METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

5. All of the services on this page have rates effective as of September 1, 2010

a. Podiatrists' – Payment is made on the basis of a fixed fee schedule, set at 53% of the 2005 Medicare fee schedule..
State-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of March 29, 2009 and is effective for services provided on or after that date. All rates are published http://www.maine.gov/dhhs/audit/rate-setting/documents/S95R03292009.pdf

b. Optometrists' – Payment is made on the basis of a fixed fee schedule set at 53% of the lowest level in the current Medicare fee schedule. State-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of March 29, 2009 and is effective for services provided on or after that date. All rates are published http://www.maine.gov/dhhs/audit/rate-setting/documents/S75R03292009.pdf

c. Physician Provided Optometric Procedures – Payment is made based on a fixed fee schedule set at 70% of the 2009 Medicare fee schedule. State-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of September 1, 2010 and is effective for services provided on or after that date. All rates are published http://www.maine.gov/dhhs/audit/rate-setting/documents/S75R03292009.pdf

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

6. a. Chiropractors –State-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of November 23, 2009 and is effective for services provided on or after that date. All rates are published http://www.maine.gov/dhhs/audit/rate-setting/documents/S15R11232009.pdf

   b. Psychologists – The State agency will apply the payment rate as described in Attachment 4.19-A when provided by a hospital and as described in Item 5 above when provided as physicians' Services. Please see below for more information regarding reimbursement methodologies within specific services.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

7. a.. Home Health Care Services – Intermittent or part time nursing home health aide services, physical therapy, speech-language pathology, occupational therapy, furnished by a licensed and Medicare certified home health agency. Payment is made on the basis of the lowest of :a fixed fee, based on the provider's Medicare cost reports; or the provider's usual and customary charge. State-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of October 18, 2010 and is effective for services provided on or after that date. All rates are published http://www.maine.gov/dhhs/audit/rate-setting/documents/S40R10182010.pdf

   b. Medical Supplies, equipment, and appliances for use of patients in their own home, payments are the lowest of:

      1. a fee schedule at http://www.maine.gov/dhhs/audit/rate-setting/documents/S60R08092010.pdf, or
      2. acquisition cost plus forty percent (with 40% not to exceed $2000) or
      3. the provider's usual and customary charge.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

8. Private Duty Nursing – Nursing services furnished by a licensed home health agency or an independent professional registered nurse. Payment is made on the basis of a fixed fee schedule. State-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of January 9, 2011 and is effective for services provided on or after that date. All rates are published http://www.maine.gov/dhhs/audit/rate-setting/documents/S96R01092011.pdf

   Levels of care I through V have financial caps as follows below. For individuals qualifying under EPSDT, the service caps may be exceeded if services are determined medically necessary. Reimbursement of care coordination and skills training do not count toward the monthly cost caps.

Level I	$750/month
Level II	$950/month
Level III	$1,550/month
Level IV (under 21 years of age, only)	$3,133/month
Level V	$20,682/month
Level VIII	$750/month
Level IX	$1,436/month

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

9. Clinic Services – Payment is made on the basis of a fixed fee schedule. State-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of December 21, 2009 and is effective for services provided on or after that date. All rates are published http://www.maine.gov/dhhs/audit/rate-setting/documents/S3R09012010.pdfPayment is also made to Sec. 638 tribal facilities in accordance with the periodic Federal Register notice addressing the HIS encounter rate. The following services were included in the all inclusive rate paid to Indian Health Centers:
    - Laboratory And X-Rays
    - EPSDT
    - Family Planning Services
    - Physician Services
    - Medical And Surgical Services Provided By A Dentist
    - Podiatrist's Services
    - Chiropractor's Services
    - Psychological Examiner's Services
    - Licensed Clinical Social Workers And LCPCs
    - Intermittent Or Part Time Nursing Services
    - Home Health Aide Services
    - Physical, Occupational and Speech/Language Therapy and Audiology Services provided by a Home Health Agency
    - Private Duty Nursing Services
    - Clinic Services
    - Dental Services
    - Physical Therapy
    - Occupational Therapy
    - Services for Speech, Hearing and Language Disorder
    - Mental Health Diagnostic Services
    - STD Screening
    - Mental Health Preventive Services
    - Nurse Midwife Services
    - Pregnancy Related and Postpartum Services
    - Extended Services to Pregnant Women
    - Ambulatory Prenatal Care for Pregnant Women
    - Certified Pediatric or Family Nurse Practitioner's Services
    - Advanced Practice Nurses

