19. Case management services and tuberculosis related services.

 a. Case management services as defined in, and to the group(s) specified in, Supplement 1 to Attachment 3.1-A (in accordance with Section 1905(a)(19) or Section 1915(g) of the Act).

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Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):
[Describe target group and any subgroups. If any of the following differs among the subgroups, submit a separate State plan amendment describing case management services furnished; qualifications of case management providers; or methodology under which case management providers will be paid.]

The target group is Medicaid eligible individuals, regardless of age, who are enrolled on Home and Community-based Services (HCBS) waivers administered by the Ohio Department of Developmental Disabilities (DODD) and all other Medicaid eligible individuals, age 3 or above, who are determined to have a developmental disability according to Section 5126.01 of the Ohio Revised Code.

☑ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 180 *[insert a number; not to exceed 180]* consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):

☑ Entire State.
☐ Only in the following geographic areas: *[Specify areas]*

Comparability of Services (§§1902(a)(10)(B) and 1915(g)(1))

☐ Services are provided in accordance with §1902 (a)(10)(B) of the Act.
☑ Services are not comparable in amount, duration, and scope (§1915(g)(1)).

Definition of Services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services. Targeted Case Management includes the following assistance:

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- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
  - Taking client history;
  - Identifying the individual's needs and completing related documentation; and
  - Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.

  [Specify and justify the frequency of assessments.]

  The service and support administrator (SSA) assesses an individual's needs for services upon request of the individual. The SSA reassess the indivdual's needs at least annually thereafter.

  (i) Activities performed to make arrangements to obtain from therapists and appropriately qualified persons the initial and on-going assessments of an eligible individual's need for any medical, educational, social, and other services.

  (ii) Eligibility assessment activities that provide the basis for the recommendation of an eligible individual's need for HCBS waiver services administered by DODD.

  (iii) Activities related to recommending an eligible individual's initial and on-going need for services and associated costs for those individuals eligible for HCBS waiver services administered by DODD.

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
  - Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - Identifies a course of action to respond to the assessed needs of the eligible individual.

- Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:

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- Activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

❖ Monitoring and follow-up activities:
- Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
  - Services are being furnished in accordance with the individual's care plan;
  - Services in the care plan are adequate; and
  - Changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

  [Specify the type of monitoring and justify the frequency of monitoring.]

  (i) Activities and contacts that are necessary to ensure that the individual service plan is effectively implemented and adequately addresses the needs of the eligible individual.

  (ii) Conducting quality assurance reviews on behalf of a specific eligible individual and incorporating the results of quality assurance reviews into amendments of a individual service plan.

  (iii) Reviewing the individual trends and patterns resulting from reports of investigations of unusual incidents and major unusual incidents and integrating prevention plans into amendments of individual service plans.

  (iv) Ensuring that services are provided in accordance with the individual service plan and individual service plan services are effectively coordinated through communication with service providers.

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(v) Activities and contacts that are necessary to ensure that guardians and eligible individuals receive appropriate notification and communication related to unusual incidents and major unusual incidents.

Monitoring is required if an individual is enrolled on DODD operated waivers. The waivers requires that an individual receive at least one waiver service monthly or if less than monthly, the individual must be monitored on a monthly basis by the SSA to assure the individual's health and welfare.

☑ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case manager to changes in the eligible individual's needs. (42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
[Specify provider qualifications that are reasonably related to the population being served and the case management services furnished.]

Qualified providers are County Boards of Developmental Disabilities (CBsDD), as established under Chapter 5126. of the Ohio Revised Code. In addition, each County Board must have a signed Ohio Medicaid Provider Agreement with the single State Medicaid Agency.

The only individuals allowed to deliver targeted case management for the CBsDD or their contract agencies are service and support administration supervisors, service and support administrators, and conditional status service and support administrators (SSAs). SSAs must meet the registration or certification requirements of the Ohio Department of Developmental Disabilities. Minimum qualifications for SSA certification includes completion of an associates degree if the individual is supervised by a certified person with a bachelor's degree.

Freedom of choice (42 CFR 441.18(a)(1):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in the plan.

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2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

☑ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services. *[Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]*

The state will limit providers of targeted case management to CBsDD as established under Chapter 5126. of the Ohio Revised Code. CBsDD may sub-contract for the service. This limitation is in compliance with Section 4302.2, paragraph D. of the State Medicaid Manual.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

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Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows:

(i) The name of the individual;
(ii) The dates of the case management services;
(iii) The name of the provider agency (if relevant) and the person providing the case management service;
(iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved;
(v) Whether the individual has declined services in the care plan;
(vi) The need for, and occurrences of, coordination with other case managers;
(vii) A timeline for obtaining needed services;
(viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903 (c) of the Act. (§§1902(a)(25) and 1905(c))

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[Specify any additional limitations.]

Coverage exclusions:

(a) Activities performed on behalf of an eligible individual residing in an institution are not billable for targeted case management services reimbursement except for the last one hundred eighty consecutive days of residence when the activities are related to moving the eligible individual from an institution to a non-institutional community setting.

(b) Emergency intervention services as described in paragraph (Q) of rule 5123:2-1-11 of the Administrative Code. This does not preclude those activities covered in paragraph (D)(1) of rule 5101: 3-48-01 of the Administrative Code when responding to an emergency and provided by a certified or registered service and support administrator.

(c) Conducting investigations of abuse, neglect, unusual incidents, or major unusual incidents.

(d) The provision of direct services (medical, educational, vocational, transportation, or social services) to which the eligible individual has been referred and with respect to the direct delivery of foster care services, including but not limited to those described in paragraph (A)(iii) of section 1915(g) of the Social Security Act (42 U.S.C. 1396n(g)(2)) as effective January 1, 2006.

(e) Services provided to individuals who have been determined to not have mental retardation or another developmental disability according to section 5126.01 of the Revised Code, except for individuals eligible for coverage of TCM services pursuant to paragraph (C)(1)(a) of rule 5101:3-48-01 of the Administrative Code.

(f) Conducting quality assurance systems reviews.

(g) Conducting quality assurance reviews for an eligible individual for whom the service and support administrator serves as the single point of accountability.

(h) Payment or coverage for establishing budgets for services outside of the scope of individual assessment and care planning.

(i) Activities related to the development, monitoring or implementation of an individualized education program (IEP).

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(j) Services provided to groups of individuals.

(k) Habilitation management as defined in rule 5123:2-1-11 of the Administrative Code.

(l) Eligibility determinations for CBDD services.

DODD will review claims monthly to assure that each TCM practitioner does not bill more than 26, 15-minute units a day. This maximum is applied to services rendered on a daily basis rather than an average of service volume for some period of time greater than one day. DODD will conduct a retrospective prior authorization for units that exceed the established limit in cases where individuals receiving services meet medical necessity criteria established in Ohio Administrative Code rule. If any such claim does not meet the criteria for medical necessity, the CB/DD will return overpayment within two quarters of the state fiscal year to the state Medicaid agency. The return will be handled through the DODD Medicaid Billing System if the claims are less than 330 days from the date of service. Otherwise, the return will be processed as a separate transaction.