

Administrator
Washington, DC 20201

AUG 1 2 2008

Mr. John R. Corlett Medicaid Director 30 East Broad Street Columbus, OH 43215-3414

Dear Mr. Corlett:

This letter concerns the pending reconsideration request for Ohio State plan amendment (SPA) 05-020. The State of Ohio originally submitted SPA 05-007 and SPA 05-020, which proposed to provide services under the rehabilitation benefit to Medicaid-eligible children attending Ohio's public schools and participating in the State's Medicaid School Program. SPA 05-020 seeks to comply with Federal coverage and rate-setting requirements for Medicaid school-based services funded by certified public expenditures (CPEs).

The Centers for Medicare & Medicaid Services (CMS) disapproved these amendments on October 28, 2005, due to their lack of compliance with Federal law. Specifically, these SPAs violated numerous provisions of section 1902 of the Social Security Act (the Act), including section 1902(a)(1), which requires that services be available statewide; 1902(a)(10)(B) which requires that services be comparable within groups of Medicaid-eligible beneficiaries; and 1902(a)(23), which guarantees beneficiaries free choice of providers. Under the proposed SPAs, services would have been covered only for select groups of students in participating schools.

Ohio indicated that the non-Federal share of claimed expenditures for school-based services would be provided through CPEs, but did not show any auditable method for determining or documenting such expenditures. As a result, CMS could not conclude that the proposed plan would provide for the non-Federal share required under section 1902(a)(2) of the Act. In addition, the State did not provide documentation to demonstrate that the rates reflected the cost of providing the services. Thus, CMS could not conclude that the proposed level of payment would be consistent with efficiency, economy, and quality of care, as required by section 1902(a)(30)(A) of the Act. Finally, because the State's proposal did not include conclusive cost information, Ohio did not establish that the proposed payments could be the basis for claimed expenditures consistent with section 1903(a)(1) of the Act, and for the overall Federal-State financial partnership that is established under title XIX of the Act.

On February 8, 2008, the State submitted a revised SPA 05-020 to replace the proposals that were submitted under SPA 05-007 and the former 05-020, which were pending reconsideration by CMS. Specifically, the revised SPA 05-020 proposed changes to rehabilitative and mental health services as well as nursing services and physical therapy. The SPA also included a cost-based reimbursement for Individuals with Disabilities Education Act services, and reimbursement changes for case management services provided in schools. With the submission of this SPA, Ohio addressed all the concerns raised in the disapproval letter and met all the

statutory requirements for the additional services. As it relates to the services that were previously disapproved, the additional information showed that the services may be provided by any willing and qualified provider and are comparable in amount, duration, and scope for all Medicaid beneficiaries, and offered statewide. The information included in the State plan provides the necessary assurances that services are not restricted to the school setting and that providers meet the required qualification to render services to Medicaid beneficiaries. This additional information demonstrates that the State plan complies with sections 1902(a)(10)(B), 1902(a)(1), and 1902(a)(23) of the Act.

Additionally, the State implemented, and described in the State plan, an auditable cost identification methodology that is approvable by CMS and supports the use of CPEs as the source of the State share of Medicaid payments. Specifically, the State has developed a statistically valid time-study that is used to identify the amount of time Medicaid-qualified practitioners engage in the provision of covered services. The State also developed a CMS-approved cost report that instructs providers to report the appropriate direct and indirect costs of Medicaid-covered services. These costs are allocated to the Medicaid program using an allocation percentage to isolate and reconcile Medicaid's obligation for the service costs. This information is sufficient to demonstrate that the proposed payments comply with the requirements of sections 1902(a)(2), 1902(a)(30)(A), and 1903(a)(1) of the Act.

The revised SPA 05-020 meets all statutory requirements necessary for approval. Therefore, I am pleased to inform you that the amendment has been approved with an effective date of July 1, 2005. The revised approved plan pages are enclosed for incorporation into the Ohio Medicaid State plan.

As you may be aware, CMS published a final rule on December 28, 2007, eliminating reimbursement for costs related to transportation of school-age children between home and school. While this rule is currently subject to a statutory moratorium that precludes CMS implementation or enforcement, once this moratorium is lifted, CMS anticipates that all or part of the transportation services authorized under SPA 05-020 will no longer be eligible for Federal financial participation.

