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§1. High Risk Pregnant Women and Children. (12 VAC 30-50-410)

A. Target Group: To reimburse case management services for high-risk Medicaid eligible pregnant women and children up to age 2.

B. Areas of State in which services will be provided:

☒ 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. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services: The case management services will provide maternal and child health coordination to minimize fragmentation of care, reduce barriers, and link clients with appropriate services to ensure comprehensive, continuous health care. The Maternity Care Coordinator will provide:

1. Assessment-Determining clients' service needs, which include psychosocial, nutrition, medical, and educational factors.

2. Service Planning-Developing an individualized description of what services and resources are needed to meet the service needs of the client and help access those resources.

3. Coordination & Referral-Assisting the client in arranging for appropriate services and ensuring continuity of care.

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4. Follow-up & Monitoring-Assessing ongoing progress and ensuring services are delivered.

5. Education & Counseling-Guiding the client and developing a supportive relationship that promotes the service plan.

E. Qualifications of Providers: Any duly enrolled provider which the department determines is qualified who has signed an agreement with Department of Medical Assistance Services to deliver Maternity Care Coordination services. Qualified service providers will provide case management regardless of their capacity to provide any other services under the Plan. A Maternity Care Coordinator is the Registered Nurse or Social Worker employed by a qualified service provider who provides care coordination services to eligible clients. The RN must be licensed in Virginia and should have a minimum of one year of experience in community health nursing and experience in working with pregnant women. The Social Worker (MSW, BSW) must have a minimum of one year of experience in health and human services, and have experience in working with pregnant women and their families. The Maternity Care Coordinator assists clients in accessing the health care and social service system in order that outcomes which contribute to physical and emotional health and wellness can be obtained.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of §1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for 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.

§2. Seriously mentally ill adults and emotionally disturbed children. (12 VAC 30-50-420)

A. Target Group: The Medicaid eligible individual shall meet the DMHMRSAS definition for "serious mental illness", or "serious emotional disturbance in children and adolescents".

1. An active client for case management shall mean an individual for whom there is a plan of care in effect which requires regular direct or client-related contacts or communication or activity with the client, family, service providers, significant others and others including at least one face-to-face contact every 90-days. Billing can be submitted for an active client only for months in which direct or client-related contacts, activity or communications occur.

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TARGETED CASE MANAGEMENT SERVICES

A. Target group (42 CPR§§ 441.18(8)(i) and 441.18(9):

1. The targeted group is described on page 2 of this Supplement.

2. N/A Target group includes individuals transitioning to a community setting. Case management services will be made available for up to _____ consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions.

B. Areas of State in which services will be provided(§ 1915(g)(l) of the *Act).*

X Entire State

____ Only in the following geographic areas (§ 1915(g)(l) of the *Act):*

C. Comparability of services(§§ 1902(a)(10)(B) and 1915(g)(l).

___ Services are provided in accordance with§ 1902(a)(lO)(B) of the *Act.*

X Services are not comparable in amount, duration, and scope.(§ 1915(g)(l) of the *Act);* see also page 3 of this Supplement.

D. Definition of services (42 CPR 440.169): 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:

a. Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social, or other services. Needs shall be reassessed at least annually.

b. 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.

c. 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 individual.

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1. 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

2. Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the ISP is effectively implemented and adequately addresses the needs of the eligible .individual, and which may be with the individual, family members, services providers, or other and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:

   Services are being furnished in accordance with the individual's care plan; services in the care plan are adequate; and changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include malting arrangements with providers, as more fully described on pages 3 and 4 of this Supplement.

C. Qualifications of providers. (42 CFR §§441.18(a)(8)(v) and441.lS(b).

1. Services are not comparable in amount, duration, and scope. Authority of § 1915(g)(l) of the *Act* is invoked to limit case management providers for individuals with mental retardation and individuals with serious/chronic mental illness to the Community Services Boards (CSBs) only to enable them to provide services to serious/chronically mentally ill or mentally retarded individuals without regard to the requirements of§ 1902(a)(10)(B) of the *Act.* Toe CSBs are the local-level agencies for the Department of Behavioral Health and Developmental Services, are the enrolled Medicaid providers and whose employees render case management services.

2. To qualify as a provider of services through DMAS for targeted case management for seriously/chronically mentally ill adults and emotionally disturbed children/adolescents, the provider of the services must meet certain criteria. These criteria shall be:

   a. The provider must have the administrative and financial management capacity to meet state and federal requirements;

   b. The provider must have the ability to document and maintain individual case records in accordance with state and federal requirements;

   c. Toe provider must be licensed as a provider of case management services by the DBHDS;

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d. Employees of the case management provider must have knowledge of:

(1) Services, systems, and programs available in the community including primary health care, support services, eligibility criteria and intake processes, generic community resources, and mental health, mental retardation, and substance abuse treatment programs;

(2) The nature of serious mental illness, mental retardation (intellectual disability), substance abuse (substance use disorders), or co-occurring disorders depending on the individuals served, including clinical and developmental issues.

e. Employees of the case management provider must have abilities to:

(1) Work as team members, maintaining effective inter- and intra-agency working relationships;

(2) Work independently, performing position duties under general supervision, and

(3) Engage and sustain ongoing relationships with individuals receiving services.

3. Providers may bill Medicaid for mental health case management only when the services are provided by qualified mental health case managers.

D. Freedom of choice. (42 CPR § 441.18(a)(l).

1. Freedom of choice is described on page 6 of this Supplement.

2. Freedom of choice exception(§ 1915(g)(l) and 42 CPR§ 441.lS(b)):

N/A 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.

E. Payment for case management services under the plan does not duplicate payments made to public agencies of private entities under other program authorities for this same purpose. Case management services may not be billed concurrently with intensive community treatment services, treatment foster care case management services or intensive in-home services for children and adolescents.

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H. Access to Services. (42 CFR §§ 441.18(a)(2), 44l.18(a)(3), 441.18(a)(6)). The state assures the following:

l. Case management services shall be provided in a manner consistent with the best interest of recipients and shall not be used to restrict an individual's access to other Medicaid services.

2. Individuals shall not be compelled to receive case management services. The receipt of other Medicaid services shall not be a condition for the receipt of case management services, and the receipt of case management services shall not be a condition for receipt of other Medicaid services.

3. Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other Medicaid services.

I. Case records. (42 CPR 441.18(a)(7). Case management services must be documented and maintained in individual case records in accordance with 42 CPR § 441.18(a)(7) and other state and federal requirements.

J. Limitations.

l. Case management does not include, and Federal Financial Participation (PPP) is not available in expenditures for services defined in § 441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F)

2. Case management does not include, and Federal Financial Participation (PPP) is not available in expenditures for services defined in § 441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social or other covered services.

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K. Targeted case management services **(pursuant to Snpp.1 of Attach 3.1-A&B, pp. 30-31.4).**

1. Reimbursement shall be provided only for "active" targeted case management clients, as defined. An active client for targeted case management shall mean an individual for whom there is a plan of care in effect which requ.ires regular direct or client-related contacts or activity or communication with the client or families, significant others, service providers, and others including a minimum of one face-to-face client contact within a 90-day period. Billing can be submitted only for months in which direct or client-related contacts, activity or communications occur.

2. The Medicaid eligible individual shall meet the DBHDS criteria of serious mental illness, serious emotional disturbance in children and adolescents, or youth at risk of serious emotional disturbance.

3. There shall be no maximum service limits for targeted case management services. Targeted case management shall not be billed for persons in institutions for mental disease.

4. The ISP must document the need for targeted case management and be fully completed within 30 days of initiation of the service, and the case manager shall review the ISP every three months. The review will be due by the last day of the third month following the month in which the last review was completed. A grace period will be granted up to the last day of the fourth month following the month of the last review. When the review was completed in a grace period, the next subsequent review shall be scheduled three months from the month the review was due and not the date of actual review..

5. The ISP shall be updated at least annually.

6. The provider of targeted case management services shall be licensed by DBHDS as a provider of targeted case management services.

NOTE: Subsection K (Targeted Case Mgt. Services) was formerly Subsection E of Attachment Page 3.1-C, Page 33 of 43

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§3. Youth at risk of serious emotional disturbance. (12 VAC 30-50-430)

A. Target Group: Medicaid eligible individuals who meet the DBHDS definition of youth at risk of serious emotional disturbance.

1. An active client shall mean an individual for whom there is a plan of care in effect which requires regular direct or client-related contacts or communication or activity with the client, family, service providers, significant others and others including at least one face-to-face contact every 90-days. Billing can be submitted for an active client only for months in which direct or client-related contacts, activity or communications occur.

2. Target group includes individuals transitioning to a community setting. Case management services will be made available for up to 30 consecutive days prior to discharge from 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).

B. Areas of State in which services will be provided:

☒ 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. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services: Mental health services. Case management services assist youth at risk of serious emotional disturbance in accessing needed medical, psychiatric, social, educational, vocational, and other supports essential to meeting basic needs. Services to be provided include:

1. Assessment and planning services, to include developing an Individual Service Plan;

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2. Linking the individual directly to services and supports specified in the treatment/services plan;

3. Assisting the individual directly for the purpose of locating, developing or obtaining needed service and resources;

4. Coordinating services and service planning with other agencies and providers involved with the individual;

5. Enhancing community integration by contacting other entities to arrange community access and involvement, including opportunities to learn community living skills, and use vocational, civic, and recreational services;

6. Making collateral contacts which are non-therapy contacts with an individual's significant others to promote treatment and/or community adjustment;

7. Following-up and monitoring to assess ongoing progress and ensuring services are delivered; and

8. Education and counseling which guides the client and develops a supportive relationship that promotes the service plan.

E. Qualifications of Providers

1. Services are not comparable in amount, duration, and scope. Authority of 1915(g)(1) of the Act is invoked to limit case management providers to the Community Service Boards only to enable them to provide services to serious/chronically mentally ill or mentally retarded individuals without regard to the requirements of 1902(a)(10)(B) of the Act. To qualify as a provider of case management services to youth at risk of serious emotional disturbance, the provider of the services must meet the following criteria:

a. The provider must meet state and federal requirements regarding its capacity for administrative and financial management;

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b. The provider must have the ability to document and maintain individual case records in accordance with state and federal requirements;

c. The services shall be in accordance with the Virginia Comprehensive State Plan for Mental Health, Mental Retardation and Substance Abuse Services; and

d. The provider must be certified as a mental health case management agency by the DMHMRSAS.

e. Persons providing case management services must have knowledge of:

(1) Services, systems, and programs available in the community including primary health care, support services, eligibility criteria and intake processes, generic community resources, and mental health, mental retardation, and substance abuse treatment programs;

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(2) The nature of serious mental illness, mental retardation, and substance abuse depending on the population served, including clinical and developmental issues;

(3) Different types of assessments, including functional assessments, and their uses in service planning;

(4) Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning, and service coordination;

(5) The service planning process and major components of a service plan;

(6) The use of medications in the care or treatment of the population served; and

(7) All applicable federal and state laws, state regulations, and local ordinances.

f. Persons providing case management services must have skills in:

(1) Identifying and documenting an individual's needs for resources, services, and other supports;

(2) Using information from assessments, evaluations, observation, and interviews to develop individual service plans;

(3) Identifying services and resources within the community and established service system to meet the individual's needs; and documenting how resources, services, and natural supports, such as family, can be utilized to achieve an individual's personal habilitative/rehabilitative, and life goals; and

(4) Coordinating the provision of services by public and private providers.

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g. Persons providing case management services must have abilities to:

(1) Work as team members, maintaining effective inter- and intra-agency working relationships;

(2) Work independently, performing position duties under general supervision; and

(3) Engage and sustain ongoing relationships with individuals receiving services.

3. Providers may bill Medicaid for mental health case management only when the services are provided by qualified mental health case managers.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of §1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

H. Case management services may not be billed concurrently with intensive community treatment services, treatment foster care case management services or intensive in-home services for children and adolescents.

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§4. Individuals with mental retardation. (12 VAC 30-50-440)

A. Target Group. Medicaid eligible individuals who are mentally retarded as defined in state law.

1. An active client for mental retardation case management shall mean an individual for whom there is a plan of care in effect which requires regular direct or client-related contacts or communication or activity with the client, family, service providers, significant others and others including at least one face-to-face contact every 90-days. Billing can be submitted for an active client only for months in which direct or client-related contacts, activity or communications occur.

