therapies using the same CPT. Medicaid will continue to review these claims to ascertain if duplication occurred even though these claims represent 0.4% of the sample of claims used in this study.

SUMMARY:

DHHS partners with the Department of Public Instruction (DPI) serving as a key stakeholder into existing and proposed Medicaid clinical policies, State Plan Amendments (SPA), and other quality improvements. The success of the partnership reflects the ongoing collaboration of Mr. Bill Hussey, State Director of the Exceptional Children Program at the Department of Public Instruction and myself and the Medicaid team. These leaders demonstrate commitment to assuring necessary services and programs to Medicaid enrolled students with disabilities while maintaining fiscal accountability for the use of federal and state funds. I believe this report substantiates this strong partnership between our agencies.

DHHS is submitting the SPA to include the use of the child's 504 plan to document medically needed services. We anticipate approval from the Centers of Medicare and Medicaid Services (CMS) in early 2019 and plans to promulgate the revised clinical policy at that time.

Thank you and your team for conducting this study. I look forward to the upcoming exit conference in early November.

Sincerely,

Dave Richard
Deputy Secretary, North Carolina Medicaid

PUBLIC SCHOOLS OF NORTH CAROLINA
DEPARTMENT OF PUBLIC INSTRUCTION | Mark Johnson, *Superintendent of Public Instruction*
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November 9, 2018

John W. Turcotte, Director
Program Evaluation Division
300 N. Salisbury Street, Suite 100
Raleigh, NC. 27603-5925

Dear Mr. Turcotte:

I welcome the opportunity to respond on behalf of the Department of Public Instruction (DPI) to the Program Evaluation Division's (PED) final report on Services for Students with Disabilities. The reponses in this letter are based on information provided by PED to DPI and State Board of Education staff.

Recommendation 1. The General Assembly should direct the Department of Public Instruction to establish methods for soliciting feedback from Exceptional Children Directors of local education agencies.

The Department agrees that a satisfaction survey would enhance the communication between local directors and the state agency. While there is current practice in place to solicit feedback and input, a satisfaction survey will provide information that can better enable EC Division staff to provide technical support to these local directors.

Recommendation 2. The General Assembly should direct the Department of Information Technology, in conjunction with the Departments of Health and Human Services and Public Instrruction, to determine the feasibility of and fiscal impact on local education agencies in meeting mandatory NC HealthConnex connectivity requirements.

The Department supports the feasibility study on connectivity requirements for NC HealthConnex. In light of the recent damage and disaster recovery efforts still ongoing, some LEAs will struggle to make the June 1, 2019 deadline. Additional time to develop support and technical assistance from DPI will be necessary to fully support LEAs on this requirement.

Additional Feedback. Recently, the Friday Institute completed a study and submitted a report that includes a proposal for a tiered funding model to best leverage the state funding for exceptional children. It is recommended that this model be presented to the Joint Legislative Task Force on Education Finance Reform for their consideration as part of their full focus around K-12 finance reform for the schools.

Sincerely,

Mark Johnson
NC Superintendent

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NC DIT NORTH CAROLINA DEPARTMENT OF INFORMATION TECHNOLOGY

ROY COOPER
GOVERNOR

J. ERIC BOYETTE
SECRETARY & STATE CHIEF INFORMATION OFFICER

November 5, 2018

Mr. John W. Turcotte, Director
N.C. General Assembly Legislative Services Office
Program Evaluation Division
300 N. Salisbury Street, Suite 100 LOB
Raleigh, NC 27603-5925

Dear Director Turcotte:

Thank you very much for the opportunity to review the Division's preliminary draft report as it pertains to the statutory requirement that health care providers that receive state funds connect to N.C. HealthConnex, the state's health information exchange.

As your study notes, staff for the N.C. Health Information Exchange Authority (NC HIEA), which is housed within the Department of Information Technology, were unaware of the potential implications of the statutorily required June 1, 2019, connectivity deadline upon local education agencies. To date, our focus has been on the health care community – specifically hospitals, physicians, and nurse practitioners that receive Medicaid and have electronic health record technology. The Department and the NC HIEA are committed to executing the law as it is written and working with all state agencies and health care providers affected by the HIE Act. We will work with all local education entities that ask for extensions under the law.

We agree with the Division's recommendations. Specifically, we look forward to working with the Departments of Health & Human Services and Public Instruction to examine the consequences of this law applying to local education agencies and the logistics of full compliance.

I appreciate your team's collaboration throughout the Division's study process. If you have any questions, please do not hesitate to contact me or DIT's legislative liaison Nate Denny at (919) 397-2124 or nate.denny@nc.gov.

Sincerely,

J. Eric Boyette

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