# TARGETED CASE MANAGEMENT SERVICES

## A. TARGET GROUP

Effective 10/01/95

### 1. Mentally Retarded/Developmentally Disabled

The population to be served consists of individuals who meet diagnostic criteria according to the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition) for mental retardation and/or the definition of developmental disability defined in West Virginia Code 42-4A-2 as "a severe, chronic disability of a person which: (1) is attributable to a mental or physical impairment or a combination of mental and physical impairments; (2) is manifested before the person attains age twenty-two; (3) results in substantial functional limitations in three or more of the following areas of major life activity: (A) Self-care; (B) receptive and expressive language; (C) learning; (D) mobility; (E) self-direction; (F) capacity for independent living; and (G) economic self-sufficiency; (4) Reflects the person's need for services and supports which are of lifelong or extended duration and are individually planned and coordinated."

Medical necessity for case management services will include a determination that individuals demonstrate substantial functional limitations in three (3) major life areas (see item 3, paragraph 1) as determined by a State-approved standardized assessment instrument appropriate to the individual being assessed. Recipients must be reassessed at six-month intervals at a minimum for functional limitation status in order to determine continuing medical need.

Recipients qualifying for Targeted Case Management must be currently living in the community or within 30 days of placement in the community through discharge planning from a Medicaid-certified facility.

Targeted case management will not be provided to individuals between the ages of 22 and 64 who are inpatients in institutions for mental disease nor to those recipients of case management through a home and community-based waiver.

E. DEFINITION OF SERVICES

Case management services are those services which will assist Medicaid-eligible recipients in the target group to gain access to needed medical, social, educational and other services.

The core elements of targeted case management shall include the following:

(1) Assessment: The ongoing process of determining the recipient's potential strengths, resources and needs for service which form the basis for development of a comprehensive individualized service plan in conjunction with the recipient, family and other individuals appropriate to service delivery.

(2) Service Planning: The development of a comprehensive individualized service plan which records the full range of services, treatment and/or other support necessary to meet the recipient's goals. The comprehensive individualized service plan will be reviewed at regularly scheduled intervals.

(3) Linkage/Referral: The process of making service contacts, appointments, etc., on behalf of the recipient in order to assure access to all services identified in the comprehensive individualized service plan such as behavioral health services, housing, medical, social, or nutritional services.

(4) Advocacy: Advocacy includes those actions taken on behalf of the recipient in order to assure his/her rightful access to (and continuity of) services and benefits under federal and state law; flexibility and integration of services; and proper utilization of facilities and resources.

(5) Crisis Response Planning: Planning which assures necessary and appropriate crisis response procedures for those recipients with an assessed need for crisis services.

(6) Service Plan Evaluation: Continuous re-evaluation of the individual's comprehensive service plan at regularly scheduled intervals, or as indicated by a significant change in the recipient's needs. Modifications to the plan will be made as necessary, new linkages established, and other service delivery changes made as necessary.

(7) Monitoring and Coordination: Checking and reviewing the delivery of needed services to assure the appropriateness and quality of services delivered.

Coordinating with the Medicaid certified facility discharge planner in the 30-day period prior to the recipient's discharge into the community. Coordination under this activity is not intended to duplicate services which the certified facility must otherwise provide as part of the normal discharge planning process.

E. PROVIDER QUALIFICATIONS

The option to restrict providers for the Mentally Retarded/Developmentally Disabled is not being exercised under Targeted Case Management.

A provider of Targeted Case Management Services to the Mentally Retarded/Developmentally Disabled must hold licensure as a behavioral health agency pursuant to 27-2A-1 of the West Virginia Code. Providers must demonstrate a capacity to provide targeted case management services through a comprehensive provider agreement. This agreement requires 24-hour service availability by the provider and stipulates that the recipient's freedom of choice must be assured by the provider. It also requires the following:

1) Specification of the target population(s) served and the geographic areas in which they have the capacity to serve the target population(s).

2) Demonstrated capacity to link recipients in the target group(s) to a comprehensive array of services.

3) Assurance that agency staff are sufficient in number and appropriately qualified through training and experience to address the needs of the target population(s) served.

4) An administrative capacity to ensure quality of services; documentation of services; and maintenance of individual records in accordance with state and federal requirements.

5) The financial management capacity to document services and prepare and submit claims for these services.

6) Assure through the client enrollment process that all recipients are informed that recipients may choose from available certified case management providers.

