DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)

FINAL

ORDER

School-Based Health Services

Nature of the Proceedings:

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance (DMMA) initiated proceedings to amend the Title XIX Medicaid State Plan related to School-Based Health Services. The Department's proceedings to amend its regulations were initiated pursuant to 29 **Delaware Code** Section 10114 and its authority as prescribed by 31 **Delaware Code** Section 512.

The Department published its notice of proposed regulation changes pursuant to 29 **Delaware Code** Section 10115 in the May 2008 Delaware *Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by May 31, 2008 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

Summary of Proposed Amendment

The proposed amends the Title XIX Medicaid State Plan as it relates to School-Based Health Services.

Statutory Authority

- Section 504 of the Rehabilitation Act of 1973;
- 45 CFR Part 84, *Nondiscrimination on the Basis of Handicap in Programs or Activities Receiving Federal Financial Assistance*;
- Individuals with Disabilities Education Act (IDEA) - P.L. 94-142;
- Section 411(k)(13) of the Medicare Catastrophic Coverage Act of 1988 - P.L. 100-360;
- 42CFR§440.40, *Early and Periodic Screening and Diagnosis and Treatment;*
- 42CFR§431.53, *Assurance of Transportation*; and,
- 42CFR§433.20, *Rates of FFP for Administration: Reimbursement for School-Based Administrative Expenditures (NEW)*

Background

School-Based Health Services

The Medicaid program can pay for certain medically necessary services which are specified in Medicaid law when provided to individuals eligible under the state plan for medical assistance. The Individuals with Disabilities Education Act (IDEA) formerly called the Education of the Handicapped Act, authorized Federal funding to states for programs that impact Medicaid payment for services provided in schools.

Section 411(k)(13) of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) amended section 1903(c) of the Act to permit Medicaid payment for medical services provided to children under IDEA through a child's Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP). This amendment was enacted to ensure that Medicaid would cover the health-related services under IDEA.

Under Part B of IDEA, school districts must prepare an IEP for each child which specifies all special education and "related services" needed by the child. The Medicaid program can pay for some of the "health related services" required by Part B of IDEA in an IEP, if they are among the services specified in Medicaid law. In addition, the services must be included in the state's Medicaid plan or available through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program. Examples of such services include physical therapy, speech pathology services, occupational therapy, psychological services and medical screening and assessment services.

In summary, the Centers for Medicare and Medicaid Services' (CMS) policy is that health-related services

included in a child's IEP or IFSP can be covered under Medicaid if all relevant statutory and regulatory requirements are met. A state may cover services often included in an IEP or IFSP as long as: 1) the services are medically necessary and coverable under a Medicaid coverage category (speech therapy, physical therapy, etc.); 2) all other Federal and state regulations are followed, including those for provider qualifications, comparability of services and the amount, duration and scope provisions; and, 3) the services are included in the state's plan or available under the EPSDT Program.

School Administration Expenditures and Costs Related to Transportation of School-Age Children Between Home and School

On December 28, 2007, CMS published a final rule, at 72 Federal Register 73635, which would eliminate Federal Medicaid payment for school administration expenditures and costs related to transportation of school-aged children between home and school. The Secretary has found that these activities are not necessary for the proper and efficient administration of the Medicaid State plan and are not within the definition of the optional transportation benefit.

Based on these determinations, under this final rule, Federal Medicaid payments will no longer be available for administrative activities performed by school employees or contractors, or anyone under the control of a public or private educational institution, and for transportation from home to school.

This regulation is effective on February 26, 2008. Under legislation passed by Congress, there is a six-month delay in implementing these changes so school budgets in the 2007-2008 school year will not be affected. However, Congress is making new efforts to delay CMS's rules to allow time for further review of the financial impact the rules will have on states, local government agencies and providers. The current moratorium that precludes CMS from implementing these rules will expire on June 30, 2008.

