THIS PAGE NOT FOR PUBLICATION

Title of Rule:	SSI Medicaid Eligibility Effective Date Rules for Children Under 21, Section 8.110
Rule Number:	MSB 07-01-31-B
Division / Contact / Phone:	Legal / Brian Zolynas / 303-866-2814

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 07-01-31-B, SSI Medicaid Eligibility Effective Date Rules for Children Under 21, Section 8.110
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.110.1, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current text in **§8.110 MEDICAL ASSISTANCE FOR THE AGED, DISABLED OR BLIND; §8.110.1 SSI ELIGIBLES** beginning at **§8.110.11** through the end of **§8.110.12** with the new text attached. This change is effective 8/30/2008.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	SSI Medicaid Eligibility Effective Date Rules for Children Under 21, Section 8.110
Rule Number:	MSB 07-01-31-B
Division / Contact / Phone:	Legal / Brian Zolynas / 303-866-2814

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The purpose of this rule change is to revise the Supplemental Security Income (SSI) Medicaid eligibility requirements to incorporate changes in federal law governing the effective date of eligibility for individuals under 21 and to provide criteria for granting eligibility to infants who are found to be disabled shortly after birth.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR §435.120, 42 CFR §435.909(b)(1), 42 CFR §435.914, 42 USC §1396a(a)(10)(A)(i)(II)(cc)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2007);
   25.5-4-104(1), C.R.S. (2007)

Initial Review	**05/09/2008**	Final Adoption	**07/11/2008**
Proposed Effective Date	**09/01/2008**	Emergency Adoption	

DOCUMENT #04

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	SSI Medicaid Eligibility Effective Date Rules for Children Under 21, Section 8.110
Rule Number:	MSB 07-01-31-B
Division / Contact / Phone:	Legal / Brian Zolynas / 303-866-2814

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

The proposed rule changes will affect children under the age of 21 who are eligible for or who are receiving SSI benefits and infants found to be disabled at or shortly after birth who are eligible for or who are receiving SSI. Under the current rules, Medicaid eligibility for these infants does not begin until the date on which they are found eligible for SSI, and this sometimes does not occur until days or weeks after the child was born. As a result, some disabled children do not have insurance coverage to cover the cost of their birth and first few days or weeks of hospitalization. Current Department policy allows the effective date for Medicaid eligibility for individuals eligible for or receiving SSI benefits to be backdated up to 90 days, if the individual otherwise meets the SSI financial and disability criteria, and this policy has been employed to provide coverage for some infants in these situations. The proposed rule change would clarify that Medicaid coverage is available for SSI-eligible infants found to be disabled shortly after birth by providing for automatic coverage back to the date of birth if certain criteria are met.

The proposed rule changes will also affect caseworkers at the county departments of social/human services and medical assistance sites who make determinations of Medicaid eligibility. These individuals will need to become familiar with the new rules and with procedures for implementing them.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

The proposed rule change will eliminate gaps in insurance coverage experienced by some disabled infants who are eligible for or who receive SSI. These gaps in coverage result in medical bills that become the responsibility of the infant's parents, counties, or other parties, and often end up unpaid, unless the infant's Medicaid eligibility is backdated 90 days. While the Department's policy has been to backdate Medicaid eligibility for up to 90 days for these infants if they otherwise meet the SSI financial criteria, this has not been done consistently or expeditiously in all cases. The proposed regulations should help alleviate this problem.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

Current Department policy already allows for backdating Medicaid eligibility for individuals who are eligible for or who are receiving SSI benefits up to 90 days, if they meet the SSI financial and disability criteria. This policy has not been consistently applied in all cases in which it could have been invoked and has resulted in some individuals who may have been eligible for Medicaid coverage of their medical bills not receiving that coverage. The proposed rule change is intended to help reduce the prevalence of this problem among infants, and, to the extent that it is successful, there may be a fiscal impact to the Department in providing that coverage. The Department does not have data at this time with which to quantify this potential fiscal impact.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

Inaction would result the department being out of compliance with federal statute. It would also result in some SSI eligible disabled infants continuing to experience difficulties in obtaining Medicaid coverage for bills incurred from date of birth until the date on which SSI eligibility is established. The proposed rule would alleviate this problem.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

There are no less costly or less intrusive methods for achieving the purpose of the proposed rule.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

There are no effective alternative methods for achieving the purpose of the proposed rule.