2. There shall be no maximum service limits for case management services except case management services for individuals residing in institutions or medical facilities. For these individuals, reimbursement for case management shall be limited to thirty days immediately preceding discharge. Case management for institutionalized individuals may be billed for no more than two pre-discharge periods in twelve months.

B. Areas of State in which services will be provided:

☒ 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. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of §1902(a)(10)(B) of the Act.

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D. Definition of Services: Mental retardation services to be provided include:

1. Assessment and planning services, to include developing a Consumer Service Plan (does not include performing medical and psychiatric assessment but does include referral for such assessment);

2. Linking the individual to services and supports specified in the consumer service plan;

3. Assisting the individual directly for the purpose of locating, developing or obtaining needed services and resources;

4. Coordinating services and service planning with other agencies and providers involved with the individual;

5. Enhancing community integration by contacting other entities to arrange community access and involvement, including opportunities to learn community living skills, and use vocational, civic and recreational services;

6. Making collateral contacts with the individual's significant others to promote implementation of the service plan and community adjustment;

7. Following-up and monitoring to assess ongoing progress and ensuring services are delivered; and

8. Education and counseling which guides the client and develops a supportive relationship that promotes the service plan.

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E. Qualifications of Providers:

1. Services are not comparable in amount, duration, and scope. Authority of §1915(g)(1) of the Act is invoked to limit case management providers for individuals with mental retardation and serious/chronic mental illness to the Community Services Boards only to enable them to provide services to serious/chronically mentally ill or mentally retarded individuals without regard to the requirements of §1902(a)(10)(B) of the Act.

2. To qualify as a provider of services through DMAS for rehabilitative mental retardation case management, the provider of the services must meet certain criteria. These criteria shall be:

   a. The provider must guarantee that clients have access to emergency services on a 24-hour basis;

   b. The provider must demonstrate the ability to serve individuals in need of comprehensive services regardless of the individual's ability to pay or eligibility for Medicaid reimbursement;

   c. The provider must have the administrative and financial management capacity to meet state and federal requirements;

   d. The provider must have the ability to document and maintain individual case records in accordance with state and federal requirements;

   e. The services shall be in accordance with the Virginia Comprehensive State Plan for Mental Health, Mental Retardation and Substance Abuse Services; and

   f. The provider must be certified as a mental retardation case management agency by the DMHMRSAS.

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3. Providers may bill for Medicaid mental retardation case management only when the services are provided by qualified mental retardation case managers. The case manager must possess a combination of mental retardation work experience or relevant education which indicates that the individual possesses the following knowledge, skills, and abilities. The incumbent must have at entry level the following knowledge, skills and abilities. These must be documented or observable in the application form or supporting documentation or in the interview (with appropriate documentation).

   a. Knowledge of:

      (1) the definition, causes and program philosophy of mental retardation

      (2) treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning and service coordination

      (3) different types of assessments and their uses in program planning

      (4) consumers' rights

      (5) local community resources and service delivery systems, including support services, eligibility criteria and intake process, termination criteria and procedures and generic community resources

      (6) types of mental retardation programs and services

      (7) effective oral, written and interpersonal communication principles and techniques

      (8) general principles of record documentation

      (9) the service planning process and the major components of a service plan

   b. Skills in:

      (1) interviewing

      (2) negotiating with consumers and service providers

      (3) observing, recording and reporting behaviors

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(4) identifying and documenting a consumer's needs for resources, services and other assistance

(5) identifying services within the established service system to meet the consumer's needs

(6) coordinating the provision of services by diverse public and private providers

(7) using information from assessments, evaluations, observation and interviews to develop service plans

(8) formulating, writing and implementing individualized consumer service plans to promote goal attainment for individuals with mental retardation;

(9) Using assessment tools

(10) Identifying community resources and organizations and coordinating resources and activities

c. Abilities to:

(1) demonstrate a positive regard for consumers and their families (e.g. treating consumers as individuals, allowing risk taking, avoiding stereotypes of people with mental retardation, respecting consumers' and families' privacy, believing consumers can grow)

(2) be persistent and remain objective

(3) work as team member, maintaining effective inter- and intra-agency working relationships

(4) work independently, performing position duties under general supervision

(5) communicate effectively, verbally and in writing

(6) establish and maintain ongoing supportive relationships

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F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of §1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payments for 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.

§5. Individuals with mental retardation and related conditions who are participants in the Home and Community-Based Care waivers for persons with mental retardation and related conditions. (12 VAC 30-50-450)

A. Target group: Medicaid eligible individuals with mental retardation and related conditions, or a child under 6 years of age who is at developmental risk, who have been determined to be eligible for Home and Community Based Care Waiver Services for persons with mental retardation and related conditions.

1. An active client for waiver case management shall mean an individual who receives at least one face-to-face contact every 90 days and monthly on-going case management interactions. There shall be no maximum service limits for case management services. Case management services may be initiated up to 3 months prior to the start of waiver services, unless the individual is institutionalized.

2. There shall be no maximum service limits for case management services except case management services for individuals residing in institutions or medical facilities. For these individuals, reimbursement for case management shall be limited to thirty days immediately preceding discharge. Case management for institutionalized individuals may be billed for no more than two pre-discharge periods in twelve months.

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B. Areas of State in which services will be provided:

☒ 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. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services: Mental retardation case management services to be provided include:

1. Assessment and planning services, to include developing a Consumer Service Plan (does not include performing medical and psychiatric assessment but does not include referral for such assessment);

2. Linking the individual to services and supports specified in the consumer service plan;

3. Assisting the individual directly for the purpose of locating, developing or obtaining needed services and resources;

4. Coordinating services with other agencies and providers involved with the individual;

5. Enhancing community integration by contacting other entities to arrange community access and involvement, including opportunities to learn community living skills, and use vocational, civic and recreational services;

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6. Making collateral contacts with the individual's significant others to promote implementation of the service plan and community adjustment; and

7. Following-up and monitoring to assess ongoing progress and ensuring services are delivered; and

8. Education and counseling which guides the client and develop a supportive relationship that promotes the service plan.