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

10. Dental Services – Payment for these services is made on the basis of a fixed fee schedule, State-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of August 9, 2010 and is effective for services provided on or after that date. All rates are published http://www.maine.gov/dhhs/audit/rate-setting/documents/S25R08092010.pdf

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

11. Physical Therapy and related services.

a. Physical Therapy – Payment is made on the basis of a fixed fee schedule. State-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rates were set as of September 1, 2010 respectively and were effective for services provided on or after that date. All rates are published http://www.maine.gov/dhhs/audit/rate-setting/documents/S85R09012010.pdf

b. Occupational Therapy –State-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rates were set as of September 28, 2010 and were effective for services provided on or after that date. All rates are published http://www.maine.gov/dhhs/audit/rate-setting/documents/S68R09282010.pdf

c. Services for individuals with speech, hearing, and language disorder –State-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rates were set as of September 1, 2010 and were effective for services provided on or after that date. All rates are published http://www.maine.gov/dhhs/audit/rate-setting/documents/S109R912010a.pdf

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

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d. Dentures – See item 10 above.

e. Prosthetic Devises – Payment is based upon the lowest of fixed fees, usual and customary and manufacturer's suggested retail cost for these devices. (See 7 b. above).

b. Eyeglasses – Payment is made on the basis of a fixed fee schedule that is included in a negotiated contract., , State-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rates were set as of July 1, 2010 and were effective for services provided on or after that date. All rates are published http://www.maine.gov/dhhs/audit/rate-setting/documents/S75R03292009.pdf

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

12. Other diagnostic, screening, preventive and rehabilitative services – The State agency will apply the payment rate as described in Attachment 4.19-A when provided by a hospital and as described in Item 5 above when provided as physicians' Services. Rehabilitation Services:
    a. Private non-medical institutions – Payment is made under contracts which are based on capitation rates.

    b. Mental health agency services– State-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of July 7, 2011 and is effective for services provided on or after that date. State-developed fee schedules are never higher than the Medicare allowable amount for those services covered by Medicare. All rates are published http://www.maine.gov/dhhs/audit/rate-setting/documents/S23R09282010.pdf

    c. Substance Abuse Treatment Services– State-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of July 1, 2010 and is effective for services provided on or after that date. All rates are published http://www.maine.gov/dhhs/audit/rate-setting/documents/S65R06072011.pdf

    d. Day Health Services – State-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rates were set as of September 1, 2010 and were effective for services provided on or after that date. All rates are published http://www.maine.gov/dhhs/audit/rate-setting/documents/S26R09012010.pdf

    e. Rehabilitation Services–State-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rates were set as of September 28, 2010 and were effective for services provided on or after that date. All rates are published http://www.maine.gov/dhhs/audit/rate-setting/documents/S102R04012010.pdf.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

13. Skilled and intermediate care nursing services for individuals 65 years of age or over in an institution for mental disease – See Attachment 4.19-D.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

14. Nursing Facility Services – (other than in institutions for mental disease as described under #14 above) – See Attachment 4.19-D.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

15. Inpatient Psychiatric Hospital Services for individuals under 22. See Attachment 4.91-A (under Inpatient Hospital Services

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

16. Nurse-midwives – Payment is made on the basis of a fixed fee schedule. State-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of September 1, 2010 and is effective for services provided on or after that date. All rates are published http://www.maine.gov/dhhs/audit/rate-setting/documents/S3R09012010.pdf

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

17. Any other medical care and any other type of remedial care recognized under State law:

a. Ambulance Services – State-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rates were set as of August 1, 2010 and were effective for services provided on or after that date. All rates are published http://www.maine.gov/dhhs/audit/rate-setting/documents/S5R08012010.pdf

b. Skilled Nursing Facility Services to patients under 21 – See Attachment 4.19-D.

c. Emergency Hospital Services – The State agency will apply the payment rate as described in Attachment 4.19-A.

d. Personal Care Services:

1. Payment is made on the basis of a fixed fee schedule. The amount of personal care services in combination with home health services and private duty nursing services will be limited to an annual or monthly cap as determined by the Department. State-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of January 9, 2011 and is effective for services provided on or after that date. All rates are published http://www.maine.gov/dhhs/audit/rate-setting/documents/S96R01092011.pdf

