School Health Services Program Program Manual

Appendix 7
State Plan Amendment 05-006: School Health Services

A.7 State Plan Amendment 05-006: School Health Services

TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
SCHOOL HEALTH SERVICES PROGRAM
COLORADO

SCHOOL HEALTH SERVICES BENEFITS AND ELIGIBLE PROVIDERS

4b.(I) School Health Services Program Benefits

School-based services, known as School Health Services (SHS) or Medicaid Extended Health Services (MESH) in Colorado, are delivered by the school districts, boards of cooperative educational services (BOCES) and K-12 educational institutions (herein after referred to as "providers" for this section of the State Plan). Providers deliver services to Medicaid-eligible beneficiaries under the age of 21, as included in the Medicaid statute (section 1905(a) of the Act) and as described in the Code of Colorado Regulations, 10 CCR 2505-10, Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance and Colorado Revised Statutes (C.R.S. 25.5-5-318. Health Services – Provision by School Districts). Services are delivered in the least restrictive environment consistent with the nature of the specific service(s) and the physical and mental condition of the client. Participation by Medicaid-eligible recipients is optional.

A. Qualified Providers

Services may be performed in the school, at the client's home or at another site in the community by qualified personnel or a qualified health care professional. Qualified personnel must meet State Education Agency–recognized certification, licensing, registration, or other comparable requirements of the profession in which they practice. A qualified health care professional is defined as an individual who is registered, certified or licensed by the Department of Regulatory Agencies as a health care professional and who acts within the profession's scope of practice. In the absence of state regulations, a qualified health care professional must be registered or certified by the relevant national professional health organization and must be allowed to practice if the provider is qualified per State law.

B. Medical Necessity

A medically necessary service is a benefit service that will, or is reasonably expected to prevent, diagnose, cure, correct, reduce or ameliorate the pain and suffering, or the physical, mental, cognitive or developmental effects of an illness, injury or disability; and for which there is no other equally effective or substantially less costly course of treatment suitable for the child's needs. Medical necessity is determined as the result of a service furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, by a qualified health professional operating within the scope of his/her practice.

Where required by Medicaid regulations, a qualified licensed practitioner of the healing arts must refer a child for services. Services are provided in accordance with the client's individual need and are not subject to any arbitrary limitations as to scope, amount or duration.

C. Free Choice of Providers

The State assures that the provision of services will not restrict an individual's free choice of qualified providers in violation of section 1902(a)(23) of the Social Security Act. The Medicaid-eligible individual may obtain Medicaid Services from any institution, agency, pharmacy, person or organization that is qualified to perform services. School health services will be made available to all Medicaid eligible targeted recipients and shall be delivered by any participating qualified provider on a statewide basis with procedures to ensure continuity of services without duplication and in compliance with federal and state mandates and regulations related to serving the targeted population in a uniform and consistent manner.

II. School Health Services and Qualified Providers

A. Physician Services

Definition:

Physician services are available to a Medicaid-eligible beneficiary under the age of 21 for whom the services are medically necessary. Physician services are provided with the intent to diagnose, identify or determine the nature and extent of a student's medical or other health related condition.

Physician Services include:

1. Evaluation and consultation with providers of covered services for diagnostic and prescriptive services including participation in a multi-disciplinary team assessment.
2. Record review for diagnostic and prescriptive services.

3. Diagnostic and evaluation services to determine a beneficiary's medically related condition that results in the beneficiary's need for Medicaid services.

Physician services may be provided only in an individual setting.

Providers:

Physician services must be provided by a qualified physician who meets the requirements of, and in accordance with, 42 CFR § 440.50(a) or a psychiatrist who meets the requirements of, and in accordance with, 42 CFR § 440.60(a) and other applicable state and federal law or regulation.

Services may be provided by:

- A currently Colorado-licensed physician (MD or DO);
- A currently Colorado-licensed psychiatrist.

B. Nursing Services

Definition:

Nursing services are available to a Medicaid-eligible beneficiary under the age of 21 for whom the services are medically necessary and documented in an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP). Services considered observational or stand-by in nature are not covered. Medical policy will follow the current Colorado Nurse Practice Act scope of practice guidelines for nursing practices.

Services

Nursing services are professional services relevant to the medical needs of the beneficiary provided through direct intervention. Direct service interventions must be medically based services that are within the scope of the professional practice of the Registered Nurse or Licensed Practical Nurse, provided during a face-to-face encounter and provided on a one-to-one basis. Medically necessary nursing services are health care, diagnostic services, treatments and other measures to identify, correct, reduce, cure or ameliorate the pain and suffering, or

the physical, mental, cognitive or developmental effects of an illness, injury or disability.