Summary of Proposed Amendment

CMS reviewed both the School-Based Health Services program and reimbursement methodology included in the Title XIX Medicaid State Plan. Pending that review, CMS only approved the current methodology until July 1, 2008. The Division of Medicaid and Medical Assistance (DMMA) must amend the State Plan at Attachment 3.1-A to clarify and update the description of covered categories of services and revise the reimbursement methodology for these services at Attachment 4.19-B.

Therefore, effective July 1, 2008, reimbursement for covered services provided or purchased by the Department of Education (DOE) or Local Education Agencies (LEA) is determined on a fee-for-service basis. Rates include allowable direct costs (salaries, benefits, purchase of service and other costs directly related to the delivery of the medical services) and indirect costs, allocated as part of an approved Cost Allocation Plan per OMB Circular A-87. Rates must be consistent with efficiency, economy and quality of care. Also, upon implementation by CMS, Federal Financial Participation (FFP) will not be available for the cost of transportation of school-age children between home and school pursuant to 42 CFR §§431.53(b) and 433.20.

The provisions of this amendment are subject to approval by the Centers for Medicare and Medicaid Services (CMS).

SUMMARY OF COMMENTS RECEIVED WITH AGENCY RESPONSE AND EXPLANATION OF CHANGES

The Governor's Advisory Council for Exceptional Citizens (GACEC) and the State Council for Persons with Disabilities (SCPD) offered the following observations and recommendations summarized below. DMMA has considered each comment and responds as follows:

As background, CMS issued proposed regulations last year [72 Fed. Reg. 51397 (September 7, 2007)] narrowing eligibility for Medicaid reimbursement of school transportation of students with disabilities between home and school and back. The regulations generated a groundswell of negative comments but were adopted as final standards at the end of 2007 [72 Fed. Reg. 73635 (December 28, 2007)]. Congress delayed implementation of the regulations through Section 206 of P.L. 110-173 until June 30, 2008. As a prophylactic measure, DMMA is now issuing regulatory amendments to become effective July 1, 2008 to comport with the CMS regulations. The Councils have the following observations.

First, there are multiple references in the Plan [§4.b.2) on p. 1423 and §5(d) on pp. 1424-1425] which refer to the DOE and the Local Education Agency (LEA) eligibility for reimbursement. DMMA may wish to consider whether

these references are “underinclusive”. For example, charter schools are also public schools [Title 14 **Del.C.** §§501 and 503] which could logically benefit from participation in the Medicaid cost reimbursement program. Likewise, students placed by the DOE and districts in specialized private schools pursuant to Title 14 **Del.C.** §3124 would have Individualized Education Plans (IEPs). It is unclear if school-based health services of such students are recovered by the DOE and districts or if it would be beneficial to allow the private school to seek reimbursement.

DMMA Response: DMMA did not intend in its reference to DOE and LEA’s to limit the schools that may participate in the Medicaid program. The term “LEA” was intended to cover the districts and their schools, including charter schools that wish to participate in the Medicaid program and that otherwise meet the criteria. Rather this change in language was an attempt to clarify the previous language that referred only to services “provided in a school setting”. That language did not distinguish between services provided or purchased *by* schools from those that are merely furnished *in* schools by entities that have no relationship to the schools, such as the School-based Wellness Centers that are operated by the Division of Public Health. That distinction was the purpose of adding the more specific language.

Second, the prohibition on recovery of transportation services only applies to “school-age children”. See 72 Fed. Reg. at 51403 and 72 Fed Reg. at 73645 and 73648. CMS indicates that “(w)e do intend the term ‘school-age children’ to be defined by age.” At 73648. DMMA can lessen the adverse impact of the CMS regulation by adopting a restrictive definition of “school-age children”. Options include age 3 [based on Title 14 **Del.C.** §3101(5) and 16 **DE Admin Code** 900, §1.0]; or age 5 [based on Title 14 **Del.C.** §202 and 2721]. We recommend that DMMA affirmatively incorporate the age 5 standard in its Plan. For clarity, it would also be useful to indicate that students with IFSPs are still eligible for transportation reimbursement. Students with IFSPs are always under 36 months of age. See Title 16 **Del.C.** §§212 and 215.

