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February 8, 2008

Hye Sun Lee
Acting Associate Regional Administrator
Division of Medicaid and Children's Health
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601 5519

Dear Ms. Lee:

In March 2006, Ohio withdrew a response to the Centers for Medicare & Medicaid Services (CMS) request for additional information (RAI) regarding the Ohio State Plan Amendment (SPA) #05-027. SPA #05-027 includes Attachment 3.1-A, "Case Management Services To Children Age 3 To 21 With a Disability (Delivered Through Participating Schools)". The previously submitted Attachment 4.19-B for Item 19, "Case Management Services To Children Age 3 To 21 With a Disability (Delivered Through Participating Schools)" is now combined with and submitted concurrently, under separate cover, as SPA #05-020, "Cost-Based Reimbursement for IDEA Services Provided in Schools".

We are now providing a response to the RAI and request CMS to initiate the review process. Following is Ohio's response.

Additional Information on Notification:

CMS Question #1 Public Notice Under 42 CFR 447.205, Medicaid agencies must provide public notice of any significant proposed change in its methods and standards for setting payment rates for services. Please provide evidence that a public notice has been issued on the State's proposed changes.

Ohio's Response: **When approval of the TCM state plan amendment is imminent, Ohio will initiate the rule-making process to propose the changes. During that process, clearance, public hearings and hearings by the Joint Committee on Agency Rule Review will be held. Public notice regarding the proposed changes will be provided through the Ohio Legislative Services Commission electronic rule filing system (in accordance with ORC 103.0511). We will provide CMS a copy of the public notice at that time.**

Additional Information on Coverage:

CMS Question #2 Target Groups Under §1915(g), the State is required to submit a separate amendment for each target group to whom the State intends to provide services. The State is not limited in the number or size of its designated target groups. Please submit a separate amendment for each target group, carefully delineating the characteristics specific to each population

Ohio's Response: **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 if 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..**

CMS Question #3 Case Management Services and Provider Limitations Section 1915(g) allows States to limit the providers of case management when serving beneficiaries with AIDS, tuberculosis, developmental disabilities or chronic mental illness. This limitation however, is permissible only when the State seeks to provide services to one of the aforementioned populations, and when no other diagnostic categories are included.

The State, under its plan amendment, has identified its target group as "...hearing handicapped, speech handicapped, visually disabled, etc." Given the definition of its target groups, the State may not invoke Section 1915 (g) to restrict providers of case management services. Rather, the State must ensure a free choice of providers wherein an eligible individual must be allowed to receive case management services from any willing and qualified provider of these services. Please address how the State intends to comply with this regulation, through either redefining the target populations or ensuring a free choice of providers.

Ohio's Response:

Section 1915(g) of the Act provides that a state may restrict free choice of provider for the provision of case management services. Although, this state plan amendment limits providers of case management to Local Education Agencies and State schools for the blind and deaf, it will not limit the eligible recipients' free choice of providers of other medical care under the plan. The population identified above qualifies as an appropriate target group under Section 1915(g). The Health Care Financing Administration (HCFA) published the "Medicaid and School Health: A Technical Assistance Guide". In that, HCFA provided the following interpretation of this portion of the act.

"TCM must be provided to the targeted group of high risk individuals identified and characterized in the state plan. There is no limit to the number or size of target groups to whom a state may provide case management services. The target group may be the state's entire Medicaid population, or may focus on groups such as individuals with AIDS or HIV related disorders, pregnant women and infants up to age one, and developmentally disabled persons as defined by the state. Some states have approved TCM programs for children with disabilities, and for children under an IEP or IFSP. Geographically, states can also provide TCM on a less than-statewide basis."

Ohio is not aware of any regulatory changes or statutory changes that would affect the federal agency guidance and interpretation. Ohio is not aware that CMS has formally repudiated its official federal publication and official interpretation. The proposed state plan amendment complies with the above federal interpretation. On that basis, Ohio respectfully requests that Ohio be permitted to structure its TCM state plan amendment in a manner consistent with the letter of that formal federal publication.