E. Qualifications of Providers:

1. Services are not comparable in amount, duration, and scope. Authority of §1915(g)(1) of the Act is invoked to limit case management providers for individuals with mental retardation and serious/chronic mental illness to the Community Services Boards only to enable them to provide services to seriously or chronically mentally ill or mentally retarded individuals without regard to the requirements of §1902(a)(10)(B) of the Act.

2. To qualify as a provider of services through DMAS for rehabilitative mental retardation case management, the provider of the services must meet certain criteria. These criteria shall be:

   a. The provider must guarantee that clients have access to emergency services on a 24-hour basis;

   b. The provider must demonstrate the ability to serve individuals in need of comprehensive services regardless of the individuals' ability to pay or eligibility for Medicaid reimbursement;

   c. The provider must have the administrative and financial management capacity to meet state and federal requirements;

   d. The provider must have the ability to document and maintain individual case records in accordance with state and federal requirements;

   e. The services shall be in accordance with the Virginia Comprehensive State Plan for Mental Health, Mental Retardation and Substance Abuse Services; and

   f. The provider must be certified as a mental retardation case management agency by the DMHMRSAS.

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3. Providers may bill for Medicaid mental retardation case management only when the services are provided by qualified mental retardation case managers. The case manager must possess a combination of mental retardation work experience or relevant education which indicates that the individual possesses the following knowledge, skills, and abilities, at the entry level. These must be documented or observable in the application form or supporting documentation or in the interview (with appropriate documentation).

   a. Knowledge of:

      (1) the definition, causes and program philosophy of mental retardation

      (2) treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning and service coordination;

      (3) different types of assessments and their uses in program planning

      (4) consumers' rights

      (5) local service delivery systems, including support services

      (6) types of mental retardation programs and services

      (7) effective oral, written and interpersonal communication principles and techniques

      (8) general principles of record documentation

      (9) the service planning process and the major components of a service plan

   b. Skills in:

      (1) interviewing

      (2) negotiating with consumers and service providers

      (3) observing, records and reporting behaviors

      (4) identifying and documenting a consumer's needs for resources, services and other assistance

      (5) identifying services within the established service system to meet the consumer's needs

      (6) coordinating the provision of services by diverse public and private providers

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(7) analyzing and planning for the service needs of mentally retarded persons

(8) formulating, writing and implementing individualized consumer service plans to promote goal attainment for individuals with mental retardation

(9) using assessment tools.

c. Abilities to:

(1) demonstrate a positive regard for consumers and their families (e.g., treating consumers as individuals, allowing risk taking, avoiding stereotypes of mentally retarded people, respecting consumers' and families' privacy, believing consumers can grow)

(2) be persistent and remain objective

(3) work as team member, maintaining effective inter- and intra-agency working relationships

(4) work independently, performing positive duties under general supervision

(5) communicate effectively, verbally and in writing

(6) establish and maintain ongoing supportive relationships.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of §1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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6.0 Elderly Case Management repealed, effective 7/1/03 (SPA 03-01)

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§8. Case Management for Foster Care Children. (12 VAC 30-50-480)

A. Target Group: Children or youth with behavioral disorders or emotional disturbances who are referred to treatment foster care by the Family Assessment and Planning Team of the Comprehensive Services Act for Youth and Families (CSA). 'Child' or 'youth' means any Medicaid eligible individual to 21 years of age who is otherwise eligible for CSA services. Family Assessment and Planning Teams (FAPT) are multidisciplinary teams of professionals established by each locality in accordance with § 2.1-754 of the *Code of Virginia* to assess the needs of referred children. The FAPT shall develop individual service plans for youths and families who are reviewed by the team. The FAPT shall refer those children needing treatment foster care case management to a qualified participating case manager.

B. Areas of State in which services will be provided:

☒ 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. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services: Case management shall assist individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of a child. Case management services will coordinate services to minimize fragmentation of care, reduce barriers, and link children with appropriate services to ensure comprehensive, continuous access to needed medical, social, educational, and other services appropriate to the needs of the child. The treatment foster care case manager will provide:

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1. Periodic assessments to determine clients' needs for psychosocial, nutritional, medical, and educational services.

2. Service planning by developing individualized treatment and service plans to describe what services and resources are needed to meet the service needs of the client and help access those resources. Such service planning shall not include performing medical and psychiatric assessment but shall include referrals for such assessments. The case manager shall collaborate closely with the FAPT and other involved parties in preparation of all case plans.

3. Coordination and referral by assisting the client in arranging for appropriate services and ensuring continuity of care for a child in treatment foster care. The case manager shall link the child to services and supports specified in the individualized treatment and service plan. The case manager shall directly assist the child to locate or obtain needed services and resources. The case manager shall coordinate services and service planning with other agencies and providers involved with the child by arranging, as needed, medical, remedial, and dental services.

4. Follow-up and monitoring by assessing ongoing progress in each case and ensuring services are delivered. The case manager shall continually evaluate and review each child's plan of care. The case manager shall collaborate with the FAPT and other involved parties on reviews and coordination of services to youth and families.

5. Education and counseling by guiding the client and developing a supportive relationship that promotes the service plan.

E. Provider Participation. Any public or private child placing agency licensed or certified by the Department of Social Services for treatment foster care may be a provider of treatment foster care case management.

Providers may bill for Medicaid for case management for children in treatment foster care only when the services are provided by qualified treatment foster care case managers. The case manager must meet, at a minimum, the case worker qualifications found in the Minimum Standards for Child Placing Agencies (22 VAC 40-130-

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10 through 22 VAC 40-130-550). In addition, the case manager must possess a combination of mental health work experience or relevant education which indicates that the individual possesses the following minimum knowledge, skills, and abilities. The following must be documented or observable in the application form or supporting documentation or in a job interview (with appropriate documentation).

1. Knowledge of:

   a. The nature of serious mental illness and serious emotional disturbance in children and adolescents;

   b. Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning and service coordination;

   c. Different types of assessments, including behavioral and functional assessments, and their uses in service planning;

   d. Children's rights;

   e. Local community resources and service delivery systems, including support services (e.g. housing, financial, social welfare, dental, educational, transportation, communication, recreational, vocational, legal/advocacy), eligibility criteria and intake processes, termination criteria and procedures, and generic community resources (e.g. churches, clubs, and self-help groups);

   f. Types of mental health treatment services.