DMMA Response: DMMA agrees with the recommendation of the SCPD to define the term “school age children” as children ages 5 through 20 consistent with Title 14 **Del.C.** §202 and will amend its proposed language accordingly.

Third, there are some hospital-based school sites that should arguably continue to be eligible for transportation reimbursement (e.g. the First State School and A.I. duPont school program). Although somewhat cryptic, CMS appears somewhat less rigid in the context of transportation to medical sites. In response to an inquiry about schools sending children to alternative placements because of a student’s medical needs, CMS responded as follows:

We agree, however, that when an individual is transported for the provision of medical services to a location that is not a school, such as a community provider, the transportation would be covered because that transportation was necessary to access a medical service not available in a school.

At 73646.

DMMA Response: DMMA will add language to the proposed State Plan amendment to clarify that transportation to and from a facility whose primary purpose is to provide medical treatment will continue to be a covered service even if the regulation at 42 CFR §§431.53(b) is implemented.

Fourth, CMS emphasizes that the limitation on transportation reimbursement does not affect eligibility for “medical services that might be required under an IEP or IFSP in the course of such transportation”, including “a personal care attendant or home health aide during transportation from home to school and back. At 73642. See also commentary at 73645 (authorizing “monitoring or medical related services during transport” and commentary at 73646 (coverage continues for “medical equipment, appliances and supplies that are covered under the home health benefit”). DMMA may wish to include some clarifying provision or note in the State Plan to highlight the continued eligibility of such services. For example, on p. 1425, DMMA could add the following concluding sentence: “FFP for medical equipment, appliances, supplies, monitoring of related services, and home health services during transportation remain available.” The same sentence could also be included after “date.” in §4.b.(d) on p. 1423.

DMMA Response: DMMA agrees that the purpose of this amendment is not to limit other medically necessary state plan services that a recipient may receive during transportation to and from a school setting to

which a recipient may be entitled. We have, therefore, added language similar to that which was proposed by the Councils that achieves the same clarifying purpose.

Fifth, there is "typo" at the top of p. 1423. The heading refers to "Remdial" which should be "Remedial".

DMMA Response: DMMA thanks the Councils for pointing out this typo that also exists in the current version of this section of the State Plan. Correction made.

Sixth, p. 1423 contains the following standard:

> With the exception of EPSDT screens, all services provided under this section are diagnostic or active treatments designed to reasonably improve the student's physical or mental condition and are provided to the student whose condition or function can be expected to reasonably improve with interventions.

This statement essentially requires that services are limited to those linked to "medical improvement". This is inaccurate. Under EPSDT, children are entitled to "health care, diagnostic services, treatment, or other measures ...to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services...". See 42 U.S.C. 1396d(r)(5. This has historically been interpreted to include maintenance of function or prevention of worsening of conditions:

EPSDT covers "necessary" diagnostic and treatment services to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screen. This definition of necessary EPSDT services is obviously broad. Thus, services must be covered if they correct, compensate for, or improve a condition, or prevent a condition from worsening - even if the condition cannot be prevented or cured.

NHeLP, "An Advocate's Medicaid EPSDT Reference Manual" (1993) at p. 6 [excerpt attached].

This concept is reflected in the attached DMMA "medical necessity" regulation which is not limited to services causing medical improvement but include those which "prevent the worsening of conditions or effects of conditions" and services which allow a beneficiary to "retain" independence, self-care, etc.. A strict "medical improvement" standard would disallow all palliative services for a terminally ill child, palliative services to a non-terminally ill child experiencing pain, and all therapies and interventions for children with chronic health conditions which may never "improve" but whose functioning can be "maintained" or "prevented from worsening".