CMS Question #4 Statewide Availability The State has indicated that the SPA will cover the entire state. Please explain how the provider restrictions proposed in this amendment will afford targeted individuals throughout the State, the opportunity to receive services from any willing and qualified provider of their choice.

Ohio's Response: **With regard to statewide availability, every LEA, state school for the blind and deaf throughout each of the 88 counties in the state of Ohio will be able to participate in the proposed TCM program. LEA's are representative of Ohio's public school system which is itself accessible statewide. LEA's and public school districts are not defined in the context of county government, e.g. "Columbus Public Schools", or "Cincinnati Public Schools".**

In light of the target group, the provider qualifications, and the nature of LEA's in the state, Ohio believes that there should be no issue of statewide availability. However, if there is some political subdivision that does not participate, Ohio requests approval of the state plan amendment on a less than statewide basis as allowed by federal law.

CMS Question #5 Provider Qualifications The 42 CFR §440 includes descriptions of provider qualifications for a variety of Medicaid services. The statute does not set minimum standards for the provision of case management services. Therefore, the State will need to establish minimum qualifications for providers of case management services. These qualifications should be related to the functions a provider is expected to perform. Please address the following:

- A) Indicate how the qualifications for providers will be relevant to beneficiaries in the target group that are not characterized as developmentally disabled or chronically mentally ill.
- B) Indicate how the provider qualifications indicated in the SPA are relevant to the Medicaid service that a case management provider is expected to perform.
- C) Indicate how the provider qualifications qualify the individual provider to perform the case management services for all individuals who will be covered by this SPA.

Ohio's Response: **Since the target group for this amendment is Medicaid eligible children age 3 to 21 who require special education, the qualifications established are to ensure providers of case management services have a level of understanding of the comprehensive needs, to include medical needs, of the children requiring special education.**

CMS Question #6 Medical Necessity Determination and Prior Authorization Under 42 CFR 431.10(e), the State Medicaid Agency may not delegate the determination of eligibility. The State has indicated in this SPA that "Case Management services are defined as those services identified as a Medicaid targeted case management service in a child's IEP and delivered by a qualified case manager...The frequency, scope and duration of services will be as prescribed/recommended by the case manager." Please address the following:

- A) How does the Medicaid agency determine that an individual is eligible to receive case management?

Ohio's Response: **Medicaid eligibility is determined by the Ohio Department of Job and Family Services, the single state agency. A child age 3-21 who requires special education, who is eligible to receive Medicaid, will be eligible to receive case management services from a participating LEA.**

- B) What role does the IEP team play in making this determination?

Ohio's Response: **The IEP team will identify the need for special education.**

- C) The SPA proposes that an individual case manager will prescribe and authorize the amount, duration, and scope of the case management for an eligible beneficiary. How is this consistent with the Federal regulations which prohibit delegation of the prior authorization function to anyone other than a Medicaid Agency employee?

Ohio's Response: **Although the IEP team will identify the need for special education, the state Medicaid agency establishes Medicaid eligibility and also establishes the prior authorization limits on targeted case management services to not more than eight (8) hours of service per day to be provided by the child's case manager, only. Beyond that limitation, Ohio will rely on IEPs in the same manner as the state of Indiana (please see attached Indiana Medicaid Update dated June 19, 1998).**

Questions Regarding Reimbursement:

CMS Question #7 Non-Duplication of Payment for Case Management Services In authorizing States to offer case management services, Congress recognized that there was some potential for duplicate payments because the same or similar services have often been provided by other programs or under the Medicaid program itself. H. Rep. No. 453, 99th Cong., 1st Session 546 (1985), which accompanies P.L. 99-272, emphasizes that payment for case management services under §1915(g) must not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Please address the following:

- A) How are the services in this SPA different for the target population than for those individuals receiving Special Education or regular education services through the State?" If they are the same, please explain why this should not be considered a duplication of payment.