Approval of this SPA does not relieve the State of its responsibility to comply with changes in Federal laws and regulations, and to ensure that claims for Federal funding are consistent with all applicable requirements.

Sincerely.

Kerry Weems

Acting Administrator

Enclosure

TRANSMITTAL AND NOTICE OF APPROVAL OF	1. TRANSMITTAL NUMBER:	2. STATE		
STATE PLAN MATERIAL	0 5 - 020	ОНЮ		
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES	3. PROGRAM IDENTIFICATION: TIT SOCIAL SECURITY ACT (MEDICA			
TO: REGIONAL ADMINISTRATOR	4. PROPOSED EFFECTIVE DATE			
CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	July 1, 2005			
5. TYPE OF PLAN MATERIAL (Check One):				
, ,				
☐ NEW STATE PLAN ☐ AMENDMENT TO BE O	CONSIDERED AS NEW PLAN			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AME	NDMENT (Separate Transmittal for each	amendment)		
6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:			
42CFR430.12, 42CFR440.130	a. FFY 2008	\$ 38.8M		
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	b. FFY 2009	\$ 52.3M		
Attachment 3.1-A, Pre-print pages 2 and 3, Item 6. "Other Practitioners' Services	9. PAGE NUMBER OF THE SUPERS			
(Continued), Nursing Services" Page 1 of 1.	OR ATTACHMENT (If Applicable):			
Attachment 3.1-A, Pre-print page 4, Item 11, a,b,c. "Physical Therapy and related services" Pages 1 through 3.	Attachment 3.1-A, Pre-print page 4, Item 11, a,b,c. "Physical Therapy and related services" Pages 1 through 2.			
Attachment 3.1-A, Pre-print pages 5 and 6, Item 13. "Other diagnostic, screening preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan. (Continued) d. Rehabilitative services. (Continued) 1.(a) Mental Health Services delivered through Medicaid School Program Providers" Page 1 through 3				
Supplement 1 to Attachment 3.1-A From Pre-Print Page 8, Item 19, Page 1-D through 5-D				
Attachment 4.19-B, (Filed at end), Reference Attachments 3.1-A, ITEMS 6, 11, 13, 19 and 24, Pages 1 through 4, "Cost-Based Reimbursement for IDEA Services Provided in Schools"				
10. SUBJECT OF AMENDMENT: NURSING SERVICES DELIVERED THROUGH MEDICAID SCHOOL PROGRAM PROVIDERS PHYSICAL THERAPY AND RELATED SERVICES MENTAL HEALTH SERVICES DELIVERED THROUGH MEDICAID SCHOOL PROGRAM PROVIDERS CASE MANAGEMENT SERVICES TO CHILDREN AGE 3 TO 21 WITH A DISABILITY (DELIVERED THROUGH PARTICIPATING SCHOOLS)				
11. GOVERNOR'S REVIEW (Check One):				
GOVERNOR'S OFFICE REPORTED NO COMMENT	☑ OTHER, AS SPECI			
COMMENTS OF GOVERNOR'S OFFICE ENCLOSED	Governor has delegated			
NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL	to ODJFS Director. Dir			
12. SIGNATURE OF STATE AGENCY OFFICIAL:	signature authority to 1 16. RETURN TO:	Medicaid Director		
Adu R. Collett /CNC 4/21/08				
13. TYPED NAME John R. Corlett	Becky Jackson OHP/Bureau of Health Plan Policy			
14. TITLE: MEDICAID DIRECTOR	Ohio Department of Job and Family S P.O BOX 182709	iervices		
15. DATE SUBMITTED:	Columbus, Ohio 43218			
FOR REGIONAL OF	FICE USE ONLY			
17. DATE RECEIVED:	18. DATE APPROVED:			
	August 1:	2, 2008		
PLAN APPROVED – ONI				
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFF	ICIAL:		
July 1, 2005	(les			
21. TYPED NAME: Verlon Johnson	22. TITLE: Associate Regional Add	ministrator		
23. REMARKS:				