Providers:

Nursing services must be provided by a qualified nurse who meets the requirements of, and in accordance with, 42 CFR § 440.60(a) and other applicable state and federal law or regulation.

Services may be provided by:

- A currently Colorado-licensed registered nurse;
- A currently Colorado-licensed practical nurse.

Nursing services may be delegated in accordance with 42 CFR § 440.130(d) and according to the delegation clause in Section 12-38-132, C.R.S. of the Colorado Nurse Practice Act to the following:

- A currently Colorado-qualified Nurse Aide or Health Technician.

The delegating nurse shall provide all training to the delegate for delegated activities and is solely responsible for determining the required degree of supervision the delegate will need.

C. Personal Care Services

Definition:

Personal care services are available to a Medicaid-eligible beneficiary under the age of 21 for whom the services are medically necessary and documented in an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP). Services must be authorized by a physician in accordance with a plan of treatment or authorized for the individual in accordance with a service plan approved by the State.

SCHOOL HEALTH SERVICES BENEFITS AND ELIGIBLE PROVIDERS

Services:

Personal care services are a range of human assistance services provided to persons with disabilities and chronic conditions, which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may be in the form of hands on assistance or cueing so that the person performs the task by him/herself.

Providers:

Personal care services must be provided by a qualified provider in accordance with 42 CFR § 440.167, who is 18 years or older and has been trained to provide the personal care services required by the client.

Services may be provided by:

- A currently Colorado-licensed registered nurse;
- A currently Colorado-licensed practical nurse;
- A currently Colorado-qualified Nurse Aide;
- A qualified Health Technician
- Special Education Teacher
- Special Education Teacher's Aide
- Child Care/Group Leader
- Teaching Assistant
- Bus Aide

D. Psychological, Counseling and Social Work Services

Definition:

Psychological, Counseling and Social Work services are medically necessary services documented in the student's IEP/IFSP, which documents the planning, managing, and provision of a program of face-to-face services for Medicaid eligible beneficiaries under the age of 21, with diagnosed psychological or behavioral conditions. Medically necessary services must require the skills, knowledge and education of a physician, psychiatrist, psychologist, counselor or social worker to provide treatment.

SCHOOL HEALTH SERVICES BENEFITS AND ELIGIBLE PROVIDERS

Services:

Medically necessary services are health care, diagnostic services, treatments and other measures to identify, correct or ameliorate any disability and/or chronic condition. Services are provided as health and behavior interventions to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical and mental health problems. These services are intended for the benefit of the Medicaid eligible beneficiary.

Psychological, Counseling and Social Work services may be provided in an individual or group setting.

Providers:

- Qualified providers who meet the requirements of, and in accordance with, 42 CFR § 440.50 and 42 CFR § 440.60(a) and other applicable state and federal law or regulation, a qualified physician who meets the requirements of, and in accordance with, 42 CFR § 440.50 and other applicable state and federal law or regulation, a qualified counselor who meets qualification requirements of, and in accordance with, 42 CFR § 440.60(a) and other applicable state and federal law or regulation or a qualified Social Worker who meets qualification requirements of, and in accordance with 42 CFR § 440.60(a) and other applicable state and federal law or regulation.

Services may be provided by:

- A currently Colorado-licensed Psychologist (Doctoral level);
- A currently Colorado-licensed Psychiatrist;
- A currently Colorado-licensed Physician (MD or DO);
- A currently Colorado-licensed Counselor;
- A currently Colorado-licensed Marriage and Family Therapist;
- A currently Colorado-licensed Social Worker (Master's level);
- A currently Colorado-licensed Clinical Social Worker (Master's level).

SCHOOL HEALTH SERVICES BENEFITS AND ELIGIBLE PROVIDERS

E. Orientation, Mobility and Vision Services

Definition:

Vision, orientation and mobility training services are available to a Medicaid-eligible beneficiary under the age of 21 for whom the services are medically necessary and documented in an IEP/IFSP. Medically necessary health services are health care, diagnostic services, treatments, and other measures to correct or ameliorate any disability and chronic condition.

Services:

Orientation, mobility and vision services are evaluations and training performed to correct or alleviate movement deficiencies created by a loss or lack of vision.

Providers:

Services must be provided by a Medicaid qualified provider in accordance with 42 CFR § 440.130(d) and other applicable state or federal law. Providers include:

- An Orientation and Mobility Specialist certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP).

