COLORADO
School Health Services Program

SCHOOL HEALTH SERVICES PROGRAM MANUAL

Appendix 4

Time Study Implementation Guide

The School Health Services Program is a joint effort between the Colorado Department of Education and Department of Health Care Policy and Financing.
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Appendix 4: COLORADO SCHOOL HEALTH SERVICES PROGRAM TIME STUDY IMPLEMENTATION GUIDE FOR DIRECT SERVICES, TARGETED CASE MANAGEMENT AND ADMINISTRATIVE CLAIMING EFFECTIVE: October 1, 2009

Vision

The State of Colorado, Department of Health Care Policy and Financing (HCPF) is committed to providing an efficient and effective School Health Services (SHS) program. The program is comprised of Direct Services, Medicaid Targeted Case Management (TCM), and Administrative components designed to ensure the optimum delivery of services to our clients. In keeping with this vision, HCPF implemented a statewide Random Moment Time Study (RMTS) methodology to support proper Medicaid reimbursement for delivered services.

Introduction

In 1997, Colorado established the SHS program to be administered by HCPF. Colorado state law allows reimbursement for the provision of Medicaid-covered health services for Medicaid eligible children in public schools. Any public-school district or Board of Cooperative Education Services (BOCES) may participate in the SHS program.

HCPF partnered with school districts and BOCES to implement a new reimbursement program for Direct Service, TCM and Administrative Claiming (MAC) in Colorado, according to the specifications and approval of the federal Centers for Medicare and Medicaid Services (CMS). The purpose of these agreements is to assist HCPF in providing effective and timely access to care for Medicaid recipients; to assure more appropriate utilization of Medicaid covered services; and to promote activities that reduce the risk of poor health outcomes for the state's most vulnerable populations. HCPF requires that participating school districts and BOCES (collectively referred to as "the school districts") participate in the statewide Random Moment Time Study.

SHS Enrollment Criteria

Effective upon approval of SPA 05-006 and the approved time study methodology, school districts began operating under the federal guidelines as outlined in the state's approved Time Study Implementation Guide for Direct Services and TCM. The proposed Time Study Implementation Guide was revised to include Administrative Claiming. Once CMS approved the state's Time Study Implementation Guide for Direct Services, TCM and Administrative Claiming, HCPF implemented regulation changes that outline new time study guidelines for participating school districts.

HCPF must be assured that each SHS Program provider is capable of administering the project and requires that each school district assign an SHS Program RMTS Coordinator to act as a liaison between HCPF and the school district's providers.

Required Personnel

Each school district must designate an employee as the SHS Program RMTS Coordinator. This single individual is designated within a local agency to provide oversight for the implementation of the time study and to ensure that policy decisions are implemented appropriately. The school district must also designate an SHS Program Assistant RMTS Coordinator to provide back-up support and oversee time study responsibilities when the RMTS Coordinator is absent or on leave.

The RMTS Coordinator responsibilities include but are not limited to:

- Identifying qualified staff for participation in the time study,
- Maintaining the school district RMTS staff pool list,
- Providing participant information for the RMTS staff pool list to the State's RMTS contractor,
- Monitoring staff participation in the time study,
- Understanding the SHS program rules and distribution of information, and
- Acting as a liaison between the State and participant.

Central coding is not a function of the school district but of the State's RMTS contractor. Thus, school district staff are not trained on Medicaid allowable activities vs. non-Medicaid activities. The training for the RMTS Coordinator has been designed to assist them in appropriately identifying staff that are eligible to participate in the program. In order for the coordinators to be able to support the identification of staff, the training materials outline examples of activities that are reimbursable under the program. These examples allow the RMTS Coordinator to make a match between eligible staff and reimbursable activities.

HCPF requires RMTS Coordinators attend an initial RMTS training and any additional mandatory RMTS trainings as requested. The Assistant RMTS Coordinator may also attend the initial RMTS training or be trained by the RMTS Coordinator. Other school district staff may also attend trainings, at the request of the district and at HCPF's discretion. Training is further described on pages 12 and 13.

Random Moment Time Study (RMTS) Methodology

Sometimes referred to as Random Moment Sampling, RMTS is a federally accepted method for tracking employee time and activities within school districts. According to OMB Circular A-87 (revised 5/10/04), and its accompanying implementation guide ASMB C-10, "Substitute systems for allocating salaries and wages to federal awards may be used in place of activity reports. These systems are subject to approval if required by the cognizant agency. Such systems may include, but are not limited to, random moment sampling…."

Random moment sampling or RMTS is particularly useful, because:

- It uses a verifiable, statistically valid random sampling technique that produces accurate labor distribution results, and

- It greatly reduces the amount of staff time needed to record an individual time study participant's activities.

The RMTS method polls participants on an individual basis at random time intervals over a quarterly (three month) time period and totals the results to determine work effort for the entire population of eligible staff over that same period. The RMTS method provides a statistically valid means of determining what portion of the selected group of participant's workload is spent performing activities that are reimbursable by Medicaid.

Sampling Requirements

In order to achieve statistical validity, maintain program efficiencies and reduce unnecessary school district administrative burden, HCPF implements a consistent sampling methodology for all activity codes and groups to be used. HCPF has constructed the statewide RMTS sampling methodology to achieve a level of precision of +/- 2% (two percent) with a 95% (ninety-five percent) confidence level for activities.

As stated, the HCPF RMTS sampling methodology is designed to permit a level of precision of +/- 2% (two percent) with a 95% (ninety-five percent) confidence level for activities. Statistical calculations show that a minimum statewide sample of 2,401 completed moments each quarter, per cost pool, is adequate to obtain this precision when the total pool of moments is greater than 3,839,197. Additional moments are selected each quarter to account for any invalid moments. Invalid moments are observations that cannot be used for analysis, i.e., moments selected for staff who are no longer at the school district, or who changed jobs and are no longer in an allowable position and their old position has not been filled.

The following formula is used to calculate the number of moments sampled for each time study cost pool:

$$ss = \frac{Z2 * (p) * (1 - p)}{C2}$$

where:

Z = Z value (e.g. 1.96 for 95% confidence level)

p = percentage picking a choice, expressed as decimal (.5 used for sample size needed)

c = confidence interval, expressed as decimal (e.g., .02 = ±2)

Correction for Finite Population

$$new\ ss = \frac{ss}{1 + \frac{ss - 1}{Pop}}$$

where:

Pop = population

The following table shows the sample sizes necessary to assure statistical validity at a 95% confidence level and tolerable error level of 2%. Additional moments are selected to account for invalid moments, as previously defined. An over sample of 15% is used to account for invalid moments.

N=	Sample Size Required	Sample Size plus 15% Oversample
100,000	2,345	2,69
200,000	2,373	2,72
300,000	2,382	2,73
400,000	2,387	2,84
500,000	2,390	2,84
750,000	2,393	2,85
1,000,000	2,395	2,85
3,000,000	2,399	2,85
>3,839,19	2,401	2,86

RMTS Process

The sampling period is defined as a three-month quarterly period. The following are the quarters followed for the SHS program:

- October 1 – December 31
- January 1 – March 31
- April 1 – June 30
- July 1 – September 30

The sampling period is designed to be in accordance with the May 2003 Medicaid School-Based Administrative Claiming Guide:

> *"If the school year ends in the middle of a calendar quarter (for example, sometime in June, the last time study for the school year should include all days through the end of the school year. Therefore, if the school year ends June 25th, then all days through and including June 25th must be included among the potential days to be chosen for the time study." (page 42, Example 4)*

Each quarter, HCPF will determine the dates that school districts will be in session and for which their staff members are compensated. School district staff members are paid to work during those dates that school districts are in session; as an example, districts may end the school year sometime in May each year. All days including and through the end of the school year would be included in the potential days to be chosen for the time study. It is important to understand that although school districts may end the school year prior to the close of the quarter staff members are paid for services provided through the end of the quarter. School districts typically spread staff compensation over the entire calendar year even when staff members are not working. The school district considers this compensation reimbursement for time when staff members actually work rather than compensation for the staff members' time off during the summer months.

HCPF will review school district calendars each quarter to determine the date's schools pay for their staff to work, and those dates will be included in the sample. Since school calendars change on an annual basis, HCPF will also evaluate school calendars on an annual basis, determine the period to be sampled each quarter, and document this process annually.