TRANSMITTAL AND NOTICE OF APPROVAL OF	1. TRANSMITTAL NUMBER:	10.000		
STATE PLAN MATERIAL	0.5 - 020	2. STATE (1)		
STATE PLAN MATERIAL	0 5 - 020	ОНЮ		
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)			
TO: REGIONAL ADMINISTRATOR	4. PROPOSED EFFECTIVE DATE			
CENTERS FOR MEDICARE & MEDICAID SERVICES	July 1, 2005			
DEPARTMENT OF HEALTH AND HUMAN SERVICES	July 1, 2003			
5. TYPE OF PLAN MATERIAL (Check One):				
□ NEW STATE PLAN □ AMENDMENT TO BE O	CONSIDERED AS NEW PLAN			
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19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFF	ICIAL:		
July 1, 2005				
21. TYPED NĀME:	22. TITLE:			
Verlon Johnson	Associate Regional Administrator			
23. REMARKS:				

- 6. Medical care and any other types of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by State law. (Continued)
 - d. Other Practitioners' Services. (Continued)

Nursing Services Delivered Through A Medicaid School Program Provider

Nursing services described here are available when provided through a Medicaid school program provider. Reimbursement for nursing services may require that the services be prescribed by a Medicaid authorized prescriber, who is either a physician, podiatrist, or dentist, licensed by the state and working within his or her scope of practice as defined by Ohio law. Services must be delivered by a licensed registered nurse or licensed practical nurse working within their scope of practice as defined in Ohio law. Such services may include, but are not limited to, tube feeds, bowel and bladder care, catheterizations, dressing changes, and medication administration. Nursing services are also available out side of a Medicaid school program provider as a part of physician services, home health services, ambulatory care center/clinic services, outpatient hospital services, nursing facility services and private duty nursing services.

In order to receive reimbursement for nursing services the Medicaid school program provider must document the service in a child's individualized education program (IEP) developed in accordance with the Individuals with Disabilities Education Act (IDEA) prior to the provision of the service. Services may also include the initial assessment conducted by a licensed registered nurse or licensed practical nurse as a part of the multi-factored evaluation team, and for subsequent assessments and reviews conducted in accordance with IDEA.

Coverage of nursing services provided by a licensed nurse must meet conditions of medical necessity established by the department.

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11. Physical Therapy and related services.

a. Physical Therapy

Reimbursement for physical therapy services requires that the services be prescribed by a Medicaid authorized prescriber, who is either a physician, podiatrist, or dentist, licensed by the state and working within his or her scope of practice as defined by Ohio law. A prescription by a Medicaid authorized prescriber will not be required as a condition for Medicaid reimbursement for services delivered by a Medicaid School Program (MSP) provider, as defined in OAC, if the services are authorized by a licensed practitioner of the healing arts and indicated in an individualized education program (IEP) developed in accordance with the Individuals with Disabilities Education Act (IDEA).

At a minimum, a qualified physical therapist will be a licensed physical therapist, licensed in accordance with Ohio law, who meets the provider qualifications outlined in 42 CFR 440.110.

At a minimum, a qualified physical therapist assistant will be a licensed physical therapist assistant, licensed in accordance with Ohio law, who has completed a two-year program of education. The licensed physical therapist assistant can provide physical therapy only under the supervision of a qualified physical therapist who will conduct face-to-face client evaluations initially and periodically (not less than annually) thereafter to determine the current level of physical functioning of the patient and to identify appropriate therapeutic interventions to address the findings of the evaluation/re-evaluation.

Independent practitioners of physical therapy must also be certified under the Medicare program and must maintain an independent practice as defined and determined under Medicare.

Physical therapy services must be for a reasonable amount, frequency, and duration.

A physician or licensed physical therapist must develop and forward to the Medicaid authorized prescriber a plan of care for the patient that must be based on the evaluation of the patient. The plan of care must include specific therapeutic procedures to be used, specific functional goals, the prescription for services, and updates to the plan of care. For the MSP provider, the plan of care will be included in the individualized education program (IEP) and maintained by the MSP provider.

A physician, licensed physical therapist, or licensed physical therapist assistant working within his or her scope of practice as defined by state law must furnish the physical therapy services in accordance with the patient's plan of care that has been approved by the Medicaid authorized prescriber or in accordance with the IEP.

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TN No. 93-22 Effective Date 7/1/05

Limitations

In accordance with the EPSDT program, children may receive services beyond established limits, when medically necessary and approved through the prior authorization process.

