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State/Territory Name: OH

State Plan Amendment (SPA) #: 16-0028

This file contains the following documents in the order listed:

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

October 13, 2016

John B. McCarthy, Director
Ohio Department of Medicaid
P.O. Box 182709
50 West Town Street, Suite 400
Columbus, Ohio 43218

RE: TN 16-028

Dear Mr. McCarthy:

Enclosed for your records is an approved copy of the following State Plan Amendment (SPA):

Transmittal #16-028 - Targeted Case Management Services Provided to Individuals with Development Disabilities
- Effective Date: November 1, 2016

If you have any questions about this SPA, please contact Christine Davidson at (312) 886-3642 or by email at christine.davidson@cms.hhs.gov.

Sincerely,

/s/

Ruth A. Hughes
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

cc: Carolyn Humphrey, ODM
Sarah Curtin, ODM
Becky Jackson, ODM
Greg Niehoff, ODM

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES	1. TRANSMITTAL NUMBER: **16-028 Revised**	2. STATE **OHIO**
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **November 1, 2016**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ **AMENDMENT**

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: Sections 1905(a)(19) and 1915(g)(2) of the Social Security Act; 42 CFR 440.169; 440.225; and 441.18	7. FEDERAL BUDGET IMPACT: a. FFY 2017 $13,800 thousands b. FFY 2018 $14,500 thousands
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 1 to Attachment 3.1-A, pages 1-C through 7-C [Target Group C: DD] Attachment 4.19-B, Item 19-a, Target Group C: DD, pp 1-3 of 3	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Supplement 1 to Attachment 3.1-A, pages 1-C through 8-C [Target Group C: DODD] (TN 11-007) Attachment 4.19-B, Item 19-a, Target Group C: DD, pp 1-3 of 3 (TN 15-005)

10. SUBJECT OF AMENDMENT: TCM services provided to individuals with developmental disabilities

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The State Medicaid Director is the Governor's designee

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	16. RETURN TO: **Carolyn Humphrey** **Ohio Department of Medicaid** **P.O. BOX 182709** **Columbus, Ohio 43218**
13. TYPED NAME: **JOHN B. McCARTHY**	
14. TITLE: **STATE MEDICAID DIRECTOR**	
15. DATE SUBMITTED: August 23, 2016	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: August 23, 2016	18. DATE APPROVED: October 13, 2016
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: November 1, 2016	20. SIGNATURE OF REGIONAL OFFICIAL: /s/
21. TYPED NAME: Ruth A. Hughes	22. TITLE: Associate Regional Administrator

23. REMARKS:

Instructions on Back

FORM CMS-179 (07-92)

State Plan under Title XIX of the Social Security Act
State/Territory: Ohio

TARGETED CASE MANAGEMENT SERVICES
Certain Medicaid eligible individuals who are determined to have developmental disabilities

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 in 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 an intellectual or other 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:

❖ Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services, which include employment-related services. These assessment activities include:

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TARGETED CASE MANAGEMENT SERVICES
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- 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 reassesses the individual'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, including employment-related services.

(ii) 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;
- Identifies a course of action to respond to the assessed needs of the eligible individual; and
- Includes other services, including employment-related services.

❖ 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
- Employment–related providers and employment-related programs and services.

❖ 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) 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.

  (iii) 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 in DODD-administered waivers. The waivers require 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.

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☑ 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. 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 and service and support administrators (SSAs). SSAs must meet the certification requirements of the Ohio Department of Developmental Disabilities. Minimum qualifications for SSA certification include a degree from an accredited college or university.

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.
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.]*

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Certain Medicaid eligible individuals who are determined to have developmental disabilities

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))

[Specify any additional limitations.]

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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 response system services provided by a certified service and support administrator when responding to an emergency.

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

(d) The provision of direct services (medical, educational, employment-related, 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 an intellectual or other developmental disability according to section 5126.01 of the Revised Code, except for Medicaid-eligible individuals, regardless of age, who are enrolled in HCBS waivers administered by DODD.

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

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

(h) Services provided to groups of individuals.

(i) Habilitation management.

(j) Eligibility determinations for CBDD services.

19. Case management services and tuberculosis related services.

a. Methods and standards for payment/reimbursement of case management services as defined in, and to the group specified in, Supplement 1 to Attachment 3.1-A Target Group C: DD (in accordance with Section 1905(a) (19) of Section 1915(g) of the Act).