Ohio's Response: **This question is not applicable in light of the federal mandates of Section 1903(c) of the Act which provides:**

“Nothing in this title shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or restrict, payment under subsection (a) for medical assistance for covered services furnished to a handicapped child because such services are included in the child’s individualized education program established pursuant to part B of the Individual with Disabilities Education Act or furnished to a handicapped infant or toddler because such services are included in the child’s individualized family service plan adopted pursuant to part H of such Act”

According to the HCFA publication, Medicaid and School Health: A Technical Assistance Guide, under Section 1903(c) of the Act, “Medicaid is the primary payer to the Department of Education.” Under our proposed state plan amendment, a LEA may request Medicaid reimbursement before resorting to education funds to cover the cost of delivering TCM services. To the extent that the payment is for a Medicaid service, the LEA must accept payment from the Medicaid program as payment in full. It will be incumbent upon the individual provider to allocate its education funds to other school functions or expenses that are not specific to the TCM service for a given child. Under the above federal mandate, any inaccuracy or inefficiency in the allocation or use of education funds is not material to the entitlement to Medicaid reimbursement for an allowable Medicaid service.

- B) Section 1902(a)(30)(A) of the Social Security Act (the Act) requires that States have methods and procedures to assure that payments are consistent with efficiency, economy, and quality of care. Section 1902(a)(4) of the Act specifies that the State plan must provide for such methods of administration as are found by the Secretary to be necessary for the proper and efficient administration of the plan.

Ohio has proposed reimbursement at the lesser of the claimed amount or \$13.17 per 15 minute unit. Annualized in the following manner: \$13.17 per 15 minute unit X 4 units per hour X 40 hours per week X 49 weeks per year equals approximately \$103,253 in reimbursement. We understand that the proposed rate is not based on the actual cost of the providers. Moreover, it appears that this rate would recover indirect cost in excess of the direct cost of compensation for TCM practitioners. In light of these two factors, how does the State justify the proposed level of payment? As part of the explanation, please provide information on the average salary and fringe benefit costs associated with case managers who deliver this service. Additionally, please explain why it would be reasonable to potentially reimburse case managers for eight hours of service per day when the school day is typically only six hours long.

Ohio’s Response: **An average school year is typically much shorter than 49 weeks. It is not assumed that a case manager would bill 8 hours per day for one**

child; but, instead no more than 8 hours per day, period (regardless of caseload). And, although school may be in session for approximately six hours in a day, the actual time staff work on school activities, including administrative activities related to services provided, may be longer. The rate per unit in our state plan amendment is based upon historical information regarding paid claims and units to school providers.

Ohio submits that the rates and reimbursement methodology proposed in this state plan amendment adequately demonstrate the propriety of the rate itself. As noted in our responses to the funding questions, the rate will not result in payments that in the aggregate exceed the reasonable cost of providing the service. However, if some aberrant LEA fails to accurately allocate education funds and effectively overcompensates itself for delivering units of TCM, it will effectively have taken Medicaid reimbursement as not “payment in full” and would be subject to repayment to the state and federal government for any such Medicaid TCM payments that are disclosed as part of an audit or post payment review process. All provider claims will be subject to utilization review.

Questions regarding source of state funding:

CMS Question #8 Standard Funding Questions Please respond to the following questions in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA:

Ohio’s Response: **NOTE: Responses to these questions were provided with the submission of the state plan amendment and the informal request for additional information. We are providing those responses again. If something more is needed with regard to these questions, please be more specific about what is being requested.**

- A) Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers retain all of the Medicaid payments including the Federal and State share (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

Yes. Participating MSP providers provide services and bill the state Medicaid agency directly via an EDI trading partner. The state Medicaid agency pays the federal and non-federal share of the claim at the full approved rate. Providers of services under this state plan amendment are local education agencies (LEA) and the state schools for the blind and deaf. Providers will receive 100% of the fee schedule rate.

B) Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the State share is from appropriations from the legislature, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the State to provide State share. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the State agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the State to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

- (i) a complete list of the names of entities transferring or certifying funds;
- (ii) the operational nature of the entity (state, county, city, other);
- (iii) the total amounts transferred or certified by each entity;
- (iv) a clarification on whether the certifying or transferring entity has general taxing authority; and,
- (v) a clarification whether the certifying or transferring entity received appropriations (identify level of appropriations).