Providers must assure that all staff providing targeted case management services possess one of the following qualifications:

a) A licensed psychologist with a Masters or Doctoral degree;

b) A licensed social worker;

c) A registered nurse;

d) A Doctorate, Masters or Bachelors degree in Human Services Field; or

e) A Bachelors degree in a non-human services area and/or a temporary social work license may also qualify when there has been successful completion of a state-approved training program and a minimum of six months of experience working with the specific target population under the direct supervision of a case manager (i.e., a case manager who meets one of the educational requirements in a through d above and who has at least one year experience with the target population and who has met all other credentialling requirements of his/her agency.)

A. TARGET GROUP

2. Chronically Mentally Ill/Substance Abuse

The population to be served consists of individuals who meet diagnostic criteria according to the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition) for chronic mental illness or substance abuse.

Medical necessity for case management services will include a determination that individuals demonstrate substantial functional limitations in two (2) major life areas as determined by a State-approved standardized assessment instrument(s) appropriate to the individual being assessed. Major life areas include: vocational, education, homemaker, social or interpersonal, community, and self-care or independent living. Individuals must be reassessed at six-month intervals at a minimum for functional limitation status in order to determine continuing medical need.

Recipients qualifying for Targeted Case Management must be currently living in the community or within 30 days of placement in the community through discharge planning from a Medicaid-certified facility.

Targeted case management will not be provided to individuals between the ages of 22 and 64 who are inpatients in institutions for mental disease nor to those recipients of case management through a home and community-based waiver.

D. DEFINITION OF SERVICES

Case management services are those services which will assist Medicaid-eligible recipients in the target group to gain access to needed medical, social, educational and other services.

The core elements of targeted case management shall include the following:

(1) Assessment: The ongoing process of determining the recipient's potential strengths, resources and needs for service which form the basis for development of a comprehensive individualized service plan in conjunction with the recipient, family and other individuals appropriate to service delivery.

(2) Service Planning: The development of a comprehensive individualized service plan which records the full range of services, treatment and/or other support necessary to meet the recipient's goals. The comprehensive individualized service plan will be reviewed at regularly scheduled intervals.

(3) Linkage/Referral: The process of making service contacts, appointments, etc., on behalf of the recipient in order to assure access to all services identified in the comprehensive individualized service plan such as behavioral health services, housing, medical, social, or nutritional services.

(4) Advocacy: Advocacy includes those actions taken on behalf of the recipient in order to assure his/her rightful access to (and continuity of) services and benefits under federal and state law; flexibility and integration of services; and proper utilization of facilities and resources.

(5) Crisis Response Planning: Planning which assures necessary and appropriate crisis response procedures for those recipients with an assessed need for crisis services.

(6) Service Plan Evaluation: Continuous re-evaluation of the individual's comprehensive service plan at regularly scheduled intervals, or as indicated by a significant change in the recipient's needs as a result of this process. Modifications to the plan will be made as necessary, new linkages established, and other service delivery changes made as necessary.

(7) Monitoring and Coordination: Checking and reviewing the delivery of needed services to assure the appropriateness and quality of services delivered.

Coordinating with the Medicaid certified facility discharge planner in the 30-day period prior to the recipient's discharge into the community. Coordination under this activity is not intended to duplicate services which the certified facility must otherwise provide as part of the normal discharge planning process.

E. PROVIDER QUALIFICATIONS

The option to restrict providers for the Chronically Mentally Ill and Substance Abuse population is not being exercised under Targeted Case Management.

A provider of Targeted Case Management Services to the Chronically Mentally Ill and Substance Abuse must hold licensure as a behavioral health agency pursuant to 27-2A-1 of the West Virginia Code. Providers must demonstrate a capacity to provide targeted case management services through a comprehensive provider agreement. This agreement requires 24-hour service availability by the provider and stipulates that the recipient's freedom of choice must be assured by the provider. It also requires the following:

1) Specification of the target population(s) served and the geographic areas in which they have the capacity to serve the target population(s).

2) Demonstrated capacity to link recipients in the target group(s) to a comprehensive array of services.

3) Assurance that agency staff are sufficient in number and appropriately qualified through training and experience to address the needs of the target population(s) served.

4) An administrative capacity to ensure quality of services; documentation of services; and maintenance of individual records in accordance with state and federal requirements.

5) The financial management capacity to document services and prepare and submit claims for these services.

6) Assure through the client enrollment process that all recipients are informed that recipients may choose from available certified case management providers.

