DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

CORRECTED

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 0 8 – 0 9

2. STATE: Oklahoma

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

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
March 3, 2008

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION
42 CFR Parts 431, 440, and 441

7. FEDERAL BUDGET IMPACT
a. FFY 2008 $ 0
b. FFY 2009 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Refer to Attachment

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Refer to Attachment

10. SUBJECT OF AMENDMENT
Targeted Case Management for persons with mental retardation and/or related conditions who are served by the HCBS Waivers or individuals who reside in institutions and have requested HCBWS and receive TCM services during the transition period or who are being assessed for admission to HCBW

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

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
The Governor does not review State Plan material.

12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPED NAME
Mike Fogarty

14. TITLE
Chief Executive Officer

15. DATE SUBMITTED
March 31, 2008

16. RETURN TO
Oklahoma Health Care Authority
Attn: Cindy Roberts
4545 N. Lincoln Blvd., Suite 124
Oklahoma City, OK 73105

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
31 March, 2008

18. DATE APPROVED
25 August, 2010

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
3 March, 2008

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME
Bill Brooks

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

23. REMARKS
c: Mike Fogarty
Cindy Roberts
Tywanda Cox
Traylor Rains

FORM CMS-179 (07/92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

TARGETED CASE MANAGEMENT SERVICES

Target Group [42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)]:
The target group is persons with mental retardation and/or related conditions who are served by the Home and Community Based Services (HCBS) Waiver; or individuals who reside in institutions and have requested HCBS and receive TCM prior to entering the waiver; or who are being assessed for admission to the HCBS Waivers.

__X__ Target group includes individuals transitioning to a community setting. Case management services will be made available for up to 180 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 of the Act):
X Entire State
_ Only in the following geographic areas:

Comparability of services [§1902(a)(10)(B) and 1915(g)(1)]
___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
_X_ Services are not comparable in amount, duration, and scope [§1915(g)(1)]

Definition of services [42 CFR 440.169(b)]: Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services. Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. These assessment activities include:
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

  Assessments are completed prior to enrollment in the home and community based waivers and at least annually thereafter in order to identify needs and develop and update the plan of care.

Revised 03-03-08

SUPERSEDES: TN- 01-08

STATE Oklahoma
DATE REC'D 3-31-08
DATE APP'D 8-25-10
DATE EFF 3-3-08
HCFA 179 08-09

A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Targeted Case Management (continued)
Definition of services (continued)

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;

- Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

- Monitoring and follow-up activities:
  - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
    1. services are being furnished in accordance with the individuals' care plan;
    2. services in the care plan are adequate; and
    3. changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

    Case managers conduct monitoring and follow up activities based on the needs of the participant. At a minimum, case managers conduct face-to-face visits twice a year to monitor the participant's health and welfare and the effectiveness of the plan of care in meeting the participant's needs. Case managers may also observe service delivery and review related documentation, talk with participants, family members, guardians, advocates and service providers regarding the health and welfare of the participant and implementation of the plan of care and its effectiveness in meeting the person's needs in order to identify any follow up or changes needed.

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STATE Oklahoma
DATE REC'D. 3-31-08
DATE APP'D 8-25-10
DATE EFF 3-3-08
HCFA 179 08-09

A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Targeted Case Management (continued)
Definition of services (continued)
Monitoring and follow-up activities (continued)

The case manager must provide documentation to supplement the plan of care which includes:

1. information supporting the selection of outcomes;
2. information supporting the approaches selected;
3. information supporting case management decisions and actions;
4. documentation of communication with the client and, as appropriate, his/her representative;
5. documentation of linkages with resources;
6. documentation of follow-up and monitoring of the plan;
7. other factual information relevant to the case.

_X_ Case management may include 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. [42 CFR 440.169(e)]

Qualifications of providers [42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)]:
Case Management Agency Qualifications:
The provider agency must:

1. meet applicable State and Federal laws governing the participation of providers in the Medicaid program.
2. be certified by the OHCA as a qualified DDSD Provider.