Since HCPF is conducting a statewide time study sample, each quarter HCPF will review a representative sample of district calendars to determine the most common begin and end dates for statewide sampling purposes. HCPF will review and document their review of school district calendars on an annual basis. At a minimum, the eligible sample dates will be based off of the calendars for at least 25% of statewide district staff.

Because activities and services are not provided in the school districts when school is not in session, HCPF will not conduct a time study from July to September, but will use an average of the prior three quarters time study results to calculate a claim for the summer months. This is in accordance with the May 2003 Medicaid School-Based Administrative Claiming Guide:

> *"…the results of the time studies performed during the regular school year would be applied to allocate the associated salary costs paid during the summer. In general, this is acceptable if administrative activities are not actually performed during the summer break, but salaries (reflecting activities performed during the regular school year) are prorated over the year and paid during the summer break." (page 42)*

HCPF has determined that activities are not performed during the summer months when districts are not in session.

Moment Generation

Each selected moment is defined as a specific one-minute unit and is assigned to a specific time study participant. Each moment selected from the pool is included in the time study and coded according to the documentation submitted by the employee.

The following is the moment generation process used by the State contractor's RMTS software:

A moment is generated in a specific sequence in compliance with the federal rules. The rules require that a **date** and a **time**, collectively called a **moment**, be randomly selected initially; then this moment is assigned (associated) to a randomly selected participant from the roster poll.

The statewide sample comprises multiple school **districts**; each **district** may have its own work/non-work days (defined by the calendar of the client) and work hours.

Moments are generated for the entire three-month quarterly period prior to the start of the quarter. To generate moments randomly in compliance with the federal rules, the following steps take place by order in advance of each quarterly period:

1. Random Date
    a. Obtain the start date and end date of the client. This date pair is usually the quarter start date and the quarter end date;
    b. Randomly generate a date within (inclusive) the above two dates;
    c. Evaluate the date to make sure it is not on weekend (See #3 for non-work day); otherwise, another date is generated until a work day is generated.

2. Random Time

District	Start Time	End Time
District1	7:30 a.m.	4:30 p.m.
District2	8:30 a.m.	5:30 p.m.

    a. Obtain the time parameters:
        i. Morning start time (7:30 am)
        ii. Afternoon end time (5:30 pm)
    b. Randomly generate a moment, in hour and minute.
    c. Evaluate the generated moment, making sure it is within the limit of the time parameters.

3. Random Participant
    a. Randomly select a participant from the staff pool list;
    b. Obtain this participant's **district**;
    c. Check the generated **moment** against the non-work days of this **district**
        iii. If the date of the generated moment falls into a **non-work day**, abandon this participant and randomly select another participant, until the **date** of the generated moment (date) falls into the **work days**;
        iv. If the date of the generated moment falls into a **work day**, proceed to next step: Check the work hours.
    d. Check the generated **moment** against the work hours of the **district**
        v. If the hour and minute of the generated moment falls within a **non-work hour**, abandon this participant and randomly select another participant, until this participant is working on the generated moment (hour and minute).
        vi. If the hour and minute of the generated moment falls within the **work hour**, associate the participant with the moment (date, hours and minute).

Time study participants are notified via e-mail or paper of their requirement to participate in the time study and of their sampled moment. Sampled participants are notified of their sampled moment no more than five days prior to their sampled moment and at least one reminder e-mail is sent out 24 hours before the moment. After the prescribed moment has passed, each sampled participant is asked to record and submit his/her activity for that particular moment.

The majority of time study participants receive notifications via e-mail; however, Colorado also provides paper-based moments for those participants who do not have e-mail access at work if the participant does not also have access to the internet to complete their

sampled moment. The paper form mirrors the online time study, asking participants to respond to the same questions in the same order. Paper moments are to the RMTS Coordinator, who is responsible for ensuring the participant receives it.

The following steps are taken to ensure that participants enrolled in the paper-based time study receive their moments and proper notifications:

1. The State's RMTS contractor receives an initial e-mail from the RMTS system notifying the participant of an upcoming moment.
2. The State's RMTS contractor sends the notification e-mail and a blank time study form to the school district RMTS coordinator via e-mail. (The username and password are deleted from the notification email before it is sent to the RMTS Coordinator.)
3. The RMTS Coordinator ensures the participant receives notification and time study form in a timely fashion.
4. RMTS Coordinator reminds a participant of the upcoming moment 24 hours in advance of the moment.
5. Participant either:
   a. Logs onto web site using any Internet-ready computer and fills out the time study online within five school days after the moment has occurred; or
   b. Fills out paper-based time study form and fax to the State RMTS contractor at a toll-free number within five school days after the moment has occurred.
6. RMTS Coordinator follows up with the participant within 24 hours after the moment has occurred to ensure compliance.
   a. The RMTS Coordinator will contact the sampled participant's whose moments have not been completed to remind them of the moment and the importance of completing the moment.
   b. The RMTS Coordinator can provide the participant website or the support telephone number that they can utilize to receive additional support they may need to complete the moment such as their username, password, website, etc.
   c. The RMTS Coordinator utilizes a variety of communication methods to contact the participant. Those communication methods include, but are not limited to, phone, email, fax and in-person.

Throughout this entire process, the district's SHS Program RMTS Coordinators have real-time access in the online system to view their sampled staff, the dates/times of their sampled staff's moments, and whether or not the moment has been completed. As explained later in this document, if the return rate of valid moments is less than 85%, then all non-returned moments will be included and coded as non- Medicaid.

A validity check of the time study results is completed each quarter prior to the calculation of the claim. The validity check ensures the minimum number of valid responses is received each quarter to meet the required confidence level. The number of completed and returned time study moments is analyzed to confirm that confidence level requirements have been met. Once the validity of the sample has been confirmed the

time study results are calculated, prepared for use in the annual cost settlement and reconciliation process, and included in the overall quarterly time study results.

At the end of each quarter, once all random moment data has been received and time study results have been calculated, statistical compliance reports are generated to serve as documentation that the statewide sample results met the necessary statistical requirements.

Valid Moments

All documentation of sampled moments must be returned within five days after the sampled date. Documentation of moments not received within the required time frame cannot be used in the calculation of the necessary number of moments needed to satisfy the level of precision of +/- 2% (two percent) with a 95% (ninety-five percent) confidence interval.

Valid moments are completed moments that have been received by HCPF and have been determined by HCPF to be complete and accurate.

Non-returned moments are moments not returned by the school district. If the staff for whom the moment was intended is no longer employed by the school district but the position that staff person was in has been refilled, the moment will be completed by the replacement staff person. If the position remains vacant, a notation of such is made on the moment and the State's RMTS contractor marks the moment "invalid."

Non-returned moments are dropped from the overall quarterly time study results as long as the 85% compliance rate is met. If the 85% compliance rate is not met, all non-returned moments are coded as non-Medicaid time and included in the overall quarterly time study results.

Validation Method

The State's contractor randomly selects a 5% sample of coded responses which are submitted to HCPF each quarter for validation. The validation consists of reviewing the participant responses and the corresponding code assigned by the contractor to determine if the code was accurate. A representative from HCPF separately reviews the sub-sample of responses and coding to identify any disagreements with the coding staff. If a disagreement occurs HCPF and the coding staff discuss the discrepancies. After the discussion on coding, coding instructions would be modified to document those coding decisions so that they can be consistently applied in future quarters.

Time Study Participants

The purpose of the Colorado statewide time study is to identify the proportion of Direct Service, TCM, and Administrative time allowable and reimbursable under Medicaid. This information is used for Direct Service and TCM cost reporting to enable the State of Colorado to conduct a cost settlement at the end of the fiscal year for the SHS program. The MAC time study results are applied to the allowable administrative costs of the

participating districts to calculate the quarterly Medicaid Administrative Claim. Staff performing Medicaid related activities in a school district seeking reimbursement are required to participate in the statewide time study using the approved RMTS methodology.

All school districts that participate in the time study must identify allowable Medicaid Direct Service, TCM, and Administrative costs within a given school district. The staff members who perform Direct Service, TCM, and Administrative activities are required to participate in a quarterly time study. School districts must certify that any staff providing services or participating in the time study meets the educational, experiential and regulatory requirements. Staff pool lists will be updated quarterly to reflect staff changes at the school district level. If a staff person leaves the school district and the position is then filled, the school district must notify the time study contractor to update the contact information associated with that position. In the event that a new position is created or a district does not include that position on the staff pool list created at the beginning of the quarter, which is used to generate the statewide sample, the district will have to wait until the next quarter to add that staff person/position. Costs cannot be claimed for a position unless that position is included in the sample pool list. Therefore, only positions included on the staff pool list for potential RMTS sampling can have costs included in the cost pool for MAC, Direct Service or TCM claiming purposes.

