Table of Contents

State Name: West Virginia

State Plan Amendment (SPA) #: 12-006

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

CENTERS FOR MEDICARE & MEDICAID SERVICES

Region III/Division of Medicaid and Children's Health Operations

SWIFT #091220124038

NOV 25 2014

Ms. Cynthia E. Beane, MSW, LCSW
Acting Commissioner
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, West Virginia 25301-3706

Dear Acting Commissioner Beane:

The Centers for Medicare & Medicaid Services (CMS) has reviewed West Virginia's School Based Health Services State Plan Amendment (SPA) 12-006, in which you propose to more accurately match payments to the cost of services being provided to Medicaid members receiving direct medical services outlined on the Individualized Education Plan (IEP) in the school setting. West Virginia SPA 12-006 is a response to CMS companion letters for SPA 09-02 and SPA 11-011.

This SPA is acceptable. Therefore, we are approving SPA 12-006 with an effective date of July 1, 2014. Enclosed are the approved SPA pages and the signed CMS-179 form. Please note that accompanying this approval of SPA 12-006, there is an enclosed companion letter addressing unrelated issues that arose in review of this SPA.

If you have further questions about this SPA, please contact Margaret Kosherzenko of my staff at 215-861-4288.

Sincerely,

/S/

Francis McCullough
Associate Regional Administrator

Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

CENTERS FOR MEDICARE & MEDICAID SERVICES

Region III/Division of Medicaid and Children's Health Operations

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NOV 25 2014

Ms. Cynthia E. Beane, MSW, LCSW
Acting Commissioner
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, West Virginia 25301-3706

Dear Acting Commissioner Beane:

This letter is being sent as a companion to our approval of West Virginia's State Plan Amendment (SPA) 12-006, School Based Health Services. While we are proceeding with approval of West Virginia SPA 12-006, this letter follows up on other matters that were not in compliance with current Federal regulation, so that we can work with you to resolve the issues.

Section 1902(a) of the Social Security Act (the Act) requires that States have a State Plan for medical assistance that meets certain Federal requirements that set out a framework for the State program. Implementing regulations at 42 CFR §430.10 requires that the State Plan be a comprehensive written statement describing the nature and scope of the State's Medicaid Program and that it contain all information necessary for the Centers for Medicare & Medicaid Services (CMS) to determine whether the State Plan can be approved to serve as the basis for Federal financial participation (FFP) in the State program. During our review of the SPA, CMS performed an analysis of the coverage and reimbursement pages related to this SPA, and found that additional clarification is necessary.

In reviewing the State Plan pages, CMS found companion page issues related to Clinic Services on Supplement 2 to Attachment 3.1-A and 3.1-B, Page 3aa that are a result of removing all the language the State wished to strike from the page. 42 CFR §440.90 outlines that Clinic Services are outpatient services, that can be preventive, diagnostic, therapeutic, rehabilitative or palliative services that are furnished by a facility, under the direction of a physician or dentist, and is further explained in the Medicaid Manual at Section 4320. Please revise the Clinic Services State Plan page to identify the types of clinics covered under the benefit and identify any limitations on these clinics.

The State has 90 days from the receipt of this letter to submit a corrective action plan describing in detail how West Virginia will resolve in a timely manner the issues identified above. Failure to respond will result in the initiation of a formal compliance process. During the 90 day period, CMS will provide any technical assistance that is needed to resolve the issues described in this letter.

If you have any questions regarding this letter, please contact Margaret Kosherzenko at 215-861-42288. We look forward to working with you on these issues.

Sincerely,

/S/

Francis McCullough
Associate Regional Administrator

cc: Rachel Dressel, CMCS

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: 1 2 - 0 0 6

2. STATE: West Virginia

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

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

4. PROPOSED EFFECTIVE DATE
July 1, 2014

5. TYPE OF PLAN MATERIAL (Check One)

[X] NEW STATE PLAN [ ] AMENDMENT TO BE CONSIDERED AS NEW PLAN [X] AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1905(a)(5) of the Social Security Act; IDE Act Part B, 42 CFR 440.60, 440.101, 440.130, 440.167 and 441.62

7. FEDERAL BUDGET IMPACT:
a. FFY 2015 $ 50,271,000
b. FFY 2016 $ 52,332,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Addudnum 3.1-A, Pages 1 - 12 (new)
Attachment 4.19-B, Pages 18 - 22B(new) Supplement 2 to Attachment 3.1-A and 3.1-B page 3aa (Revised) Attachment 4 19-B page 6, page 14, and page 15 (revised); Attachment for A, D and E of Supplement 1 to Attachment 3.1-A pages 1-3 (TN-No 90-15)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):
Attachment 4 19-B, page 6 and page 14 and 15; Attachment for A, D, and E of Supplement 1 to Attachment 3.1-A Page 1-3 (TN-NO. 90-15)

10. SUBJECT OF AMENDMENT:
The purpose of this amendment is to more accurately match payments to the cost of services being provided to Medicaid Members receiving direct medical services, outlined on the Individualized Education Plan ("IEP"), in the school setting.