Providers must assure that all staff providing targeted case management services possess one of the following qualifications:

a) A licensed psychologist with a Masters or Doctoral degree;

b) A licensed social worker;

c) A registered nurse;

d) A Doctorate, Masters or Bachelors degree in Human Services Field; or

e) A Bachelors degree in a non-human services area and/or a temporary social work license may also qualify when there has been successful completion of a state-approved training program and a minimum of six months of experience working with the specific target population under the direct supervision of a case manager (i.e., a case manager who meets one of the educational requirements in a) through d) above and who has at least one year experience with the target population and who has met all other credentialing requirements of his/her agency.)

## A. TARGET GROUP:

3. Children Under Age 3 Who Are at Risk for Developmental Delay/Disability or Social-Emotional Disorder, or Children Under Age 5 who have a Diagnosed Developmental Delay/Disability or Social-Emotional Disorder

The population to be served consists of children who exhibit areas of concern or priority identified through either (1) the use of an approved evaluation/assessment process under Part C of the Individuals with Disabilities Education Act and administered through an agency under contract with the West Virginia Department of Health and Human Resources, Bureau for Public Health, Office of Maternal Child and Family Health, or (2) the children demonstrate impairment in two or more areas as measured by at least two norm or criterion-referenced instruments approved by the State as specified in the Targeted Case Management Manual.

Children qualifying for Targeted Case Management must be currently living in the community or within 30 days of placement in the community through discharge planning from a Medicaid-certified facility.

## D. DEFINITION OF SERVICES

Case management services are those services which will assist Medicaid-eligible recipients in the target group to gain access to needed medical, social, educational and other services.

The core elements of targeted case management shall include the following:

(1) **Assessment**: The ongoing process of determining the recipient's potential strengths, resources and needs for service which form the basis for development of a comprehensive individualized service plan in conjunction with the recipient, family and other individuals appropriate to service delivery.

(2) **Service Planning**: The development of a comprehensive individualized service plan which records the full range of services, treatment and/or other support necessary to meet the recipient's goals. The comprehensive individualized service plan will be reviewed at regularly scheduled intervals.

(3) **Linkage/Referral**: The process of making service contacts, appointments, etc., on behalf of the recipient in order to assure access to all services identified in the comprehensive individualized service plan such as behavioral health services, housing, medical, social, or nutritional services.

(4) **Advocacy**: Advocacy includes those actions taken on behalf of the recipient in order to assure his/her rightful access to (and continuity of) services and benefits under federal and state law; flexibility and integration of services; and proper utilization of facilities and resources.

(5) **Crisis Response Planning**: Planning which assures necessary and appropriate crisis response procedures for those recipients with an assessed need for crisis services.

(6) **Service Plan Evaluation**: Continuous re-evaluation of the individual's comprehensive service plan at regularly scheduled intervals, or as indicated by a significant change in the recipient's needs as a result of this process. Modifications to the plan will be made as necessary, new linkages established, and other service delivery changes made as necessary.

(7) **Monitoring and Coordination**: Checking and reviewing the delivery of needed services to assure the appropriateness and quality of services delivered. Coordinating with the Medicaid certified facility discharge planner in the 30 day period prior to the recipient's discharge into the community.

Coordination under this activity is not intended to duplicate services which the certified facility must otherwise provide as part of the normal discharge planning process.

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

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

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

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

E. PROVIDER QUALIFICATIONS

A provider of Targeted Case Management Services to Children Under Age 3 who are at risk for Developmental Delay/Disability or Social/Emotional Disorder, must be credentialed as a provider of Part C Services for the Individuals with Disabilities Education Act as certified under cooperative agreement by the West Virginia Department of Health and Human Resources, Bureau for Public Health, Office of Maternal, Child and Family Health (Title V).

A provider of Targeted Case Management Services to Children Under Age 5, who are not eligible in Part C and who have a Developmental Delay/Disability or Social-Emotional Disorder, must hold licensure as a behavioral health agency pursuant to 27-2A-1 of the West Virginia Code. Targeted Case Management Services for Children under Age 3 who are Part C eligible are provided through the Title V agreement.

Providers must demonstrate a capacity to provide targeted case management services through a comprehensive provider agreement. This agreement requires 24-hour service availability by the provider and stipulates that the recipient's freedom of choice must be assured by the provider. The 24-hour service availability does not apply to providers for children under age 3 who are Part C eligible. It also requires the following:

(1) Specification of the target population(s) served and the geographic areas in which they have the capacity to serve the target population(s).

(2) Demonstrated capacity to link recipients in the target group(s) to a comprehensive array of services.

(3) Assurance that agency staff are sufficient in number and appropriately qualified through training and experience to address the needs of the target population(s) served

(4) An administrative capacity to ensure quality of services; documentation of services; and maintenance of individual records in accordance with state and federal requirements.