F. Speech, Language and Hearing Services

Definition:

Speech therapy services are available to a Medicaid-eligible beneficiary under the age of 21 for whom the services are medically necessary and documented in an IEP/IFSP. Medically necessary health services are health care, diagnostic services, treatments, and other measures to correct or ameliorate any disability and chronic condition. Services must require the skills, knowledge and education of a qualified speech language pathologist (SLP) or audiologist.
Services:

SCHOOL HEALTH SERVICES BENEFITS AND ELIGIBLE PROVIDERS

Speech and language services require a referral from a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. Services are necessary to diagnose, evaluate, treat, and provide for amelioration activities for specific speech, language and hearing disorders. Services include any necessary supplies and equipment. Services may include direct assistance with the selection, acquisition, training, or use of an assistive technology device (ATD).

An assistive technology device (ATD) is defined as "any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of a child with a disability" (IDEA, 1997, 20, USC, Ch. 33, Sec. 1401 [25] US).

Speech and language therapy services may be provided in an individual or group setting.

Providers:

Services must be provided by a Medicaid qualified provider in accordance with 42 CFR § 440.110 and other applicable state or federal law. Providers include:

- A qualified speech language pathologist possessing a current Certificate of Clinical Competence (CCC) certification from the American Speech-Language-Hearing Association (ASHA).

- A qualified audiologist with a master's or doctoral degree in audiology and possessing a current Certificate of Clinical Competence (CCC), certification from the American Speech-Language-Hearing Association (ASHA) or licensure from the Colorado Department of Regulatory Agencies.

- An appropriately supervised speech-language pathologist and/or audiology candidate (i.e., in his/her clinical fellowship year or having completed all requirements but has not yet obtained a CCC). A speech-language pathology or audiology candidate may only deliver services under the direction of a qualified therapist in accordance with 42 CFR § 440.110(c).

SCHOOL HEALTH SERVICES BENEFITS AND ELIGIBLE PROVIDERS

Speech and language services require a referral from a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. Services are necessary to diagnose, evaluate, treat, and provide for amelioration activities for specific speech, language and hearing disorders. Services include any necessary supplies and equipment. Services may include direct assistance with the selection, acquisition, training, or use of an assistive technology device (ATD).

An assistive technology device (ATD) is defined as "any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of a child with a disability" (IDEA, 1997, 20, USC, Ch. 33, Sec. 1401 [25] US).

Speech and language therapy services may be provided in an individual or group setting.

Providers:

Services must be provided by a Medicaid qualified provider in accordance with 42 CFR § 440.110 and other applicable state or federal law. Providers include:

- A qualified speech language pathologist possessing a current Certificate of Clinical Competence (CCC) certification from the American Speech-Language-Hearing Association (ASHA).

- A qualified audiologist with a master's or doctoral degree in audiology and possessing a current Certificate of Clinical Competence (CCC), certification from the American Speech-Language-Hearing Association (ASHA) or licensure from the Colorado Department of Regulatory Agencies.

- An appropriately supervised speech-language pathologist and/or audiology candidate (i.e., in his/her clinical fellowship year or having completed all requirements but has not yet obtained a CCC). A speech-language pathology or audiology candidate may only deliver services under the direction of a qualified therapist in accordance with 42 CFR § 440.110(c).

All documentation must be reviewed and signed by the appropriately credentialed supervising SLP or audiologist;

- A qualified teacher of students with speech and language impairment with current Colorado Department of Education specialty certificate of endorsement for speech and language impairments when acting under the direction of a qualified SLP in accordance with 42 CFR § 440.110(c) and other applicable state and federal law.

G. Occupational Therapy

Definition:

Occupational therapy services are available to a Medicaid-eligible beneficiary under the age of 21 for whom the services are medically necessary and documented in an IEP/IFSP. Occupational therapy services must require the skills, knowledge and education of an Occupational Therapist Registered (OTR) or Certified Occupational Therapy Assistant (COTA) to provide services.

Services:

Occupational therapy (OT) services must be prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. Services include any necessary supplies and equipment. Medically necessary services are health care, diagnostic services, treatments, and other measures to correct or ameliorate any disability and/or chronic condition. Services are provided to improve, develop, or restore functions impaired or lost through illness, injury, or deprivation. Services may include direct assistance with the selection, acquisition, training, or use of an assistive technology device (ATD).

Occupational therapy services may be provided in an individual or group setting.