11. GOVERNOR'S REVIEW (Check One)

[ ] GOVERNOR'S OFFICE REPORTED NO COMMENT
[ ] OTHER, AS SPECIFIED:
[X] COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
[ ] NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL
/S/

13. TYPED NAME:
Cynthia E. Beane, Acting Commissioner, MSW, LCSW

14. TITLE:
Commissioner

15. DATE SUBMITTED:
September 12, 2012

16. RETURN TO:
Bureau for Medical Services
350 Capitol Street Room 251
Charleston West Virginia 25301

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 12, 2012

18. DATE APPROVED:
NOV 25 2014

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2014

20. SIGNATURE OF REGIONAL OFFICIAL:
/S/

21. TYPED NAME:
Francis McCullough

22. TITLE:
Associate Regional Administrator

23. REMARKS:

FORM HCFA-179 (07-92)

INSTRUCTIONS ON BACK

School-Based Health Services (Special Education):

The School-Based Health Services program includes medically necessary covered health care services identified pursuant to an IEP Plan provided by or through the West Virginia Department of Education (DOE) or a Local Education Agency (LEA). These medically necessary health care services must be ordered by a physician or other licensed practitioners of the healing arts within the scope of license as defined under the West Virginia Code to eligible special education students from birth to age 21. The State assures full EPSDT services as defined under 1905(r) will be provided for individuals under 21 who are covered under the State Plan under section 1902(a) (10) (A) to ensure early and periodic screening, diagnostic, and treatment services are provided when medically necessary.

The State assures that the provision of services will not restrict an individual's free choice of qualified providers in violation of section 1902(a)(23) of the Social Security Act. The Medicaid-eligible individual may obtain Medicaid Services from any institution, agency, pharmacy, person or organization that is qualified to perform services.

The services are defined as follows:

A. **Audiology, Speech, Hearing and Language Disorders Services:**

Definition: Per 42 CFR §440.110 (c): Services for individuals with speech, hearing, and language disorders means diagnostic, screening, preventive, or corrective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. It includes any necessary supplies and equipment.

Services may include, but are not limited to, testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning:

- Auditory acuity (including pure tone air and bone conduction), speech detection, and speech reception threshold;
- Auditory discrimination in quiet and noise;
- Impedance audiometry, including tympanometry and acoustic reflex;
- Central auditory function;
- Testing to determine the child's need for individual amplification; selection and fitting of aid(s);

- Hearing aid evaluation;
- Auditory training; and training for the use of augmentative communication devices.

All services shall be fully documented in the medical record.

Qualified Practitioners: Qualified providers must meet the requirements in 42 CFR §440.110 and be licensed by the WV Board of Examiners of Speech, Language Pathology, and Audiology. Speech, hearing, and language disorders services can also be provided by a Speech-Language Pathology Assistant or Audiology Assistant provided the requirements outlined in W.Va. Code St. R. §29-2-1 *et seq.* (1994) are met.

B. Occupational Therapy Services:

Definition: Per 42 CFR §440.110 (b)(1) Occupational therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction of a qualified occupational therapist. It includes necessary supplies and equipment.

Services may include, but are not limited to, testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning:

- Activities of daily living assessment and training;
- sensory integration;
- sensorimotor assessment and training;
- neuromuscular assessment and development;
- muscle strengthening and endurance training;
- fine motor assessment and skills facilitation;
- feeding/oral motor assessment and training;
- adaptive equipment application;
- visual perceptual assessment and training;
- perceptual motor development assessment and training;
- musculo-skeletal assessment;
- fabrication and application of splinting and orthotic devices;
- manual therapy techniques;
- gross motor assessment and skills facilitation; and
- functional mobility assessment.

All services shall be fully documented in the medical record.

Qualified Practitioners: Qualified providers must meet the requirements in 42 CFR §440.110 and be licensed by the West Virginia Board of Occupational Therapy. Occupational Therapy services can also be provided by a certified occupational therapy assistant (COTA) under the supervision of a licensed occupational therapist, provided the conditions outlined in W.Va. Code St. R. §13-1-1 et seq. (2010) are met.