8.110 MEDICAL ASSISTANCE FOR THE AGED, DISABLED OR BLIND

8.110.1 SSI ELIGIBLES

.11 Benefits of the Colorado Medicaid Program must be provided to the following:

a. persons receiving financial assistance under the federal Supplemental Security Income program (SSI);

b. persons who are eligible for financial assistance under SSI, but are not receiving SSI;

c. persons receiving SSI payments based on presumptive eligibility for SSI pending final determination of disability or blindness; and

d. persons receiving SSI payments based on conditional eligibility for SSI pending disposal of excess resources.

.115 For individuals under 21 years of age who are eligible for or who are receiving SSI, the effective date of Medicaid eligibility shall be the date on which the individual applied for SSI or the date on which the individual became eligible for SSI, whichever is later.

a. Special Provisions for Infants

1. For an infant who is eligible for or who is receiving SSI, the effective date of Medicaid eligibility shall be the infant's date of birth if:

a) the infant was born in a hospital;

b) the disability onset date, as reported by the Social Security Administration, occurred during the infant's hospital stay; and

c) the infant's date of birth is within three (3) months of the date on which the infant became eligible for SSI.

.12 The State Department of Social Services has entered into an agreement with the Social Security Administration (SSA) in which SSA shall determine Medicaid eligibility for all SSI applicants.

Medicaid benefits shall be provided to all individuals receiving SSI benefits as are determined by SSA to be eligible for Medicaid.

The county department shall receive a weekly unmatched listing of all individuals newly approved and also, a weekly SSI-Cases Denied or Discontinued listing. These lists shall include the necessary information for the county to complete an eligibility form authorizing medical assistance.

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Changes to School Health Services Program, Section 8.290

Rule Number: MSB 08-04-01-A

Division / Contact / Phone: Program Eligibility and Implementation / Cheryl Nelson / 3131

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 08-04-01-A, Changes to School Health Services Program, Section 8.290
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.290.1, 8.290.2, 8.290.3, 8.290.4, 8.290.5, 8.290.6 and 8.290.7, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

This is a complete re-write of **§8.290 SCHOOL HEALTH SERVICES.** Please replace current text from **§8.290** through **§8.290.7** with the new text attached. This change is effective 8/30/2008.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Changes to School Health Services Program, Section 8.290

Rule Number: MSB 08-04-01-A

Division / Contact / Phone: Program Eligibility and Implementation / Cheryl Nelson / 3131

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The rule change is necessary in order to bring the School Health Services Program in compliance with mandates from CMS regarding provider qualifications and a cost-based reimbursement methodology. CMS is reviewing a corresponding State Plan Amendment and has provided strict conditions that must be met for the School Health Services Program to continue. In addition, the changes are necessary to bring the program in compliance with CMS regulation 2237-IFC, regarding case management services.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   CMS' direction in relation to State Plan Amendment 05-006 and CMS 2237-IFC

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2007);
   25.5-5-318, C.R.S. (2007)

Initial Review — Final Adoption **07/11/2008**

Proposed Effective Date **09/01/2008** — Emergency Adoption **05/09/2008**

DOCUMENT #05

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Changes to School Health Services Program, Section 8.290

Rule Number: MSB 08-04-01-A

Division / Contact / Phone: Program Eligibility and Implementation / Cheryl Nelson / 3131