Maintenance services are non-covered services.

b. Occupational Therapy

Medicaid-authorized providers of occupational therapy services include MSP providers and outpatient hospitals.

A prescription by a Medicaid authorized prescriber will not be required as a condition for Medicaid reimbursement of occupational therapy services delivered by a Medicaid School Program (MSP) provider, as defined in OAC, if the services are authorized by a licensed practitioner of the healing arts and indicated in an individualized education program (IEP) developed in accordance with the Individuals with Disabilities Education Act (IDEA).

At a minimum, a qualified occupational therapist will be a licensed occupational therapist, licensed in accordance with Ohio law, who meets the provider qualifications outlined in 42 CFR 440.110.

At a minimum, a qualified occupational therapy assistant will be a licensed occupational therapy assistant, licensed in accordance with Ohio law, who has completed a two-year program of education. The licensed occupational therapy assistant can provide occupational therapy only under the supervision of a qualified occupational therapist who will conduct face-to-face client evaluations initially and periodically (not less than annually) thereafter to determine the current sensory motor functional level of the patient and identifying appropriate therapeutic interventions to address the findings of the evaluation/re-evaluation.

Occupational therapy services must be for a reasonable amount, frequency, and duration. Each period of treatment must begin with an evaluation and end with a progress summary/progress report. If an additional treatment period is indicated, then the period of treatment must end with a re-evaluation. The development of a maintenance plan is covered, but maintenance services are not covered.

For the MSP provider, the plan of care will be included in the individualized education program (IEP) and maintained by the MSP provider.

The MSP provider must furnish the occupational therapy services in accordance with the IEP.

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c. <u>Services for individuals with speech, hearing, and language disorders (provided by or under supervision of a speech pathologist or audiologist).</u>

Services are covered if provided by a Medicaid School Program (MSP) provider or eligible providers of physician services. This includes physicians, employees of a physician working under the supervision of the physician, or clinics (both fee-for-service or cost-based clinics).

Reimbursement for speech language pathology and audiology services requires that the services be prescribed by a doctor of medicine or osteopathy working within his or her scope of practice as defined by Ohio law.

A prescription by a Medicaid authorized prescriber will not be required as a condition for Medicaid reimbursement for services delivered by a MSP provider, as defined in OAC, if the services are authorized by a licensed practitioner of the healing arts and indicated in an individualized education program (IEP) developed in accordance with the Individuals with Disabilities Education Act (IDEA).

At a minimum, a qualified speech-language pathologist (SLP) will be a licensed SLP, licensed in accordance with Ohio law, who meets the provider qualifications outlined in 42 CFR 440.110.

At a minimum, a qualified audiologist will be a licensed audiologist, licensed in accordance with Ohio law, who meets the provider qualifications outlined in 42 CFR 440.110.

At a minimum, qualified speech-language pathology and audiology (SLPA) aides will be licensed SLPA aides, licensed in accordance with Ohio law, who have completed training requirements as outlined in the approved application and specific to assigned tasks. The licensed speech-language pathologist or audiologist who signs the application for the aide shall supervise that particular aide. The aide may provide services only under the supervision of the speech-language pathology or audiology supervisor of record for that applicant who will conduct face-to-face client evaluations initially and periodically (not less than annually) thereafter to determine the current level of speech-language of the patient and to identify the appropriate speech-language treatment to address the findings of the evaluation/re-evaluation.

Speech-language pathology and audiology services must be for a reasonable amount, frequency, and duration. Each period of treatment must begin with an evaluation and end with a progress summary/progress report. If an additional treatment period is indicated, then the period of treatment must end with a re-evaluation. The development of a maintenance plan is covered, but maintenance services are not covered.

For the MSP provider, the plan of care will be included in the individualized education program (IEP) and maintained by the MSP provider.

The MSP provider must furnish the speech-language pathology or audiology services in accordance with the IEP.