Providers:

Occupational therapy services must be provided by a qualified Medicaid provider who meets the requirements of 42 CFR § 440.110(b) and in accordance with applicable state and federal law or regulation. Services may be provided by:

- An occupational therapist currently registered (OTR) in Colorado and certified by the National Board for Certification in Occupational Therapy (NBCOT);

- A certified occupational therapy assistant (COTA) under the direction of a qualified therapist in accordance with 42 CFR § 440.110 (i.e., the COTA's services must follow the evaluation and treatment plan developed by the OTR and the OTR must supervise and monitor the COTA's performance with continuous assessment of the beneficiary's progress). All documentation must be reviewed and signed by the appropriate supervising OTR.

H. Physical Therapy

Definition:

Physical therapy services are available to a Medicaid-eligible beneficiary under the age of 21 for whom the services are medically necessary and documented in an IEP/IFSP. Physical therapy services must require the skills, knowledge and education of a currently Colorado-licensed Physical Therapist (LPT) or appropriately supervised Certified Physical Therapy Assistant (CPTA) to provide therapy.

Services:

Physical therapy services must be prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. Services include any necessary supplies and equipment.

Medically necessary services are health care, diagnostic services, treatments, and other measures to correct or ameliorate any disability and chronic condition. Physical therapy services are provided for the purpose of preventing or alleviating movement dysfunction and related functional problems. Services may include direct assistance with the selection, acquisition, training, or use of an assistive technology device (ATD) or orthotic/prosthetic devices.

Physical therapy services may be provided in an individual or group setting.

Providers:

Physical therapy services must be provided by a qualified Medicaid provider who meets the requirements of 42 CFR § 440.110(a) and in accordance with applicable state and federal law or regulation. Services may be provided by:

- A currently Colorado-licensed physical therapist (LPT);
- A Colorado certified physical therapy assistant (CPTA) when the assistant is acting under the direction of a currently Colorado-licensed LPT in accordance with 42 CFR § 440.110. All documentation must be reviewed and signed by the appropriately licensed supervising LPT.

I. Specialized Transportation

Definition:

Specialized transportation services are available to a Medicaid-eligible beneficiary under the age of 21 for whom the transportation services are medically necessary and documented in an IEP/IFSP.

Services:

Services must be provided on the same date of service that a Medicaid covered service, required by the student's IEP/IFSP, is received. Transportation must be on a specially adapted school bus to and/or from the location where the Medicaid service is received. Transportation services are not covered on a regular school bus unless an Aide for the transported student(s) is present and is required by the student's IEP/IFSP.

All specialized transportation services provided must be documented in a transportation log.

Providers:

Transportation services include direct services personnel, e.g. bus drivers, aides etc. employed or contracted by the school district.

J. Targeted Case Management Services

Definition:

Targeted Case Management (TCM) services are activities, which will assist Title XIX eligible individuals, ages 0-21, who have a disability or who are medically at risk, in gaining access to services pursuant to an IEP/IFSP. A disability is defined as a physical or mental impairment that substantially limits one or more major life activities. Medically at risk refers to individuals who have a diagnosable physical or mental condition that has a high probability of impairing cognitive, emotional, neurological, social or physical development.

Activities:

Targeted Case Management (TCM) activities are a component of the IEP/IFSP treatment plan. TCM identifies special health problems and addresses needs that affect the student's ability to learn, assist the child to gain and coordinate access to a broad range of medically necessary services covered under the Medicaid program, and ensures that the student receives effective and timely services appropriate to their needs. TCM activities shall not restrict or be used as a condition to a client's access to other services under the state plan.

Recipients of TCM activities are eligible for the entire span of activities described as school health services in the Colorado Medicaid State Plan. A unit of service is defined as each completed 15-minute increment that meets the description of a case management activity with or on behalf of the individual, his or her parent(s) or legal guardian.

TCM activities include the following activities:

- Comprehensive Needs Assessment and Reassessment;
- Development and Revision of Care Plan;
- Referral and Related Activities;
- Monitoring and Follow-Up Activities;
- Case Record Documentation.

SCHOOL HEALTH SERVICES BENEFITS AND ELIGIBLE PROVIDERS

1. Comprehensive Needs Assessment and Reassessment

Reviewing the individual's current and potential strengths, resources, deficits and identifying the need for medical, social, educational and other services that are related to Medicaid-covered services. If necessary to form a complete assessment of the client, information shall be gathered from other sources, such as family members, medical providers, social workers, and educators. Results of assessments and evaluations are reviewed and a meeting is held with the individual, his or her parent(s) and/or guardian, and the case manager to determine whether services are needed and, if so, to develop a specific care plan. At minimum, an annual face-to-face reassessment shall be conducted to determine if the client's needs or preferences have changed.