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Public school districts and Board of Cooperative Education Services (BOCES) who choose to participate in the School Health Services Program will be impacted by the proposed rules. The proposed rule will reduce the number of services that a Participating District can bill, as services must be prescribed in a client's Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP). In addition, to participate in the School Health Services Program, public school districts and BOCES will need to participate in a federally mandated time study and generate annual cost reports to document the allowable costs for rendering services to Medicaid clients. Further, the rule now allows a Participating District to receive reimbursement equal to the allowable cost of providing services, rather than a rate established by the Department.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   At this time, it is not known if the reimbursement to Participating Districts will increase or decrease. The proposed rule will reduce the number of services that a Participating District can bill, but allows a Participating District to receive reimbursement equal to the allowable cost of providing services. The cost-based reimbursement methodology is expected to be higher than the current fee schedule established by the Department. The proposed rules provide specific and clear guidance so that Participating Districts can administer the program according to federal mandates and seek reimbursement accurately. Doing so will reduce the risk of overpayment and improper claiming, but will increase the administrative burden of Participating Districts as they must now participate in a federally mandated time study and generate annual cost reports to document the allowable costs for rendering services to Medicaid clients.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   There are additional costs to the Department to administer the School Health Services Program. The Department is allowed to retain up to 10% of the federal funds paid to Participating Districts to administer the program. The additional costs to establish the cost-based reimbursement methodology, time study and additional auditing requirements will be paid within the 10% allocation.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   During FY 06-07, 47,919 Medicaid clients received services through the School Health Services Program. In FY 06-07, 114 Participating Districts participated in the School Health Services Program and received Medicaid reimbursement totaling $9,995,873. Since its inception in 1997, through FY 06-07, the School Health Services Program has allowed the State to reimburse providers more than $74.0 million in Medicaid funds.

   The rule change is necessary in order to bring the School Health Services Program in compliance with mandates from CMS and federal regulation changes. If the Department does not comply, CMS may disallow the School Health Services Program starting with FY 2004-05 forward. As such, approximately $10 million in federal funds, annually, are at risk if these rules are not implemented and the program restructured according to CMS mandates.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   The Department did discuss less costly methods and less intrusive methods to operate the School Health Services Program with CMS, but the following rule change was driven by mandates from CMS.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   The Department did propose alternatives to CMS, but the following rule change was driven by mandates from CMS.

8.290 SCHOOL HEALTH SERVICES

8.290.1 DEFINITIONS

Board of Cooperative Education Services (BOCES) means a regional organization that is created when two or more school districts decide they have similar needs that can be met by a shared program. BOCES help school districts save money by providing opportunities to pool resources and share costs.

Care Coordination Plan means a document written by the District that describes how the District coordinates client services across multiple providers to assure effective and efficient access to service delivery and prevent duplication of services.

Case Management Services mean activities that assist the target population in gaining access to needed medical, social, educational and other services.

Disability means a physical or mental impairment that substantially limits one or more major life activities.

District means any BOCES established pursuant to article 5 of title 22, C.R.S., any state educational institution that serves students in kindergarten through twelfth grade including, but not limited to, the Colorado School for the Deaf and the Blind, created in article 80 of title 22, C.R.S., and any public school district organized under the laws of Colorado, except a junior college.

Individualized Education Program (IEP) means a document developed pursuant to the federal Individuals with Disabilities Education Act (IDEA). The IEP guides the delivery of special education supports and services for the student with a disability.

Individualized Family Services Plan (IFSP) means a document developed pursuant to the IDEA. The IFSP guides the delivery of early intervention services provided to infants and toddlers (birth to age 3) who have disabilities, including developmental delays. The IFSP also includes family support services, nutrition services, and case management.

~~Individualized Plan means an Individualized Education Plan (IEP) or Individualized Family Services Plan (IFSP) developed pursuant to the federal Individuals with Disabilities Education Act (IDEA).~~

Local Services Plan (LSP) means a document written by the District that describes the types and the costs of services to be provided with the federal funds received as reimbursement for providing School Health Services.

Medically at Risk means a client who has a diagnosable physical or mental condition having a high probability of impairing cognitive, emotional, neurological, social, or physical development.

Medically Necessary service means 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 client's needs.

Participating District means a District that is contracted with the Department of Health Care Policy and Financing (the Department) to provide, and receive funding for School Health Services.

Qualified Health Care Professional means 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 means an individual who is registered or certified by the relevant national professional health organization.

Qualified Personnel means an individual who meets Colorado Department of Education-recognized certification, licensing, registration, or other comparable requirements of the profession in which they practice.

School Health Service means medical or health-related assistance provided to a client, by Qualified Personnel or Qualified Health Care Professionals; which is required for the diagnosis, treatment, or care of a physical or mental disorder and is recommended by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law.