C. **Physical Therapy Services:**

Definition: Per 42 CFR §440.110 (a) (1) Physical therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law and provided to a recipient by or under the direction of a qualified physical therapist. It includes any necessary supplies and equipment.

Service may include, but are not limited to, testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning:

- Neuromotor assessment;
- range of motion;
- joint integrity and functional mobility;
- flexibility assessment;
- gait, balance and coordination assessment and training;
- posture and body mechanics assessment and training;
- soft tissue assessment;
- pain assessment;
- cranial nerve assessment;
- clinical electromyographic assessment;
- nerve conduction;
- latency and velocity assessment;
- therapeutic procedures;
- hydrotherapy;
- manual manipulation;
- gross motor development;
- muscle strengthening;
- functional training;
- facilitation of motor milestones;
- sensory motor assessment and training;
- manual muscle test;
- activities of daily living assessment and training;
- therapeutic exercise;

- cardiac assessment and training;
- Manual therapy techniques;
- fabrication and application of orthotic devices;
- pulmonary assessment and enhancement;
- adaptive equipment application; and
- feeding/oral motor assessment and training.

All services shall be fully documented in the medical record.

Qualified Practitioners: Qualified providers must meet the requirements in 42 CFR §440.110 and be licensed by the West Virginia Board of Physical Therapy. Physical therapy services can also be provided by licensed physical therapy assistants under the direct supervision of a licensed physical therapist provided the conditions outlined in W.Va. Code St. R. §16-1-1 *et seq.* (2011) are met.

D. Psychological Services:

Definition: Per 42 CFR §440.60 (a) "Medical care or any other type remedial care provided by licensed practitioners'' means any medical or remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice as defined under State law. Psychological, services include those services related to the evaluation, testing, diagnosis and treatment of social, emotional or behavioral problems.

Service may include, but are not limited to, testing and/or clinical observation as appropriate for chronological or developmental age for one or more of the following areas of functioning:

- Cognitive assessment;
- emotional/personality assessment;
- adaptive behavior assessment;
- behavior assessment;
- perceptual or visual motor assessment;
- Cognitive-behavioral therapy;
- rational-emotive therapy;
- family therapy;
- individual interactive psychotherapy using play equipment, physical devices, language interpreter or other mechanisms of non-verbal communication; and
- sensory integrative therapy.

All services shall be fully documented in the medical record.

Qualified Practitioners: Qualified providers must meet the requirements in 42 CFR §440.60. Minimum qualification for providing services are current licensure by the WV Board of Examiners of Psychologists as a licensed psychologist, licensed School psychologist or licensed School psychologist independent practitioner.

E. **Nursing Services:**

Definition: Per 42 CFR §440.60 (a), Federal regulations identify medical or other remedial care provided by licensed practitioners as "any medical or remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice as defined under State law."

Nursing services include, but are not necessarily limited to:

- anaphylactic reaction;
- manual resuscitator;
- postural drainage and percussion;
- catheterization;
- mechanical ventilator;
- seizure management;
- measurement of blood sugar;
- subcutaneous insulin infusion;
- emergency medication administration;
- oral suctioning;
- subcutaneous insulin infusion by injection;
- enteral feeding;
- ostomy care;
- tracheostomy care;
- epinephrine auto-injector;
- oxygen administration;
- inhalation therapy;
- peak flow meter; and
- long-term medication administration.

All services shall be fully documented in the medical record.

Qualified Practitioners: Qualified providers must meet the requirements in 42 C.F.R. §440.60 (a) and be licensed by the West Virginia Board of Examiners for Registered Professional Nurses as a registered professional nurse (RN).

F. **Personal Care Services:**

Definition: Per 42 CFR §440.167, Personal care services means services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for individuals with intellectual disability, or institution for mental disease that are (1) Authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State; (2) Provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and (3) Furnished in a home, and at the State's option, in another location.

Services related to a child's physical and behavioral health requirements may include, but are not limited to, the following:

- Assistance with eating, dressing, personal hygiene;
- Activities of daily living;
- Bladder and bowel requirements;
- Use of adaptive equipment;
- Ambulation and exercise;
- Behavior modification; and/or
- Other remedial services necessary to promote a child's ability to participate in, and benefit from the educational setting.

All services shall be fully documented in the medical record.