Based on the above standards, DMMA should consider the following substitute standard:

> All services provided under this section are diagnostic or active treatments designed to reasonably ameliorate, improve, or prevent the worsening of a mental or physical illness or condition.

DMMA Response: DMMA thanks the Councils for bringing to our attention the potential unintended consequence of our proposed language. DMMA did not intend to limit the definition of medically necessary EPSDT services to exclude those services necessary to maintain or prevent the worsening of a mental or physical condition. DMMA will amend its language accordingly.

Findings of Fact:

The Department finds that the proposed changes as set forth in the May 2008 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to amend the Title XIX Medicaid State Plan regarding School-Based Health services is adopted and shall be final effective August 10, 2008.

Vincent P. Meconi, Secretary, DHSS, July 15, 2008

DMMA PROPOSED REGULATIONS #08-31
REVISIONS:

ATTACHMENT 3.1-A
Page 2 Addendum

State of Delaware

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REM**[E]**DIAL CARE AND SERVICES PROVIDED TO THE
CATEGORICALLY NEEDY

LIMITATIONS:

4.b. EPSDT services are limited only by medical necessity criteria and are not arbitrarily limited in amount, duration, or scope. Limitations on organ transplants are identified in Attachment 3.1-A, Page 1 Addendum.

~~Non-State Plan~~ EPSDT services include:

1) Prescribed Pediatric Extended Care (PPEC) ~~services~~ facilities that are licensed as such by the State's Office of Health Facilities, Licensing and Certification and that are provided as an alternative to more expensive institutionalization or as an alternative to community/home care for children who are determined to be in medical need of the service. These services include nursing, nutrition, developmental assessment, speech therapy, physical therapy and occupational therapy provided in an outpatient setting, up to twelve hours per day, five days a week.

PPEC services ~~will~~ must be prior authorized ~~on an individual basis,~~ using policy established by the Delaware Medicaid program.

ATTACHMENT 3.1-A
Page 2 Addendum

State of Delaware

AMOUNT, DURATION, AND SCOPE OF MEDICAL
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4.b. (continued)

2) School-Based Health Services – Medicaid covers the following health and mental health services provided ~~in a school setting~~ or purchased by the Delaware Department of Education (DOE) or Local Education Agency (LEA) when they are medically necessary and furnished by providers meeting specified criteria:
   (a) EPSDT screens, including vision, dental, immunization, orthopedic and developmental screening (per 42 CFR §440.40(b) and 441 Subpart B)
   (b) Nursing Services, including provision of one-on-one individualized Health Education (per 42 CFR §440.60 and §440.170)
   (c) ~~Assessment and/or Treatment as follows:~~
   Physical Therapy, Occupational Therapy, Speech Therapy, Language~~,~~ and Hearing Services, ~~Vision, Dental, Immunizations, Developmental/Orthopedic, Health Education, Psychological~~ (per 42 CFR §440.110)
   (d) Medically necessary behavioral health services designed to correct or ameliorate a mental

health or developmental disability and restore a recipient to his or her best possible level of functioning as determined via an EPSDT screen and documented in an Individualized Education Plan (IEP)/Individualized Family Service Plan (IFSP) (per 42 CFR §§440.130 and 440.160), including:

- Mental health assessment
- Psychological and developmental testing
- Counseling and therapy
- Facility-based mental health or developmental disability treatment
- Inpatient psychiatric services for individuals under age 21

[~~If~~ Upon federal implementation of] the regulatory changes at 42 CFR §§431.53(b) and 433.20 regarding the elimination of reimbursement for the cost of transportation of school-age children between home and school either as a reimbursable service or administrative activity are implemented, Delaware will cease claiming for those costs as of the effective date. **[For the purpose of this section, the term "school age children" shall mean children ages 5 through 20 years. Medically necessary services that might be required under an IEP or IFSP in the course of such transportation, such as: medical equipment, appliances, supplies, monitoring of related services and home health services shall remain allowable services to the extent that they meet all applicable requirements under the State Plan. Upon implementation of the regulation at 42 CFR §§431.53(b) by CMS, transportation to and from a facility whose primary purpose is to provide medical care and treatment and where a school age child also receives legally mandated education services, shall continue to be a covered service.]**