(5) The financial management capacity to document services and prepare and submit claims for these services.

(6) Assure through the client enrollment process that all recipients are informed that recipients may choose from available certified case management providers.

Providers must assure that all staff providing targeted case management services possess one of the following qualifications:

(a) A licensed psychologist with a Masters or Doctoral degree;

(b) A licensed social worker;

(c) A registered nurse;

(d) A Doctorate, Masters or Bachelors degree in Human Services Field; or

(e) A Bachelors degree in a non-human services area and/or a temporary social work license may also qualify when there has been successful completion of a state-approved training program and a minimum of six months of experience working with the specific target population under the direct supervision of a case manager (i.e., a case manager who meets one of the educational requirements in (a) through (d) above and who has at least one year experience with the target population and who has met all other credentialing requirements of his/her agency.)

(f) Credentialed and enrolled by Title V for Birth to three, Part C, IDEA children.

## CASE MANAGEMENT SERVICES

A. Target Group:

To reimburse case management services for Medicaid-eligible pregnant women up to sixty days postpartum and children up to age 1.

D. Definition of Services:

Case management services are those services which will assist Medicaid eligible recipients in this target group to gain access to needed medical, social, educational and other services. Activities to be undertaken by the Care Coordinator are as follows:

1. **Assessment** - based on the medical treatment plan established by the client's physician, the client and the Care Coordinator will develop a realistic goal. The client's situation will be evaluated and needed services identified.

2. **Service Plan Development** - the Care Coordinator in conjunction with the client will develop an action plan that specifies concrete activities which are to be completed so that the established agreed upon goals can be achieved. The Care Coordinator must react promptly to emergency situations which may jeopardize the goal of the Service plan.

3. **Coordination and Referral** - the Care Coordinator will locate resources or make referrals or arrangements for treatment and support services relative to the Service Plan. At times the Care Coordinator may necessarily act as a facilitator to resolve access problems that arise in implementing the Service Plan.

4. **Follow up and Monitoring** - the Care Coordinator will ensure appropriate quality, quantity and effectiveness of services in accordance with the Service Plan. The Care Coordinator will confer with the client and review the Service Plan periodically as determined by the Department for continuity of needs and services received.

CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid-eligible children 18 years of age or less who: have been or are in danger of becoming abused or neglected; who are parents or expectant parents; or who have been adjudicated to be delinquent by a court of juvenile jurisdiction. Case management services provided to this target population will focus on assessing individual needs and assuring access to child protective, medical, and psychological services and monitoring the provision of and outcomes of those services.

Medicaid recipients receiving case management services under waivers granted through Section 1915(c) of the Social Security Act are excluded.

D. Definition of Services:

Case Management services are those services which will assist Medicaid-eligible recipients in the target group to gain access to needed medical, social, educational and other services. Case management does not include the direct provision of medical services. Case management is provided for an indefinite period of time and at a level of intensity determined by the individual recipient's degree of impairment, dysfunction and need as determined through comprehensive assessments. Services are provided in settings accessible to the recipient, and the receipt of such services will be at the option of the individual in the target group.

The goals of case management are to assure that eligible individuals have access to needed services and resources; necessary evaluations are conducted for eligible recipients; Individual Program Plans are developed and implemented; and reassessment of recipients' needs and service provision occurs on an ongoing basis and at regularly scheduled intervals. All the above criterion is consistent with 1902(23) of the Act.

E. Qualification of Providers:

Providers of case management services are organizations/agencies or individuals which meet the following criteria established for specified subgroup or groups of the target population, and who enter into a contract with the Department of Health and Human Resources for provision of such services.

Individuals serving as case managers for this target group shall be persons licensed by the West Virginia Board of Social Work Examiners under Chapter Thirty, Article 30, of the Code of West Virginia. All providers of case management services must meet all of the criteria listed below:

1. Demonstrated capacity to provide all core elements of case management services, including:

a. Comprehensive client assessment;

b. Comprehensive service plan development;

c. Linking/coordination of services;

d. Monitoring and follow-up of services; and

e. Reassessment of the recipient's status and needs.

2. Demonstrated case management experience in coordinating and linking such community resources as required by the target population. services.

3. Demonstrated experience with the target population.

4. A sufficient number of staff to meet the case management service needs of the target population.

5. A physical location or place of service through which eligible individuals in target group will have access to case management services.

6. An administrative capacity to ensure quality of services in accordance with state and federal requirements.

7. A financial management capacity and system that provides documentation of services and costs.

8. Capacity to document and maintain individual case records in accordance with state and federal requirements.

Items one through seven above refer to requirements for case management provider agencies. There is nothing in this definition which would preclude an individual from being designated as a provider agency if that individual meets all of the requirements outlined above.