Qualified Practitioners: Qualified providers must meet the requirements in 42 CFR §440.167. Services are furnished by providers who have satisfactorily completed a program for home health aides/nursing assistants, or other equivalent training, or who have appropriate background and experience in the provision of personal care or related services for individuals with a need for assistance due to physical or behavioral conditions.

G. **Targeted Case Management:**

Definition: Targeted Case Management services, provided in accordance with 1902(a)(10)(B) of the Act and as defined under 1905(a)(19) of the Act and 42 CFR 440.169, are activities that assist Title XIX eligible school-age children who are referred for, or are receiving, medical services pursuant to a Service Plan.

__N/A_Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to ___ 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):

___X Entire State

___ Only in the following geographic areas: **[Specify areas]**

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

___X 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)).

Targeted Case Management services are a component of the TCM Service Plan. Targeted Case Management 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 medical, social, educational, and other services, and ensures that the student receives effective and timely services appropriate to their needs.

In accordance with State Medicaid regulations, the school district shall complete and submit to the State a TCM Service Plan for the delivery of Targeted Case Management services. The district shall have a representative group of parents and community-based providers, including the local public health department, EPSDT case managers and any existing school-based health centers to assist in developing the TCM Service Plan. Included in the TCM Service Plan is the provision for coordination of benefits and Targeted Case Management across multiple providers to:

- Achieve service integration, monitoring and advocacy;
- Provide needed medical, social, educational, and other services;
- Ensure that services effectively complement one another; and
- Prevent duplication of services.

The school district shall inform the family of a Medicaid-eligible student receiving Targeted Case Management services from more than one provider that the family may choose one lead case manager to facilitate coordination.

Targeted Case Management services must include any of the following activities:

- Needs Assessment and Reassessment;
- Development and Revision of Service Plan;

- Referral and Related Activities; or
- Monitoring and follow-up activities;

1. Needs Assessment and Reassessment: Reviewing of the individual's current and potential strengths, resources, deficits and need for medical, social, educational and other services. 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. 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 service 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 the TCM Service Plan: Developing a written plan based on the assessment of strengths and needs, which identifies the 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. Development (and periodic revision) of the TCM Service Plan will specify the goals and actions to address the medical, social, educational, and other services needed by the eligible individual. The service plan describes the nature, frequency, and duration of the activities and assistance that meet the individual's needs. Periodic revisions to the TCM Service Plan will be made at a minimum annually.

3. Referral and Related Activities: Facilitating the individual's access to the care, services and resources through linkage, coordination, referral, consultation, and monitoring. 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 will occur as necessary, but at least annually. This may include facilitating the recipient's physical accessibility to services such as arranging transportation to medical, social, educational and other services; facilitating communication between the individual, his or her parent(s) or legal guardian and the case manager and between the individual, his or her parent(s) or legal guardian and other service providers; or, arranging for translation or another mode of communication. It also includes 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 a specific individual. This may also 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.

4. Monitoring and Follow-up Activities: The case manager shall conduct regular monitoring and follow-up activities with the client, the client's legal representative, or with other related service providers. Monitoring will be done to ensure that services are being furnished in accordance with the individual's TCM Service Plan. Periodic review of the progress the individual has made on the service plan goals and objectives and the appropriateness and effectiveness of the services being provided on a periodic basis. This review may result in revision or continuation of the plan, or termination of Targeted Case Management services if they are no longer appropriate. Periodic reviews may be done through personal and telephone contacts with the individual and other involved parties. The periodic reviews will be conducted as necessary but at least annually.

All services shall be fully documented in the medical record.

Non-Duplication of Services: To the extent any eligible School-Based Health Services recipients are receiving Targeted Case Management services from another provider agency as a result of being members of other covered targeted groups; the School-Based Health Services providers will ensure that Targeted Case Management activities are coordinated to avoid unnecessary duplication of service.

Targeted 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 managers to changes in the eligible individual's needs. Targeted Case Management activities shall not restrict or be used as a condition to restrict a client's access to other services under the state plan.

Qualified Practitioner: Targeted Case Management activities may be provided by any willing qualified provider pursuant to 1902(a)(23) of the Social Security Act. Case Managers must be affiliated with a licensed Behavioral Health Services Provider or School Based Health Services Provider and possess one of the following qualifications:

- A psychologist with a Masters' or Doctoral degree from an accredited program
- A licensed social worker
- A licensed registered nurse
- A Masters' or Bachelors' degree granted by an accredited college or university in one of the following human services fields:
    - Psychology
    - Criminal Justice
    - Board of Regents with health specialization

- Recreational Therapy
- Political Science
- Nursing
- Sociology
- Social Work
- Counseling
- Teacher Education
- Behavioral Health
- Liberal Arts or;
- Other degrees approved by the West Virginia Department of Education (WVDE).

