5101:3-48-01 **Medicaid coverage of targeted case management services provided to individuals with mental retardation and developmental disabilities.**

(A) Purpose.

(1) This rule specifies the conditions for medicaid payment of targeted case management (TCM), which is comprised of those activities described in section 5126.15 of the Revised Code and in rule 5123:2-1-11 of the Administrative Code, but only to the extent that they are listed in paragraph (D) of this rule as reimbursable activities for medicaid eligible individuals with mental retardation and/or a developmental disability.

(2) The department of mental retardation and developmental disabilities (ODMRDD), through an interagency agreement with the department of job and family services (ODJFS), administers the TCM program on a daily basis in accordance with section 5111.91 of the Revised Code.

(B) Definitions.

(1) "IEP" means an individualized education ~~plan~~ program and has the same meaning as described in rule 3301-51-07 of the Administrative Code.

(2) "Institution" means a nursing facility, an intermediate care facility for the mentally retarded (ICF/MR), a state-operated intermediate care facility for the mentally retarded (ICF/MR) or a medical institution.

(3) "ISP" means an individualized service plan as defined in rule 5123:2-1-11 of the Administrative Code.

(4) "Major unusual incident" (MUI) has the same meaning as defined in rule 5123:2-17-02 of the Administrative Code.

(5) "Service and support administration" has the same meaning as described in section 5126.15 of the Revised Code.

(6) "Targeted case management" means services which will assist individuals in gaining access to needed medical, social, educational and other services as described in this rule. Targeted case management is also referred to as medicaid case management.

(7) "Unusual incident" has the same meaning as defined in rule 5123:2-17-02 of the Administrative Code.

(C) Eligible individuals.

(1) Individuals eligible for medicaid coverage of TCM services are:

(a) Medicaid eligible individuals, regardless of age, who are enrolled on home and community-based service (HCBS) waivers administered by the ODMRDD, and

(b) All other medicaid eligible individuals, age three or above, who are determined to have mental retardation or other developmental disability according to section 5126.01 of the Revised Code.

(D) Reimbursable activities.

(1) Medicaid services listed in paragraph (D) are reimbursable only if provided to or on behalf of a medicaid eligible individual as defined in paragraph (C) of this rule and by qualified providers as defined in paragraph (E) of this rule. Payment for targeted case management services may not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Medicaid reimbursable TCM services are:

(a) Assessment. Activities reimbursable under the assessment category are limited to the following:

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

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

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

(b) Care planning. Activities reimbursable under the care planning category are limited to the following:

(i) Activities related to ensuring the active participation of the ~~medicaid-~~eligible individual and working with the eligible individual and others to develop goals and identify a course of action to respond to the assessed needs of the ~~medicaid-~~eligible individual. ~~This activity results~~ These activities result in the development, monitoring, and on-going revision of an individualized service plan (ISP).

(c) Referral and linkage. Activities reimbursable under the referral and linkage category are limited to the following:

(i) Activities that help link ~~medicaid-~~eligible individuals with medical, social, educational providers and/or other programs and services that are capable of providing needed services.

(d) Monitoring and follow-up. Activities reimbursable under the monitoring and follow-up category are limited to the following:

(i) Activities and contacts that are necessary to ensure that the ISP is effectively implemented and adequately addresses the needs of the ~~medicaid-~~eligible individual.

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

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

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

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

(e) State hearings: Activities reimbursable under the state hearing category are limited to the following:

(i) Activities performed to assist an eligible individual in preparing for a state hearing related to the reduction, termination or denial of a service on an ISP.

(2) Coverage exclusions.

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

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

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

(d) The provision of direct services (medical, educational, vocational, transportation, or social services) to which the ~~medicaid~~ eligible individual has been referred.

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

(f) Conducting quality assurance systems reviews.

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

(h) ~~Does not include payment~~ Payment or coverage for establishing budgets for services outside of the scope of individual assessment and care planning.

(i) Activities related to the development, ~~or~~ monitoring or implementation of

an individualized education ~~plan~~ program (IEP).

(j) Services provided to groups of individuals.

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

(l) Eligibility determinations for county board of mental retardation and developmental disabilities (CBMRDD) services.

(E) Qualified providers.