Although some staff may perform any combination of Direct Service, TCM, and Administrative related activities, depending on their qualifications and role, they will only be allowed to participate in one of the three following cost pools:

- The first cost pool is comprised of Direct Service staff, including those who conduct Direct Services, TCM and/or Administrative activities as well as Direct service staff only, and the respective costs for those staff.
- The second cost pool is comprised of TCM staff including those who may perform Administrative activities and the respective costs for those staff.

The third cost pool is comprised of Administrative service staff only.

The three universes of time study participants and associated cost pools are mutually exclusive, and the only direct costs that can be claimed under Medicaid related to this program are derived from the three cost pools above.

The following categories of staff have been identified as appropriate participants for the Colorado statewide time studies. Additions to the list may be made depending upon job duties. The decision and approval to include additional staff will be made on a case-by-case basis, and participants subsequently approved by CMS from additional State Plan Amendments will be included in the list during future updates.

Staff may report into one of three cost pools: a "Direct Service Provider" cost pool, a "TCM Provider" cost pool and an "Administrative Service Provider Only" cost pool. The three cost pools are mutually exclusive, i.e., a staff person cannot be included as a participant in more than 1 (one) cost pool. The following provides an overview of the eligible categories in each cost pool as approved in Colorado's

State Plan Amendment (SPA) 05-006. Refer to Attachment B for the types of service that may be delivered by the Direct Service Provider categories.

Direct Service Cost Pool

- 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 Special Education Teacher;
- 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 Social Worker (Master's level);
- A currently Colorado-licensed Clinical Social Worker (Master's level);
- A currently Colorado-licensed Marriage and Family Therapist;
- 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 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. 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 and other applicable state and federal law;
- A currently Colorado-licensed Occupational Therapist (OT) or 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;
- A currently Colorado-licensed Physical Therapist (PT); and
- A Colorado-qualified Physical Therapy Assistant (PTA) when the assistant is acting under the direction of a currently Colorado-licensed PT (i.e., the PT supervises and monitors the PTA's performance with continuous assessment of the student's progress) in accordance with 42 CFR § 440.110. All documentation must be reviewed and signed by the appropriately licensed supervising PT.

TCM Cost Pool

The TCM provider is required to 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. Additionally, only those TCM providers who hold a CDE License for Special Services and who bill TCM throughout the school year will be included on the cost reporting forms to ensure the appropriate cost allocation for reimbursement purposes. No providers included in the Direct Service or Administrative Services Cost Pool are included in the TCM Cost Pool. There will be no duplication of staff in the three cost pools.

A provider that meets the qualifications established by the State's licensure act for educators as special service providers who develop and/or implement Individualized Plans for services under the Individuals with Disabilities Education Act (IDEA) may also provide TCM. 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 TCM services.

Administrative Service Provider Only Cost Pool

The following staff categories are eligible to participate in Medicaid Administrative Claiming (MAC):

- Administrators
- Counselors
- Interpreters & Interpreter Assistants
- Pupil Support Services Administrators
- Pupil Support – Technicians
- Psychologist Interns
- Special Education Administrators
- Special Education – Support Technicians
- Program Specialist
- Non-licensed Psychologists
- Non-licensed Social Workers
- Non-licensed Orientation & Mobility Specialist
- Resource Specialist/ Family Liaisons

- School Bilingual Assistants
- Nurses – that do not provide direct services or targeted case management
- Special Education Teachers- that do not provide Case Management or Personal Care Services
- Special Education Teacher's Aide- that do not provide Case Management or Personal Care Services
- Other groups/individuals that may be identified by the school district and approved by HCPF

Providers included in the Administrative Service Provider Pool cannot be included in the Direct Service or TCM Cost Pool. There will be no duplication of staff in the three cost pools. Only staff who perform Medicaid-related administrative activities should be included in this cost pool.

Staff Pool List

Before the statewide sample is generated, each school district must certify that the list of staff they submit to be included in the eligible staff pool are appropriate for inclusion in the time study and subsequent claims. Staff deemed inappropriate during review of time study quarters will be removed from the time study and excluded from claims. All allowable staff must be listed on an approved staff pool list prior to the time study quarter. Each quarter the RMTS Coordinator is required to review the staff pool list, update changes (new staff assignments or vacancies), and certify the staff pool list. In the middle of a quarter, if a staff person leaves the school district and the position is then filled, the school district must notify the time study contractor to update the contact information associated with that position. In the event that a new position is created or a district does not include that position on the staff pool list created at the beginning of the quarter, which is used to generate the statewide sample, the district must wait until the next quarter to add that staff person/position. Costs cannot be claimed for a position unless that position is included in the sample pool.

The RMTS Coordinator will assign staff to a specific job category in one of the three cost pools. As mentioned in previous sections, staff may only be listed in one cost pool. The RMTS Coordinator will determine cost pool and position and the contractor will use the district's certified staff list for each cost pool to generate the statewide sample for each pool. The contractor does not add staff, delete vacancies or create the cost pool list for any district. The cost pools and staff within those pools are completed directly by the RMTS Coordinator. The contractor will summarize the individual district cost pool lists into a statewide cost pool that is used to generate the sample for the given sample period.

School district personnel who participate in the time study must be assigned to job categories that describe their job function. If a category includes a limited mix of job functions and titles, the functional (or working) job title must be listed beside each person's name.

The statewide time study is comprised of three mutually exclusive cost pools (Direct Service, TCM, and Administrative activities). The administration of the time study is identical for each of the cost pools.

Time Study Compliance

HCPF requires a statewide response rate for the time study survey of at least 85%. In the event that an 85% compliance rate is not met, all non-returned moments are coded as non-Medicaid. If the quarterly 85% compliance rate is reached, no action will be taken with those non-returned moments.

To assist in reaching the statewide goal of 85% compliance, HCPF monitors the school districts to ensure they are properly returning sample moments. If a school district has non-returns greater than 15% and greater than five (5) moments for a quarter, the school district may receive a warning letter from HCPF. If the same school district is in default the next quarter after being warned, they may not be able to participate for a one year period of time. As a hypothetical example, if a school district has non-returns greater than 15% and greater than five (5) moments for the quarters ending December 31 and March 31 of the same calendar year, the school district may not be allowed to claim for the remainder of that Fiscal Year. If such a penalty is imposed, the school district is required to return any payments received for that fiscal year under the SHS Program.

HCPF gathers as much information as possible from the RMTS Coordinators or participants to explain the reasons the non-returned moments were unanswered. HCPF analyzes this data to ensure that the non- returns are reflective of the time study results. This data is not included in the claiming process but is used to ensure the school districts are not purposely withholding non-Medicaid related moments.

Oversight and Monitoring

Federal guidelines require oversight and monitoring of Medicaid claiming programs. Oversight and monitoring must be done at both the school district and the state level, to include coding quality assurance, training, documentation, and desk reviews.

Coding Quality Assurance

HCPF ensures that all coding is accurate through an intensive quality assurance process. All coding is conducted centrally by the State's RMTS contractor. The "coders" refer to the time study codes and activity descriptions outlined in this Implementation Guide. Every valid response is coded initially by one "coder" and verified by a second "coder". This provides a check on the accuracy of each code before it is finalized. If there is insufficient information to determine the appropriate code for the activity description provided by the time study participant, the "coder" will contact the participant for additional information. If the participant does not respond to the "coders" request then the coded response will default to non- Medicaid and be included in the overall quarterly time study results. If a discrepancy is encountered, the "coders" will discuss the code before coming to a final decision.