Specialized Transportation means transportation service necessary to provide a client with access to Medicaid services performed in the school or at another site in the community.

8.290.2 CLIENT ELIGIBILITY

8.290.2.A. Clients shall be eligible to receive services from Participating Districts if they are:

1. Enrolled in Medicaid,

2. Enrolled with a Participating District;

3. Under the age of 21;

4. Has a Disability or is Medically at Risk; and

5. Receives a referral for School Health Services according to an Individualized Education ~~Plan~~ Program (IEP) or Individualized Family Service Plan (IFSP).

8.290.3 PARTICIPATING DISTRICTS

8.290.3.A. Contracts may be executed with Districts throughout Colorado that meet the following minimum criteria:

1. Approval of a Local Service Plan (LSP) by the Colorado Department of Education and the Department;

2. An assessment, documented in the LSP, of the health needs of students enrolled in the District; and

3. Evidence, documented in the LSP, of community input on the health services to be delivered to public school students.

8.290.3.B. The Participating District may employ or subcontract with Qualified Personnel or Qualified Health Care Professionals to provide School Health Services.

8.290.4 SCHOOL HEALTH SERVICES, BENEFITS AND LIMITATIONS

8.290.4.A. School Health Services provided by Participating Districts to clients shall be Medically Necessary and prescribed under an IEP or IFSP.

8.290.4.B. School Health Services shall be provided in accordance with the client's individual need and shall not be subject to any arbitrary limitations as to scope, amount or duration.

8.290.4.C. School Health Services shall be delivered in the least restrictive environment consistent with the nature of the specific service(s) and the physical and mental condition of the client.

8.290.4.D. School Health Services shall not be for academic assessment.

8.290.4.E. Except for School Health Services delivered pursuant to the federal Individuals with Disabilities Education Act (IDEA), the Participating District shall not claim reimbursement for School Health Services to clients enrolled in health maintenance organizations that would normally be provided for clients by their health maintenance organization.

8.290.4.F. School Health Services shall be performed in a school setting, at the client's home or at another site in the community and may include the following:

1. Physician Services

    a. Physician services shall be provided by a Qualified Health Care Professional 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.

    b. Physician services shall be provided with the intent to diagnose, identify or determine the nature and extent of a student's medical or other health related condition.

    c. Physician services shall be provided only in an individual setting.

2. Nursing Services

    a. Nursing services shall be provided by a Qualified Health Care Professional who meets the requirements of, and in accordance with, 42 CFR § 440.60(a) and other applicable state and federal law or regulation.

    b. Nursing services shall be medically based services that are within the scope of the professional practice of a Registered Nurse or Licensed Practical Nurse, provided during a face-to-face encounter and provided on a one-to-one basis.

    c. Nursing services shall be provided or 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.

    d. 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.

3. Personal Care Services

    a. Personal Care services shall be provided by Qualified Personnel or a Qualified Health Care Professional 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.

    b. Personal Care services may be 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 or herself.

4. Psychological, Counseling and Social Work Services

a. Psychological, Counseling and Social Work services shall be performed by:

i) A Qualified Health Care Professional who meets the requirements of, and in accordance with, 42 CFR § 440.50 or 42 CFR § 440.60(a) and other applicable state and federal law and regulation;

b. Psychological, Counseling and Social Work services may be 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.

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

5. Orientation, Mobility and Vision Services

a. Orientation, Mobility and Vision services shall be provided by a Qualified Health Care Professional in accordance with 42 CFR § 440.130(d) and other applicable state or federal law.

b. Orientation, Mobility and Vision services shall be evaluations and training performed to correct or alleviate movement deficiencies created by a loss or lack of vision.

6. Speech, Language and Hearing Services

a. Speech, Language and Hearing services shall be provided by a Qualified Health Care Professional who meets the requirements of, and in accordance with, 42 CFR § 440.110(c).

b. Speech, Language and Hearing services shall require a referral from a physician or licensed practitioner of the healing arts within the scope of his or her practice under state law.

c. Speech, Language and Hearing services may include any necessary supplies and equipment.

d. Speech, Language and Hearing services may include direct assistance with the selection, acquisition, training, or use of an assistive technology device (ATD).

e. Speech, Language and Hearing services may be provided in an individual or group setting.