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TN No. <u>NEW Effective Date 7/1/05</u>

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan. (Continued)

d. Rehabilitative services. (Continued)

1.(a) MENTAL HEALTH SERVICES DELIVERED THROUGH A MEDICAID SCHOOL PROGRAM PROVIDER

Counseling, social work and psychology/school psychology services described here are available when provided through a Medicaid school program provider when the service is recommended by a licensed counselor, social worker, or psychologist/school psychologist acting within the scope of his or her practice as defined in Ohio law. These services will be provided in compliance with 42 CFR 440.130. Counseling, social work and psychology/school psychology (mental health) services are also available through the community mental health system.

In order to be reimbursed for the provision of counseling, social work and psychology/school psychology services provided through a Medicaid school program provider the service must be documented in a child's individualized education program (IEP) developed in accordance with the Individuals with Disabilities Education Act (IDEA) prior to the provision of the service. Services may include, but are not limited to behavioral health counseling and therapy, mental interactive psychotherapy, individual health assessment. psychotherapy and family therapy when services are provided to or for the Medicaid eligible child to maximize the reduction of a mental disability and to restore the child to his best possible functional level. Services may also include the initial assessment conducted by a licensed counselor, psychologist/school psychologist or social worker as a part of the multi-factored evaluation team and for subsequent assessments and reviews conducted in accordance with IDEA.

Qualified practitioner who can deliver the services:

Licensed clinical counselor who holds a current, valid license to practice issued under Ohio Revised Code, and who holds a graduate degree in counseling from an accredited educational institution, completes a minimum of ninety quarter hours of graduate credit in counselor training, and has had 2 years post-graduate or 1 year post-doctorate supervised experience in counseling.

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SUPERSEDES		-
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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan. (Continued)

d. Rehabilitative services. (Continued)

1.(a) MENTAL HEALTH SERVICES DELIVERED THROUGH A MEDICAID SCHOOL PROGRAM PROVIDER

Licensed counselor who holds a current, valid license to practice issued under Ohio Revised Code, and who holds a graduate degree in counseling from an accredited educational institution and complete a minimum of ninety quarter hours of in-graduate or post-graduate credit in counselor training.

Licensed independent social worker who holds a current, valid license to practice issued under Ohio Revised Code, and who holds a master or doctorate degree in social work from an accredited educational institution and complete at least two years of post-master's degree social work experience supervised by an independent social worker.

Licensed social worker who holds a current, valid license to practice issued under Ohio Revised Code, and who holds from an accredited educational institution either a baccalaureate degree in social work, a baccalaureate degree in a program closely related to social work (prior to October 10, 1992 and approved by the committee), a master of social work degree, or a doctorate in social work.

Licensed psychologist who holds a current, valid license to practice psychology issued under Ohio Revised Code, who has received from an educational institution accredited or recognized by national or regional accrediting agencies as maintaining satisfactory standards an earned doctoral degree in psychology, school psychology, or a doctoral degree deemed equivalent by the Ohio State Board of Psychology the board), and has had at least two years of supervised professional experience in psychological work of a type satisfactory to the board, at least one year of which must be postdoctoral.

Licensed school psychologist who holds a current, valid license to practice school psychology issued under Ohio Revised Code, who has received from an educational institution accredited or recognized by

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13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan. (Continued)

d. Rehabilitative services. (Continued)

1.(a) MENTAL HEALTH SERVICES DELIVERED THROUGH A MEDICAID SCHOOL PROGRAM PROVIDER

national or regional accrediting agencies as maintaining satisfactory standards, including those approved by the state board of education for the training of school psychologists, at least a master's degree in school psychology, or a degree considered equivalent by the board; has completed at least sixty quarter hours, or the semester hours equivalent, at the graduate level, of accredited study in course work relevant to the study of school psychology.

Coverage of counseling and psychology/school psychology services provided by a licensed counselor, psychologist/school psychologist or social worker must meet conditions of medical necessity established by the department.

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TN No new

CASE MANAGEMENT SERVICES TO CHILDREN AGE 3 TO 21 WITH A DISABILITY (DELIVERED THROUGH PARTICIPATING SCHOOLS)

A. <u>Target Group</u>: Medicaid eligible child age 3 to 21 with a developmental disability as defined in section 5123.01 of the Ohio Revised Code who, by reason thereof, requires special education in accordance with the Ohio Revised Code and who are not receiving targeted case management (TCM) from county boards of Mental Retardation and Development Disabilities (MRDD).