Note: West Virginia does not enroll independent Target Case Manager Providers.

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

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 (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, 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))

H. Specialized Transportation:

Definition: Per 42 CFR §440.170 (a)(1) "Transportation" includes expenses for transportation and other related travel expenses determined to be necessary by the agency to secure medical examinations and treatment for a recipient. This service is limited to transportation of an eligible child to health related services as listed in a recipient's IEP.

Covered Services and Limitations: Specialized transportation is Medicaid reimbursable if:

1. It is provided to a Medicaid eligible EPSDT recipient who is enrolled in an LEA;
2. It is being provided on a day when the recipient receives an IEP health-related Medicaid covered service;
3. The Medicaid covered service is included in the recipient's IEP;
4. The recipient's need for specialized transportation is documented in the child's IEP; and
5. The driver must meet all State and County license and certification requirements.

Each school district is responsible for maintaining written documentation, such as a trip log, for individual trips provided. No payment will be made to, or for parents providing transportation.

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9. **Clinic Services**

Services may be limited by prior authorization.

10. **Dental Services**

Prior Authorization may be required for restorative/replacement procedures. For prior authorization criteria see generally www.wvdhhr/bms/manuals Chapter 505: Dental: sections 505.8, 505.10 and Attachments 1,2 and 3. Dental service limits provided under EPSDT can be exceeded based on medical necessity. Certain emergency dental services are covered for adults, see section 505.7

NOV 25 2014

4.19 Payments for Remedial Care and Services

Inpatient Hospital Services

8. Private Duty Nursing Services
Payment is based on an hourly rate by skill level; i.e., R.N., LPN, Aide, considering customary charges and rate paid for these services by private insurance, or other state agencies.

9. Clinic Services
Payment for services provided by established clinics may be an encounter rate based on all inclusive costs, or on a fee for the services provided in the clinic. Payment not to exceed that allowed for the services when provided by other qualified providers. Payment for free standing ambulatory surgery center services shall be the lesser of 90% of the Medicare established fee or the provider billed charge.

10. Dental; Services

4.19 Payments for Medical and Remedial Care and Services

23. Pediatric or Family Nurse Practitioner Services

Payment may not exceed the amount paid to physicians for the service the provider is authorized by State Law to perform, or the provider's customary charge, whichever is less.

For services provided on and after 11.01.94, the following methodology will apply:

An upper limit is established using a resource-based relative value for the procedure times a conversation factor as determined by the type of service. The conversion factors were developed using utilization and payment level data for the defined service group. Payment will be the lessor of the upper limit or the provider's customary charge for the service to the general public.

1. a. Transportation

Payment is made for transportation and related expenses necessary for recipient access to covered medical services via common carrier or other appropriate means; cost of meals and lodging, and attendant services where medically necessary.

Reimbursement Upper Limits:

(i) Common Carriers (bus, taxi, train or airplane) – the rates established by any applicable regulatory authority, or the provider's customary charge to the general public.

(ii) Automobile – Reimbursement is computed at the prevailing state employee travel rate per mile.

(iii) Ambulance – Reimbursement is the lesser of the Medicare geographic prevailing fee of EMS provider charge to the general public as reported on the State Agency survey.

(iv) Meals - $5.00 per meal during travel time for patient, attendant, and transportation provider.

(v) Lodging – At cost, as documented by receipt, at the most economical resource available as recommended by the medical facility at destination.

PERSONAL CARE

4.19 Payments for Medical and Remedial Care and Services
Methods and Standards for Estahlishine Payment Rates

26. Personal Care Services

Personal Care services will be reimbursed using a statewide fee-for-service rate schedule based on units of services authorized in the approved plan of care. Payment for Personal Care services under the State Plan will not duplicate payments made to public agencies or private entities under other program authorities for the same purpose. Medicaid will be the payer of last resort. Unless specifically noted otherwise in the plan, the state-developed fee schedule rate is the same for both governmental and private providers. Providers will be reimbursed at the lesser of the provider's usual and customary billed charge or the Bureau for Medical Services (Bureau) fee schedule.