Each quarter HCPF audits a 5% sub-sample of coded moments to ensure coding completeness, accuracy, and consistency. The contractor generates a random 5% sample of moments, and produces a report showing the sampled staff name, sampled staff position, district, moment due date, moment submitted date, all narrative responses, and any follow-up communications with the participant. HCPF reviews the participants' response to each question completed for the sampled moment to determine the correct code. HCPF refers to the time study codes and activity descriptions outlined in this Implementation Guide. HCPF coding is compared with the contractors coding for agreement. If there is a discrepancy between HCPF coding and the contractors coding, it is summarized by HCPF in written format to the contractor and discussed verbally during a quarterly coding meeting. The contractor may contact the participant if additional information is necessary to resolve the discrepancy. The centralized "coder" reviews the moments with any discrepancies and shall adjust those, and any similar moments, to the coding decision identified by HCPF. Necessary changes will be made and reflected in the final time study results for that sample period. Based on these discussions, additional guidance and training for centralized coding will occur. HCPF may choose to broaden the sub-sample based on results of their review. The RMTS results are finalized upon completion of HCPF's sub-sample review and approval.

SHS Program RMTS Coordinator Training (RMTS)

HCPF reviews and approves all RMTS training materials used by the State's contractor. HCPF in conjunction with the State's RMTS contractor, provides initial training for the SHS Program RMTS Coordinators, which includes an overview of the RMTS software system and information on how to access and input information into said system. Each school district RMTS Coordinator is required to attend the time study training. It is essential for the RMTS Coordinators to understand the purpose of the time studies, the appropriate completion of the RMTS, the timeframes and deadlines for participation, and that their role is crucial to the success of the program. The RMTS Coordinator ensures participants are provided with detailed information for completing and submitting the time study documentation for the sampled moment. The RMTS Coordinator is supplied with the "Medicaid School-Based Administrative Claiming Guide" and "Medicaid and School Health: A Technical Assistance" which identify Medicaid allowable activities. All training materials are accessible to the RMTS Coordinators. In addition, annual training is provided to the RMTS Coordinators to cover topics such as SHS program updates, process modifications and compliance issues. HCPF is also developing a comprehensive program manual intended for the RMTS Coordinators, time study participants, and school district providers which shall be ready for publication during the fall of 2010.

Centralized Coding Staff Training (Activity Coding)

"Coders" are employed by the State's contractor to review the documentation of participant activities performed during the selected moments and to determine the appropriate activity code. In a situation when insufficient information is provided to determine the appropriate activity code, the "coder" may contact the RMTS Coordinator and request submission of additional information. Once the information is received, the moment is coded and included in the final time study percentage calculation. The

moments and the assigned codes are reviewed for consistency and adherence to the state approved activity codes. HCPF and the State's contractor meet at least monthly or as needed to discuss issues surrounding the coding of moments and activity codes, and the processes for making coding determinations. HCPF audits coding decisions quarterly to ensure completeness and accuracy and verify selected codes are correct.

Sampled (Participant) Staff Training

Colorado implements a centralized coding methodology so training around the activity codes is not required as sampled staff members do not code their moments. However, the RMTS documentation system includes an online tutorial containing information about the program, the participant's role in the program, as well as, how to complete their sampled moment in the system. The sampled staff member must visit these screens prior to being able to document their moment. For these reasons, training of sampled staff members on Medicaid allowable activities and non-Medicaid activities is not a required element for completion of their moment.

Documentation and Recordkeeping Requirements

All documentation of sampled moments must be returned within five days after the sampled date. Documentation of moments not received within the required time frame cannot be used in the calculation of the necessary number of moments needed to satisfy the level of precision of +/- 2% (two percent) with a 95% (ninety-five percent) confidence interval.

Documentation of sampled moments must be sufficient to provide answers to five questions needed for accurate coding:

1. Were you working?
2. What were you doing?
3. Why were you performing this activity?
4. Who were you working with at the sampled moment?
5. Was the service you performed listed on the child's IEP / IFSP?

Each sampled participant must complete the 5 questions above for each moment in which they were selected. Responses to questions 1-4 are completed by the participant in free form text. Participants choose a response of yes, no or N/A for question 5. After answering the 5 questions the sampled staff certify the accuracy of their response prior to submission.

Additional documentation maintained by the State and its contractor include:

a. Sampling and selection methods used,
b. Identification of the moment being sampled, and
c. Timeliness of the submitted time study moment documentation.

The school districts must certify that all RMTS participants hold the necessary provider qualifications to bill Medicaid for their services and maintain documentation of licensures or credentials.

All participating school districts are required to maintain documentation supporting the RMTS results, which are used in the Medicaid claim. Districts are required to maintain the following documents:

- A Direct Service Cost Pool list of eligible individuals, including job categories;
- A TCM Cost Pool list of eligible individuals, including job categories; and
- An Administrative Service Provider Only Cost Pool of eligible individuals, including job categories.

School districts must maintain and have available upon request by state or federal entities their contract with the state to participate in the SHS program. The contract requires school districts to comply with all state regulations regarding the SHS program. In addition, school districts are required to maintain any financial data used to develop the Administrative claim and/or cost report and a copy of the completed cost report.

Documentation must be retained for a time period sufficient to meet federal and state regulations.

SHS Time Study Desk Review

HCPF or its duly authorized agent shall perform desk reviews to ensure the integrity and accuracy of all of the time study data and results for the SHS Program. Annual desk reviews will be completed on at least 50% of the school districts participating in the program. The reviews shall consist of auditing the cost reports, the RMTS staff pool list and claims. Specifically, the reviews shall verify:

- The school districts participation in HCPF's required SHS Program RMTS Coordinator training required for participation in the RMTS;
- Submission and certification of quarterly participant staff pool lists;
- The RMTS compliance rate to ensure each school district meets the 85% compliance rate level requirement;
- Current and required participating provider credentials or licensures;
- Claims submissions including a post payment claims review to identify potential errors and payments;
- Services provided and eligibility of recipients receiving services; and
- The cost report workbook and corresponding financial data.

In addition, records that may be reviewed include, but are not limited to: attendance records, clinical notes or service logs, contracted staff costs/invoices, personnel records which outline salary, job descriptions, and payroll/accounting records.

HCPF will contact the school district by e-mail requesting explanation, clarification, and/or correction of discrepancies. HCPF may also pursue remedial action for school districts that fail to meet SHS program requirements or fail to correct problems identified during

reviews. Sanctions HCPF may impose include placing school districts on "payment hold," conducting more frequent monitoring reviews, recoupment of funds, or ultimately, cancellation of the school districts contract. Examples of actions that may cause sanctions include, but are not limited to:

- Failure to meet minimum the 85% compliance rate in response to the time study;
- Failure to cooperate with State and/or federal staff during reviews or other requests for information;
- Failure to maintain adequate documentation;
- Repeated and/or uncorrected errors in claims; and
- Failure to provide accurate and timely information to the State.

HCPF meets with the State's RMTS contractor at least monthly or as needed to provide oversight and review weekly provider compliance reports, the sampling methodology, quarterly time study results, and provider and/or contractor related issues.

In addition, the Colorado Department of Education (CDE) maintains oversight of school districts participating in the Medicaid School Health Services Program by performing onsite visits with school program coordinators, Special Education directors, financial staff and additional parties. The visits performed by CDE are separate from the reviews and visits performed by the Department, During the CDE visit the district's local service plan and school health services program are assessed. CDE utilizes a self-evaluation rubric to evaluate the school districts programmatic strengths and weaknesses. After conducting each visit a report is prepared for the school district and maintained by CDE. School districts are offered technical assistance and CDE determines annual training needs based on the results of the visits.

Time Study Activities/Codes

Time study codes assist in the determination of time and associated costs related to and reimbursable under the Medicaid program. The time study codes have been designed to reflect all of the activities performed by time study participants.

The time study codes are assigned indicators that determine its allowability, federal financial participation (FFP) rate, and Medicaid share. A code may have one or more indicators associated with it. These indicators should not be provided to time study participants. The time study code indicators are:

Code	Description
U	Unallowable – refers to an activity that is unallowable under the Medicaid program. This is regardless of whether or not the population served includes Medicaid eligible individuals.
TM	Total Medicaid – refers to an activity that is 100 percent allowable under the Medicaid program.
PM	Proportional Medicaid – refers to an activity, which is allowable under the Medicaid program, but for which the allocable share of costs must be determined by the application of the IEP Ratio.
R	Reallocated – refers to those general administrative activities which must be reallocated across the other activity codes on a pro rata basis. These reallocated activities are reported under General Administration.