Developmental disability as defined in section 5123.01 of the Ohio Revised Code means a severe, chronic disability that is characterized by all of the following:

- 1. It is attributable to a mental or physical impairment or a combination of mental and physical impairments, other than a mental or physical impairment solely caused by mental illness as defined in division (A) of section 5122.01 of the Revised Code.
- 2. It is manifested before age twenty-two.
- 3. It is likely to continue indefinitely.
- 4. It results in one of the following:
 - a. In the case of a person under three years of age, at least one developmental delay or an established risk;
 - b. In the case of a person at least three years of age but under six years of age, at least two developmental delays or an established risk;
 - c. In the case of a person six years of age or older, a substantial functional limitation in at least three of the following areas of major life activity, as appropriate for the person's age: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and, if the person is at least sixteen years of age, capacity for economic self-sufficiency.
- 5. It causes the person to need a combination and sequence of special, interdisciplinary, or other type of care, treatment, or provision of services for an extended period of time that is individually planned and coordinated for the person.
- B. Areas of State in which services will be provided:

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CASE MANAGEMENT SERVICES TO CHILDREN AGE 3 TO 21 WITH A DISABILITY (DELIVERED THROUGH PARTICIPATING SCHOOLS)

	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:
C.	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 these services.
D.	Definition of Services: Case management services are defined as those services identified by the multi-factored evaluation team of the provider as a Medicaid targeted case management service in a child's IEP and delivered by a qualified case manager that will assist the child in gaining access to medical, social, educational and other needed services relative to the educational needs identified in the child's IEP. The IEP team will identify the need for special education. The amount, scope and duration of the case management services, as well as the case manager responsible for providing the case management service, will be indicated in the child's IEP developed in accordance with the Individuals with Disabilities Education Act (IDEA). The components of the case management services are:
	 Assessment (initial assessment conducted by a qualified case manager as a part of the multi-factored evaluation when the initial assessment results in case management services delivered as part of an IEP developed within eleven months of assessment, and for subsequent TN No. 05-020 APPROVAL DATE: APPROVAL DATE: 7H/05 TN No. new EFFECTIVE DATE: 7H/05

CASE MANAGEMENT SERVICES TO CHILDREN AGE 3 TO 21 WITH A DISABILITY (DELIVERED THROUGH PARTICIPATING SCHOOLS)

assessments and reviews conducted in accordance with IDEA)

- Care Planning
- Referral and Linkage
- Monitoring and Follow-Up

The service unit for case management will be 15 minutes.

The frequency, scope and duration of services will be as recommended by the case manager.

- E. Qualification of Providers: Qualified providers are local education agencies (for purposes of this state plan amendment, this includes a city, local, or exempted village school district in Ohio as defined respectively in sections 3311.02 through 3311.04 of the Ohio Revised Code), community schools defined in Chapter 3314. of the Ohio Revised Code, and the state school for the deaf and the state school for the blind described in section 3325.01 of the Ohio Revised Code. The provider will employ or contract with (an) individual(s) to deliver case management The individual(s) employed to services to recipients. provide case management will be one of the following: 1) a registered nurse with an Ohio license, 2) an individual with a baccalaureate degree with a major in education or social work, 3) an individual who has earned credit in course work equivalent to that required for a major in a specific special education area, or 4) a person who has a minimum of three (3) years personal experience in the direct care of an individual with special needs.
- F. 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.

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CASE MANAGEMENT SERVICES TO CHILDREN AGE 3 TO 21 WITH A DISABILITY (DELIVERED THROUGH PARTICIPATING SCHOOLS)

- 1. Eligible recipients will have free choice of the providers of other medical care under the plan.
- The state will limit providers of case management for children age 3 to 21 with a developmental disability to local education agencies, community schools, and the state school for the deaf and the state school for the blind.