2. Personal Care Services provided by a Private Non-Medical Institution - State-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rates for Appendix B were set as of November 15, 2010, Appendix C were set as of July 1, 2011, Appendix E were set as of July 1, 2010 and Appendix F were set as of July 1, 2011; all rates were effective for services provided on or after that date. All rates are published: Appendix B: http://www.maine.gov/dhhs/audit/rate-setting/documents/S97BR01012010.pdf, Appendix C: http://www.maine.gov/dhhs/audit/rate-setting/documents/S97CR07012011.pdf, Appendix E http://www.maine.gov/dhhs/audit/rate-setting/documents/S97ER07012010.pdf, Appendix F http://www.maine.gov/dhhs/audit/rate-setting/documents/S97FR07012011.pdf

e. Hospice Services – State-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of October 6, 2010 and is effective for services provided on or after that date. All rates are published http://www.maine.gov/dhhs/audit/rate-setting/documents/S43R10062010.pdf.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

18. Transportation Services – Payment is made on the basis of a fee schedule. State-developed fee schedule rates are the same for both governmental and private providers . The agency's fee schedule rate was set as of September 28, 2010 and is effective for services provided on or after that date. All rates are published http://www.maine.gov/dhhs/audit/rate-setting/documents/S113R09282010.pdf

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

19. Case Management Services – Payments for all Targeted Case Management services are made in accordance with 42 CFR 441.18 and will not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. All payment rates for Targeted Case Management services are based on an established fee schedule using a standardized unit of service and a maximum per unit rate. The same level of provider furnishes all of the targeted case management services.

    The following are established for the eight types of Targeted Case Management Services;

    - Targeted Case Management Services for Adults with Developmental Disabilities are paid for a weekly unit of service and are paid at the lesser of the following: the fee established by MaineCare, the lowest payment allowed by Medicare or the provider's usual and customary charge.

      State-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of September 1, 2010 and is effective for services provided on or after that date. All rates are published http://www.maine.gov/dhhs/audit/rate-setting/documents/S13R09012010.pdf

      Coverage and reimbursement of case management services for the protective services target group will cease on November 1, 2011.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

- Targeted Case Management Services for Children with Chronic Health Conditions are paid for in fifteen (15) minute units of service and are paid at the lesser of the following: the fee established by MaineCare, the lowest payment allowed by Medicare or the provider's usual and customary charge.

  State-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of September 1, 2010 and is effective for services provided on or after that date. All rates are published http://www.maine.gov/dhhs/audit/rate-setting/documents/S13R09012010.pdf

  Coverage and reimbursement of case management services for the protective services target group will cease on November 1, 2011.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

- Targeted Case Management Services for Members with HIV are paid for in fifteen (15) minute units of service and are paid at the lesser of the following: the fee established by MaineCare, the lowest payment allowed by Medicare or the provider's usual and customary charge.

  State-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of September 1, 2010 and is effective for services provided on or after that date. All rates are published http://www.maine.gov/dhhs/audit/rate-setting/documents/S13R09012010.pdf

  Coverage and reimbursement of case management services for the protective services target group will cease on November 1, 2011.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

- Targeted Case Management Services for Children involved with Protective Services provided by contract agencies are paid for in fifteen (15) minute units of service and are paid at the lesser of the following: the fee established by MaineCare, the lowest payment allowed by Medicare or the provider's usual and customary charge. For those services provided by state agencies the unit of service is weekly and they are paid at the lesser of the following: the fee established by MaineCare, the lowest payment allowed by Medicare or the provider's usual and customary charge.

  State-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of September 1, 2010 and is effective for services provided on or after that date. All rates are published http://www.maine.gov/dhhs/audit/rate-setting/documents/S13R09012010.pdf

  Coverage and reimbursement of case management services for the protective services target group will cease on November 1, 2011.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

- Targeted Case Management Services for adults involved with protective services are paid for in fifteen (15) minute units of service and are paid at the lesser of the following: the fee established by MaineCare, the lowest payment allowed by Medicare or the provider's usual and customary charge.

  State-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of September 1, 2010 and is effective for services provided on or after that date. All rates are published http://www.maine.gov/dhhs/audit/rate-setting/documents/S13R09012010.pdf

  Coverage and reimbursement of case management services for the protective services target group will cease on November 1, 2011.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

- Targeted Case Management Services for Adults with Substance Abuse Disorders are paid for in fifteen (15) minute units of service and are paid at the lesser of the following: the fee established by MaineCare, the lowest payment allowed by Medicare or the provider's usual and customary charge.