(1) Qualified providers of medicaid TCM services are ~~county boards of mental retardation and developmental disabilities (~~CBMRDD~~)~~ as established under Chapter 5126. of the Revised Code. Only those eligible activities as defined in this rule performed by CBMRDD employees or CBMRDD sub-contractors meeting the registration or certification standards contained in rule 5123:2-5-02 of the Administrative Code are eligible for payment.

(F) Documentation requirements.

(1) To receive medicaid reimbursement for TCM activities provided under this rule, documentation must include, but is not limited to, the following elements:

(a) The date that the activity was provided, including the year;

(b) The name of the person for whom the activity was provided;

(c) A description of the activity provided and location of the activity delivery (may be in case notes or a coded system with a corresponding key);

(d) The duration in minutes or time in/time out of the activity provided. Duration in minutes is acceptable if the provider's schedule is maintained on file;

(e) The identification of the activity provider by signature or initials on each entry of service delivery. Each documentation recording sheet must contain a legend that indicates the service provider's name (typed or printed), title, signature, and initials to correspond with each entry's identifying signature or initials.

~~(f) Each provider's financial and statistical information used to substantiate costs incurred must be current, accurate, and in sufficient detail to support payments made for services rendered to beneficiaries. This includes all ledgers, books, records and original evidence of cost, purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payroll, and any other basis for apportioning cost.~~

~~(2) For the purpose of this rule, a unit of service is equivalent to fifteen minutes. Minutes of service provided to a specific medicaid eligible individual can be accrued over one calendar day. The number of units that may be billed during a day is equivalent to the total number of minutes of TCM provided during the day for a specific medicaid eligible individual divided by fifteen plus one additional unit if the remainder from the division is eight or greater minutes.~~

~~(3) Billable units of service are those tasks/contacts made with the eligible individual or on behalf of the eligible individual. Activities which are not performed on behalf of or are not specific to an individual are not billable.~~

(G) Reimbursement and claims submission.

(1) Each CBMRDD shall maintain a current fee schedule of usual and customary charges. ~~for each service.~~ Records of fee schedules must be maintained for a period of six years. The CBMRDD shall bill ODMRDD its usual and customary charge for a TCM covered service. TCM services will be reimbursed the lesser of the CBMRDD's usual and customary charge or the rate ~~as delineated in accordance with appendix A of this rule, subject to year-end cost settlement~~. found in appendix A of this rule for the cost of doing business (CODB) region in which the service is delivered.

(2) Each CBMRDD is responsible for instituting collection efforts against ~~individual(s) or~~ third party liability companies ~~in order to recover unpaid costs related to rendering~~ for TCM services. ~~to non-medicaid eligible individuals.~~ The CBMRDD must maintain sufficient documentation to substantiate collection activities and any payments received. CBMRDDs shall not alter or adjust usual and customary rates charged to the medicaid program if such adjustments will result in a direct or indirect charge for costs of uncompensated care being charged to the medicaid program.

(3) CBMRDDs are required to submit claims to ODMRDD within three hundred thirty days from the date of service in accordance with the format specified by ODMRDD. Failure to submit claims within the specified three hundred thirty days may result in the CBMRDD not being reimbursed for such claims. The CBMRDD shall have no recourse to recover such non-reimbursed

claims.

~~(4) CBMRDDs which certify expenditure of their own public funds as representing expenditures eligible for federal financial participation (FFP) in accordance with 42 CFR 433.51 as in effect on July 1, 2005, must make a full cash disbursement for any amount prior to submitting claims for reimbursement of such amounts to ODMRDD. Reimbursement will be limited to the FFP amount for such claims. In addition, any such entity shall be deemed to be a sub-recipient and shall operate in accordance with "OMB Circular A-133", available at http://www.whitehouse.gov/omb/circulars/a133/a133.html as in effect on July 1, 2005, and 45 CFR part 92 as in effect on July 1, 2005.~~

~~(5)~~(4) Medicaid reimbursement for TCM services shall constitute payment in full. Medicaid recipients may not be billed for medicaid covered services.

~~(6)~~(5) In the event a fiscal review reveals that an overpayment has been made, and/or there is a disallowance of medicaid payments, the amount of the overpayment and/or disallowance shall be recovered from the CBMRDD no later than sixty days from the date that the state notifies the CBMRDD of the overpayment in accordance with 42 CFR 433.300 to 433.322 as in effect on January 1, 2006.