2. Development and Revision of Care Plan

Developing a specific written care plan based on the assessment of the individual's strengths and needs. The written care plan shall be a distinct component of the IEP or IFSP and shall identify the health-related activities and assistance needed to accomplish the goals collaboratively developed by the individual, his or her parent(s) or legal guardian, and the case manager. The care plan shall describe the amount, duration and scope of TCM activities. Service planning may include acquainting the individual, his or her parent(s) or legal guardian with resources in the community and providing information for obtaining services through community programs.

3. Referral and Related Activities

Facilitating the individual's access to the care, services and resources needed through linkage, coordination, referral, and consultation. This is accomplished through in-person and telephone contacts with the individual, his or her parent(s) or legal guardian, and with service providers and other collaterals on behalf of the individual. This may include facilitating the recipient's physical accessibility to services such as arranging transportation to medical, social, educational and other services that are related to Medicaid-covered services; facilitating communication

between the individual, his or her parent(s) or legal guardian and the case manager or other service providers; or, arranging for translation or another mode of communication. It may include advocating for the individual in matters regarding access, appropriateness and proper utilization of services; and evaluating, coordinating and arranging immediate services or treatment needed in situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for a specific individual.

4. Monitoring and Follow-Up Activities

As necessary, but at least annually, the case manager shall conduct monitoring and follow-up activities with the client or the client's legal representative. Monitoring and follow-up activities are necessary to insure the care plan is effectively implemented and adequately addresses the needs of the client. The review of the care plan may result in revision or continuation of the plan, or termination of case management services if they are no longer appropriate. Monitoring may involve either face-to-face or telephone contacts with the individual and other involved parties. Results of the monitoring and follow-up shall be documented in the care plan.

5. Case Record Documentation

Case record documentation of the above service components is included as a case management activity. Providers shall maintain case records that document for all individuals receiving TCM, the dates of service; the nature, content and units of TCM services received; status of goals specified in care plan; whether client declined services in care plan; the need for and coordination with other case managers; a timeline for obtaining needed services and a timeline for reevaluation of the care plan.

SHS Program Targeted Case Management activities do not include:

- Activities related to the development, implementation, annual review and triennial review of IEP documents, that are the inherent responsibility of the Colorado Department of Education;

SCHOOL HEALTH SERVICES BENEFITS AND ELIGIBLE PROVIDERS

- Activities related to IDEA functions such as scheduling IFSP team meetings, and providing prior written notice;
- Activities or interventions specifically designed to only meet the student's educational goals;
- Activities, for which an individual may be eligible, that are integral to the administration of another non-medical program, except for case management that is included in an IEP or IFSP;
- Program activities of the agency itself that do not meet the definition of targeted case management;
- Administrative activities necessary for the operation of the agency providing case management services other than the overhead costs directly attributable to targeted case management;
- Treatment or instructional services, including academic testing;
- Services that are an integral part of another service already reimbursed by Medicaid; and
- Activities that are an essential part of Medicaid administration, such as outreach, intake processing, eligibility determination or claims processing.

Providers:

The targeted case management provider must meet state or national licensure, registration, or certification requirements of the profession in which they practice and must act within the profession's scope of practice. Targeted case managers who also provide direct services will not self-refer for the provision of direct services. Additionally, only those TCM providers who bill TCM throughout the school year will be included on the cost reporting forms to ensure the appropriate cost allocation for reimbursement purposes.

Targeted case management activities may be provided by any willing qualified provider pursuant to 1902(a)23 of the Social Security Act. Additionally, a provider that meets the qualifications established by the State's licensure act for educators as special service providers who develop and implement Individualized Plans for services under the Individuals with Disabilities Education Act (IDEA) may also provide targeted case management activities. State Education Agency (SEA) providers must hold a Colorado Department of Education Professional, Provisional or Alternative Teacher License with an appropriate endorsement in

special education. Individuals providing special education services through Temporary Teacher Eligibility (TTE) under 3.04(2) of the Rules for the Administration of the Exceptional Children's Education Act (ECEA) are considered qualified to provide Medicaid Targeted Case Management activities.