Rates:

Qualified Targeted Case Management (TCM) providers, which are limited to County Boards of Developmental Disabilities (CBDDs), are reimbursed for the actual incurred costs of providing TCM to eligible Medicaid beneficiaries. The CMS-approved Department of Developmental Disabilities, County Boards Income and Expense Report is submitted by the CBDDs at the end of May for the previous calendar year. Reconciliation is completed after all county board cost reports have been audited for the reporting period. CBDDs are paid an interim rate of $19.50 per fifteen minute unit for providing TCM services. Once all CBDD cost reports have been audited, a final settlement will be processed. The payments will be paid to each provider in an amount based on the provider's reconciled costs for providing TCM services to Medicaid recipients, less amounts already paid to the provider for TCM services under the state plan. Reconciled costs will be calculated using CMS-approved cost reporting methods. Government providers are required to comply with cost allocation principles found in 2 CFR 200. For purposes of the TCM payments, effective for services provided on or after November 1, 2016, costs shall be calculated as described in paragraphs A through E.

A. Direct Services Payment Methodology

The annual cost settlement methodology will consist of audited CMS-approved cost reports and cost reconciliation. If Medicaid payments exceed Medicaid-allowable costs, the excess will be recouped and returned to the federal government.

The Medicaid-allowable direct and indirect costs of providing direct services to Medicaid recipients receiving Targeted Case Management services are determined as follows:

(1) Direct costs are those that can be identified directly to a particular program/cost objective. These costs are primarily made up of payroll and other expenses related to the compensation of employees, but also include costs not related to compensation, such as cost of materials, equipment, travel, and similar items that can be directly assigned to the benefitting program/cost objective as described in 2 CFR 200.
(2) Indirect costs are those that are general in nature and not directly assignable to a particular program/cost objective. These indirect costs are allocated through the approved cost report to ensure that all revenue and non-revenue producing programs/cost objectives receive the appropriate share of these costs.
(3) Determine the amount of each provider's Medicaid reimbursement for claims incurred during the provider's fiscal year and adjudicated to a paid status through the Medicaid Information Technology System (MITS).

(4) Determine the amount of each provider's reconciled costs for the provider's fiscal year for providing TCM services for Medicaid-eligible persons.
(5) Determine the cost settlement ceiling which will be the lesser of the CBDD's actual cost per unit or 112% times a weighted statewide average cost per unit. The 112% weighted statewide average rate will be calculated by removing outliers and weighting the average using the total number of units. Outliers are defined as any rate exceeding three standard deviations from the mean rate; these outliers will be removed prior to calculation of the average. Costs will be settled at the lower of the CBDD's audited rate or the cost settlement ceiling. Reimbursement will not exceed the cost of providing service to Medicaid-eligible persons.
(6) If the amount calculated in item (5) is greater than zero, the provider will receive a payment equal to the amount calculated in item (5) multiplied by the Federal Medical Assistance Percentage (FMAP) rate in effect at the time of the payment. If the amount calculated in item (5) is less than zero, the Medicaid reimbursement exceeds the cost calculated in item (4). The federal portion of the overpayment would be collected and returned to the federal government.

All expenditures reported and allocation methodologies used must be in compliance with 2 CFR 200 and all reports are audited. Audits are currently performed by the office of the Ohio auditor of State.

B. Certification of Expenditures

Qualified targeted case management (TCM) providers, which are limited to CBDDs, certify actual incurred costs of providing TCM to eligible Medicaid beneficiaries. Each provider must certify its expenditures as eligible for federal financial participation in order to settle to actual incurred costs for Medicaid TCM services.

C. Annual Cost Report Process

CBDDs are required to file a cost report for the preceding calendar year not later than the last date of May unless a later date is established.

Cost reports are filed and audited. The audit is certified as complete and a copy of the certified audit is filed in the office of the clerk of the governing body, executive officer of the governing body, and chief fiscal officer of the audited CBDD.

D. The Cost Reconciliation Process

CBDDs are paid an interim rate per fifteen minute TCM unit. Once all CBDD cost reports have been audited, a cost settlement will be processed. The payments will be paid to

each provider in an amount based on the provider's reconciled costs for providing TCM services to Medicaid recipients, less amounts already paid to the provider for TCM services under the state plan. Reconciled costs will be calculated using CMS-approved cost reporting methods. CBDDs are required to comply with cost allocation principles found in 2 CFR 200.

E. The Cost Settlement Process

For purposes of these payments, for costs calculated in item A of this document for payments exceeding the Medicaid allowable costs, the provider will remit the federal share of the overpayment. Reconciliation is completed after the Ohio Auditor of State has audited all county board cost reports for the reporting period.

Unit Definition:

A unit of service is equivalent to fifteen (15) minutes. Minutes of service provided to a specific individual can be accrued over one calendar day. The number of units that may be billed during a day is equivalent to the total number of minutes of TCM provided during the day for a specific individual divided by fifteen plus one additional unit if the remaining number of minutes is eight or greater minutes.

Claims Payment Process:

Providers will submit claims to the Ohio Department of Developmental Disabilities (DODD). For all providers of TCM, DODD will have a voluntary reassignment of claims payment form on file.

DODD will receive the claims through their system, conduct up-front edits and forward the claims to the Ohio Department of Medicaid for adjudication.

DODD will post claims adjudication status as well as remittance advice information to their secure website for providers to access and download.