Personal care services are limited **on a per unit, per month basis (15 minutes per unit) with all services subject to prior authorization. Individuals can receive up to a maximum of 840 units (210) hours) each month.**

Rate Methodology:
Rates for Personal Care services arc developed using a market-factor rate-setting model. The model reflects individual service definition, operational service delivery, administrative, capital and technology considerations. The following factors arc used in determining the rates:

- Wage - Wage data is obtained from the Bureau for Labor Statistics (BLS). The wage is based **on** two elements consisting of occupation/wage categories reported by BLS and identified by Medicaid staff as comparable to services delivered under the personal care program as well as results of a formal provider survey
- Inflation - The base wage is adjusted by an inflationary factor determined by the percent change in Consumer Price Index (CPI-U. U.S. City: All Items 1982-84 = 100) from base period 2009 to current rate period.
- Payroll Taxes - The payroll taxes factor represents the percentage of the employer's contribution to Medicare, Social Security, workers' compensation and unemployment insurance.
- Employee Benefits - The employee benefits factor represents the percentage of employer's contribution to employee health insurance and retirement benefits. The employee benefit factor varies by employee type. This factor is discounted to reflect the Medicaid agency's share of cost based on the Medicaid payer mix.
- Allowance for Administrative Costs - The allowance for administrative costs factor represents the percentage of service costs that results from non-billable administrative activities performed by direct care staff and services provided by employer administrative support and executive start This factor is discounted to the Medicaid payer mix as determined by provider survey conducted in 2010 and 2011.
- Allowance for Transportation Costs - The allowance for transportation costs factor represents an allowance for average travel time by the provider as indicated by the provider survey.
- Allowance for Capital and Technology - The allowance for capital and technology factor represents weighting of various income and balance sheet account information and provider survey data to calculate a capital and technology cost per dollar of employee wages. This factor is discounted to reflect the Medicaid agency's share of cost based on the Medicaid payer mix.
- Room and Board - Room and Board shall not **be a component used in developing the rate methodology.**

REIMBURSEMENT TO SCHOOL-BASED SERVICE PROVIDERS:

A. Reimbursement Methodology for School-Based Service Providers

Reimbursement to Local Education Agencies (LEAs) for School-Based Service Providers is based on a cost based methodology.

Medicaid Services provided by School-Based Service Providers are services that are medically necessary and provided to Medicaid recipients by LEAs in accordance with an Individualized Education Program (IEP) under the Individuals with Disabilities Education Act (IDEA):

1. Audiology and Speech-Language Pathology Services
2. Occupational Therapy Services
3. Physical Therapy Services
4. Psychological Services
5. Nursing Services
6. Personal Care Services
7. Targeted Case Management Services
8. Specialized Transportation

Providers will be paid interim rates based on historical cost data for school-based direct medical services. For the initial periods covered by this SPA the interim rate will be based on the current rates for school based health services until sufficient cost data has been collected through the annual cost report process to establish revised interim rates. Annually, provider specific cost reconciliation and cost settlement processes will occur to identify and resolve all over and under payments.

B. Direct Medical, Personal Care Services, and Targeted Case Management Payment Methodology

Effective for dates of service on or after July 1, 2013, the Bureau for Medical Services (BMS) will institute a cost based payment system for all School-Based Service Providers. As a cost based methodology, this system will incorporate standard cost based components: payment of interim rates; a CMS approved Random Moment Time Study (RMTS) approach for determining the allocation of direct service time; a CMS approved Annual Cost Report based on the State Fiscal Year (June 30 end); reconciliation of actual incurred costs attributable to Medicaid with interim payments; and a cost settlement of the difference between actual incurred costs and interim payments.

To determine the allowable direct and indirect costs of providing medical services to Medicaid-eligible clients in the LEA, the following steps are performed on those costs pertaining to each of

the three cost pools; direct services, personal care services, and targeted case management services:

1) Direct costs for medical services include unallocated payroll costs and other unallocated costs that can be directly charged to medical services. Direct payroll costs include the total compensation (i.e. salaries and benefits) to the service personnel identified for the provision of health services listed in the description of covered Medicaid services delivered by LEAs.

   Other direct costs include costs related to the approved service personnel for the delivery of medical services, such as materials, supplies and equipment and capital costs such as depreciation and interest. Only those materials, supplies, and equipment that have been identified and included in the approved BMS Medicaid cost reporting instructions are allowable costs and can be included on the Medicaid cost report.

   Total direct costs for medical services are reduced on the cost report by any credits, adjustments or revenue from other funding sources resulting in direct costs net of federal funds.

2) The net direct costs for each service category are calculated by applying the direct medical services percentage from the approved time study to the direct costs from Item 1 above.