~~(7)~~(6) Payment for TCM services must not duplicate payments made to ~~providers~~ CBMRDD under other programs.

(7) To support the provision of providing TCM through fee for service, utilization review procedures will be incorporated to assure compliance with 42 CFR Part 456 as in effect on January 1, 2006.

(8) Records relating to TCM services shall be made available to ODMRDD, ODJFS, centers for medicare and medicaid services (CMS) or any of their representatives to verify actual units of service provided are in compliance with federal requirements and are adequately supported.

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

(10) Billable units of service are those tasks/contacts made with the eligible individual or on behalf of the eligible individual. Activities which are not performed on behalf of or are not specific to an eligible individual are not billable.

(H) Record requests and retention.

(1) CBMRDD shall make available all records including but not limited to work papers, supporting reports, medical reports, progress notes, charges, journals, ledgers, computer tapes, computer disks, and fiscal reports for review by representatives from ODJFS, ODJFS' designee, CMS, or ODMRDD at the discretion and request of these representatives.

(2) Documentation will be retained for a period of six years from the date of receipt of final payment or until such time as a lawsuit or audit finding has been resolved, whichever is longer. The records shall be provided to ODJFS or its designee upon request in a timely manner. Records produced electronically must be produced at the provider's expense, in the format specific by state or federal authorities.

~~(H) Cost reports, fiscal reviews and record retention.~~

~~(1) Annually, CBMRDDs shall submit to ODMRDD a cost report no later than ninety days after the close of the calendar year, or as otherwise specified by ODJFS, using the format specified by ODMRDD.~~

~~(2) Allowable and reasonable costs on the cost report will be determined in accordance with the provider reimbursement manual, "CMS Publication 15-1," available at www.cms.hhs.gov/manuals/cmstoc.asp, cost principles for state, local, and Indian tribal governments, and "OMB Circular A-87," available at http://www.whitehouse.gov/omb/circulars/a087/a87_2004.html as in effect on July 1, 2005.~~

~~(3) The annual cost report submitted by each CBMRDD shall include a statement of reconciliation comparing TCM medicaid revenues to allowable and allocable TCM medicaid expenditures. All CBMRDD cost reports shall accurately reflect all medicaid and non-medicaid units of service provided. Reconciliation shall incorporate minimum efficiency units into the calculation of actual cost.~~

~~(4) When a CBMRDD allowable TCM medicaid cost is less than the TCM medicaid revenue paid, the CBMRDD shall repay the excess according to a process specified by ODMRDD. Where a CBMRDD allowable TCM medicaid service cost is greater than the TCM medicaid service revenue, the CBMRDD will not be paid any additional medicaid revenue. Repayment shall not be construed as a final settlement or a final fiscal audit.~~

~~(5) As they deem necessary, ODJFS, ODMRDD and/or centers for medicare and medicaid services (CMS) representatives or other cognizant agencies may conduct an audit of a CBMRDD or of any cost report filed in accordance with this rule. As a result of inconsistent, incomplete, and/or inaccurate cost~~

reporting ODJFS or ODMRDD may require a CBMRDD to contract with a public accounting firm for the auditing of that CBMRDD's cost reports filed in accordance with paragraph (H)(1) of this rule.

(6) The contract identified in paragraph (H)(5) of this rule shall contain terms that comply with the following:

(a) Include a written summary indicating whether the costs and service units included in the report examined during the audit are allowable and allocable and comply with presentation requirements prescribed by ODJFS and ODMRDD and whether in all material aspects allowable costs are documented, reasonable, and related to recipient services; and

(b) Be conducted by public accounting firms who, during the period of the professional engagement or employment and during the period covered by the financial statements, do not have nor are committed to acquire any direct or indirect financial interest in the ownership, financing, or operation of a CBMRDD; and

(c) Be conducted by public accounting firms who, as a condition of the contract or employment, shall not audit any CBMRDD for whom they have prepared the cost report being audited; and

(d) Be conducted by public accounting firms who are otherwise independent as determined by the standards of independence established by the comptroller general of the united states in "Government Auditing Standards."

(e) The public accounting firm's working papers, including permanent files and reviews of internal control, are to be made available to the representatives of CMS, ODJFS, ODMRDD, or their designee, at all reasonable times, for review and obtaining any necessary information. All costs related to reproduction or copying of working paper records, as deemed necessary by CMS, ODJFS, ODMRDD, or their designee, shall be borne by the public accounting firm.