The following time study codes are to be used for the Random Moment Time Study:

Code	Code Text	Activity	Direct Service Indicator	TCM Indicator	MAC Indicator
	Prov Svcs	**PROVISION OF SERVICES**			
1A	Outreach	Non-Medicaid Outreach	U	U	U
1B	Outreach	Medicaid Outreach	U	U	TM/50
2A	Enrollment	Facilitating Non-Medicaid Eligibility Determination	U	U	U
2B	Enrollment	Facilitating Medicaid Eligibility Determination	U	U	TM/50
3A	Educational Services	School Related and Educational Services	U	U	U
4A	DirNonIEP	Direct Medical Services- Not Covered as IDEA/IEP Services	U	U	U
4B	DirMedIEP	Direct Medical Services- Covered as IDEA/IEP Services or Case Management for Targeted Population	PM	PM	U
6A	Translation	Non-Medicaid Translation Services	U	U	U
6B	Translation	Medicaid Translation	U	U	PM/50%
7A	Planning	Non-Medical Program Planning, Policy Development, and Interagency Coordination	U	U	U
7B	Planning	Medical Program Planning, Policy Development, and Interagency Coordination	U	U	PM/50%
8A	Training	Non-Medical/Medicaid Related Training	U	U	U
8B	Training	Medical/Medicaid Related Training	U	U	PM/50%
9A	Referral	Referral, Coordination, and Monitoring of Non-Medicaid Services	U	U	U
9B	Referral	Referral, Coordination, and Monitoring of Medicaid Services	U	U	PM/50%
10	GA	General Administration	R	R	R
11	Unallowable	Not Paid/Not Worked	U	U	U

These activity codes represent administrative, TCM and direct service activity categories that are used to code all categories of claims. Detail code definitions and examples may be found in Attachment A.

SHS Medicaid Eligibility Rate Development

Participating school districts are required to regularly submit claims to HCPF for direct medical health services rendered, according to the guidelines in the HCPF Specialty Provider Billing Manual. At the end of each fiscal year, the school district must submit a

cost reconciliation report based on annual costs, the time study, and the IEP Ratio in order to complete the cost settlement process as outlined in Attachment 4.19B of the approved Colorado Medicaid State Plan.

The SHS Program Medicaid claim uses an IEP Ratio as one of the steps in determining total allowable costs, as described in Section 4.19B of the approved Colorado Medicaid State Plan. An IEP Ratio is determined for each participating school district. When applied, this IEP Ratio discounts the Direct Service and Targeted Case Management cost pools by the percentage of IEP Medicaid students. The names and birthdates of students with a health related Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP) are identified from the December 1 Count Report each year filed annually by each school district and matched against the December 1st Medicaid eligibility file from HCPF to determine the percentage of students eligible for Medicaid. The numerator of the rate is the students with an IEP or IFSP that are eligible for Medicaid and the denominator is the total number of students with an IEP or IFSP.

Costs associated with several Medicaid administrative activities performed by the school districts are adjusted by the school district's Medicaid Eligibility Rate (MER). The MER reduces these counts to the amount for services specific to Medicaid eligible individuals. The MER for the MAC program is calculated on an annual basis. The names and birthdates of students are identified from the October 1st Student Count Report each year filed annually by each school district and matched against the October 1st Medicaid eligibility file from HCPF to determine the percentage of students eligible for Medicaid. The numerator of the MER is the total number of Medicaid eligible students in the district and the denominator is the total number of students enrolled in the district. For example, referring an individual student to a Medicaid provider in the community is allowable only to the extent that the student is Medicaid enrolled. The costs of these activities are claimable as administrative activities but only to the extent that they are directed toward the Medicaid enrolled population.

Financial Data

The financial data to be included in the calculation of the MAC claim are to be based on actual expenditures incurred during the quarter. These costs must be obtained from actual detailed expenditure reports generated by the provider's financial accounting system.

OMB Circular A-87 specifically defines the types of costs: direct costs, indirect costs and allocable costs that can be included in the program. Sections 1 through 42 provide principles to be applied in establishing the allowability or unallowability of certain items of cost. These principles apply whether a cost is treated as direct or indirect. The following items are considered allowable costs as defined and cited below by A-87.

Direct Costs

Typical direct costs identified in A-87 include:

- Compensation of employees

- Staff training and professional development
- Travel expenses incurred

Indirect Costs

Indirect costs included in the claim are computed by multiplying the costs by the school districts approved unrestricted indirect cost rate. These indirect rates are district specific and developed by the school district's state cognizant agency, Colorado Department of Education, and are updated annually. The methodology used by the respective state cognizant agency to develop the indirect rates has been approved by the cognizant federal agency, as required by the CMS guide. Indirect costs are included in the claim as reallocated costs.

HCPF shall ensure that costs included in the MAC financial data are not included in the school district's unrestricted indirect cost rate, and no costs will be accounted for more than once.

Unallowable Costs

Costs that may not be included in the claim are:

- Direct costs related to staff that are not identified as eligible time study participants
- (i.e., costs related to non-special education teachers, cafeteria, transportation, and all other non- School Based administrative areas)
- Costs that are paid with 100 percent federal funds
- Any costs that have already been fully paid by other revenue sources (federal, state/federal, recoveries, etc.)

Revenue Offset

Expenditures included in the MAC claim are often funded with several sources of revenue. Some of these revenue sources require that expenditures be offset, or reduced, prior to determining the federal share reimbursable by Medicaid. These "recognized" revenue sources requiring an offset of expenditures are:

- Federal funds (both directly received by the district and pass through from state or local agencies)
- State expenditures that have been matched with federal funds (including fee-for-service). Both the state and federal share must be used in the offset of expenditures.
- Third party recoveries and other insurance recoveries

Claim Certification

School districts will only be reimbursed the federal share of any MAC billings. The Chief Financial Officer (CFO), Chief Executive Officer (CEO), Executive Director (ED), Superintendent (SI) or other individual designated as the financial contact by the school district will be required to certify the accuracy of the submitted claim and the availability of matching funds necessary. The certification statement will be included as part of the invoice and will meet the requirements of 42 CFR 433.51.

School districts will be required to maintain documentation that appropriately identifies the certified funds used for MAC claiming. The documentation must also clearly illustrate that the funds used for certification have not been used to match other federal funds. Failure to appropriately document the certified funds may result in non-payment of claims.

ATTACHMENT A: TIME STUDY CODING INSTRUCTIONS

After RMTS participants log their moment, it is the "coders" responsibility to categorize the response. The coding structure below will determine whether the activities logged are claimable, non-claimable, an allocated expense or a cost that can be claimed in the MAC program.

All time study results are aggregated statewide and applied equally to school districts participating in the SHS Program.

The table below summarizes the codes, the activities associated with that code and the claimable status of the code.

Code	Code Text	Activity	Direct Service Indicator	TCM Indicator	MAC Indicator
	Prov Svcs	**PROVISION OF SERVICES**			
1A	Outreach	Non-Medicaid Outreach	U	U	U
1B	Outreach	Medicaid Outreach	U	U	TM/50%
2A	Enrollment	Facilitating Non-Medicaid Eligibility Determination	U	U	U
2B	Enrollment	Facilitating Medicaid Eligibility Determination	U	U	TM/50%
3	Educational Services	School Related and Educational Services	U	U	U
4A	DirNonIEP	Direct Medical Services- Not Covered as IDEA/IEP Services	U	U	U
4B	DirMedIEP	Direct Medical Services- Covered as IDEA/IEP Services or Case Management for Targeted Population	PM	PM	U
6A	Translation	Non-Medicaid Translation	U	U	U
6B	Translation	Medicaid Translation	U	U	PM/50%
7A	Planning	Non-Medical Program Planning, Policy Development, and Interagency Coordination	U	U	U
7B	Planning	Medical Program Planning, Policy Development, and Interagency Coordination	U	U	PM/50%
8A	Training	Non-Medical/ Non- Medicaid Related Training	U	U	U
8B	Training	Medical/Medicaid Related	U	U	PM/50%
9A	Referral	Referral, Coordination and Monitoring of Non-Medicaid Services	U	U	U
9B	Referral	Referral, Coordination and Monitoring of Medicaid Services	U	U	PM/50%
10	GA	General Administration	R	R	R
11	Unallowable	Not Paid/Not Worked	U	U	U

Code Descriptions

The "coder" uses the following detailed descriptions of each activity to determine how to properly code each participant's answer.