2. Skills in:

   a. Interviewing;

   b. Negotiating with children and service providers;

   c. Observing, recording, and reporting behaviors;

   d. Identifying and documenting a child's needs for resources, services, and other assistance;

   e. Identifying services within the established service system to meet the child's

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needs;

f. Coordinating the provision of services by diverse public and private providers;

g Using information from assessments, evaluations, observations, and interviews to develop service plans;

h. Formulating, writing, and implementing individualized case management plans to promote goal attainment for individuals with behavioral disorders or emotional disturbances. This individualized case management plan is performed by the foster care case manager to guide his work in monitoring and linking the child to the services identified in the child's individualized service plan;

i. Using assessment tools designated by the state;

j. Identifying community resources and organizations and coordinating resources and activities.

3. Abilities to:

a. Demonstrate a positive regard for recipients and their families (e.g., treating recipients as individuals, allowing risk taking, avoiding stereotypes of developmentally disabled people, respecting recipients' and families' privacy, believing recipients can grow);

b. Persist in applying service plan objectives towards goal attainment and remain objective;

c. Work as team member, maintaining effective inter- and intra-agency working relationships;

d. Work independently, performing position duties under general supervision;

e. Communicate effectively, orally and in writing; and

f. Establish and maintain ongoing supportive relationships.

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F. Freedom of Choice. Section 1915(g)(1) of the *Act* specifies that there shall be no restriction on free choice of qualified providers, in violation of §1902(a)(23) of the *Act*. Assure that there will be no restriction on a recipient's free choice of qualified providers of case management services. In addition, assure that case management services will not restrict an individual's free choice of providers of other Medicaid services.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

3. Eligible recipients will be free to refuse case management services.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities (for example, Title IV-E or SSA) for this same purpose. The case management service shall not be construed as case management under EPSDT.

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§9. Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):
A. Medicaid individuals with a developmental disability as defined below and who are eligible to receive services under the DD waiver.

"Developmental disability" means a severe, chronic disability of an individual that (i) is attributable to a mental or physical impairment, or a combination of mental and physical impairments, other than a sole diagnosis of mental illness; (ii) is manifested before the individual reaches 22 years of age; (iii) is likely to continue indefinitely, (iv) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (v) reflects the individual's need for a combination and sequence of special interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. An individual from birth to age nine, inclusive, who has a substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability without meeting three or more of the criteria described in clauses (i) through (v) if the individual, without services and supports, has a high probability of meeting those criteria later in life.

__X__ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to __90___consecutive days of a covered stay in a medical institution. DMAS will cover two of these 90 day periods, not necessarily consecutive, in a twelve month period. 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).

B. Areas of State in which services will be provided (§1915(g)(1) of the Act):
__X__ Entire State
___ Only in the following geographic areas: **[Specify areas]**

C. 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)).

D. Definition of services (42 CFR 440.169): 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:
An individual receiving DD case management shall have an Individual Support Plan (ISP) identifying specific service needs as set out in item D below in effect which requires monthly direct or in-person contact, communication or activity with the individual and family/caregiver, as appropriate, service providers, and other authorized representatives including at least one face-to-face contact between the individual and the case manager every 90 days. Individuals with a developmental disability as defined above who are on the DD waiting list for waiver services may receive case management services.

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Individuals with a DD diagnosis, who do not have ID, that are on the waiting list, shall have a plan of care completed with the case manager that identifies any documented special service needs. Individuals on the waitlist do not have routine case management services unless there is a documented special service. Case managers shall make face-to-face contact every 90 calendar days to monitor the special service need and documentation is required to support such contact.

1. Case management services to be provided shall include:

❖ 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~~;~~ .

❖ 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; and
- 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:
  - services are being furnished in accordance with the individual's care plan;
  - services in the care plan are adequate; and
  - 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.

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- On an annual basis the person-centered plan is conducted to review current status and changes from previous years. It also includes review of provider plans. As needed outside the annual review, the case manager may convene a meeting to re-evaluate the appropriateness of the plan if the individual's needs have changed. Case Managers conduct quarterly reviews of their services plans and effectiveness of that plan to determine if it remains appropriate and if modifications are needed.

❖ Assisting the individual directly for the purpose of locating, developing, or obtaining needed services and resources; coordinating services with other agencies and service providers involved with the individual; and enhancing community integration by contacting other entities to arrange community access and involvement.

❖ Making collateral contacts with the individual's significant others to promote implementation of the Individual Support Plan and community integration;

❖ Education and counseling which guides the individual and his family and significant others and develops a supportive relationship that promotes the individual's achievement of goals set out in the Individual Support Plan.

_X_ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

E. Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

1. DD case managers shall not be (i) the direct care staff person, (ii) the immediate supervisor of the direct care staff person, (iii) otherwise related by business or organization to the direct care staff person, or (iv) an immediate family member of the direct care staff person.
2. Parents, spouses, or any family living with the individual may not provide direct case management services for the individual or spouse of the individual with whom they live, or be employed by a company that provides case management for the individual, spouse, or the individual with whom they live.
3. To qualify as a provider of services through DMAS for DD waiver case management, the service provider shall:
   a. Guarantee that individuals have access to emergency services on a 24-hour basis;
   b. Have the administrative and financial management capacity to meet state and federal requirements;
   c. Have the ability to document and maintain individual case records in accordance with state and federal requirements;

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4. Case managers who provide DD case management services shall possess a minimum of an undergraduate degree in a human services field. Case managers who do not possess a minimum of an undergraduate degree in a human services field may continue to provide case management if they are employed by an entity with a Medicaid participation agreement to provide DD case management prior to February 1, 2005, and maintain employment with the provider under that agreement without interruption. In addition, the case manager shall possess developmental disability work experience or relevant education which indicates that the incumbent, at entry level, possesses the following knowledge, skills, and abilities which shall be documented in the employment application form or supporting documentation or during the job interview. The knowledge, skills, and abilities shall include:

a. Knowledge of:
   (1) The definition, causes, and program philosophy of developmental disabilities;
   (2) Treatment modalities and intervention techniques, such as behavior management, independent living skills, training, supportive counseling, family education, crisis intervention, discharge planning and service coordination;
   (3) Different types of assessments and their uses in program planning;
   (4) Individual rights;
   (5) Local community resources and service delivery systems, including support services, eligibility criteria and intake process, termination criteria and procedures and generic community resources;
   (6) Types of developmental disability programs and services;
   (7) Effective oral, written, and interpersonal communication principles and techniques;
   (8) General principles of record documentation; and
   (9) The service planning process and the major components of an Individual Support Plan.

