DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region 10
2201 Sixth Avenue, MS/RX 43
Seattle, Washington 98121

JUN 04 2010

Bruce Goldberg, MD, Director
Department of Human Services
Human Services Building
500 Summer Street Northeast, E-15
Salem, Oregon 97301-1097

RE: Oregon State Plan Amendment (SPA) Transmittal Number 08-013

Dear Dr. Goldberg:

The Centers for Medicare & Medicaid Services (CMS) Seattle Regional Office has completed its review of the Oregon State Plan Amendment (SPA) Transmittal Number 08-013.

This amendment was submitted to change the reimbursement methodology for children with high-risk diagnosis Targeted Case Management (TCM) services from a monthly state-wide rate to a per-contact-per individual-per day methodology.

This SPA is approved effective July 1, 2009, as requested by the State.

If you have any questions concerning this SPA, please contact me, or have your staff contact Wendy Hill Petras of my staff at (206) 615-3814 or wendy.hillpetras@cms.hhs.gov.

Sincerely,

[redacted]

Carol J.C. Peverly
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc:
Judy Mohr-Peterson, Administrator, Division of Medical Assistance Programs
Sandy Hansen, State Plan Coordinator, Division of Medical Assistance Programs

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **08-13**

2. STATE: Oregon

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) Medical Assistance

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
~~April 1, 2008~~ 7/01/2009 (P&I)
~~April 2, 2008~~ (P&I)

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:
42 CFR 440.169 and Part 441

7. FEDERAL BUDGET IMPACT:
a. FFY 2008 $ 2,000,000
b. FFY 2009 $ 4,000,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
27-31 (P&I)
Supplement 1to Attachment 3.1-A, Page ~~10-14~~ and Attachment 4.19B, Page ~~4d~~. 4i (P&I)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment to Supplement 1to Attachment 3.1-A, Page 10-14 and Attachment 4.19B, Page 4d.

10. SUBJECT OF AMENDMENT: This transmittal is being submitted to revise the reimbursement methods for the Targeted Case Management (TCM) program for children with high risk diagnoses.

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:

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]

13. TYPED NAME: Jim Edge / Bruce Goldberg, MD

14. TITLE: Administrator, DMAP / Director, DHS

15. DATE SUBMITTED: 6/27/08

16. RETURN TO:
Division of Medical Assistance Programs
Department of Human Services
500 Summer Street NE E-35
Salem, OR 97301

ATTN: Jesse Anderson, Title XIX Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: JUN 27 2008

18. DATE APPROVED: JUN 04 2010

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2009

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: Carol J.C. Peverly

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:

1/06/2009 State authorized pen and ink changes.

10/05/2009 State authorized pen and ink changes.

5/24/2010 State authorized pen and ink changes.

FORM HCFA-179 (07-92)

Targeted Case Management
Babies First/CaCoon

Target Group:
Targeted case management (TCM) services will be provided to Medicaid eligible infants and preschoolers through four years of age who have risk factors (listed below) for poor health outcomes. TCM services will be provided to Medicaid eligible children up to age 21, who have a diagnosis or very high risk factor listed below.

Medical Risk Factors (Birth through 4 yrs)	**Diagnosis** (Birth – to 21 yrs)
Drug exposed infant	Heart Disease
Alcohol Exposed infant	Chronic Orthopedic Disorders
Infant HIV positive	Neuromotor disorders including cerebral palsy and brachial palsy
Maternal PKU or HIV Positive	Cleft lip and palate and other congenital defects of the head, face
Intracranial hemorrhage grade I or II	Genetic disorders, e.g. cystic fibrosis, neurofibromatosis
Seizures or maternal history of seizures	Multiple minor anomalies
Perinatal asphyxia	Metabolic disorders, e.g. PKU
Small for gestational age	Spina Bifida
Very low birth weight (1500 grams or less)	Hydrocephalus or persistent ventriculomegaly
Mechanical ventilation for 72 hrs or more prior to discharge	Microcephaly and other congenital or acquired defects of the CNS
Neonatal hyperbilirubinemia	Hemophilia
Congenital Infection (TORCHS)	Organic speech disorders
CNS infection	Hearing Loss
Head trauma or near drowning	Traumatic Brain Injury
Failure to grow	Fetal Alcohol Spectrum Disorder
Suspect vision impairment	Autism, autism spectrum disorder
Family history of childhood onset hearing loss	Behavioral or mental health disorder WITH developmental delay
Prematurity	Chromosomal disorders
Lead exposure	Positive newborn blood screen
Suspect hearing loss:	HIV, seropositive conversion
Other risk factors not listed	Visual Impairment
Social Risk Factors	**Very High Medical Risk Factors**
Maternal Age 16 years or less	Intraventicular hemorrhage (grade III or IV) or periventricular leukomalacia (PVL) Or chronic subdurals
Parents with developmental disabilities or intellectual impairment	Perinatal asphyxia accompanied by seizures
Parental alcohol or substance abuse	Seizure disorder

Social Risk Factors	**Very High Medical Risk Factors**
At-risk caregiver	Oral-motor dysfunction requiring specialized feeding program (including gastrostomy)
Concern of parent/provider	Chronic lung disorder
Parent with limited financial resources	Suspect neuromuscular disorder
Parent with history of mental illness	**Developmental Risk Factors**
Parent with child welfare history	Developmental Delay
Parent with domestic violence history	**Other**
Other evidence based social risk factors	Other chronic conditions not listed

For case management services provided to individuals in medical institutions:

☐ Target group comprised of individuals transitioning to a community setting and case management services will be made available for up to 180 consecutive days of the covered stay in the medical institution.