PROVISION OF SERVICES

CODE 1A. OUTREACH – FACILITATING NON-MEDICAID OUTREACH

The "coder" uses this code when the participant is performing activities that inform eligible or potentially eligible individuals about non-Medicaid social (Food Stamps and Title IV-E), vocational, general health and educational programs (including special education) and how to access them; describing the range of benefits covered under these non-Medicaid social, vocational and educational programs and how to obtain them. Both written and oral methods may be used. This code includes related paperwork, clerical activities or staff travel required to perform these activities.

Examples:

- Scheduling and promoting activities which educate individuals about the benefits of healthy life-styles and practices;
- Conducting general health education programs or campaigns addressed to the general population;
- Conducting outreach campaigns directed toward encouraging persons to access social, educational, legal or other services not covered by Medicaid;
- Assisting in early identification of children with special medical/dental/mental health needs through various child find activities; and
- Outreach activities in support of programs that are 100 percent funded by State general revenue.

CODE 1B. OUTREACH – FACILITATING MEDICAID OUTREACH

The "coder" uses this code when the participant is performing specific activities to inform eligible individuals about Medicaid and EPSDT benefits and how to access the program. Information includes a combination of oral and written methods that describe the range of services available through Medicaid and EPSDT, the cost (if any), location, how to obtain services, and the benefits of preventive healthcare. This code includes related paperwork, clerical activities or staff travel required to perform these activities.

Examples:

- Interpreting materials about Medicaid to persons with children within the school district boundaries who are illiterate, blind, deaf, or who cannot understand the English language;
- Informing foster care providers of foster children residing within school district boundaries about the Medicaid and EPSDT program;
- Informing Medicaid eligible pregnant students about the availability of EPSDT services for children under the age of 21 (including children who are eligible as newborns);

- Utilizing brochures approved by the state Medicaid agency, designed to effectively inform eligible individuals about the benefits Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program and services, and about how and where to obtain services;
- Providing information about EPSDT in the schools that will help identify medical conditions that can be corrected or ameliorated by services covered through Medicaid;
- Informing children and their families about the early diagnosis and treatment services for medical/mental health conditions that are available through the Medicaid program; and
- Facilitating access to Medicaid when a staff member knows that a child does not have appropriate health care, this does not include child find activities directed to identifying children with educational handicapping conditions.

CODE 2A. ENROLLMENT – FACILITATING NON-MEDICAID ENROLLMENT OR ELIGIBILITY DETERMINATION

The "coder" uses this code when the participant is assisting an individual or family to make application for programs such as TANF, Food Stamps, WIC, day care, legal aid, and other social or educational programs and referring them to the appropriate agency to make application. Both written and oral methods may be used. Include related paperwork, clerical activities or staff travel required to perform these activities.

Examples:

- Explaining the eligibility process for non-Medicaid programs;
- Assisting the individual or family in collecting/gathering information and documents for the non-Medicaid program application;
- Assisting the individual or family in completing the application;
- Developing and verifying initial and continuing eligibility for the Free and Reduced Lunch Program. When a school district employee is verifying a student's eligibility or continuing eligibility for Medicaid for the purpose of developing, ascertaining or continuing eligibility under the Free and Reduced Lunch program, report that activity under this code; and
- Providing necessary forms and packaging all forms in preparation for the Non-Medicaid eligibility determination.

CODE 2B. ENROLLMENT – FACILITATING MEDICAID ENROLLMENT OR ELIGIBILITY DETERMINATION

The "coder" uses this code when the participant is assisting children and families in establishing Medicaid eligibility, by making referrals to the Department if Human Services for eligibility determination, assisting the applicant in the completion of the Medicaid application forms, collecting information, and assisting in reporting any required changes affecting eligibility. Includes related paperwork, clerical activities or staff travel required to perform these activities.

Examples:

- Referring an individual or family to the local assistance office to make an application for Medicaid benefits;
- Explaining the Medicaid eligibility process to prospective applicants;
- Providing assistance to the individual or family in collecting required information and documents for the Medicaid application; and
- Assisting the individual or family in completing the Medicaid application.

CODE 3. EDUCATIONAL SERVICES – SCHOOL RELATED AND EDUCATIONAL ACTIVITIES

The "coder" uses this code when the participant is performing any other school-related activities that are not Medicaid related, such as social services, educational services, teaching services; employment and job training. These activities include the development, coordination, and monitoring of a student's education plan. This code also includes all related paperwork, clerical activities, or staff travel required to perform these activities.

Examples:

- Providing general curriculum instruction to students.
- Developing lesson plans or curriculum.
- Evaluating curriculum and instructional services, policies, and procedures.
- Monitoring student academic achievement.
- Monitoring academic progress related to an IEP or IFSP.
- Providing individualized academic instruction (math or reading concepts) to a special education student.
- Conducting external relations related to school educational issues/matters.
- Testing, correcting papers.
- Compiling grades and report cards.
- Providing general supervision of students (playground, lunchroom).
- Disciplining students or referring students for discipline.
- Performing clerical activities related to instruction services or curriculum.
- Providing general nutrition and health education to students.
- Completing classroom attendance reports.
- Compiling, preparing, and reviewing reports on textbooks or attendance.
- Reviewing the academic record of new students.
- Enrolling new students or obtaining registration information.
- Conferring with students or parents about discipline, academic matters or other school related issues not related to an individualized plan.
- Administering achievement tests (CSAP, CSAP-A)
- Testing to assess specific learning disabilities or English language proficiency.
- Participating in or presenting training related to curriculum or instruction (e.g., language arts workshop, computer instruction).
- Providing Individuals with Disabilities Education Act (IDEA) mandated child find activities.

CODE 4A. DIRECT MEDICAL SERVICES - NOT COVERED AS IDEA/IEP SERVICES

The "coder" uses this code when the participant is providing direct client care services that are not IDEA and/or not IEP services. This code includes the provision of all non-IDEA/IEP medical services reimbursed through Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. This code includes pre and post activities associated with the actual delivery of the direct client care services, e.g., paperwork or staff travel required to perform these services.

All non-IDEA and/or non-IEP direct client care services:

Examples:

- Providing health/mental health services.
- Conducting medical/health assessments/evaluations and diagnostic testing and preparing related reports.
- Providing personal aide services.
- Performing developmental assessments.
- Developing a treatment plan (medical plan of care) for a student if provided as a medical service.

Performing routine or mandated child health screens including but not limited to vision, hearing, dental, scoliosis, and EPSDT screens.

- Administering first aid or prescribed injection or medication to a student.
- Providing counseling services to treat health, mental health, or substance abuse conditions.
- Making referrals for and/or coordinating medical or physical examinations and necessary medical evaluations as a result of a direct medical service.
- Immunizations and performance of routine or education agency mandated child health screens to the student enrollment, such as vision, hearing and scoliosis screens.
- Nursing services and evaluations including skilled nursing services and time spent administering/monitoring medication when the service is not included on the student's IEP. For example, medication for a short-term illness or recent injury would not normally be included in an IEP. Time spent administering/monitoring medication that is not included as part of the IEP and not documented in the IEP such as administration/monitoring of maintenance drugs (example 1: insulin for a diabetic if the insulin administration/monitoring is not in the IEP; example 2: anti-seizure medication for a child if the anti-seizure medication is not in the IEP) and administration/monitoring of non-routine medications for acute conditions when the administering/monitoring of the medication is not included as part of the IEP and not documented in the IEP

CODE 4B. DIRECT MEDICAL SERVICES – COVERED AS IDEA/IEP SERVICES OR CASE MANAGEMENT FOR TARGETED POPULATION

IDEA/ IEP SERVICES

This "coder" uses this code when school district staff (employees or contracted staff) provide direct client services as covered services delivered by school districts under the Direct Care or FFS Program. These direct client services may be delivered to an individual and/or group in order to ameliorate a specific condition and are performed in the presence of the student(s). This code includes the provision of all IDEA/IEP medical (i.e. health-related) services. It also includes functions performed pre and post of the actual direct client services (when the student may not be present), for example, paperwork, or staff travel directly related to the direct client services. Note, some of the following activities may be subject to the free care principle:

All IDEA and/or IEP direct client care services when the student is present:

- Providing health/mental health services as covered in the student's IEP.
- Conducting medical/health assessments/evaluations and diagnostic testing and preparing related reports as covered in the student's IEP.