TCM activities may be provided by:

- A currently Colorado-licensed Physician (MD or DO);
- A currently Colorado-licensed Psychiatrist;
- A currently Colorado-licensed Registered Nurse;
- A currently Colorado-licensed Practical Nurse;
- A currently Colorado-qualified Nurse Aide;
- A qualified Health Technician;
- A qualified Special Education teacher with current Colorado Department of Education Professional, Provisional or Alternative Teacher License;
- A Special Education Teacher's Aide;
- A Child Care/Group Leader;
- A Teaching Assistant;
- A Bus Aide;
- A currently Colorado-licensed Psychologist (Doctoral level);
- A currently Colorado-licensed Counselor;
- A currently Colorado-licensed Marriage and Family Therapist;
- A currently Colorado-licensed Social Worker (Master's level);
- A currently Colorado-licensed Clinical Social Worker (Master's level);
- A Teacher of students with speech and language impairment possessing a Colorado Department of Education Specialty Certificate;
- An ACVREP-certified Orientation and Mobility Specialist;
- A qualified Speech Language Pathologist possessing a current Certificate of Clinical Competence (CCC) certification from the American Speech-Language-Hearing Association (ASHA);
- A qualified Audiologist with a Master's or Doctoral degree in audiology and possessing a current Certificate of Clinical Competence (CCC), certification from the American Speech-Language-Hearing Association (ASHA) or licensure from the Colorado Department of Regulatory Agencies;
- A supervised Speech Language Pathologist Candidate;

SCHOOL HEALTH SERVICES BENEFITS AND ELIGIBLE PROVIDERS

- A supervised Audiologist Candidate;
- An Occupational Therapist currently registered (OTR) in Colorado and certified by the National Board for Certification in Occupational Therapy (NBCOT);
- A supervised NBCOT-Certified Occupational Therapy Assistant;
- A currently Colorado-licensed Physical Therapist (LPT); and
- A supervised Certified Physical Therapy Assistant.

Choice of Providers:

The State assures that the provision of services will not restrict an individual's free choice of qualified providers in violation of section 1902(a)(23) of the Social Security Act. The Medicaid-eligible individual may obtain Medicaid Services from any institution, agency, pharmacy, person or organization that is qualified to perform services.

TCM activities shall be delivered by any participating qualified provider on a statewide basis with procedures to ensure continuity of services without duplication and in compliance with federal and state mandates and regulations related to serving the targeted population in a uniform and consistent manner.

Non-Duplication of Services:

To the extent that any of the services required by the client are a Title XIX benefit of a managed care organization of which the client is a member, the School Health Service provider will ensure that timely referrals are made and that coordination of care occurs.

TCM will not be billed for activities that are components of direct services. Additionally, targeted case management activities will not be duplicative of activities that are components of the administration of the Individuals with Disabilities Education Act (IDEA). The State assures that it will not seek federal matching for case management activities that are duplicative.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

A. Reimbursement Methodology for School-Based Health and Related Services

School-based services, known as School Health Services (SHS) or Medicaid Extended Health Services (MESH) in Colorado, are delivered by the school districts, boards of cooperative educational services (BOCES) and K-12 educational institutions (herein after referred to as "providers" for this section of the State Plan), and include the following Medicaid services as described in the Code of Colorado Regulations, 10 CCR 2505-10, Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance and Colorado Revised Statutes (C.R.S. 25.5-5-318. Health Services – Provision by School Districts):

1. Physicians Services
2. Nursing Services
3. Personal Care Services
4. Psychology Services
5. Counseling Services
6. Social Work Services
7. Orientation, Mobility, and Vision Services
8. Speech-Language Services
9. Audiology Services
10. Occupational Therapy (OT)
11. Physical Therapy (PT)
12. Specialized Transportation
13. Targeted Case Management (TCM)

B. Direct Medical and Targeted Case Management Payment Methodology

Effective dates of service on or after July 1, 2005, providers will be paid on a cost basis. Providers will be reimbursed interim rates for SHS direct medical services per unit of service at the lesser of the provider's billed charges or the interim rate. On an annual basis a district-specific cost reconciliation and cost settlement for all over and under payments will be processed.

The units of service are defined by each Health Insurance Portability and Accountability Act (HIPAA) compliant current procedural terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code. Direct medical and Targeted Case Management services may be encounter-based or in 15-minute unit increments. The provider-specific interim rate is the rate for a specific service for a period that is provisional in nature, pending the completion of cost reconciliation and cost settlement for that period.

C. Data Capture for the Cost of Providing Health-Related Services

Data capture for the cost of providing health-related services will be accomplished utilizing the following data sources:

1. Total direct and indirect costs, less any federal payments for these costs, will be captured utilizing the following data:
   a. School Health Services cost reports received from school districts and BOCES;
   b. Colorado Department of Education (CDE) Unrestricted Indirect Cost Rate (ICR);
   c. Random Moment Time Study (RMTS) Activity Code 1200 (Direct Medical Services), Activity Code 2100 (Targeted Case Management) and Activity Code 3100 (General Administration):
      i. Direct medical RMTS percentage;
      ii. Targeted Case Management RMTS percentage; and
   d. School District/BOCES specific IEP Ratios.