The state (non-federal) share of the fee schedule rate is funded by appropriation from the legislature.

Total expenditures under this state plan amendment are estimated to be \$2.2 million during both FFY08 and FFY09 with a non-federal share at \$900,000.

C) Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

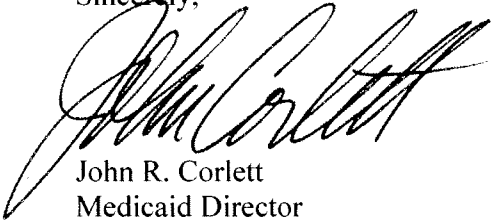
There are no supplemental or enhanced payments made to providers under this state plan amendment.

- D) Does any public provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

Providers under this fee schedule rate will not receive payments that in the aggregate exceed reasonable costs of providing services. Costs will be reconciled through a cost report.

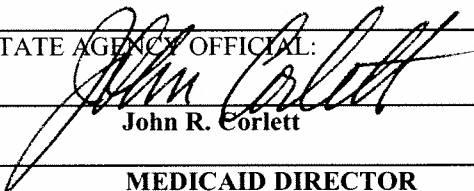
The Ohio Administrative Code (OAC) rules that will implement the provisions of this SPA will be sent under separate cover. If you have any questions, please contact me at (614) 466-4443 or Yolanda Talley at (614) 644-7130.

Sincerely,



John R. Corlett
Medicaid Director

cc: Becky Jackson, OHP/BHPP
Erika Robbins, ODJFS/OHP
Yolanda Talley, OHP/BCA
Debra Moscardino, OHP/BCA
Paolo DeMaria, ODE
Linda Tavener, CMS/CO
Mara Siler-Price, CMS/RO
Carolyn D. Brown, CMS/RO
Dave Shaner, CMS/RO

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 05 - 027	2. STATE OHIO
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES		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 July 1, 2005	
5. TYPE OF PLAN MATERIAL (Check One):			
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 42CFR430.12, 42CFR440.130		7. FEDERAL BUDGET IMPACT:	
		a. FFY 2008 \$ 550,000	
		b. FFY 2009 \$ 1,320,000	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Supplement 1 to Attachment 3.1-A From Pre-Print Page 8, Item 19, Page 1-D		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): New	
10. SUBJECT OF AMENDMENT: CASE MANAGEMENT SERVICES TO CHILDREN AGE 3 TO 21 WITH A DISABILITY (DELIVERED THROUGH PARTICIPATING SCHOOLS)			
11. GOVERNOR'S REVIEW (Check One):			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT		<input checked="" type="checkbox"/> OTHER, AS SPECIFIED:	
<input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED		Governor has delegated signature authority to ODJFS Director. Director has delegated signature authority to Medicaid Director	
<input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO:	
13. TYPED NAME: John R. Corlett		Becky Jackson	
14. TITLE: MEDICAID DIRECTOR		OHP/Bureau of Health Plan Policy	
15. DATE SUBMITTED: 2/12/08		Ohio Department of Job and Family Services	
		P.O BOX 182709	
		Columbus, Ohio 43218	
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED:	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL:		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME:		22. TITLE:	
23. REMARKS:			

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OHIO

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

- A. Target Group: 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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SUPERSEDES
TN No. new EFFECTIVE DATE: 7/1/05

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OHIO

**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, should 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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OHIO

**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 or an educational service center in Ohio as defined respectively in sections 3311.02 through 3311.058 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 services to recipients. The individual(s) employed to 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.

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SUPERSEDES
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OHIO

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

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.

1. Eligible recipients will have free choice of the providers of other medical care under the plan.
2. 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 described in section 3325.01 of the Ohio Revised Code.

G. 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. Participating providers will maintain cost allocation plans compliant with OMB Circulars A-87, A-122, and A-133. FFP will be collected for targeted case management services 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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SUPERSEDES
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