Examples:

- Audiologist services including evaluation and therapy services (only if included in the student's IEP).
- Physical Therapy services and evaluations (only if included in the student's IEP).
- Occupational Therapy services and evaluations (only if included in the student's IEP).
- Speech Language Therapy and evaluations (only if included in the student's IEP).
- Psychological services, including evaluations and assessment (only if included in the student's IEP). [Assessment services are not in the client's IEP because assessments are performed before the students IEP is developed.]
- Counseling services, including therapy services (only if included in the student's IEP).
- Providing personal aide services (only if included in the student's IEP).
- Nursing services and evaluations (only if included in the student's IEP), including skilled nursing services on the IEP and time spent administering/ monitoring medication only if it is included as part of an IEP and documented in the IEP. [For example, administration of a medication such as Ritalin would only be included as an IEP-Related Service if the student IEP's actually contained a requirement for its provision; administration/monitoring of anti- spasmotic drugs for children with cerebral palsy, such as baclofen, that is included as part of an IEP and documented in the IEP; insulin for a diabetic if the insulin administration/monitoring is in the IEP.]

This code also includes pre and post time directly related to providing direct client care services when the student is not present. Examples of pre and post time activities when the student is not present include: time to complete all paperwork related to the specific direct client care service, such as preparation of progress notes, translation of session notes, review of evaluation testing/observation, planning activities for the therapy session, travel to/from the therapy session, or completion of billing activities.

Examples:

- Pre and post activities associated with physical therapy services, for example, time to build a customized standing frame for a student or time to modify a student's wheelchair desk for improved freedom of movement for that client.

- Pre and post activities associated with speech language pathology services, for example, preparing lessons for a student to use with an augmentative communicative device or preparing worksheets for use in group therapy sessions.
- Updating the medical/health-related service goals and objectives of the IEP.
- Travel to the direct service/therapy.
- Paperwork associated with the delivery of the direct care service, as long as the student/client is not present. Such paperwork could include the preparation of progress notes, translation of session notes, or completion of billing activities.
- Interpretation of the evaluation results and/or preparation of written evaluations, when student/client is not present. (Assessment services are billed for testing time when the student is present, for interpretation time when the student is not present, and for report writing when the student is not present.)

CASE MANAGEMENT FOR TARGETED POPULATION

For school-based TCM claiming in Colorado, the targeted population includes Medicaid clients who have a disability or are medically at risk and are referred for or receiving services related to an IEP or IFSP.

TCM services are a component of the IEP or IFSP. TCM identifies and addresses special health problems and 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.

Recipients of TCM services are eligible for the entire span of activities described as school health services in the Colorado Medicaid State Plan. A unit of service must meet the description of a case management activity with or on behalf of the individual, his or her parent(s) or legal guardian.

TCM services include the following activities:

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

1. Comprehensive Needs Assessment and Reassessment

   Reviewing of 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 care plan. At a 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 a Care Plan

   Developing a specific written care plan based on the assessment of 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 parents(s) or legal guardian, and the case manager. The service plan describes the nature, frequency, and duration of the activities and assistance that meet the individual's medical needs. 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 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 the 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 ensure 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 activities shall be documented in the written 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 the care plan; whether client declined

services in the 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 services 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 Educations;
- Activities related to IDEA functions such as scheduling IFSP team meeting, 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.

CODE 6A. TRANSLATION – NON-MEDICAID TRANSLATION SERVICES

The "coder" uses this code when the participant is providing translation service for non-Medicaid activities. This code includes related paperwork, clerical activities or staff travel required to perform the activities.

Examples:

- Arranging for or providing translation services (oral or signing services) that assist the individual to access and understand social, educational, and vocational services;
- Arranging for or providing translation services (oral or signing services) that assist the individual to access and understand state education or state-mandated health screenings (e.g., vision, hearing, scoliosis) and general health education outreach campaigns intended for the student population; and
- Developing translation materials that assist individuals to access and understand social, educational, and vocational services.

CODE 6B. TRANSLATION – MEDICAID TRANSLATION SERVICES

This "coder" uses this code when translation services are not included and paid for as part of a medical assistance service and must be provided with by separate units or separate employees performing solely translation functions for the school and it must facilitate

access to Medicaid covered services. Please note that a school district does not need to have a separate administrative claiming unit for translation. This code includes related paperwork, clerical activities or staff travel required to perform these activities.

Examples:

- Arranging for or providing translation services (oral or signing) that assist the individual to access and understand necessary care or treatment covered by Medicaid; and
- Developing translation materials that assist individuals to access and understand necessary care or treatment covered by Medicaid.

CODE 7A. PLANNING – NON-MEDICAL PROGRAM PLANNING, POLICY DEVELOPMENT, AND INTERAGENCY COORDINATION

The "coder" uses this code when the participant is performing activities associated with the development of strategies to improve the coordination and delivery of non-medical services to school age children. Non-medical services may include social services, educational services, and state or state education mandated child health screenings provided to the general school population. Only employees whose position descriptions include program planning, policy development and interagency coordination may use this code. This code includes related paperwork, clerical activities or staff travel required to perform these activities.

Examples:

- Identifying gaps or duplication of non-medical services to school age children and developing strategies to improve the delivery and coordination of these services;
- Developing strategies to assess or increase the capacity of non-medical school programs;
- Monitoring the non-medical delivery systems in schools;
- Developing procedures for tracking families' requests for assistance with non-medical services and providers;
- Evaluating the need for non-medical services in relation to specific populations or geographic areas;
- Analyzing non-medical data related to a specific program, population, or geographic area;
- Working with other agencies providing non-medical services to improve the coordination and delivery of services and to improve collaboration around the early identification of non-medical problems;
- Defining the relationship of each agency's non-medical service to one another;
- Developing advisory or work groups of professionals to provide consultation and advice regarding the delivery of non-medical services and state mandated health screening to the school populations;
- Developing medical referral sources; and
- Coordinating with interagency committees to identify, promote and develop non-medical services in the school system.

CODE 7B. PLANNING – MEDICAL PROGRAM PLANNING, POLICY DEVELOPMENT, AND INTERAGENCY COORDINATION

The "coder" uses this code when the participant is performing activities associated with the development of strategies to improve the coordination and delivery of Medicaid covered medical/dental/mental health services to school age children, and when performing collaborative activities with other agencies and/or providers. Only employees whose position descriptions include program planning, policy development and interagency coordination should use this code. This code includes related paperwork, clerical activities or staff travel required to perform these activities.

Examples:

- Developing strategies to assess or increase the capacity of school medical/dental/mental health programs;
- Monitoring the medical/dental/mental health delivery systems in schools;
- Developing procedures for tracking family's requests for assistance with medical/dental/mental health services and providers, including Medicaid. (This does not include the actual tracking of requests for Medicaid services);
- Evaluating the need for medical/dental/mental health services in relation to specific populations or geographic areas;
- Analyzing Medicaid data related to a specific program, population, or geographic area;
- Working with other agencies providing medical/dental/mental health services to improve the coordination and delivery of services, to expand access to specific populations of Medicaid eligible, and to improve collaboration around the early identification of medical problems;
- Working with other agencies and/or providers to improve collaboration around the early identification of medical/dental/mental problems;
- Developing strategies to assess or increase the cost effectiveness of school medical/dental/mental health programs;
- Working with Medicaid resources, such as the Medicaid agency and Medicaid managed care plans, to make good faith efforts to locate and develop EPSDT health services referral relationships;
- Developing advisory or work groups of health professionals to provide consultation and advice regarding the delivery of health care services to the school populations;
- Developing medical referral sources such as directories of Medicaid providers and managed care plans, who will provide services to targeted population groups, e.g., EPSDT children;
- Coordinating with interagency committees to identify, promote and develop EPSDT services in the school system;
- Identifying gaps or duplication of medical/dental/mental health services to school age children and developing strategies to improve the delivery and coordination of these services; and
- Working with the state Medicaid agency to identify, recruit and promote the enrollment of potential Medicaid providers.

CODE 8A. TRAINING – NON-MEDICAL/MEDICAID RELATED TRAINING AND PROFESSIONAL DEVELOPMENT

The "coder" uses this code when the participant is coordinating, conduction, or participating in training events and seminars for outreach staff regarding the benefit of the programs other than the Medicaid program. For example, training may include how to assist families to access the services of education programs, and how to more effectively refer students for those services. This code includes related paperwork, clerical activities, or staff travel required to perform these activities.

Examples:

- Participating in or coordination training that improves the delivery of services for programs other than Medicaid; and
- Participating in or coordinating training that enhances IDEA child find programs.