  State-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of September 1, 2010 and is effective for services provided on or after that date. All rates are published http://www.maine.gov/dhhs/audit/rate-setting/documents/S13R09012010.pdf

  Coverage and reimbursement of case management services for the protective services target group will cease on November 1, 2011.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

20. Certified family and pediatric nurse practitioners – State-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of September 1, 2010 and is effective for services provided on or after that date. All rates are published http://www.maine.gov/dhhs/audit/rate-setting/documents/S14R09012010.pdf

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

21. Advanced Practice Nurses other than Nurse Midwives and Certified family and pediatric nurse practitioners – Payment is based on the established fee schedule for Physicians' Services as described in Item 5, except that these nurses are not eligible for the physician incentive plan. See Attachment 4.19-B, Physician (and other prescribers) Directed Drug Initiative (PDDI), Pages 1-b-1-d. State-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of September 1, 2010 and is effective for services provided on or after that date. All rates are published http://www.maine.gov/dhhs/audit/rate-setting/documents/S14R09012010.pdf

State Plan under Title XIX of the Social Security Act
State/Territory: Maine
TARGETED CASE MANAGEMENT SERVICES
[Children with Chronic Health Conditions]

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

Children with Chronic Health Conditions must meet the following criteria:

Eligibility Criteria for Children with Chronic Medical Conditions

1. A child who is infected with the human immunodeficiency virus (HIV), as determined by a positive HIV antibody or antigen test, or who has a diagnosis of HIV disease or AIDS;
   OR
2. A child who has:
   a. been diagnosed with an autoimmune disease, diabetes, respiratory disorder, a neurological disorder, brain injury or other chronic condition specifically recognized by the Department or its authorized agent;
   AND
   b. three (3) or more documented functional limitations as defined in 13.03-2(B) (Functional Limitations);
   OR
3. A child who has:
   a. a diagnosed physical condition or the presence of a documented history by a professional approved by the Department of prenatal, perinatal, neonatal, or early physical developmental events or conditions suggestive of damage to the central nervous system or of later atypical physical development, such as, but not limited to, cerebral palsy, meningitis, heart defects, or bronchiopulmonary dysplasia which, without intervention, has a high probability of resulting in physical developmental delay,
   AND
   b. significant impairment or limitation in adaptive functioning according to criteria as established by the Department and determined by a qualified professional approved by the Department.

_X__ Target group includes individuals transitioning to a community setting and are consistent with all federal guidelines. Case-management services will be made available for up to 30 days consecutive days of a covered stay in a medical institution. Reimbursement is made to community-based case managers and not the medical institution for this service. 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)

State Plan under Title XIX of the Social Security Act
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TARGETED CASE MANAGEMENT SERVICES
[Children with Chronic Health Conditions]

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:

- 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;

The comprehensive assessment must be completed within the first thirty (30) days of initiation of services and reassessment must minimally occur on an annual basis (or as a change in the member's needs occur).

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

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

State Plan under Title XIX of the Social Security Act
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TARGETED CASE MANAGEMENT SERVICES
[Children with Chronic Health Conditions]

- Monitoring and follow-up activities are consistent with federal regulations and include:
  - 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. **Plans must be monitored at least every 90 days, or as the member's needs change and any change in the plan must be documented in the member's file.** Monitoring will be conducted 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.

__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)):
Provider qualifications are as follows:

Staff Qualifications
Comprehensive Case Manager Qualifications

a. Staff must have a minimum of a:

1. Bachelor's Degree from an accredited four (4) year institution of higher learning with a specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing or closely related field,
OR
2. Graduate of an accredited graduate school with a Master's Degree in social work, education, psychology, counseling, nursing or closely related field,
OR
3. Bachelor's Degree from an accredited four (4) year institution of higher learning in an unrelated field and at least one (1) year of full-time equivalent relevant human services experience,
OR
4. Staff who were employed at the time this rule goes into effect (8/1/2009) as a case manager providing services under the former subsections will be considered qualified.

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TARGETED CASE MANAGEMENT SERVICES
[Children with Chronic Health Conditions]

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)):
____ 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: **[Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]**

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (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.

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TARGETED CASE MANAGEMENT SERVICES
[Children with Chronic Health Conditions]

Limitations:
Case management does not include, and Federal Financial Participation (FFP) 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).

Case management does not include, and Federal Financial Participation (FFP) 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 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))

[Specify any additional limitations.]

State Plan under Title XIX of the Social Security Act
State/Territory: Maine
TARGETED CASE MANAGEMENT SERVICES
[Members Experiencing Homelessness]

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

Members Experiencing Homelessness must meet the following criteria:
Members experiencing homelessness but who otherwise are not eligible for TCM must meet the following Eligibility Criteria to be eligible for TCM under this Section.
A member who;

1. currently resides or has in the past ninety (90) days resided in an emergency shelter in the State of Maine,
   OR
2. does not otherwise have a permanent address, residence, or facility in which they could reside,
   AND
3. requires treatment or services from a variety of agencies and providers to meet the individual's medical, social, educational, and other needs,
   AND
4. will access needed services only if assisted by a qualified targeted comprehensive case manager who, in accordance with the individual plan of care, locates, coordinates, and regularly monitors the services.