b. Skills in:
   (1) Interviewing;
   (2) Negotiating with individuals and service providers;
   (3) Observing, recording, and reporting behaviors;
   (4) Identifying and documenting an individual's needs for resources, services, and other assistance;
   (5) Identifying services to meet the individual's needs;
   (6) Coordinating the provision of services by diverse public and private service providers;
   (7) Analyzing and planning for the service needs of individuals with developmental disabilities;
   (8) Formulating, writing, and implementing Individual Support Plans to promote goal attainment for individuals with developmental disabilities; and
   (9) Using assessment tools.

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c. Ability to:

(1) Demonstrate a positive regard for individuals and their families (e.g., permitting risk taking, avoiding stereotypes of individuals with developmental disabilities, respecting individual's and families' privacy, believing individuals can grow);

(2) Persist at tasks and remain objective; (3)Work as team member, maintaining effective inter- and intra-agency working relationships;

(4) Work independently, performing positive duties under general supervision;

(5) Communicate effectively, verbally and in writing; and Establish and maintain ongoing supportive relationships.

F. 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 provider of other medical care under the plan.

3. Individuals who are eligible for or who have received the Building Independence, Community Living, and Family and Individual Supports waivers shall have free choice of the providers of case management services within the parameters described above and as follows. For those individuals that receive DD case management services:

   (a) The CSB that serves the individual will be the provider of case management.
   (b) The CSB shall provide a choice of case managers within the CSB.
   (c) If the individual or family decides that no choice is desired in that CSB, the CSB shall afford a choice of another CSB with whom the responsible CSB has a memorandum of agreement.
   (d) If the individual or family decides that no choice is desired in that CSB, or with another CSB, the CSB shall afford a choice of a private entity with whom they have a contract that was procured through the RFP process.
   (e) At any time, an individual may make a request to change his case manager.

4. When the required case management services are contracted out to a private entity, the CSB/BHA shall remain the responsible provider and only the CSB/BHA may bill DMAS for Medicaid reimbursement.

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G. Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

X Target group consists of eligible individuals with developmental disabilities. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities receive needed services:

a. Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. DMAS providers of case management services shall be limited to only those entities that are licensed by DBHDS as intellectual disability case management providers (CSBs/BHAs) in order to ensure that individuals within the target groups receive high quality, appropriate, and needed services. All CSB/BHA providers shall have a current, signed provider agreement with DMAS and shall directly bill DMAS for reimbursement.

b. To provide choice to individuals enrolled in these waivers, CSB/BHAs shall contract with private case management entities to provide DD case management, except if there are no qualified providers in that CSB/BHA's catchment area, then the CSB/BHA shall provide services.

c. If the individual or family decides not to choose the responsible CSB or the CSB with whom there is a memorandum of agreement, then they will be given a choice of a private provider with whom the responsible CSB has a contract for case management.

H. 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:

1. Case management (including targeted 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, 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
3. Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

I. 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.

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J. Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

K. 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).

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)).

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§ 12. Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9):

_X__ The Medicaid eligible individual shall meet the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) diagnostic criteria for a substance use disorder. Tobacco-related disorders or caffeine- related disorders and nonsubstance-related disorders shall not be covered. Target group includes individuals transitioning to a community setting. Case management services will be made available for up to 30 consecutive days prior to discharge from 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).

A. Areas of State in which services will be provided (§ 1915(g)(1) of the Act):

__X__Entire State
_____ Only in the following geographic areas:

B. 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)).

C. Definition of services (42 CFR 440.169): 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: An individual receiving substance use case management services shall have an active individual service plan (ISP) that requires a minimum of two substance use case management service activities each month and at least one face-to-face contact with the individual at least every 90 calendar days.

❖ Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, education, 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;
- Periodic reassessments include evaluating and updating the individual's progress toward meeting the individualized service plan objectives and shall occur as needed and at a minimum every 90 calendar days during a review of the ISP with the individual.

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- 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 the course of action to respond to the assessed needs of the eligible individual.
    - The individual service plan (ISP) shall utilize accepted placement criteria and shall be fully completed within 30 calendar days of initiation of service.
    - The substance use case manager shall review the ISP with the individual at least every 90 calendar days. The ISP shall document active substance use case management and shall require a minimum of two distinct substance use case management activities being performed each calendar month.

- 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.
    - Enhancing community integration through increased opportunities for community access and involvement and enhancing community living skills to promote community adjustment including, to the maximum extent possible, the use of local community resources available to the general public;
    - Making collateral contacts with the individual's significant others with properly authorized releases to promote implementation of the individual's ISP and his community adjustment;
    - Linking the individual to those community supports that are most likely to promote the personal habilitative or rehabilitative, recovery, and life goals of the individual as developed in the ISP;
    - Assisting the individual directly to locate, develop, or obtain needed services, resources, and appropriate public benefits;
    - Assuring the coordination of services and service planning within a provider agency, with other providers, and with other human service agencies and systems, such as local health and social services departments.

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❖ Monitoring and follow-up activities: A minimum of one fact to face client contact at least every 90 calendar day period.

- 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:
  - ♦ Services are being furnished in accordance with the individual's care plan;
  - ♦ Services in the care plan are adequate; and
  - ♦ 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.
- Monitoring service delivery through contacts with individuals receiving services, with service providers, and through site and home visits to assess the quality of care and satisfaction of the individual;
- Providing follow-up instruction, education, and counseling to guide the individual and develop a supportive relationship that promotes the ISP;
- Advocating for individuals in response to their changing needs, based on changes in the ISP;
- Planning for transitions in the individual's life;
- Knowing and monitoring the individual's health status, any medical condition, and medications and potential side effects and assisting the individual in accessing primary care and other medical services, as needed; and
- Understanding the capabilities of services to meet the individual's identified needs and preferences and to serve the individual without placing the individual, other particpants, or staff at risk of serious harm.