D. Data Sources and Cost Finding Steps

The following provides a description of the data sources and steps to complete the cost finding and reconciliation:

1. Allowable Costs: Direct costs for direct medical services and TCM include unallocated payroll costs and other unallocated costs that can be directly charged to direct medical services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct services personnel

listed in the descriptions of the covered Medicaid services delivered by school districts and BOCES in the Code of Colorado Regulations, 10 CCR 2505-10, excluding transportation personnel. These direct costs will be calculated on a district-specific level and will be reduced by any federal payments for these costs, resulting in adjusted direct costs.

Other direct costs include costs directly related to the approved direct services personnel for the delivery of medical services, such as medically-related purchased services, supplies and materials. These direct costs are accumulated on the annual School Health Services Cost Report and are reduced by any federal payments for these costs, resulting in adjusted direct costs. The cost report contains the scope of cost and methods of cost allocation that have been approved by the Centers for Medicare & Medicaid Services (CMS).

The source of this financial data will be audited Chart of Account records kept at the school district and BOCES level. The Chart of Accounts is uniform throughout the state of Colorado. Costs will be reported on an accrual basis.

a. Direct Medical Services

Non-federal cost pool for allowable providers consists of:

i. Salaries;
ii. Benefits;
iii. Medically-related purchased services; and
iv. Medically-related supplies and materials

b. Targeted Case Management Services

Medicaid allowable non-federal cost pool for Targeted Case Management providers will consist of:

i. Salaries;
ii. Benefits;
iii. Medically-related purchased services; and
iv. Medically-related supplies and materials.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

2. Indirect Costs: Indirect costs are determined by applying the school district's specific unrestricted indirect cost rate to its adjusted direct costs. Colorado public school districts and BOCES use predetermined fixed rates for indirect costs. Colorado Department of Education has, in cooperation with the United States Department of Education (ED), developed an indirect cost plan to be used by school districts and BOCES in Colorado. Pursuant to the authorization in 34 CFR §75.561(b), CDE approves unrestricted indirect cost rates for school districts for the ED, which is the cognizant agency for school districts. Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

   Indirect Cost Rate

   a. Apply the Colorado Department of Education Cognizant Agency Unrestricted Indirect Cost Rate applicable for the dates of service in the rate year.

   b. The CDE UICR is the unrestricted indirect cost rate calculated by the Colorado Department of Education.

3. Time Study Percentages: A CMS-approved time study is used to determine the percentage of time that medical service personnel spend on direct medical services, general and administrative time and all other activities to account for 100 percent of time to assure that there is no duplicate claiming. The appropriate time study results will be applied to the direct medical services and targeted case management services cost pools. The direct medical services costs and targeted case management services costs and their respective time study results must be aligned to ensure proper cost allocation. The CMS approval letter for the time study will be maintained by the State of Colorado and CMS.

4. IEP Ratio Determination: A district-specific IEP Ratio will be established for each participating school district or BOCES. When applied, this IEP Ratio will discount the Direct Medical and Targeted Case Management cost pools by the percentage of IEP Medicaid students.

   The names and birthdates of students with a health related IEP will be identified from the December 1 Count Report and matched against the Medicaid eligibility file to determine the percentage of those that are eligible for Medicaid. The

numerator of the rate will be the students with an IEP that are eligible for Medicaid and the denominator will be the total number of students with an IEP.

5. Total Medicaid Reimbursable Cost: The result of the previous steps will be a total Medicaid reimbursable cost for each school district or BOCES for Direct Medical Services and Targeted Case Management.

After valid time study/claims results have been produced for at least four consecutive quarters, the HCPF will submit for CMS review and approval a proposed methodology for documenting prior period claims by applying the time study results for purposes of adjusting the prior period claims that CMS has deferred. Claims for all prior period quarters must meet the timeliness requirements of 45 CFR 95.7 and any additional time requirements specified in individual CMS deferral letters. Reported expenditures must be reasonable, allowable, and allocable, and must be adjusted, if necessary, to comport with the guidelines specified in the CMS-approved time study. The feasibility and method for adjusting the prior period quarter claims as proposed by the State and approved by CMS shall be final and not be subject to challenge or appeal.

E. Specialized Transportation Services Payment Methodology

Effective dates of service on or after July 1, 2005, providers will be paid on a cost basis. Providers will be reimbursed interim rates for SHS Specialized Transportation services at the lesser of the provider's billed charges or the statewide enterprise interim rate. Federal matching funds will be available for interim rates paid by the State. On an annual basis a cost reconciliation and cost settlement will be processed for all over and under payments.