5. Additionally members experiencing homelessness must meet one or more of the following criteria to be eligible for TCM under this section;
   a. is in need of immediate medical care, OR
   b. is in need of an immediate crisis evaluation or mental health assessment to address a behavioral health issue, OR
   c. has a current medical or mental health condition and is at risk of losing or has lost access to medically necessary services, OR
   d. has an immediate need for medications to address an existing medical and/or behavioral health condition, OR
   e. is demonstrating physical or mental impairment such that services are necessary to improve, restore or maintain health and well-being, OR
   f. has experienced immediate or recent trauma and is demonstrating a need for assistance with gaining and coordinating access to necessary care and services appropriate to their needs.

_X__ Target group includes individuals transitioning to a community setting and are consistent with all federal guidelines. Case-management services will be made available for up to 30 days consecutive days of a covered stay in a medical institution. Reimbursement is made to community-based case managers and not the medical institution for this service. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals

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3. Bachelor's Degree from an accredited four (4) year institution of higher learning in an unrelated field and at least one (1) year of full-time equivalent relevant human services experience,

OR

4. Staff who were employed at the time this rule goes into effect (8/1/2009) as a case manager providing services under the former subsections will be considered qualified.

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)):
____ 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: **[Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]**

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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

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[Members Experiencing Homelessness]

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 §441.169 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 §441.169 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))

Services are provided to homeless individuals following a determination of medical need. The services are provided to homeless individuals who require multiple services to meet multiple assessed needs and they have services that are considered necessary to prevent, alleviate, prevent worsening of or correct conditions that endanger life, cause suffering or pain, result in illness, or interfere with a person's capacity for normal activity.

[Specify any additional limitations.]

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TARGETED CASE MANAGEMENT SERVICES
[Children with Behavioral Health Disorders]

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

Children, ages birth through 20 with behavioral health disorders. The specific eligibility requirements are as follows:
Children must meet the criteria listed below in subsections 1 OR 2. In addition children must meet the criteria listed in subsection 3 to be eligible for TCM Services.

1. A child with a completed multi-axial evaluation of an Axis I or Axis II mental health diagnosis(es) as described in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or a diagnosis described in the most recent version of the Diagnostic Classification of Mental Health and Developmental Disabilities of Infancy and Early Childhood (DC: 0-3). Axis I mental health diagnoses do not include the following: Learning Disabilities (LD) in reading, mathematics, written expression, Motor Skills Disorder, and LD NOS (Learning Disabilities Not Otherwise Specified); Communication Disorders (Expressive Language Disorders, Mixed Receptive Expressive Language Disorder, Phonological Disorder, Stuttering, and Communication Disorder NOS);

   OR

2. A child between birth and five (5) years of age who:
   a. is determined by a professional approved by the Department as being at risk of developing a mental health disorder due to known environmental or biological risks using DHHS adopted tools,
      AND
   b. has significant impairment or limitation in adaptive behavior or functioning according to criteria as established by the Department and determined by a qualified professional approved by the Department.

3. Level of Care Criteria for services assessed through the CAFAS:
   a. Case management service is authorized for up to thirty (30) days from the date of the first billed encounter if the eight (8) scale composite CAFAS score is fifty (50) or less.
   b. Case management services may continue beyond thirty (30) and up to ninety (90) days from the date of the first billed encounter if the eight (8) scale composite CAFAS score is at least between fifty-one (51) and seventy (70).
   c. Clinical information will be considered in addition to the composite CAFAS scores above as the scores are not the sole criteria for eligibility and review.
   d. Case management services may continue if the 8 scale CAFAS score is above seventy (70). Service continuation will be dependent upon clinical information submitted.

_X__ Target group includes individuals transitioning to a community setting and are consistent with all federal guidelines. Case-management services will be made available for up to 30 days consecutive days of a covered stay in a medical institution. Reimbursement is made to community-based case managers and not the medical institution for this service. The target group does not include individuals between ages

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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:

- 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;

The comprehensive assessment must be completed within the first thirty (30) days of initiation of services and reassessment must minimally occur on an annual basis (or as a change in the member's needs occur).

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

- Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including

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- 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 are consistent with federal regulations and include:
  - o 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. **Plans must be monitored at least every 90 days, or as the member's needs change and any change in the plan must be documented in the member's file.** Monitoring will be conducted to determine whether the following conditions are met:
  - o services are being furnished in accordance with the individual's care plan;
  - o services in the care plan are adequate; and
  - o 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.