7. Occupational Therapy Services

a. Occupational Therapy services shall be provided by a Qualified Health Care Professional who meets the requirements of, and in accordance with, 42 CFR § 440.110(b).

b. Occupational Therapy services shall require the skills, knowledge and education of an Occupational Therapist Registered (OTR) or Certified Occupational ~~Therapy~~ Therapist Assistant (COTA) to provide services.

c. Occupational Therapy services shall be prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law.

d. Occupational Therapy services may include any necessary supplies and equipment.

e. Occupational Therapy services may include direct assistance with the selection, acquisition, training, or use of an assistive technology device (ATD).

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

8. Physical Therapy Services

a. Physical Therapy services shall be provided by a Qualified Health Care Professional who meets the requirements of, and in accordance with, 42 CFR § 440.110(a).

b. Physical Therapy services shall require the skills, knowledge and education of a Colorado Licensed Physical Therapist (~~L~~PT) as defined in 12-41-103(5) C.R.S. or an appropriately supervised ~~Certified~~ Physical Therapist~~y~~ Assistant (~~C~~PTA) as defined in 12-41-113(1) C.R.S, to provide services.

c. Physical Therapy services shall be prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law.

d. Physical Therapy services may include any necessary supplies and equipment.

e. Physical Therapy services may include direct assistance with the selection, acquisition, training, or use of an assistive technology device (ATD) or orthotic/prosthetic devices.

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

9. Specialized Transportation Services

a. Specialized Transportation services shall be required on the client's IEP or IFSP.

b. Specialized Transportation services shall be provided on the same date of service that a School Health Service, required by the student's IEP or IFSP, is received.

c. Specialized Transportation shall be on a specially adapted school bus to and from a client's place of residence and the school or the site of a School Health Service, if the School Health Service is not provided in the school setting.

d. Specialized Transportation services shall not be covered on a regular school bus unless an aide for the transported student(s) is present and is required by the student's IEP or IFSP.

e. All Specialized Transportation services provided shall be documented in a transportation log.

f. Specialized Transportation services shall include services provided by direct service personnel, such as bus drivers and aides, employed or contracted by the school district.

10. Targeted Case Management (TCM) Services

a. TCM services shall be provided by case managers who shall be Qualified Health Care Professionals or shall meet the qualifications established by the Colorado

Department of Education to develop and or implement ~~Individualized Plans~~ an IEP, IFSP or services under the IDEA.

b. The case manager shall provide TCM services on a one-to-one basis to eligible clients. The case manager shall be the focus for coordinating and overseeing the effectiveness of all providers and programs in responding to the client's assessed needs.

c. A client with a Disability or one who is Medically at Risk is eligible for TCM services when he or she receives or is ~~a~~ referred~~al~~ for~~, or~~ School Health Services according to, an IEP or IFSP.

d. TCM services shall identify special health problems and needs that affect the client's ability to learn and assist the client to gain and coordinate access to necessary medical, social, educational, and other services.

e. TCM services shall be performed with or on behalf of the client, his or her parent(s) or legal guardian.

f. Except as specified in CFR Section 441.18(b), clients eligible for TCM services shall be free to choose their case management providers from among those qualified to participate in Medicaid.

g. Clients eligible to receive TCM services shall be given the option to decline Case Management Services.

h. A Participating District shall not require that an individual receive TCM services as a condition to receive other Medicaid School Health Services.

i. Providers of TCM services shall not serve as gatekeepers under Medicaid. Case managers may not authorize or deny the provision of other School Health Services under the plan for the client.

j. TCM services shall include:

i) A comprehensive strengths and needs assessment and annual face-to-face reassessment;

ii) Service planning that provides an individualized written, comprehensive care plan based on needs identified in the assessment;

iii) Referrals and related activities to help the client obtain needed services;

iv) Monitoring and follow-up activities necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the client;

v) At a minimum, an annual review of the care plan; and

vi) The maintenance of case records that document specific information on the TCM services provided to each client, progress of service goals and coordination activities.