Individuals serving as case managers for this target group may be social workers licensed by the West Virginia Board of Social Work Examiners; or qualified mental health professionals certified by the Office of Behavioral Health Services, West Virginia Department of Health and Human Resources.

Any person or entity meeting requirements for the provision of case management services who wishes to become a Medicaid provider of those services will be given the opportunity to do so.

F. Nonduplication of Payment

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

## CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children under age 21 in the public school system (not actively enrolled in the EPSDT Program), who have experienced delay in their physical, educational, behavioral, or social development. The individuals defined in this target group will be identified by educational, psychological testing, and other routine screening activities carried out in the public school system and referred for case management services.

Medicaid recipients receiving case management services under waivers granted through Section 1915(c) of the Social Security Act are excluded.

D. Definition of Services:

Case management services are those services which will assist Medicaid eligible recipients in the target group to gain access to needed medical, social, educational, and other services. Case management does not include the direct provision of medical or psychological services.

Services provided to this target population will focus on enabling the individual child to benefit from the school experience to his/her maximum potential by elimination of identified barriers which impede that result. The case management services will coordinate the efforts of numerous different agencies related to assuring the recipient's access to medical, social, economic support or other services required to eliminate barriers which impede realization of the individual's potential.

The services outlined here will not duplicate or replace existing administrative programs or activities of the Department of Education.

The service needs of recipients will be determined through comprehensive assessments which, by definition, is the case manager's analysis of the recipient's current status and needs. The case manager's assessment does not duplicate or overlap assessments carried out by professional medical or mental health practitioners or facilities.

The targeted case management services performed for this target group do not duplicate or overlap the medical case management activities performed in the physician directed case management program PAAS. The two functions are fundamentally different in that the PAAS Program is basically a physician/recipient lock-in program, while the targeted case management service involves coordination of a range of community support services.

## CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible individuals who are victims of abuse, neglect, or exploitation, with physical or mental health problems as a result of that abuse, neglect, or exploitation.

The members of this target population will be identified by Department of Health and Human Resources' Income Maintenance Program staff, Public Health Services community outreach workers, Mental Health officials, law enforcement or other agencies, and will be referred for case management services.

Medicaid recipients receiving case management services under waivers granted through Section 1915(c) of the Social Security Act are excluded.

D. Definition of Services:

Case management services are those services which will assist Medicaid eligible recipients in the target group to gain access to needed medical, social, educational, and other services. Case management does not include the direct provision of medical or psychological services.

The service needs of recipients will be determined through comprehensive assessments which, by definition, is the case manager's analysis of the recipient's current status and needs. The case manager's assessment does not duplicate or overlap assessments carried out by professional medical or mental health practitioners or facilities.

The targeted case management services performed for this target group do not duplicate or overlap the medical case management activities performed in the physician directed case management program PAAS. The two functions are fundamentally different in that the PAAS Program is basically a physician/recipient lock-in program, while the targeted case management service involves coordination of a range of community support services.

The goals of case management are to assure that eligible individuals have access to needed services and resources, that necessary evaluations are conducted for eligible recipients, that individual program plans are developed and implemented, and a reassessment of recipients' needs and service provision occurs on an ongoing basis and at regularly scheduled intervals. All of the above is consistent with 1902(a)(23) of the Act.

E. The Qualifications of Providers

Providers of case management services must have a provider agreement with the Medicaid agency, must be enrolled as participating providers in Medicaid, and meet the criteria outlined below.

1. Demonstrate a capacity to provide all core elements of case management services including:

   * Comprehensive client assessment and service plan development

   * Linking/Coordination of services, i.e., assuring that services are appropriate to the clients' needs and that they are not duplicative or overlapping.

   * Monitoring and follow-up services.

   * Reassessment of the recipient's status and needs.

2. Demonstrate case management experience in coordinating and linking such community resources as required by the target population.

3. Demonstrate an appropriate physical facility or place of service through which individuals in that target group will have access to case management services. The case management provider must have facilities to house the individuals who will carry out the case management functions, provide for physical custody of case records, and a place where both the Medicaid agency and the client group will have access to case records and to the individuals performing case management services.

4. Demonstrate an administrative capacity to assure quality of services in accordance with state and federal requirements.

5. Demonstrate ability to assure referral processes consistent with 1902(a)(23), freedom of choice for providers.

6. Demonstrate financial management capacity and system that provides documentation of services and cost.

7. Demonstrate capacity to document and maintain individual case records in accordance with state and federal requirements.