__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)):
Provider qualifications are as follows:

Staff Qualifications
Comprehensive Case Manager Qualifications

a. Staff must have a minimum of a:
   1. Bachelor's Degree from an accredited four (4) year institution of higher learning with a specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing or closely related field,
   OR

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2. Graduate of an accredited graduate school with a Master's Degree in social work, education, psychology, counseling, nursing or closely related field,
   OR
3. Bachelor's Degree from an accredited four (4) year institution of higher learning in an unrelated field and at least one (1) year of full-time equivalent relevant human services experience,
   OR
4. Staff who were employed at the time this rule goes into effect (8/1/2009) as a case manager providing services under the former subsections will be considered qualified.

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)):
____ 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: **[Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups 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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[Children with Behavioral Health Disorders]

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 §441.169 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 §441.169 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))

[Specify any additional limitations.]

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TARGETED CASE MANAGEMENT SERVICES
[Members with Developmental Disabilities]

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

Adults with Developmental Disabilities must meet the following criteria:

An individual is eligible for case management services if he or she is age eighteen (18) or older and meets the eligibility requirements of Title 34B M.R.S.A.§3573, which defines developmental disabilities, or Title 34B M.R.S.A. §6002, which defines autism. A person who has reached his or her eighteenth (18^{th}) birthday and is under age twenty-one (21) may choose to receive case management services as an adult.

Children with Developmental Disabilities must meet the following criteria:

Acceptable standardized instruments means, for developmental disabilities, CHAT (ages 6 through 20), Vineland Adaptive Behavior Scales (up through age 20), Battelle Developmental Inventory (up through age 7), Bayley Scales of Infant and Toddler Development (age 1 month through 2 years), and Ages and Stages (and Ages and Stages Social Emotional scales) (up through age 5).

Children must meet the criteria listed below in subsection 1 OR 2 OR 3. In addition children must meet the criteria listed in 4 to be eligible for TCM Services.

1. Meet the definition of developmental disabilities as defined in 22 M.R.S.A. §3573 or have an Axis II diagnosis of mental retardation as described in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders;
   OR
2. Have an Axis I diagnosis of pervasive developmental disorder as described in the most recent Diagnostic and Statistical Manual of Mental Disorders;
   OR
3. For children between birth and five (5) years of age:
   a. Are determined by a professional approved by the Department as being at risk of developing a Pervasive Developmental Disorder due to known environmental or biological risks using DHHS adopted tools,
   AND
   b. Have significant impairment or limitation in adaptive behavior or functioning according to criteria established by the Department (See Section 13.03-2(B)) and as determined by a qualified professional approved by the Department.
4. Level of Care Criteria for services assessed through the CHAT:
   a. Case management service is authorized for up to thirty (30) days from the date of the first billed encounter if the CHAT score is twenty (25) or less.

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b. Case management services may continue beyond thirty (30) and up to ninety (90) days from the date of the first billed encounter if the CHAT score is at least between twenty-six (26) and thirty-five (35).

c. Clinical information will be considered in addition to the CHAT scores above as the scores are not the sole criteria for eligibility and review.

d. Case management services may continue if the CHAT score is above 35. Service continuation will be dependent upon clinical information submitted.

_X__ Target group includes individuals transitioning to a community setting and are consistent with all federal guidelines. Case-management services will be made available for up to 30 days consecutive days of a covered stay in a medical institution. Reimbursement is made to community-based case managers and not the medical institution for this service. 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:

- 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;

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The comprehensive assessment must be completed within the first thirty (30) days of initiation of services and reassessment must minimally occur on an annual basis (or as a change in the member's needs occur).

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

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

- ❖ Monitoring and follow-up activities are consistent with federal regulations and include:
  - 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. **Plans must be monitored at least every 90 days, or as the member's needs change and any change in the plan must be documented in the member's file.** Monitoring will be conducted to determine whether the following conditions are met:
    - o services are being furnished in accordance with the individual's care plan;
    - o services in the care plan are adequate; and
    - o 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.

__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)):

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[Members with Developmental Disabilities]

Provider qualifications are as follows:

Staff Qualifications
Comprehensive Case Manager Qualifications

a. Staff must have a minimum of a:

1. Bachelor's Degree from an accredited four (4) year institution of higher learning with a specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing or closely related field,
OR
2. Graduate of an accredited graduate school with a Master's Degree in social work, education, psychology, counseling, nursing or closely related field,
OR
3. Bachelor's Degree from an accredited four (4) year institution of higher learning in an unrelated field and at least one (1) year of full-time equivalent relevant human services experience,
OR
4. Staff who were employed at the time this rule goes into effect (8/1/2009) as a case manager providing services under the former subsections will be considered qualified.