(f) The audit working papers must be retained by the public accounting firm for a period of three years following the final settlement of the audit. Further, whenever an audit is made by the staff of ODMRDD or ODJFS, the audit working papers for such audits shall be retained for a period of three years following the final settlement for the period subject to audit.

(7) CBMRDDs shall make available work papers, supporting reports, and summaries for review by representatives of ODJFS and ODMRDD at the discretion of these representatives.

~~(8) Notwithstanding the requirements in paragraph (H)(6)(f) of this rule, all records including but not limited to work papers, medical reports, progress notes, charges, journals, ledgers, computer tapes, computer disks, and fiscal reports will be retained for a period of six years from the date of receipt of final payment or until such time as a lawsuit or audit finding has been resolved whichever is longer. The records shall be provided to ODJFS or its designee upon request in a timely manner. Records produced electronically must be produced at the provider's expense, in the format specified by state or federal authorities.~~

(I) Monitoring, compliance and sanctions.

~~(1) A desk review will be performed by ODMRDD on all annual cost reports for the purpose of determining reasonable cost of payments made to providers. Desk review procedures, as established by ODMRDD and approved by ODJFS, will take into consideration the relationship between prior and current year costs, peer group norms, funding level, units of service provided, and the results of any external or internal audit findings as deemed appropriate. Providers are responsible for replying to or supplying any additional documentation to address issues encountered or irregularities identified during the desk review process. ODMRDD shall notify ODJFS of the desk review results.~~

~~(2) ODMRDD or their designee shall annually perform field audits. The audits will be based on an assessment of relative risks and random selection. The performance of such audits will begin one full year after the end of each reporting period (calendar year).~~

~~(3)~~(1) ODMRDD shall conduct periodic monitoring and compliance reviews related to TCM as authorized by the Revised Code. Reviews may consist of, but are not limited to, physical inspections of records and sites where services are provided, interviews of providers, recipients, and administrators. Qualified providers as defined in paragraph (E) of this rule, in accordance with the medicaid provider agreement and ODMRDD, shall furnish to ODMRDD, ODJFS, CMS, and the medicaid fraud control unit or their designees any records related to the administration and/or provision of TCM services.

(2) Annually, ODMRDD will conduct a post review of one hundred per cent of paid claims that exceed twenty-four units (six hours) of service provision in a given day to a specific individual. ODMRDD will review data and documentation for appropriate and efficient utilization by county board and by service and support administrator. A referral to the accreditation unit will occur should a plan of correction be needed to address utilization efficiency

or appropriateness.

~~(4)~~(3) ODJFS will monitor the activities of ODMRDD, as necessary, to ensure that funding applicable to the TCM program is used for authorized purposes in compliance with laws, regulations, and the provisions of the interagency agreement ~~in order to satisfy the requirements of OMB Circular A-133, §.400(d). ODJFS will also assure that all required desk reviews, audits, and settlements are correctly performed in a timely manner~~.

(J) Due process.

(1) Medicaid eligible individuals whose TCM services either affect the provision of services or whose TCM services are affected by any decision may appeal that decision at a medicaid state fair hearing. CBMRDDs must provide notice to the individual of their right to request a state fair hearing.

(2) If an eligible individual requests a hearing, as specified in Chapters 5101:6-1 to 5101:6-9 of the Administrative Code, the participation of ODMRDD, and/or ODJFS, and the CBMRDD is required during the hearing proceedings to justify the decision under appeal.

(3) All rules related to medicaid due process shall be interpreted in a manner consistent with section 1.11 of the Revised Code, which requires that they be liberally construed in order to promote their objective and assist the individual in obtaining justice. All rules relating to the right to a hearing and limitations on that right shall be interpreted in favor of the right to a hearing.

~~(K) Designation of local matching funds.~~

~~(1) CBMRDDs shall be responsible for payment of the non-federal matching funds for TCM services for each medicaid eligible individual as defined in section 5126.057 of the Revised Code. ODMRDD shall be responsible for the non-federal matching funds for TCM services for each medicaid eligible individual as defined in section 5123.047 of the Revised Code.~~

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Certification

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Date

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