Items one through seven above refer to requirements for case management provider agencies. There is nothing in this definition which would preclude an individual from being designated as a provider agency if that individual meets all of the requirements outlined above.

Individuals serving as case managers for this target group shall include persons licensed by the West Virginia Board of Social Work Examiners under Chapter 30, Article 30, of the Code of West Virginia.

Any person or entity meeting requirements for the provision of case management services who wishes to become a Medicaid provider of those services will be given the opportunity to do so.

F. Nonduplication of Payment

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

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ATTACHMENT for A, D, and E of
Supplement 1 to Attachment 3.1-A

## CASE MANAGEMENT SERVICES

A. Target Group:

To reimburse case management services for Medicaid-eligible pregnant women up to sixty days postpartum and children up to age 1.

D. Definition of Services:

Case management services are those services which will assist Medicaid-eligible recipients in this target group to gain access to needed medical, social, educational and other services. Activities to be undertaken by the Care Coordinator are as follows:

1. Assessment - based on the medical treatment plan established by the client's physician, the client and the Care Coordinator will develop a realistic goal. The client's situation will be evaluated and needed services identified.

2. Service Plan Development - the Care Coordinator in conjunction with the client will develop an action plan that specifies concrete activities which are to be completed so that the established agreed upon goals can be achieved. The Care Coordinator must react promptly to emergency situations which may jeopardize the goal of the Service plan.

3. Coordination and Referral - the Care Coordinator will locate resources or make referrals or arrangements for treatment and support services relative to the Service Plan. At times the Care Coordinator may necessarily act as a facilitator to resolve access problems that arise in implementing the Service Plan.

4. Follow up and Monitoring - the Care Coordinator will ensure appropriate quality, quantity and effectiveness of services in accordance with the Service Plan. The Care Coordinator will confer with the client and review the Service Plan periodically as determined by the Department for continuity of needs and services received.

E. Qualification of Providers:

Organizational providers of case management services for this target group are: local health departments as created in West Virginia Public Health Law, Chapter 16-2-1, 16-2-3, and 16-2A of the West Virginia Code; health centers as defined by U. S. Public Health Service Act 330, and any other organization which employs appropriately qualified individuals specified below and meets the criteria outlined herein. Qualified individuals who meet the criteria outlined herein may be enrolled as providers of case management services.

Individuals serving as case managers for this target group shall be persons licensed by the West Virginia Board of Social Work Examiners under Chapter Thirty, Article 30, of the Code of West Virginia; and West Virginia Board of Nurse Examiners.

## CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible adults (over 20 years of age), having been determined to need supported living arrangements. Such supported living arrangements may be provided either in a long term care facility or in a community placement setting. This target population will include residents of long term care facilities who are discharge ready and in need of community placement, or it may be individuals living in the community who need long term care placement or other supported living arrangements.

The individuals in this target group will have limiting physical conditions which impair their ability to independently carry out the essential activities of daily living, and it is this impairment which requires that they reside in settings where necessary support services can be made available to them.

The patient evaluation instrument which is used for preadmission screening for patients going into long term care and other supported living arrangements is the M-2 evaluation form. This form, completed by the patient's physician, defines the support needs of the patient. The M-2 is reviewed by an RN to determine the appropriate setting in which the services may be provided. A plan of care is then developed by an RN and the direct provision of the service supervised by the RN.

Medicaid recipients receiving case management services under waivers granted through Section 1915(c) of the Social Security Act are excluded.

D. Definition of Services

Case management services are "those services which will assist Medicaid eligible recipients in the target group to gain access to needed medical, social, educational, and other services." Case management does not include the direct provision of medical or psychological services.

For those individuals who are residents of long term care facilities, case management will focus on appropriate discharge, disposition, placement, and after care follow-up services. Those services will not exceed a period of 30 days prior to the estimated date of discharge. These services will compliment, not duplicate, case management services provided by the nursing facility.

For those individuals who are still in the community, services will focus upon linking the individual with the medical and social support services needed to maintain them in the community setting. If they require the kind of supportive services which can only be provided in a long term care institutional setting, case management services will focus upon linking the individual with the psychological counseling and support services which enable the individual to accept an institutional placement and to come to terms with the physical disability which makes that care setting necessary.

The service needs of recipients will be determined through comprehensive assessments which, by definition, is the case manager's analysis of the recipient's current status and needs. The case manager's assessment does not duplicate or overlap assessments carried out by professional medical or mental health practitioners or facilities.