G. The State further assures:

- 1. Case management services will not be used to restrict an individual's access to other services under the plan.
- 2. Individuals will not be compelled to receive case management services, that receipt of case management services will not be conditioned on the receipt of other Medicaid services, and that the receipt of other Medicaid services will not be conditioned on the receipt of case management services.
- 3. Individuals will receive comprehensive, case management services, on a one-to-one basis, through one case manager.
- 4. Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.
- 5. Providers maintain case records that document for all individuals receiving case management the following: the name of the individual; dates of the case management services; the name of the provider agency (if relevant) and the person providing the case management service; the nature, content, units of the case management services received and whether goals

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CASE MANAGEMENT SERVICES TO CHILDREN AGE 3 TO 21 WITH A DISABILITY (DELIVERED THROUGH PARTICIPATING SCHOOLS)

specified in the care plan have been achieved; whether the individual has declined services in the care plan; the need for, and occurrences of, coordination with other, non-Medicaid case managers; the timeline for obtaining needed services; and a timeline for reevaluation of the plan.

H. Payment for case management services under the plan does not duplicate payments made to schools participating in the Ohio Public Schools Medicaid Administrative Claiming program, or private entities under other program authorities for this same purpose, nor will county boards of MRDD receive reimbursement for services that duplicate case management services rendered by the local education agency or state school. will be collected for targeted case management services FFP provided to an individual child only where information is obtained from each Medicaid beneficiary and billing of all third party liability is documented and such filing is permitted under the IDEA. Payment under the plan will be for targeted case management services provided to a child with a developmental disability and identified in the child's IEP established pursuant to part B of the Individuals with Disabilities Education Act.

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Cost-Based Reimbursement for IDEA Services Provided in Schools

- The reimbursement for providers, other than Medicaid school program providers, is based on the lesser of the billed charge or the Medicaid maximum for the particular service performed according to the department's procedure code reference file.
- 2. Effective for dates of service on and after (<u>date approved by CMS</u>), reimbursement for direct medical services (salaries, benefits, and contract compensation) provided by a school approved as a Medicaid school program provider of services will be at an interim rate which will be the lesser of the billed charge or the Medicaid maximum for the particular service according to the department's procedure code reference file. The interim rate is the rate for a specific service for a period that is provisional in nature, pending the completion of a cost reconciliation and a cost settlement for that period. Services delivered through a Medicaid school program provider that are allowable for Medicaid reimbursement are:
 - a. Audiology (reference pre-print page 4, item 11)
 - b. Counseling (reference pre-print pages 5 and 6, item 13)
 - c. Nursing (reference pre-print pages 2 and 3, item 6)
 - d. Occupational Therapy (reference pre-print page 4, item 11)
 - e. Physical Therapy (reference pre-print page 4, item 11)
 - f. Psychology (reference pre-print pages 5 and 6, item 13)
 - g. Social Work (reference pre-print pages 5 and 6, item 13)
 - h. Speech Language Pathology (reference pre-print page 4, item 11)
 - i. Targeted Case Management (reference pre-print page 8, item 19)
 - j. Transportation Reimbursed per unit of service. The unit of service is based on a one-way trip. (reference pre-print page 9, item 24)
- 3. Certification of public expenditures: The non-federal share of the cost of the services will be paid by the Medicaid school program provider. The Medicaid school program provider shall certify, via attestation at the time of claiming, the availability of appropriate and sufficient non-federal share of the costs for which claim for reimbursement is made. The single state Medicaid agency (ODJFS) will reimburse the Medicaid school program provider at the interim rate the federal financial participation (FFP) portion of the claim only.
- 4. Reimbursement for other direct medical services (ex. Travel, materials and supplies), indirect costs, and equipment will be made through the cost report reconciliation process.
- 5. To determine the Medicaid-allowable direct and indirect costs of providing direct medical services to Medicaid-eligible clients, the following steps are performed:

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Cost-Based Reimbursement for IDEA Services Provided in Schools