Areas of state in which services will be provided:

☒ Entire State

☐ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of services:

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount duration and scope.

1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

Definition of services:

Case management services are 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:
These annual assessment activities (more frequent with significant change in condition) include:

- Evaluation of individual's history;
- Evaluation of the extent and nature of individual's needs (medical, social, educational, and other services) and completing related documents.

- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.
- Annual review or more often as indicated by change in individual needs.

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, psycho-social, educational, and other services needed by the individual;
- Includes activities such as ensuring the active participation of the eligible individual, 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 an eligible individual obtain needed services including:

- Activities that link an individual with medical, social, educational providers or other programs and services that are capable of providing needed services, that are capable of providing needed support services (including food vouchers, transportation, child care and housing assistance) to address identified needs and achieve goals specified in the care plan;

Monitoring and follow-up activities: Activities and contacts necessary to ensure the care plan is implemented and adequately addresses the individual's needs. These activities, and contacts, may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring. Monitoring and follow-up activities are ongoing and can be performed monthly or as needed and could include:

- Ongoing face-to-face or other contact to conduct follow-up activities with the participating eligible client or the client's health care decision maker(s), family members, providers or other entities or individuals when the purpose of the contact is directly related to managing the eligible client's care to ensure the service plan is effectively implemented;
- 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.
- Frequency of monitoring is based on the documented client needs.

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

Qualifications of providers:

Babies First/CaCoon Targeted Case Managers may be an employee of a Local County Health Department, or other public or private agency contracted by a Local County Health Department. The case manager must be:

- a licensed registered nurse with one year of experience in community health, public health, child health nursing;
- be a Community Health Workers, Family Advocates or Promotoras working under the supervision of a licensed registered nurse.

The minimum qualifications of the Community Health Workers, Family Advocates or Promotoras are as follows: High School Graduate, or GED with additional course work in human growth and development, health occupations or health education and 2 years experience, in public health, mental health or alcohol drug treatment settings, or any satisfactory combination of experience and training which demonstrates the ability to perform case management duties. The case manager must work under the policies, procedures, and protocols of the State Title V MCH Program.

Provider organizations must be certified by the single state agency as meeting the following criteria:

1. Demonstrated capacity to provide all core elements of case management services including:
   a. Comprehensive client assessment
   b. Comprehensive care/service plan development
   c. Linking/coordination of services
   d. Monitoring and follow-up of services
   e. Reassessment of the client's status and needs
2. Demonstrated case management experience in coordinating and linking such community resources as required by the target population.
3. Demonstrated experience with the target population.
4. A sufficient number of staff to meet the case management service needs of the target population.
5. An administrative capacity to insure quality of services in accordance with state and federal requirements.
6. A financial management capacity and system that provides documentation of services and costs.
7. Capacity to document and maintain individual case records in accordance with state and federal requirements.
8. Demonstrated ability to meet all state and federal laws governing the participation of providers in the state Medicaid program.
9. Ability to link with the Title V Statewide MCH Data System or provide another statewide computerized tracking and monitoring system.

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.

- Eligible individuals will have free choice of the providers of case management services within the specified geographic area identified in this plan.
- Eligible individuals will have free choice of the 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 providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

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 services (including targeted case management) 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 services.
- 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 (42 CFR 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 this same purpose.

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 the following:

- 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))

Payment Methodology for Targeted Case Management for Medicaid High Risk Infants and Children

"Unit" is defined as one encounter per visit. A unit consists of at least one documented contact with the individual (or other person acting on behalf of the individual) and any number of documented contacts with other individuals or agencies identified through the case planning process. Case management providers are paid on a unit-of-service basis that does not exceed 1 unit (encounter) per day.

The rate for reimbursement of the case management services is computed as follows:

Compute the	Total Annual Medicaid Encounters
Compute the	Total Annual Program Expenditures
Divide	Calculate Average Cost Per Encounter
Examine	Extreme values, develop "reasonable range"
Equals	AVERAGE COST PER ENCOUNTER

The total annual expenditures of providing targeted case management includes:

- Targeted case management staff salary and other personnel expenses;
- Supervisory salary and other personnel expenses;
- Administrative support salary and other personnel expenses;
- Services and supply expenses; and
- Expenses (General government service charges, worker's comp, property insurance, etc).

The Agency's rates are statewide rates, both public and private provider receive the same rate. The rates are set as of 7/1/2010 and are effective for services on or after that date. All rates are published on the Agency's website at http://www.dhs.state.or.us/policy/healthplan/guides/tcmngmt/main.html. Annual expenditures and rates will be reviewed no less than every two years.