k. TCM services may also include:

i) Service coordination and advocacy;

ii) Crisis assistance planning; and

iii) Contact with individuals who are not eligible for Medicaid when necessary to manage the care of the client who is receiving TCM services.

l. TCM services shall not include:

i) Activities related to the development, annual review and triennial review of IEP or IFSP documents that are the inherent responsibility of the Colorado Department of Education;

ii) Activities or interventions specifically designed to only meet the client's educational goals;

iii) Transporting or escorting the client to a service to which he or she is referred;

iv) The direct delivery of a medical, social, educational or other service to which the client is referred;

v) Program activities of the Participating District itself that do not meet the definition of Targeted Case Management;

vi) Administrative activities necessary for the operation of the Participating District providing Case Management Services other than the overhead costs directly attributable to Targeted Case Management;

vii) Diagnostic, treatment or instructional services, including academic testing;

viii) The provision of case management when it is solely part of a client's plan under Section 504 of the Rehabilitation Act;

ix) Preparing, scheduling, conducting or attending IEP or IFSP meetings, or any duplicative activities that are components of the administration of the Individuals with Disabilities Education Act;

x) Services that are an integral part of another service already reimbursed by Medicaid; or

xi) Activities that are an essential part of Medicaid administration, such as outreach, intake processing, eligibility determination or claims processing.

8.290.5 COORDINATION OF CARE

8.290.5.A. The Participating District shall coordinate the provision of care with the client's primary health care provider for routine and preventive health care.

8.290.5.B. The Participating District shall refer clients to their primary care provider, health maintenance organization or managed care provider for further diagnosis and treatment that may be identified as the result of an Early Periodic Screening, Diagnostic and Treatment (EPSDT) screen or service.

8.290.5.C. When the client is receiving Medicaid services from other health care providers and the Participating District, the Participating District shall coordinate medical care with the providers to ensure that service goals are complementary and mutually beneficial to the client or shall show cause as to why coordination did not occur.

8.290.5.D. When the client of the targeted population is receiving Case Management Services from another provider agency as the result of being members of other covered targeted groups, the Participating District shall ensure that case management activities are coordinated to avoid unnecessary duplication of Medicaid services.

8.290.5.E. The Participating District shall inform a family receiving Case Management Services from more than one provider that the family may choose one lead case manager to facilitate coordination.

8.290.5.F. The Participating District shall complete and submit to the Department, for approval, a Care Coordination Plan for the delivery of TCM services. The Participating District shall have a representative group of parents and community-based providers, including the local public health department, EPSDT case managers and any existing school-based health centers to assist in developing the Care Coordination Plan.

Included in the Care Coordination Plan shall be the provision for coordination of benefits and case management across multiple providers to:

1. Achieve service integration, monitoring, and advocacy;

2. Provide needed medical, social, educational, and other services;

3. Ensure that services effectively compliment one another; and

4. Prevent duplication of Medicaid services.

8.290.6 REIMBURSEMENT

8.290.6.A. The Participating District shall obtain from the client or the client's guardian a written informed consent to submit Medicaid claims on behalf of the client.

8.290.6.B. The Participating District shall abide by the Third Party Liability rule at 10 C.C.R. 2505-10, Section 8.061.2.23.

8.290.6.C. The Participating District shall participate in a periodic time study based on instructions documented in the Department's School Health Services Program Manual, to determine the percentage of allowable time spent providing Medicaid-claimable School Health Services.

8.290.6.D. Interim Payment

1. The Participating District shall submit a claim for each benefit service provided for each client, based on rates established by the Department.

2. Rates shall be paid on a fee-for-service basis and shall serve as an interim payment for School Health Services provided.

3. The Participating District shall receive the federal share of the rate, not to exceed 100% of the federal match rate, as interim payment.

4. School Health Services provided shall be billed as an encounter or in 15-minute unit increments, in accordance with proper billing practices as defined by the Health Insurance Portability and Accountability Act or by the Healthcare Common Procedure Coding System.

5. Specialized Transportation services shall be billed as one-way trips to and from the destination.

6. Each Participating District submitting claims for reimbursement shall follow proper billing instructions as outlined in the Department's School Health Services Program Manual.