Case Manager Qualifications:

1. Possess a bachelor's degree in human services field and one year of professional experience working directly with persons with mental retardation of other developmental disabilities or in social work, case management, special education, psychology, counseling, vocational rehabilitation, physical therapy, occupational therapy, speech therapy, nursing or a closely related field; or
2. Possess a valid permanent Oklahoma license as approved by the Oklahoma Board of nursing to practice professional nursing (as interim work permit or a temporary license issued by the Oklahoma State Board of Nursing Education will be accepted as long as it remains valid; however, a valid permanent license must be obtained prior to the completion of the probationary period), and one year of professional nursing experience working directly with persons with mental retardation or other developmental disabilities; or one year of professional nursing experience, and one year working directly with persons with mental retardation or other developmental disabilities.

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SUPERSEDES: TN- 97-14

STATE Oklahoma
DATE REC'D 3-31-08
DATE APP'D 8-25-10
DATE EFF 3-3-08
HCFA 179 08-09

A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Targeted Case Management (continued)
Case Manager Qualifications (continued)

3. Case managers will be required to possess necessary qualifications to be a qualified Mental Retardation Professional as defined in the Conditions of Participation for Intermediate Care Facilities for the Mentally Retarded.
4. Possess knowledge of:
   a. Case management methods, principles and techniques;
   b. Types of developmental disabilities represented within the caseload;
   c. Types of providers and services available for consumers;
   d. The behavioral sciences and allied disciplines involved in the evaluation, care and training of persons with developmental disabilities;
   e. Interviewing principles and techniques;
   f. Adaptive communication techniques and non-verbal communication.
5. Possess skill in:
   a. Managing a caseload;
   b. Effectively intervening in crisis situations;
   c. Working cooperatively and effectively with other professionals in a team situation;
   d. Collecting and analyzing information;
   e. Making decisions relating to services provided to consumers;
   f. Developing a logical and practical plan of treatment for consumers with developmental disabilities;
   g. Evaluating the progress of consumers and the qualify of their habilitation programs;
   h. communicating effectively;
   i. Mediating with providers and agencies to resolve problems.

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.

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SUPERSEDES: TN- 97-14

STATE Oklahoma
DATE REC'D 3-31-08
DATE APP'VD 8-25-10
DATE EFF 3-3-08
HCFA 179 08-09

A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Targeted Case Management (continued)

Freedom of Choice Exception [§1915(g)(1) and 42 CFR 441.18(b)]:
_X_ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

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: (1) 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 services; (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 §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Revised 03-03-08

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Targeted Case Management (continued)
Limitations (continued):

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 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)]

STATE Oklahoma
DATE REC'D 3-31-08
DATE APP'D 8-25-10
DATE EFF 3-3-08
HCFA 179 08-09

A

New Page 03-03-08

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

The target group is persons with mental retardation and/or related conditions who are served by the Home and Community Based Services (HCBS) Waiver; or individuals who reside in institutions and have requested HCBS and receive TCM prior to entering the waiver; or who are being assessed for admission to the HCBS Waivers.

The Developmental Disabilities Services Division Targeted Case Management (DDSDTCM) rate is based on the weekly cost per case to provide targeted case management services. The cost base consists of the annualized cost of direct case management staff, including applicable agency overhead and indirect service costs, which have been computed and allocated in accordance with the Oklahoma Department of Human Services' cost allocation plan. This plan including its methodologies for allocating costs to state and federal programs is reviewed and approved by the Department of Health and Human Services' Division of Cost Allocation. The weekly rate is computed by dividing the annual cost base, including a prior period adjustment necessary to reconcile prior years' allowable costs against total billable amounts, by a projected annual number of weekly units of service. The maximum annual number of billable units of service is estimated to be 130,000. Units of service are defined as one calendar week of targeted case management, provided that a minimum of one contact meeting the description of targeted case management was provided, with or on behalf of an eligible recipient, and documented for the calendar week.

On a quarterly basis, the actual year-to-date costs of providing services will be compared with invoiced amounts to determine any over or under recovery of Federal Financial Participation. The rate for subsequent service periods will be adjusted to accommodate this variance. Subsequent to the end of the state fiscal year, a final reconciliation between final allowable costs and total billed amounts will be performed. Any over or under recovery of funding will be factored into the following year's rate computation.

Payment for TCM services under the plan do not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private provider of case management for children with severe emotional disturbances and the fee schedule and any annual/periodic adjustments to the fee schedule are published on the agency website at www.okhca.org. The agency's fee schedule rate is set as of December 1, 2009, and is effective for services on or after that date.

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