The targeted case management services performed for this target group do not duplicate or overlap the medical case management program PAAS. The two functions are fundamentally different in that the PAAS Program is basically a physician/recipient lock-in program, while the targeted case management service involves coordination of a range of community support services.

The goals of case management are to assure that eligible individuals have access to needed services and resources, that necessary evaluations are conducted for eligible recipients, individual program plans are developed and implemented, and a reassessment of recipients needs and service provision occurs on an ongoing basis and at regularly scheduled intervals. All of the above is consistent with 1902(a)(23) of the Act.

E. Qualification of Providers:

Providers of case management services must have a provider agreement with the Medicaid agency, must be enrolled as participating providers in Medicaid, and meet the criteria outlined below.

1. Demonstrate a capacity to provide all core elements of case management services including:

   * Comprehensive client assessment and service plan development

   * Linking/Coordination of services. (By coordination of services we mean assuring that services are appropriate to the clients' needs and that they are not duplicative or overlapping.)

   * Monitoring and follow-up services.

   * Reassessment of the recipients' status and needs.

2. Demonstrate case management experience in coordinating (see definition above), and linking such community resources as required by the target population.

   This target population by definition includes people who have physical disabilities which limit their ability to carry out essential activities of daily living, and are therefore either entering or leaving supported living arrangements.

   The case management provider must be able to show that they have experience in working with people with disabling physical conditions, and with people entering and leaving supported living arrangements.

3. Demonstrate an appropriate physical facility or place of service through which individuals in that target group will have access to case management services. This means that the case management provider must have facilities to house the individuals who will carry out the case management functions, provide for physical custody of case records, and a place where both the Medicaid agency and the client group will have access to case records and to the individuals performing case management services.

4. Demonstrate an administrative capacity to assure quality of services in accordance with state and federal requirements.

5. Demonstrate ability to assure referral processes consistent with 1902(a)(23), freedom of choice for providers.

6. Demonstrate financial management capacity and system that provides documentation of services and cost.

7. Demonstrate capacity to document and maintain individual case records in accordance with state and federal requirements.

Items one through seven above refer to requirements for case management provider agencies. There is nothing in this definition which would preclude an individual from being designated as a provider agency if that individual meets all of the requirements outlined above.

Individuals serving as case managers for this target group shall include persons licensed by the West Virginia Board of Social Work Examiners under Chapter 30, Article 30, of the Code of West Virginia.

Any person or entity meeting requirements for the provision of case management services who wishes to become a Medicaid provider of those services will be given the opportunity to do so.

F. Nonduplication of Payment

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

## CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible children under age 18 who: have been placed in the legal custody, guardianship, or physical custody of the West Virginia Department of Health and Human Resources; are in subsidized adoption; have been or are in danger of becoming abused or neglected; and children who have been adjudicated delinquent by a court of juvenile jurisdiction, but who are not incarcerated in a public institution.

The legal status of the children who are placed in Department custody, and the status of those who have been judged delinquent, will be determined through the county Circuit Court or the juvenile courts respectively. Those determinations will be made following court ordered evaluations performed by social workers in the West Virginia Department of Health and Human Resources, juvenile probation officers in the court system, or appropriate medical professional practitioners.

Medicaid recipients receiving case management services under waivers granted through Section 1915(c) of the Social Security Act are excluded.

D. Definition of Services

Case management services are those services which will assist Medicaid eligible recipients in the target group to gain access to needed medical, social, educational, and other services. The case management services will include interface with the juvenile justice and legal systems on the part of the case manager. The case management services will not include case management providers acting as legal representatives. Case management does not include the direct provision of medical or psychological services.

The service needs of recipients will be determined through comprehensive assessments which, by definition, is the case manager's analysis of the recipient's current status and needs in identification of appropriate resources. The case manager's assessment does not duplicate or overlap assessments carried out by professional medical or mental health practitioners or facilities.

The targeted case management services performed for this target group do not duplicate or overlap the medical case management activities performed in the physician directed case management program PAAS. The two functions are fundamentally different in that the PAAS Program is basically a physician/recipient lock-in program, while the targeted case management service involves coordination of a range of community support services.

The case management activities carried out under this authority will supplement but not duplicate activities required under the title XX approved state plan.

The goals of case management are to assure that eligible individuals have access to needed services and resources, that necessary evaluations are conducted for eligible recipients, that individual program plans are developed and implemented, and a reassessment of recipients' needs and service provision occurs on an ongoing basis and at regularly scheduled intervals. All of the above is consistent with 1902(a)(23) of the Act.

E. Qualifications of Providers

Providers of case management services must have a provider agreement with the Medicaid agency, must be enrolled as participating providers in Medicaid, and meet the criteria outlined below.