   The RMTS incorporates a CMS approved methodology to determine the percentage of time medical service personnel spend on IEP related medical services, and general and administrative time. This time study will assure that there is no duplicative claiming of administrative costs.

3) Costs incurred through the provision of direct services by contracted staff are allowable costs net of credits, adjustments or revenue from other funding sources. This total is then added to the net direct costs identified in Item 2 above.

4) Indirect costs are determined by applying the LEA's specific unrestricted indirect cost rate to its net direct costs identified in Item 3 above. West Virginia LEAs use predetermined fixed rates for indirect costs. The West Virginia Department of Education is the cognizant agency for LEAs, and approves unrestricted indirect cost rates for LEAs for the United States Department of Education. Only allowable costs are certified by LEAs.

5) Net direct costs, from Items 2 and 3 above, and indirect costs from Item 4 above are combined.

6) Medicaid's portion of total net costs is calculated by multiplying the results from Item 5 above by the cost pool specific IEP ratio. West Virginia LEA's use a different IEP ratio for each of three service type cost pools, including direct services, personal care services, and targeted case management services. For direct services the numerator will be the number of Medicaid IEP students in the LEA who have an IEP with a direct medical service outlined in their IEP and the denominator will be the total number of students in the LEA with an IEP with a direct medical service outlined in their IEP. For personal care services the numerator will be the number of Medicaid IEP students in the LEA who have an IEP with a personal care service outlined in their IEP and the denominator will be the total number of students in the LEA with an IEP with a personal care service outlined in their IEP. For targeted case management services the numerator will be the number of Medicaid IEP students in the LEA who have an IEP with a targeted case management service outlined in their IEP and the denominator will be the total number of students in the LEA with an IEP with a targeted case management service outlined in their IEP.

C. Specialized Transportation Payment Methodology

Effective for dates of services on or after July 1, 2014, providers will be paid on a cost basis. Providers will be paid interim rates based on historical cost data for specialized transportation services. For the initial periods covered by this SPA the interim rate will be based on the current rates for school based health services until sufficient cost data has been collected through the annual cost report process to establish revised interim rates. Annually, provider specific cost reconciliation and cost settlement processes will occur to identify and resolve all over and under payments.

Specialized transportation is allowed to or from a Medicaid covered direct IEP service which may be provided at school or other location as specified in the IEP. Transportation may be claimed as a Medicaid service when the following conditions are met:

1. Specialized transportation is specifically listed in the IEP as a required service;
2. The child required specialized transportation in a vehicle that has been modified as documented in the IEP; and
3. The service billed only represents a one-way trip; and
4. A Medicaid IEP medical service (other than transportation) is provided on the day that special transportation is billed

Transportation costs included on the cost report worksheet will only include those personnel and non-personnel costs associated with specialized transportation reduced by any federal payments for these costs, resulting in adjusted costs for transportation. The cost identified on the cost report includes the following:

1. Personnel Costs – Personnel costs include the salary and benefit costs for transportation providers employed by the school district. The definitions for allowable salary and benefit costs for transportation services are the same as for direct medical service providers. The personnel costs may be reported for the following staff:
   a. Bus Drivers
   b. Attendants
   c. Mechanics
   d. Substitute Drivers
2. Transportation Other Costs – Transportation other costs include the non-personnel costs incurred in providing the transportation service. These costs include
   a. Lease/Rental costs
   b. Insurance costs
   c. Maintenance and Repair costs
   d. Fuel and Oil cost
   e. Contracted – Transportation Services and Transportation Equipment cost
3. Transportation Equipment Depreciation Costs – Transportation equipment depreciation costs are allowable for transportation equipment purchased for more than $5,000.

The source of these costs will be audited general ledger data kept at the LEA level.

LEAs may report their transportation costs as specialized transportation only costs when the costs can be discretely identified as pertaining only to specialized transportation or as general transportation costs when the costs cannot be discretely identified as pertaining only to specialized transportation.

All specialized transportation costs reported on the annual cost report as general transportation costs will be apportioned through two transportation ratios; the Specialized Transportation Ratio and the Medicaid One Way Trip Ratio. All specialized transportation costs reported on the annual cost report as specialized transportation only will only be subject to the Medicaid One Way Trip Ratio.

a. **Specialized Transportation Ratio** – The Specialized Transportation Ratio is used to discount the transportation costs reported as general transportation costs by the percentage of Medicaid eligible IEP students receiving specialized transportation services. This ratio ensures that only the portion of transportation expenditures related to the specialized transportation services for Medicaid eligible students are included in the calculation of Medicaid allowable transportation costs.