CODE 8B. TRAINING – MEDICAL/MEDICAID RELATED TRAINING AND PROFESSIONAL DEVELOPMENT

The "coder" uses this code when the participant is coordinating, conducting, or participating in training events and seminars for outreach staff regarding the benefit of medical/Medicaid related services, how to assist families to access such services, and how to more effectively refer students for those services. This code includes related paperwork, clerical activities, or staff travel required to perform these activities.

Examples:

- Participating in or coordination training that improves the delivery of medical/Medicaid related services;
- Participating in or coordinating training that enhances early identification, intervention, screening and referral of students with special health needs to such services (e.g., Medicaid EPSDT services); and
- Participating in training on administrative requirements related to medical/Medicaid services.

CODE 9A. REFERRAL - REFERRAL, COORDINATION AND MONITORING OF NON-MEDICAID SERVICES

The "coder" uses this code when the participant is making referrals for, coordinating, and/or monitoring the delivery of non-medical, such as educational services. This code includes related paperwork, clerical activities, or staff travel necessary to perform these activities.

Examples:

- Making referrals for and/or coordinating access to social and educational services such as child care, employment, job training, and;
- Making referrals for, coordinating, and/or monitoring the delivery of state education agency mandated child health screens;

- Making referrals for, coordinating, and/or monitoring the delivery of scholastic, vocational, and other non-health related examinations;
- Gathering any information that may be required in advance of these non-Medicaid related referrals;
- Participating in a meeting/discussion to coordinate or review a student's needs for scholastic, vocational, and non-health related services not covered by Medicaid.

CODE 9B. REFERRAL - REFERRAL, COORDINATION AND MONITORING OF MEDICAID SERVICES

The Central "coder" uses this code when the participant is making referrals for, coordinating, and/or monitoring the delivery of medical (Medicaid covered) services. Referral, coordination and monitoring activities related to services in an IEP are reported in this code. Activities that are part of a direct service are not included in this code. This code includes related paperwork, clerical activities, or staff travel necessary to perform these activities.

Examples:

- Identifying and referring adolescents who may be in need of Medicaid family planning services;
- Making specific medical referrals for and/or coordinating medical or physical examinations and necessary medical/dental/mental health evaluations;
- Making referrals for and/or scheduling EPSDT screens, interperiodic screens, and appropriate immunization, but not to include the state-mandated health services;
- Referring students for necessary medical health, mental health, or substance abuse services covered by Medicaid;
- Arranging for any Medicaid covered medical/dental/mental health diagnostic or treatment services that may be required as the result of a specifically identified medical/dental/mental health condition;
- Gathering information that may be required in advance of these medical/dental/mental health referrals;
- Participating in a meeting/discussion to coordinate or review a student's needs for health- related services covered by Medicaid;
- Providing follow-up contact to ensure that a child has received the prescribed medical/dental/mental health services;
- Coordinating the completion of the prescribed services, termination of services, and the referral of the child to other Medicaid service providers as may be required for continuity of care;
- Providing information to other staff on the child's related medical/dental/mental health services and plans;
- Monitoring and evaluating the Medicaid service components of the IEP as appropriate; and
- Coordinating the delivery of community based medical/dental/mental health services for children with special/severe health care needs.

CODE 10 - GENERAL ADMINISTRATION

The "coder" uses this code when the participant is performing activities not directly assignable to program activities. Include related paperwork, clerical activities, or staff travel time required to perform administrative activities. Note that certain functions, such as payroll, maintaining inventories, developing budgets, executive direction, etc., are considered overhead and, therefore, are only allowable through the application of an approved indirect cost rate.

Below are typical examples of general administrative activities, but they are not all inclusive:

- Taking lunch, breaks, leave, vacation, sick, or other paid time off not at work.
- Establishing goals and objectives of health-related programs as part of the school's annual or multi-year plan.
- Ordering supplies.
- Reviewing school or district procedures and rules.
- Attending or facilitating board meetings or other district meetings.
- Performing administrative or clerical activities related to general building or district functions or operations.
- Providing general supervision of staff, including supervision of student teachers or classroom volunteers, and evaluation of employee performance.
- Reviewing technical literature and research articles.
- Other general administrative activities of a similar nature as listed above that cannot be specifically identified under other activity codes.

CODE 11 UNALLOW – UNPAID TIME OFF

This code is used if the participant indicates that the moment occurred at a time when he or she was not scheduled to work, including unpaid days off.

ATTACHMENT B: SCHOOL HEALTH SERVICES QUALIFIED PROVIDERS

Professional Category	Type of Service
Administrator	Medicaid Administrative Services and Outreach
Audiologist	Speech, Language and Hearing Services or Targeted Case Management Medicaid Administrative Services and Outreach
Audiology Candidate	Speech, Language and Hearing Services or Targeted Case Management Medicaid Administrative Services and Outreach
Bus Aide	Personal Care Services or Targeted Case Management Medicaid Administrative Services and Outreach
Child Care/Group Leader	Personal Care Services or Targeted Case Management Medicaid Administrative Services and Outreach
Counselor	Psychological, Counseling and Social Work Services or Targeted Case Management Medicaid Administrative Services and Outreach
Health Technician	Personal Care Services; Nursing Services; or Targeted Case Management Medicaid Administrative Services and Outreach
Interpreter and Interpreter Assistant	Medicaid Administrative Services and Outreach
Marriage and Family Therapist	Psychological, Counseling and Social Work Services or Targeted Case Management Medicaid Administrative Services and Outreach
Nurse Aide	Personal Care Services; Nursing Services; or Targeted Case Management Medicaid Administrative Services and Outreach
Nurse (RN or LPN)	Personal Care Services; Nursing Services; or Targeted Case Management Medicaid Administrative Services and Outreach
Occupational Therapist	Occupational Therapy or Targeted Case Management Medicaid Administrative Services and Outreach
Occupational Therapy Assistant	Occupational Therapy or Targeted Case Management Medicaid Administrative Services and Outreach
Orientation and Mobility Specialist	Orientation, Mobility and Vision Services or Targeted Case Management Medicaid Administrative Services and Outreach
Non-Licensed Orientation and Mobility Specialist	Medicaid Administrative Services and Outreach

Professional Category	Type of Service
Physical Therapist	Physical Therapy or Targeted Case Management Medicaid Administrative Services and Outreach
Physical Therapy Assistant	Physical Therapy or Targeted Case Management Medicaid Administrative Services and Outreach
Physician (MD or DO)	Physician Services; Psychological, Counseling and Social Work Services; or Targeted Case Management Medicaid Administrative Services and Outreach
Program Specialist	Medicaid Administrative Services and Outreach
Psychiatrist	Physician Services; Psychological, Counseling and Social Work Services or Targeted Case Management Medicaid Administrative Services and Outreach
Psychologist	Psychological, Counseling and Social Work Services or Targeted Case Management Medicaid Administrative Services and Outreach
Psychologist – Intern	Medicaid Administrative Services and Outreach
Non-Licensed Psychologist	Medicaid Administrative Services and Outreach
Pupil Support Service Administrator	Medicaid Administrative Services and Outreach
Pupil Support Technicians	Medicaid Administrative Services and Outreach
Resource Specialist/Family Liason	Medicaid Administrative Services and Outreach
School Bilingual Assistant	Medicaid Administrative Services and Outreach
Non-Licensed Social Worker	Medicaid Administrative Services and Outreach
Social Worker or Clinical Social Worker	Psychological, Counseling and Social Work Services or Targeted Case Management Medicaid Administrative Services and Outreach
Special Education Administrator	Medicaid Administrative Services and Outreach
Special Education – Support Technician	Medicaid Administrative Services and Outreach

Professional Category	Type of Service
Speech/Language Pathologist	Speech, Language and Hearing Services or Targeted Case Management Medicaid Administrative Services and Outreach
Speech/Language Pathologist Candidate	Speech, Language and Hearing Services or Targeted Case Management Medicaid Administrative Services and Outreach
Speech/ Language Impairment Teacher	Speech, Language and Hearing Services or Targeted Case Management Medicaid Administrative Services and Outreach
Special Education Teacher	Personal Care Services or Targeted Case Management Medicaid Administrative Services and Outreach
Special Education Teacher Aide	Personal Care Services or Targeted Case Management Medicaid Administrative Services and Outreach
Teaching Assistant	Personal Care Services or Targeted Case Management Medicaid Administrative Services and Outreach