1. Demonstrate a capacity to provide all core elements of case management services including:

   * Comprehensive client assessment and service plan development

   * Linking/Coordination of services. Coordination of services is assuring that services are appropriate to the clients' needs and that they are not duplicative or overlapping.

   * Monitoring and follow-up services.

   * Reassessment of the recipient's status and needs.

2. Demonstrate case management experience in coordinating and linking such community resources as required by the target population.

3. Demonstrate an appropriate physical facility or place of service through which individuals in that target group will have access to case management services. The case management provider must have facilities to house the individuals who will carry out the case management functions, provide for physical custody of case records, and a place where both the Medicaid agency and the client group will have access to case records and to the individuals performing case management services.

4. Demonstrate an administrative capacity to assure quality of services in accordance with state and federal requirements.

5. Demonstrate ability to assure referral processes consistent with 1902(a)(23), freedom of choice for providers.

6. Demonstrate financial management capacity and system that provides documentation of services and cost.

7. Demonstrate capacity to document and maintain individual case records in accordance with state and federal requirements.

Items one through seven above refer to requirements for case management provider agencies. There is nothing in this definition which would preclude an individual from being designated as a provider agency if that individual meets all of the requirements outlined above.

Individuals serving as case managers for this target group shall include persons licensed by the West Virginia Board of Social Work Examiners under Chapter 30, Article 30, of the Code of West Virginia.

Any person or entity meeting requirements for the provision of case management services who wishes to become a Medicaid provider of those services will be given the opportunity to do so.

F. Nonduplication of Payment

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

CASE MANAGEMENT SERVICES

A. Target Group:

Medicaid eligible individuals who are parents of abused, neglected, or exploited children.

West Virginia state law requires that Medical practitioners and facilities, social workers, and law enforcement officials, report any suspected instances of child abuse, neglect, or exploitation to the Child Protective Services Division of the Department of Health and Human Resources. All such reports are investigated by staff of that agency. The determination of abuse, neglect, or exploitation for purposes of defining this target group will occur as a consequence of that investigation.

Medicaid recipients receiving case management services under waivers granted through Section 1915(c) of the Social Security Act are excluded.

D. Definition of Services

Case management services are those services which will assist Medicaid eligible recipients in the target group to gain access to needed medical, social, educational, and other services. Case management does not include the direct provision of medical or psychological services.

Services provided to this target population will focus on assuring access to mental health services, financial assistance, educational or other support services necessary to eliminate the underlying causes of abuse, neglect, or exploitation of children.

The service needs of recipients will be determined through comprehensive assessments which, by definition, is the case manager's analysis of the recipient's current status and needs. The case manager's assessment does not duplicate or overlap assessments carried out by professional medical or mental health practitioners or facilities.

The targeted case management services performed for this target group do not duplicate or overlap the medical case management activities performed in the physician directed case management program PAAS. The two functions are fundamentally different in that the PAAS Program is basically a physician/recipient lock-in program, while the targeted case management service involves coordination of a range of community support services.

The goals of case management are to assure that eligible individuals have access to needed services and resources, that necessary evaluations are conducted for eligible recipients, individual program plans are developed and implemented, and a reassessment of recipients' needs and service provision occurs on an ongoing basis and at regularly scheduled intervals. All of the above is consistent with 1902(a)(23) of the Act.

E. Qualifications of Providers

Providers of case management services must have a provider agreement with the Medicaid agency, must be enrolled as participating providers in Medicaid, and meet the criteria outlined below.

1. Demonstrate a capacity to provide all core elements of case management services including:

   * Comprehensive client assessment and service plan development.

   * Linking/Coordination of services. Coordination of services is assuring that services are appropriate to the clients' needs and that they are not duplicative or overlapping.

   * Monitoring and follow-up services.

   * Reassessment of the recipient's status and needs.

2. Demonstrate case management experience in coordinating and linking such community resources as required by the target population.

3. Demonstrate an appropriate physical facility or place of service through which individuals in that target group will have access to case management services. The case management provider must have facilities to house the individuals who will carry out the case management functions, provide for physical custody of case records, and a place where both the Medicaid agency and the client group will have access to case records and to the individuals performing case management services.

4. Demonstrate an administrative capacity to assure quality of services in accordance with state and federal requirements.

5. Demonstrate ability to assure referral processes consistent with 1902(a)(23), freedom of choice for providers.

6. Demonstrate financial management capacity and system that provides documentation of services and cost.

7. Demonstrate capacity to document and maintain individual case records in accordance with state and federal requirements.