8.290.6.E. Cost Reconciliation and Final Payment

1. Each Participating District shall complete an annual cost report for School Health Services delivered during the previous state fiscal year covering July 1 through June 30. The Cost Report shall:

   a. Document the Participating District's total Medicaid allowable scope of costs for delivering School Health Services, based on an approved cost allocation methodology; and

   b. Reconcile the interim payments made to the Participating District to the Medicaid allowable scope of costs, based on an approved cost allocation methodology.

2. Each Participating District shall complete and submit to the Department a cost report on or before October 1 of the fiscal year following the end of the reporting period.

3. All annual cost reports shall be subject to an audit by the Department or its designee.

4. If a Participating District's interim payments exceed the actual, certified costs of providing School Health Services, the Participating District shall return an amount equal to the overpayment.

5. If a Participating District's actual, certified cost of providing School Health Services exceeds the interim payments, the Department will pay the federal share of the difference to the Participating District.

6. Each Participating District shall follow cost-reporting procedures detailed in the Department's School Health Services Program Manual.

8.290.6.F. Certification of Funds

1. The Participating District shall complete a certification of funds statement, included in the cost report, certifying the Participating District's actual, incurred costs and expenditures for providing School Health Services.

8.290 SCHOOL HEALTH SERVICES

8.290.1 DEFINITIONS

Care Coordination Plan means a document written by the District that describes how the District coordinates client services across multiple providers to assure effective and efficient access to service delivery and prevent duplication of services.

Disability means a physical or mental impairment that substantially limits one or more major life activities.

Individualized Plan means an Individualized Education Plan or Individualized Family Services Plan developed pursuant to the federal Individuals with Disabilities Education Act, an Accommodation Plan developed pursuant to Section 504 of the federal Rehabilitation Act of 1973, as amended, 29 U.S.C., Section 794 or an Individualized Health Services Plan developed in accordance with "The Procedure Guidelines for Health Care of Students with Special Needs in the School Setting" published by the Colorado Department of Education.

Local Services Plan (LSP) means a document written by the District that describes the types and the costs of services to be provided with the reimbursed federal funds.

Medically at Risk means a client who has a diagnosable physical or mental condition having a high probability of impairing cognitive, emotional, neurological, social, or physical development.

Medically Necessary service means 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 client's needs.

Qualified Health Care Professional means 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 means an individual who is registered or certified by the relevant national professional health organization.

Transportation means transportation service necessary to provide a client with access to Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) Medicaid services.

8.290.2 ELIGILBILTY

8.290.2.A. An eligible client shall be:

1. Enrolled in Medicaid,

2. Enrolled in a public school of a participating District and

3. Under the age of 21.

8.290.2.B. A person with a disability or who is Medically at Risk is eligible for targeted case management benefits as set forth in § 8.290.3.C when he or she receives a referral for or services according to an Individualized Plan.

8.290.3 SERVICES, BENEFITS AND LIMITATIONS

8.290.3.A. EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT) Services

1. EPSDT services shall meet the requirements at 10 C.C.R. 2505-10, Section 8.280 et seq.

2. EPSDT rehabilitation services shall be services to reduce physical or mental disability and which may improve physical or mental health level. Rehabilitation services shall be recommended by a physician or other licensed practitioner of the healing arts.

3. EPSDT services shall not be for academic assessment.

4. Except for services delivered pursuant to the federal Individuals with Disabilities Education Act or Section 504 of the federal Rehabilitation Act of 1973, the District shall not claim reimbursement for EPSDT services to clients enrolled in health maintenance organizations that would normally be provided for clients by their health maintenance organization.

8.290.3.B. Transportation shall be required on the client's Individualized Plan or shall be for EPSDT screens provided during the normal school day at non-school locations. Transportation shall be to and from a client's place of residence and the school, or the site of a Medicaid reimbursable service if the service is not provided at the school.

8.290.3.C. Targeted Case Management Services (TCM)

1. TCM services shall be services to assist the individual client who is Medically at Risk to access needed medical, social, educational, and other services.