   The Specialized Transportation Ratio will be calculated based on the number of Medicaid eligible students receiving specialized transportation services in the school district. The numerator for the ratio will be the total number of Medicaid eligible IEP students receiving

specialized transportation services. The denominator for this ratio will be the total number of all students receiving transportation services. The data for this ratio will be based on the same point in time as is used for the calculation of the IEP ratio.

The Specialized Transportation Ratio is defined by the following formula:

Numerator = Total number of Medicaid eligible students receiving Specialized Transportation services per their IEP

Denominator = Total number of all students receiving transportation services

An example of how the Specialized Transportation Ratio will be calculated is shown below:

Specialized Transportation Ratio	
Total Number of Medicaid Eligible Students Receiving Specialized Transportation Services per their IEP	100
Total Number of ALL Students Receiving Transportation Services (Specialized or Non-Specialized)	1,500
	7%

b. **Medicaid One Way Trip Ratio-** An LEA-specific Medicaid One Way Trip Ratio will be established for each participating LEA. When applied, this Medicaid One Way Trip ratio will discount the transportation costs by the percentage of Medicaid IEP one way trips. This ratio ensures that only Medicaid allowable transportation costs are included in the cost settlement calculation.

The Medicaid One Way Trip Ratio will be calculated based on the number of one way trips provided to students requiring specialized transportation services per their IEP. The numerator of the ratio will be based on the Medicaid paid one way trips for specialized transportation services as identified in the state's MMIS data. The denominator will be based on the school district transportation logs for the number of one-way trips provided to Medicaid eligible students with specialized transportation in the IEP. The denominator should be inclusive of all one way trips provided to students with specialized transportation in their IEP, regardless of whether the trip qualified as Medicaid specialized transportation or not. The data for this ratio will be based on the total number of trips for the entire period covered by the cost report, i.e. all one way trips provided between July 1 and June 30.

The Specialized Transportation Ratio is defined by the following formula:

Numerator = Total Medicaid paid one way trips for specialized transportation services per MMIS

Denominator = Total one way trips for Medicaid eligible students with specialized transportation in their IEP (from bus logs)

An example of how the Specialized Transportation Ratio will be calculated is shown below:

Medicaid One Way Trip Ratio	
Total Number of Paid Medicaid One Way Trips for Specialized Transportation Services (per MMIS)	250
Total Number of ALL One Way Trips for Medicaid Eligible Students with Specialized Transportation in their IEP (per bus logs)	600
	42%

D. Annual Cost Report Process

Each provider will complete an annual cost report for all school-based services delivered during the previous state fiscal year covering July 1 through June 30. The cost report is due on or before December 31st of the same year of the reporting period. The primary purposes of the cost report are to:

1. Document the provider's total allowable costs for delivering services by School-Based Service Providers, including direct costs and indirect costs, based on cost allocation methodology procedures; and

2. Reconcile interim payments to total allowable costs based on cost allocation methodology procedures.

All filed annual Cost Reports are subject to a desk review.

E. Certification of Funds Process

On an annual basis, each LEA will certify through its cost report its total actual, incurred allowable costs/expenditures, including the federal share and the nonfederal share.

F. The Cost Reconciliation Process

The total allowable costs based on cost allocation methodology procedures are compared to the provider's Medicaid interim payments for school-based service providers during the reporting period as documented in the Medicaid Management Information System (MMIS), resulting in a cost reconciliation. West Virginia will complete the review of the cost settlement within a

reasonable time following the submission of the annual cost reports and the completion of all interim billing activities by the providers for the period covered by the cost report.

G. The Cost Settlement Process

For services delivered for a period covering July 1st through June 30th, the annual School Based Service Providers Cost Report is due on or before December 31st of the same year.

If a provider's interim payments exceed the actual, certified costs of the provider for school-based services to Medicaid clients, the provider will return an amount equal to the overpayment.

If the actual, certified costs of a provider for school-based services exceed the interim Medicaid payments, BMS will pay the federal share of the difference to the provider in accordance with the final actual certification agreement and submit claims to the CMS for reimbursement of that payment.

BMS shall issue a notice of interim settlement that denotes the amount due to or from the provider. West Virginia will process the interim settlement within 6 to 12 months following the submission of the annual cost reports. BMS shall also issue a notice of final settlement that denotes the final amount due to or from the provider upon completion of the final cost reconciliation. The final settlement will be issued within 24 months following the final submission of the annual cost reports.