Transportation to and from school may be claimed as a Medicaid service when the following conditions are met:

1. Special transportation is specifically listed in the IEP as a required service;

2. The child required transportation in a vehicle adapted to serve the needs of an individual with a disability;

3. A medical service is provided on the day that specialized transportation is billed; and

4. The service billed only represents a one-way trip.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Transportation costs included on the cost report worksheet will only include those personnel and non-personnel costs associated with special education reduced by any federal payments for these costs, resulting in adjusted costs for transportation. The cost identified on the cost report includes the following:

1. Bus Drivers
2. Mechanics
3. Substitute Drivers
4. Fuel
5. Repairs & Maintenance
6. Rentals
7. Contract Use Cost
8. Depreciation

The source of these costs will be audited Chart of Accounts data kept at the school district and BOCES level. The Chart of Accounts is uniform throughout the State of Colorado. Costs will be reported on an accrual basis.

Special education transportation costs include those for wheelchair lifts and other special modifications which are necessary to equip a school bus in order to transport children with disabilities (Colorado State Board of Education, Department of Education 2251-R-4 Rules).

When school districts or BOCES are not able to discretely identify the special education transportation cost from the general education transportation costs, a special education transportation cost discounting methodology will be applied. A rate will be established and applied to the total transportation cost of the school district or BOCES. This rate will be based on the *Total IEP SPED Students in District Receiving Specialized Transportation* divided by the *Total Students in District Receiving Transportation.* The result of this rate (%) multiplied by the *Total School District or BOCES Transportation Cost* for each of the categories listed above will be included on the cost report. It is important to note that this cost will be further discounted by the ratio of *Medicaid Eligible SPED IEP One Way Trips* divided by the total number of *SPED IEP One Way Trips*. This data will be provided from bus logs. The process will ensure that only one way trips for Medicaid eligible Special Education children with IEP's are billed and reimbursed for.

F. Certification of Funds Process

Each provider certifies on an annual basis an amount equal to each interim rate times the units of service reimbursed during the previous federal fiscal year. In addition, each provider certifies on an annual basis through its cost report its total actual, incurred allowable costs/expenditures, including the federal share and the non-federal share.

Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

G. Annual Cost Report Process

Each provider will complete an annual cost report for all school health services delivered during the previous state fiscal year covering July 1 through June 30. The cost report is due on or before October 1 of the year following the reporting period. The primary purposes of the cost report are to:

1. Document the provider's total CMS-approved, Medicaid allowable scope of costs for delivering school health services, including direct costs and indirect costs, based on CMS-approved cost allocation methodology procedures; and

2. Reconcile its interim payments to its total CMS-approved, Medicaid-allowable scope of costs based on CMS-approved cost allocation methodology procedures.

The annual SHS Cost Report includes a certification of funds statement to be completed, certifying the provider's actual, incurred costs/expenditures. All filed annual SHS Cost Reports are subject to a desk review by the Department of Health Care Policy and Financing (HCPF) or its designee.

H. The Cost Reconciliation Process

The cost reconciliation process must be completed within twenty-four months of the end of the reporting period covered by the annual SHS Cost Report. The total CMS-approved, Medicaid allowable scope of costs based on CMS-approved cost allocation methodology procedures are compared to the provider's Medicaid interim payments for school health services delivered during the reporting period as documented in the Medicaid Management Information System (MMIS), resulting in a cost reconciliation.

For the purposes of cost reconciliation, the state may not modify the CMS-approved scope of costs, the CMS-approved cost allocation methodology procedures, or its CMS-

approved time study for cost-reporting purposes. Any modification to the scope of cost, cost allocation methodology procedures, or time study for cost-reporting purposes requires approval from CMS prior to implementation; however, such approval does not necessarily require the submission of a new state plan amendment.

I. The Cost Settlement Process

For services delivered for a period covering July 1st, through June 30th, the annual SHS Cost Report is due on or before October 1st of the preceding year (4 months after the fiscal year end), with the cost reconciliation and settlement processes completed no later than April 1st (9 months after the fiscal year end).

If a provider's interim payments exceed the actual, certified costs of the provider for school health services to Medicaid clients, the provider will return an amount equal to the overpayment.

If the actual, certified costs of a provider for school health services exceed the interim Medicaid payments, HCPF will pay the federal share of the difference to the provider in accordance with the final actual certification agreement and submit claims to the CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

HCPF shall issue a notice of settlement that denotes the amount due to or from the provider.