With the exception of EPSDT screens, all services provided under this section are diagnostic or active treatments designed to reasonably **[ameliorate,]** improve **[or prevent the worsening of]** the student's physical or mental condition and are provided to the student whose condition or functioning can be expected to reasonably improve with interventions.

Such services shall be medically necessary and shall be prescribed in a written treatment plan signed by a licensed practitioner within the scope of practice as defined under state law or regulations and documented in the student's IEP/IFSP. Services must be performed by qualified professionals operating within the scope of their practice under State law and regulations.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL
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Services must be provided by qualified providers who meet the requirements of the regulations cited above in this section and other applicable state law and regulations. Unlicensed professionals may operate under the direction of a licensed practitioner who acts as supervisor and is responsible for the work, who plans the work and methods, who regularly reviews the work performed and who is accountable for the results. Supervision must adhere to the requirements of the practitioner's applicable licensing board. The licensed practitioner must co-sign documentation for all services provided by practitioners under his or her direction.

Providers must maintain all records necessary to fully document the nature, quality, amount and medical necessity of services furnished to Medicaid recipients.

3) Mental Health and Drug/Alcohol services approved and monitored through the Department of Services for Children, Youth and their Families. These include:
   (a) Mental Health Outpatient Services
   (b) Mental Health Case Management
   (c) Professional Medical Services (i.e., neurologists, clinical psychologists, psychiatric social workers and other licensed medical providers)
   (d) Psychiatric facility services
   (e) Drug/Alcohol Rehabilitation Services

4) Assistive Technology

5) Orthotics and Prosthetics

6) Chiropractic Services

7) Any other medical or remedial care provided by licensed medical providers

8) Any other services as required by §6403 of OBRA '89 as it amended §1902(a)(43), §1905(a)(4)(B) and added a new §1905(r) to the Act

(Break in Continuity of Sections)

5. Other EPSDT Services

Reimbursement for services not otherwise covered under the State Plan is determined by the Medicaid agency through review of a rate setting committee. Non-institutional services are paid on a fee-for-service basis. Institutional services are per diem rates based on reasonable costs. These services include:

(a) Prescribed Pediatric Extended Care - see ATT. 4.19-B, Page 7

(b) Inpatient and Partial Hospital Psychiatric Services – reimbursed on a per diem basis

(c) Outpatient Psychiatric Facility Services - fee-for-service

(d) School-Based Health Services - ~~fee-for-service: this reimbursement methodology will expire effective July 1, 2008~~ reimbursement for covered services provided or purchased by the Department of Education (DOE) or Local Education Agencies (LEA) is determined on a fee-for-service basis. Rates include allowable direct costs (salaries, benefits, purchase of service and other costs directly related to the delivery of the medical services) and indirect costs, allocated as part of an approved Cost Allocation Plan per OMB Circular A-87. Rates must be consistent with efficiency, economy and quality of care. Upon implementation by CMS **[of the regulation at 42 CFR §431.53(b)]**, FFP will not be available for the cost of transportation of school-age children**[, as defined in ATTACHMENT 3.1-A 4(b)(2)(d) of the State Plan, ~~between home and school pursuant to 42 CFR §§431.53(b) and 433.20~~].**

(e) Mental Health and Drug/Alcohol Rehabilitation Services:
   • Institutional - per diem

- Non-Institutional - fee-for-service or, if managed by the Department of Services for Children, Youth and Their Families' Division of Child Mental Health (see ATTACHMENT 4.19-B, Page 19 Addendum).

12 DE Reg. 228 (08/01/08)