▪

__X__ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligble individual's needs. (42 CFR 440.169(e))

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D. Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
The enrolled provider shall:

- Have the administrative and financial management capacity to meet state and federal requirements;
- Have the ability to document and maintain individual case records in accordance with state and federal requirements; and
- Be licensed by the Department of Behavioral Health and Developmental Services (DBHDS) as a provider of substance abuse case management services.

Services shall be provided by a professional or professionals who meet at least one of the following criteria:

- At least a bachelor's degree in one of the following fields (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling) and has at least either (i) one year of substance use related direct experience providing services to individuals with a diagnosis of substance use disorder or (ii) a minimum of one year of clinical experience working with individuals with co-occurring diagnoses of substance use disorder and mental illness;
- Licensure by the Commonwealth as a registered nurse with (i) at least one year of substance use related direct experience providing services to individuals with a diagnosis of substance use disorder or (ii) minimum of one year of clinical experience working with individuals with co-occurring diagnoses of substance use disorder and mental illness; or
- Certification as a Board of Counseling Certified Substance Abuse Counselor (CSAC) or CSAC-Assistant under supervision as defined in 18 VAC 115-30-10 et seq.

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E. 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 shall have free choice of the providers of substance abuse case management services.

2. Eligible individuals shall have free choice of the providers of other services under the plan.

F. 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 managmenet (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
- Providers of case management services do not exercise the agency's authority to authorized or deny the provision of other services under the plan;
- Payment for substance use care management or substance use care coordination services under the Plan does not duplicate payments for other case management made to public agencies or private entities under other title XIX program authorities for this same purpose;
- The state assures that substance use case management is only provided by and reimbused to community case management providers;
- The state assures that substance use case management does not include the following:
- 1. The direct delivery of an underlying medical, education, social, or other service to which an eligible individual has been referred.
- 2. Activities for which an individual may be eligible, that are integral to the administration of another nonmedical program, except for case management that is included in an individualized education program or individualized family service plan consistent with § 1903(c) of the Social Security Act.

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G. 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.

H. Case Records (42 CFR 441.19(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows:

(i) The name of the individual;
(ii) The dates of case management services;
(iii) The name of the provider agency (if relevant) and the person providing the case management service;
(iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved;
(v) Whether the individual has declined services in the care plan;
(vi) The need for, and occurrences, of coordination with other case managers;
(vii) A timeline for obtaining needed services;
(viii) A tmeline for reevaluation of the plan.

I. 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 consitute the direct delivery of underlying medical, education, 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, education, 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)).

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§ 11. Case Management for Early Intervention (Part C). (12 VAC 30-50-415)

A. Target group (42 CFR §§ 441.18(8)(i) and 441.18(9):

1. Medicaid eligible children from birth up to age three years who have (i) a 25% developmental delay in one or more areas of development, (ii) atypical development, or (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay who participate in the early intervention services system described in Chapter 53 (§ 2.2-5300 et seq.) of Title 2.2 of the *Code of Virginia*.

2. _N/A__ Target group includes individuals transitioning to a community setting. Case management services will be made available for up to _____ consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions.

B. Areas of State in which services will be provided (§ 1915(g)(1) of the *Act*).

☒ Entire State

☐ Only in the following geographic areas (§ 1915(g)(1) of the *Act*):

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

☐ Services are provided in accordance with § 1902(a)(10)(B) of the *Act*.

☒ Services are not comparable in amount, duration, and scope. (§ 1915(g)(1) of the *Act*).

D. Definition of services (42 CFR 440.169): 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:

Early intervention case management services are services furnished to assist individuals eligible under the State plan who reside in a community setting in gaining access to needed medical, social, educational, and other services. Early intervention case management includes the following assistance as defined in 42 § CFR 440.169 and Chapter 53 (§ 2.2-5300 et seq.) of Title 2.2 of the *Code of Virginia:*

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1. Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social, or other services, including EPSDT services. Needs shall be reassessed at least annually.

2. Development and periodic revision of an Individualized Family Service Plan (IFSP) as defined in coverage of Early Intervention Services under Part C of IDEA (Attachment 3.1 A/B, Supplement 1 section 4 b EPSDT (12 VAC 30-50-131)) based on the information collected through the assessment. The IFSP shall be updated at least annually. A face-to-face contact with the child's family is required for the initial development and annual revision of the IFSP. The case manager shall be responsible for determining if the family's particular situation warrants additional face-to-face visits.

3. Referral and related activities to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the IFSP.

4. Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the IFSP is effectively implemented and adequately addresses the needs of the eligible individual. At a minimum one telephone, e-mail, or face-to-face contact shall be made with the child's family every three calendar months, or attempts of such contacts documented. The case manager shall be responsible for determining if the family's particular situation warrants additional family contacts.

5. Early intervention case management includes contacts with family members, service providers, and other non-eligible individuals and entities that are directly related to the identification of the eligible individual's needs and care. (42 CFR 440.169(e)).

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E. Qualifications of providers. (42 CFR §§441.18(a)(8)(v) and 441.18(b).

Individual providers providing early intervention case management must be certified as an Early Intervention Case Managers by Department of Behavioral Health and Developmental Services (DBHDS).

F. Freedom of choice. (42 CFR § 441.18(a)(1).

1. The state assures that the provision of case management services will not restrict an individual's free choice of provider in violation of § 1902(a)(23) of the *Act*.

a. Eligible recipients shall have free choice of the providers of early intervention case management services within the specified geographic area identified in this plan.

b. Eligible recipients shall have free choice of the providers of other medical care under the plan.

2. Freedom of choice exception (§ 1915(g)(1) and 42 CFR § 441.18(b)):

__XX__ 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.

Authority of § 1915(g)(1) of the *Act* is invoked to limit providers of early intervention case management services without regard to the requirements of § 1902(a)(10)(B) of the *Act*. Providers are limited to entities designated by the local lead agencies under contract with the Department of Behavioral Health and Developmental Services (DBHDS) pursuant to §2.2-5304.1 of the *Code of Virginia* to ensure that the case managers for individuals with developmental disabilities are capable of ensuring that such individuals receive needed services.