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)):
____ 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: **[Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups 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

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receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and

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

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (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 §441.169 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 §441.169 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))
[Specify any additional limitations.]

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State/Territory: Maine
TARGETED CASE MANAGEMENT SERVICES
[Members with Developmental Disabilities]

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

Adults with Developmental Disabilities must meet the following criteria:

An individual is eligible for case management services if he or she is age eighteen (18) or older and meets the eligibility requirements of Title 34B M.R.S.A.§3573, which defines developmental disabilities, or Title 34B M.R.S.A. §6002, which defines autism. A person who has reached his or her eighteenth (18^{th}) birthday and is under age twenty-one (21) may choose to receive case management services as an adult.

Children with Developmental Disabilities must meet the following criteria:

Acceptable standardized instruments means, for developmental disabilities, CHAT (ages 6 through 20), Vineland Adaptive Behavior Scales (up through age 20), Battelle Developmental Inventory (up through age 7), Bayley Scales of Infant and Toddler Development (age 1 month through 2 years), and Ages and Stages (and Ages and Stages Social Emotional scales) (up through age 5).

Children must meet the criteria listed below in subsection 1 OR 2 OR 3. In addition children must meet the criteria listed in 4 to be eligible for TCM Services.

1. Meet the definition of developmental disabilities as defined in 22 M.R.S.A. §3573 or have an Axis II diagnosis of mental retardation as described in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders;
   OR
2. Have an Axis I diagnosis of pervasive developmental disorder as described in the most recent Diagnostic and Statistical Manual of Mental Disorders;
   OR
3. For children between birth and five (5) years of age:
   a. Are determined by a professional approved by the Department as being at risk of developing a Pervasive Developmental Disorder due to known environmental or biological risks using DHHS adopted tools,
   AND
   b. Have significant impairment or limitation in adaptive behavior or functioning according to criteria established by the Department (See Section 13.03-2(B)) and as determined by a qualified professional approved by the Department.
4. Level of Care Criteria for services assessed through the CHAT:
   a. Case management service is authorized for up to thirty (30) days from the date of the first billed encounter if the CHAT score is twenty (25) or less.

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b. Case management services may continue beyond thirty (30) and up to ninety (90) days from the date of the first billed encounter if the CHAT score is at least between twenty-six (26) and thirty-five (35).

c. Clinical information will be considered in addition to the CHAT scores above as the scores are not the sole criteria for eligibility and review.

d. Case management services may continue if the CHAT score is above 35. Service continuation will be dependent upon clinical information submitted.

_X__ Target group includes individuals transitioning to a community setting and are consistent with all federal guidelines. Case-management services will be made available for up to 30 days consecutive days of a covered stay in a medical institution. Reimbursement is made to community-based case managers and not the medical institution for this service. 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:

- 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;

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The comprehensive assessment must be completed within the first thirty (30) days of initiation of services and reassessment must minimally occur on an annual basis (or as a change in the member's needs occur).

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

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

- ❖ Monitoring and follow-up activities are consistent with federal regulations and include:
  - 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. **Plans must be monitored at least every 90 days, or as the member's needs change and any change in the plan must be documented in the member's file.** Monitoring will be conducted to determine whether the following conditions are met:
    - o services are being furnished in accordance with the individual's care plan;
    - o services in the care plan are adequate; and
    - o 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.

__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)):

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[Members with Developmental Disabilities]

Provider qualifications are as follows:

Staff Qualifications
Comprehensive Case Manager Qualifications

a. Staff must have a minimum of a:

1. Bachelor's Degree from an accredited four (4) year institution of higher learning with a specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing or closely related field,
OR
2. Graduate of an accredited graduate school with a Master's Degree in social work, education, psychology, counseling, nursing or closely related field,
OR
3. Bachelor's Degree from an accredited four (4) year institution of higher learning in an unrelated field and at least one (1) year of full-time equivalent relevant human services experience,
OR
4. Staff who were employed at the time this rule goes into effect (8/1/2009) as a case manager providing services under the former subsections will be considered qualified.

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)):
____ 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: **[Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups 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

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receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and

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

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (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 §441.169 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 §441.169 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))
[Specify any additional limitations.]

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Members in Protective Services of DHHS

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

Adults in Protective Custody must meet the specific eligibility requirements as follows:

Has attained the age of 18 years or is a legally emancipated minor; and a request or referral or nomination of guardianship or conservatorship has been submitted to the Office of Elder Services.