2. TCM services may include:

a. Individualized strengths and needs assessment,

b. Needs-based service planning that provides an individualized written, comprehensive service plan based on needs identified in the assessments,

c. Service coordination, monitoring and advocacy,

d. Crisis assistance planning.

3. Targeted case management services shall not include:

a. Program activities of the District that do not meet the description of the TCM benefit,

b. Administrative activities necessary for the operation of the District,

c. Diagnostic, treatment or instructional services, including academic testing, or

d. Services that are an integral part of another service already reimbursed by Medicaid.

8.290.4 PROVIDER STANDARDS

8.290.4.A. The District shall have a Department approved Local Services Plan to obtain a contract with the Department.

8.290.4.B. Individual EPSDT service providers employed by or subcontracted by the District shall be Qualified Health Care Professionals. The following providers are considered qualified:

1. Occupational therapy assistants certified by the National Board for Certification of Occupational Therapy when providing services according to the standards of practice described in the American Journal of Occupational Therapy (December 1998),

2. Physical therapy assistants when providing services pursuant to Section 12-41-101, C.R.S., *et seq.*, and

3. Health technicians when providing skilled nursing services under the delegation clause of Section 12-38-101, C.R.S., *et seq.*

8.290.4.C. The District shall have a Care Coordination Plan approved by the Department for the delivery of TCM services.

8.290.4.D. The District shall complete and submit to the Department a Care Coordination Plan for the delivery of TCM services. The District shall have a representative group of parents and community-based providers, including the local public health department, EPSDT case managers and any existing school-based health centers to assist in developing the Care Coordination Plan.

Included in the care coordination plan is the provision for coordination of benefits and case management across multiple providers to:

1. Achieve service integration, monitoring, and advocacy,

2. Provide needed medical, social, educational, and other services,

3. Ensure that services effectively complement one another and

4. Prevent duplication of services.

8.290.4.E. Individual TCM providers shall be Qualified Health Care Professionals or shall meet the qualifications established by the Colorado Department of Education to develop and implement Individualized Plans or services under the Individuals with Disabilities Education Act.

8.290.5 COORDINATION OF CARE

8.290.5.A. The District shall coordinate the provision of care with the client's primary health care provider for routine and preventive health care.

8.290.5.B. The District shall refer clients to their primary care provider, health maintenance organization or managed care provider for further diagnosis and treatment that may be identified as the result of an EPSDT screen or service.

8.290.5.C. When the client is receiving Medicaid services from other health care providers and the District, the District shall coordinate medical care with the providers to ensure that service goals are complementary and mutually beneficial to the client or shall show cause as to why coordination did not occur.

8.290.5.D. When the client of the targeted population is receiving case management services from another provider agency as the result of being members of other covered targeted groups, the District shall ensure that case management activities are coordinated to avoid unnecessary duplication of services.

8.290.5.E. The District shall inform a family receiving case management services from more than one provider that the family may choose one lead case manager to facilitate coordination.

8.290.6 REIMBURSEMENT

8.290.6.A. The District shall obtain from the client or the client's guardian a written informed consent to submit Medicaid claims on behalf of the client.

8.290.6.B. The District shall abide by the Third Party Liability rule at 10 C.C.R. 2505-10, Section 8.061.2.23.

8.290.6.C. Rates

1. Transportation rates are based on special transportation cost information received from the Department of Education.

2. Rates, other than transportation rates, are developed according to Department methodology based on averaged costs to Districts for providing services. Costs are the salary and fringe benefits of qualified providers, direct support and indirect support.

3. The District shall provide salary and fringe benefits cost data for use in rate setting as part of the required independent audit report submitted annually to the Department of Education.

4. The District shall periodically participate in a time study to determine the direct support rate.

5. The indirect support rate is a standard rate published annually by the Department of Education.

8.290.6.D. Payment

1. The District shall submit a claim for each benefit service provided for each client.

2. The District shall receive reimbursement on a fee for service basis.

3. The District shall receive the federal share of the determined rate, not to exceed 100% of the federal match rate, as payment.

8.290.7 CERTFICATION OF MATCH

The District shall certify to the Department that it has expended local and state monies to provide Medicaid services in an amount sufficient to meet the nonfederal share of expenditures claimed for federal financial participation.