G. Access to Services. (42 CFR §§ 441.18(a)(2), 441.18(a)(3), 441.18(a)(6)). The state assures the following:

1. Case management services shall be provided in a manner consistent with the best interest of recipients and shall not be used to restrict an individual's access to other Medicaid services.

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2. Individuals shall not be compelled to receive case management services. The receipt of other Medicaid services shall not be a condition for the receipt of case management services, and the receipt of case management services shall not be a condition for receipt of other Medicaid services.

3. Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other Medicaid services.

H. Payment for 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. Refer to Attachment 4.19-B section J(2) (page 9e of 15) for the reimbursement method.

I. Case records. (42 CFR 441.18(a)(7).

Case management services must be documented and maintained in individual case records in accordance with 42 CFR § 441.18(a)(7) and other state and federal requirements.

J. Limitations.

1. Early intervention case management shall not include the following:

   a. Activities not consistent with the definition of case management services in 42 CFR § 440.169.

   b. The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred.

   c. Activities integral to the administration of foster care programs.

   d. Activities for which third parties are liable to pay, except for case management that is included in an IFSP consistent with § 1903(c) of the *Act*.

2. Payment for case management services under the plan must not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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3. Providers shall not be reimbursed for case management services provided for these following groups when these children also fall within the target group for early intervention case management as set out herein:

a. Seriously Mentally Ill Adults and Emotionally Disturbed Children (Section 2 of Supplement 2 to Attachment 3.1-A page 2 of 25)(12VAC30-50-420)

b. Youth at Risk of Serious Emotional Disturbance (Section 3 of Supplement 2 to Attachment 3.1-A p 7 of 25)(12VAC30-50-430)

c. Individuals with Mental Retardation (Section 4 of Supplement 2 to Attachment 3.1-A p 12 of 25)(12VAC30-50-440)

d. Individuals with Mental Retardation and Related Conditions who are participants in the home and community based care waivers for persons with mental retardation and related conditions (Section 5 of Supplement 2 to Attachment 3.1-A p 17 of 25)(12VAC30-50-450)

4. Case management shall be reimbursed only when all of the following conditions are met:

a. At least one documented case management service is furnished during the month, and;

b. The provider is certified by DBHDS and enrolled with DMAS as an Early Intervention Case Management provider.

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Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):
Medicaid eligible individuals age 18 and older who meet the DMAS definition of traumatic brain injury (TBI). The Medicaid eligible individual shall have a physician or primary care physician documented diagnosis of a severe traumatic brain injury. Individuals under the age of 21 may receive case management services through other state plan options, including developmental disability case management, mental health and addictions treatment case management, treatment foster care case management or early intervention case management for those aged below three years who meet the criteria to receive case management services. Medicaid eligible individuals who qualify for other state plan targeted case management options may only receive one TCM service at a time. The individual will need to choose the TCM service option which meets their individualized service and support needs. Brain damage secondary to other neurological insults (e.g., infection of the brain, stroke, brain tumor, Alzheimer's disease, and similar neuro-degenerative diseases) shall not be covered. The TBI shall be severe as indicated by a T-score of 50 or above on the Mayo-Portland Adaptability Inventory (MPAI-4).

___X___ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 180 days consecutive days of a covered stay in a medical institution. (The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):
X____Entire State
_____Only in the following geographic areas: **[Specify areas]**

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
_____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): 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: An individual receiving Brain Injury Services (BIS) case management services shall have an individual service plan that requires a minimum of one BIS case management service activity each month and at least one face-to-face contact with the individual at least every 90 calendar days.

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- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services, including services provided as an EPSDT service if applicable. These assessment activities include:
  - Taking client history;
  - Identifying the individual's needs and completing related documentation;
  - 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; and
  - Periodic reassessments include evaluating and updating the individual's progress toward meeting the individual service plan objectives and shall occur as needed and at a minimum every 90 calendar days during a review of the individual service plan with the individual.

- Development (and periodic revision) of a specific individual service 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 individual service plan;
  - Enhancing and linking to community integration through increased opportunities for community access and involvement, such as opportunities to learn living skills to promote community adjustment to the maximum extent possible, vocational, civic, recreational services, and the use of other local community resources available to the general public;

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- Making collateral contacts for the direct benefit of the individual with the individual's significant others (legally responsible individuals, legal guardians, service providers, anyone with a role in the individual's recovery) with properly authorized releases to promote implementation of the individual's individual service plan and community adjustment;
- Assisting the individual directly to locate, develop, or obtain needed services, resources, and appropriate public benefits to promote implementation of the individual's individual service plan and community adjustment; and
- Assuring the coordination of services and service planning within a provider agency, with other providers, and with other human service agencies and systems, such as local health and social services departments.

❖ 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:
  - Services are being furnished in accordance with the individual's individual service plan;
  - Services in the individual service plan are adequate; and
  - Changes in the needs or status of the individual are reflected in the individual service plan. Monitoring and follow-up activities include making necessary adjustments in the individual service plan and service arrangements with providers.
- On an annual basis, the person-centered individual service plan is conducted to review current status and changes from previous years. It also includes a review of provider plans. As needed outside the annual review, the case manager may convene a meeting to re-evaluate the appropriateness of the plan if the individual's needs have changed. Case Managers conduct reviews every 90 calendar days of their services plans and effectiveness of that plan to determine if it remains appropriate and if modifications are needed.

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X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
The enrolled provider shall:

- Be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) or
- Be licensed by the Department of Behavioral Health and Developmental Services (DBHDS) as a provider of case management services.

The enrolled provider shall also:

- Guarantee that individuals have access to emergency services on a 24-hour basis.
- Demonstrate the ability to serve individuals in need of comprehensive services regardless of the individual's ability to pay or eligibility for Medicaid reimbursement.
- Have the administrative and financial management capacity to meet state and federal requirements.
- Have the ability to document and maintain individual case records in accordance with state and federal requirements.

Case management services shall be provided by a professional or professionals who meet the following criteria:

- At least a bachelor's degree from an accredited college or university and
- Be a Qualified Brain Injury Support Provider (QBISP) or Certified Brain Injury Specialist (CBIS) or
- Licensure by the Commonwealth as a registered nurse and
- Be a Qualified Brian Injury Support Provider (QBISP) or Certified Brain Injury Specialist (CBIS)

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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.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
N/A 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**.**

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Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

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