Children in Protective Custody must meet the specific eligibility criteria:

A child is under the age of eighteen (18) and is abused or neglected, or is suspected to be at risk of abuse or neglect; AND either a request or referral for investigation of suspected child abuse or neglect is submitted to the Office of Child and Family Services; OR
A child or young adult under age twenty-one (21) if the individual is either in the custody of the Department of Health and Human Services or of an agency in another State pursuant to a court order, or is in voluntary care of the Department or an agency in state pursuant to a written agreement or is a family receiving post-adoption services or services provided within a Private Non-Medical Institution, as defined in Section 97, Private Non-Medical Institutions, of the MaineCare Benefits Manual.

_X__ Target group includes individuals transitioning to a community setting and are consistent with all federal guidelines. Case-management services will be made available for up to 30 days consecutive days of a covered stay in a medical institution. Reimbursement is made to community-based case managers and not the medical institution for this service. 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)

Coverage and reimbursement of case management services for the protective services target group will cease on November 1, 2011.

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)).

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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:

- 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;

The comprehensive assessment must be completed within the first thirty (30) days of initiation of services and reassessment must minimally occur on an annual basis (or as a change in the member's needs occur).

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

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

- Monitoring and follow-up activities are consistent with federal regulations and include:
  - 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. **Plans must be monitored at least every 90 days, or as the member's needs change and any change in the plan must be documented in the member's file.**

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Monitoring will be conducted 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.

__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))

Targeted Case Management Services for Members involved with protective/social welfare services are provided following a determination of the medical necessity for the services. The State Medicaid Agency determines the medical necessity for these services. Targeted Case Management services are provided after a determination that they are necessary to prevent, alleviate, prevent the worsening of or correct conditions that endanger life, cause suffering or pain, result in illness, interfere with a person's capacity for normal activity.

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
Provider qualifications are as follows:

Staff Qualifications
Comprehensive Case Manager Qualifications

a. Staff must have a minimum of a:
   1. Bachelor's Degree from an accredited four (4) year institution of higher learning with a specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing or closely related field,
      OR
   2. Graduate of an accredited graduate school with a Master's Degree in social work, education, psychology, counseling, nursing or closely related field,
      OR
   3. Bachelor's Degree from an accredited four (4) year institution of higher learning in an unrelated field and at least one (1) year of full-time equivalent relevant human services experience,
      OR

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4. Staff who were employed at the time this rule goes into effect (8/1/2009) as a case manager providing services under the former subsections will be considered qualified.

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)):
____ 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: **[Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]**

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (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

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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 §441.169 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 §441.169 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))

[Specify any additional limitations.]

Coverage and reimbursement of case management services for the protective services target group will cease on November 1, 2011.

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[Adults with Substance Abuse Disorders]

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

Adults with Substance Abuse Disorders must meet the specific eligibility requirements as follows:

1. An adult who has an Axis I diagnosis(es) of substance abuse disorder(s) described in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) AND
2. Who is currently seeking substance abuse treatment services by a DHHS approved substance abuse treatment provider; AND
3. Who is pregnant, who is living with his or her minor children, and/or who is an intravenous drug user, AND
4. Who is enrolled in a substance abuse program which receives funding by the Substance Abuse Prevention Treatment Block Grant as provided by 42 U.S.C. section 300x-22(b).

_X__ Target group includes individuals transitioning to a community setting and are consistent with all federal guidelines. Reimbursement is made to community-based case managers and not to the medical institution for this service. Case-management services will be made available for up to thirty (30) 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:

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- 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;

The comprehensive assessment must be completed within the first thirty (30) days of initiation of services and reassessment must minimally occur on an annual basis (or as a change in the member's needs occur).

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

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

- Monitoring and follow-up activities are consistent with federal regulations and include:
    - 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. **Plans must be monitored at least every 90 days, or as the member's needs change and any change in the plan must be documented in the member's file.** Monitoring will be conducted 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.

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Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

__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)):
Provider qualifications are as follows:

Staff Qualifications
Comprehensive Case Manager Qualifications

a. Staff must have a minimum of a:

1. Bachelor's Degree from an accredited four (4) year institution of higher learning with a specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing or closely related field,
OR
2. Graduate of an accredited graduate school with a Master's Degree in social work, education, psychology, counseling, nursing or closely related field,
OR
3. Bachelor's Degree from an accredited four (4) year institution of higher learning in an unrelated field and at least one (1) year of full-time equivalent relevant human services experience,
OR
4. Staff who were employed at the time this rule goes into effect (8/1/2009) as a case manager providing services under the former subsections will be considered qualified.

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)):
_____ 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

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disabilities or with chronic mental illness receive needed services: **[Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]**

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (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 §441.169 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 §441.169 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;

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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))

[Specify any additional limitations.]