- a. Direct costs for direct medical services include unallocated payroll costs and other unallocated costs that can be directly charged to direct medical services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct services personnel listed in the descriptions of the covered Medicaid services delivered by schools, excluding transportation personnel.
- b. Other direct costs include costs directly related to the approved direct services personnel for the delivery of medical services, such as purchased services, capital outlay, travel, materials and supplies. These direct costs are accumulated on the annual cost report, resulting in total direct costs.
- Total direct costs for direct medical services are reduced by any federal payments for those costs, resulting in <u>adjusted direct costs</u> for direct medical services.
- d. Adjusted direct costs are then allocated to direct medical services regardless of payer source by applying the direct medical services percentage from the CMS-approved time study, resulting in <u>net direct</u> costs.
- e. A CMS-approved time study methodology is used to determine the percentage of time that medical service personnel spend on direct medical services, including targeted case management, general and administrative time and all other activities to account for 100 percent of time to assure that there is no duplicate claiming. This time study methodology will utilize three mutually exclusive cost pools representing individuals performing administrative activities and direct services. A sufficient number of medical services personnel will be sampled to ensure time study results that will have a confidence level of at least 98 percent within a precision of plus or minus two percent overall. The same single direct medical services time study percentage is applied against costs for all medical disciplines.
- f. Indirect costs are determined by applying the school district's specific unrestricted indirect cost rate to its *net direct costs* as approved by ODE under the authority of USDE, which is the cognizant agency for school districts.
- g. Net direct costs and indirect costs are combined, and the results are multiplied by the ratio of the total number of students with Individualized Education Programs (IEPs) receiving medical services and eligible for Medicaid to the total number of students with IEPs receiving medical services.
- h. To determine the direct and indirect costs of specialized transportation services to Medicaid-eligible students, the following steps are performed:

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Cost-Based Reimbursement for IDEA Services Provided in Schools

- i. Identification of direct costs for covered specialized transportation services includes: direct payroll costs (salaries and benefits and contract compensation) of bus drivers and mechanics, gasoline and other fuels, other maintenance and repair costs, vehicle insurance, rentals, and vehicle depreciation. Depreciation must be documented by completing the depreciation schedule in the cost report. These direct costs are accumulated on the annual cost report, resulting in total direct transportation costs.
- ii. <u>Total direct transportation costs</u> are reduced by any federal payments for those costs, resulting in <u>adjusted direct transportation costs</u>.
- iii. Adjusted direct transportation cots are then allocated to Medicaid by applying the ratio of one-way trips provided pursuant to an IEP to Medicaid beneficiaries over total one-way specialized trips resulting in net direct transportation costs. Trip logs will be maintained daily to record one-way specialized transportation trips.
- iv. Indirect costs are determined by applying the school district's specific unrestricted indirect cost rate to its *net direct transportation costs* as approved by ODE under the authority of USDE, which is the cognizant agency for school districts.
- v. Net direct costs and indirect costs are combined.
- 6. Annual Cost Report Process: Each Medicaid school program provider will complete an annual cost report for all services delivered during the previous state fiscal year covering July 1 through June 30. The primary purposes of the cost report are to:
 - a. Document the provider's total CMS-approved, Medicaid-allowable scope
 of costs for delivering Medicaid school services, including direct costs and
 indirect costs, based on a CMS-approved cost allocation methodology and
 procedures, and
 - b. Reconcile its interim payments to its total CMS-approved Medicaidallowable scope of costs based on CMS-approved cost allocation procedures.
- 7. The Cost Reconciliation Process: The cost reconciliation process will be completed within twelve (12) months of the State fiscal year. The total CMS-approved, Medicaid allowable scope of costs based on CMS-approved cost allocation methodology procedures are compared to the provider's Medicaid interim payments for school services delivered during the reporting period as documented in the Medicaid Management Information System (MMIS), resulting in cost reconciliation.

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Cost-Based Reimbursement for IDEA Services Provided in Schools

For the purposes of cost reconciliation, Ohio will not modify the CMS-approved scope of costs, the CMS-approved cost allocation methodology procedures, or the CMS-approved time study for cost-reporting purposes referenced in this state plan amendment except by CMS approval prior to implementation; however, such approval does not necessarily require the submission of a new state plan amendment.

For claims submitted after the effective date of SPA 05-007 and SPA 05-020; that is July 1, 2005, and prior to the implementation of the CMS-approved time study only, cost reconciliation will be performed in accordance with a methodology developed by the Department and approved by CMS that utilizes the quarterly results of the prospectively approved time study and applies them to prior period claims.

8. Cost Settlement for a Medicaid school program provider: The actual Medicaid share of each Medicaid school programs provider's costs for the year will be compared to the total Medicaid reimbursements to the Medicaid school program provider for that year. Any overpayment determined as a result of the annual reconciliation of cost will be paid and/or collected and reimbursed in accordance with State and federal Medicaid rules. Any underpayment determined as a result of the annual reconciliation of cost will be paid in accordance with State and federal Medicaid rules.

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