

New York
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[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
CASE MANAGEMENT SERVICES]

[A. Target Group: A

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

[] Entire State.

[X] Only in the following geographic area (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

The counties of Albany, Allegany, Cattaraugus, Cayuga, Chemung, Columbia, Cortland, Dutchess, Franklin, Fulton, Genesee, Herkimer, Jefferson, Livingston, Madison, Monroe (zip codes 14605, 14621, and 14609), Onondaga, Orange, Orleans, Rensselaer, St. Lawrence, Schenectady, Schoharie, Schuyler, Seneca, Steuben, Suffolk, Sullivan, Tompkins, Ulster, Washington, Westchester, Wyoming, Yates, and New York City (Bronx Commun. Dist. 1-4, Brooklyn Commun. Dist. 5, 8, 9, 16-18, Manhattan Commun. Dist. 9-12, Queens Commun. Dist. 3, 4, 6, 7, 8, 11-13, and Richmond Commun. Dist. 1-3)

C. Comparability of Services

[] Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

[X] Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See attached.

E. Qualification of Providers:

See Page 1-A10.]

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- [F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of case management services.
 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.]

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CASE MANAGEMENT SERVICES

[A. TARGET GROUP

The primary targeted group consists of an adolescent, male or female, under 21 years of age who is a categorically needy or medically needy Medicaid eligible and is a parent and resides in the same household with his or her child(ren), or is pregnant.

The target group may also consist of any eligible child of an adolescent or any adolescent, male or female under 21 years of age, who is a categorically needy or medically needy Medicaid eligible and is deemed to be at risk of pregnancy or parenthood and meets one or more of the following at-risk criteria:

- 1) receives public assistance in his or her own right;
- 2) is homeless or at imminent risk of becoming homeless;
- 3) has had an abortion or miscarriage
- 4) has had a pregnancy test, even if the test outcome was negative;
- 5) is sexually active;
- 6) is the non-custodial mother or father of a child;
- 7) is the younger sibling of an individual who was or is a teenage parent;
- 8) is a rape or incest victim;
- 9) has dropped out of high school without graduating;
- 10) is having academic and/or disciplinary problems in school;
- 11) requests case management activities, or his or her authorized representative requests such activities on behalf of the adolescent; or
- 12) is the child of adolescent parent(s).

Sixty percent of the current ADC cases in New York State are headed by mothers who were teenagers when they gave birth to their first child. The goal of case management for this target population is to provide access for youth to medical, educational, employment and other services which will increase their potential to become financially independent. Case management services continue for this target population through age 21.]

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[B. AREAS OF STATE IN WHICH SERVICES WILL BE PROVIDED TO TARGET GROUP A

Case management services will be provided to residents of the following counties: Albany, Allegany, Cattaraugus, Cayuga, Chemung, Columbia, Cortland, Dutchess, Franklin, Fulton, Genesee, Herkimer, Jefferson, Livingston, Madison, Monroe (zip codes 14605, 14621, and 14609), Onondaga, Orange, Orleans, Rensselaer, St. Lawrence, Schenectady, Schoharie, Schuyler, Seneca, Steuben, Suffolk, Sullivan, Tompkins, Ulster, Washington, Westchester, Wyoming, Yates and New York City (Bronx Commun. Dist. 1-4, Brooklyn Commun. Dist. 5, 8, 9, 16-18, Manhattan Commun. Dist. 9-12, Queens Commun. Dist. 3, 4, 6, 7, 8, 11-13, and Richmond Commun. Dist. 1-3)

D. DEFINITION OF COMPREHENSIVE MEDICAID CASE MANAGEMENT REIMBURSABLE UNDER MEDICAID

Case management is a process which will assist persons eligible for Medical Assistance to access necessary services in accordance with goals contained in a written case management plan.

BASIC PREMISES OF COMPREHENSIVE MEDICAID CASE MANAGEMENT

1. Case management services are those services which will assist persons eligible for Medical Assistance to obtain needed medical, social, psychological, educational, financial, and other services.
2. Case management is a human services agency tool for the effective management of multiple resources for the benefit of individuals identified as high utilizers of service, or having problems accessing care, or belonging to certain age, diagnosis or specialized program groups. Effective management is concerned with service: the quality, adequacy and continuity of service, and a concern for cost effectiveness to assure each eligible individual served receives the services appropriate to their needs. Targeted groups consist of persons with multiple needs or high vulnerability who require intensive and/or long term intervention by health and other human services providers.]

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- [3. Case management services enable Medicaid eligibles to exercise their freedom of choice by providing knowledge of services available to them, providing access to the most appropriate service to meet their needs and assisting them to achieve their maximum level of functioning and independence in their most appropriate environment. Case managers do not have the authority to prior authorize Medicaid service or to limit the amount, duration or scope of Medicaid services.
4. Case management empowers the individual by encouragement in the decision making process, allowing choice among all available options as a means of moving the individual to the optimum situation where the person and/or his/her support system can address his/her needs. Case management implies utilization and development of such support networks as will maximize the effectiveness, efficiency and accountability of support services on behalf of the individual.

DEFINITION OF CASE MANAGEMENT RELATED TO TARGET GROUP A

Case management for Target Group A means those activities performed by case management staff, in consultation with an adolescent parent of an eligible child or with a eligible adolescent and other individuals involved with the child or adolescent if appropriate, related to ensuring that the adolescent and child have full access to the comprehensive array of services and assistance available in the community which the adolescent needs to maintain and strengthen family life and to attain or retain capability for maximum self support and personal independence.

Case management for Target Group A requires referral to and coordination with medical, social, educational, psycho-social, employment, habilitation, rehabilitation, financial, environmental, legal and child care services available within the community appropriate to the needs of the adolescent.

CASE MANAGEMENT FUNCTIONS

Case management functions are determined by the recipient's circumstances and therefore must be determined specifically in each case and with each recipient's involvement. A separate case record must be established for each individual recipient of case management services and must document each case management function provided, including:]

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[A. Intake and screening.

This function consists of: the initial contact with the recipient providing information concerning case management; exploring the recipient's interest in the case management process; determining that the recipient is a member of the provider's targeted population; and, identifying potential payors for services.

B. Assessment and reassessment.

The case manager must secure directly, or indirectly through collateral sources, with the recipient's permission: a determination of the nature and degree of the recipient's functional impairment through a medical evaluation; a determination of the recipient's functional eligibility for services; information from other agencies/individuals required to identify the barriers to care and existing gaps in service to the recipient; assessment of the recipient's service needs including medical, social, psychosocial, educational, financial and other services; and, a description of the recipient's strengths, informal support system and environmental factors relative to his/her care.

C. Case Management plan and coordination.

The case management activities required to establish a comprehensive written case management plan and to effect the coordination of services include: identification of the nature, amount, frequency, duration and cost of the case management services required by a particular recipient; selection of the nature, amount, type, frequency and duration of services to be provided to the recipient with the participation of the recipient, the recipient's informal support network and providers of services; specification of the long term and short term goals to be achieved through the case management process; collaboration with hospital discharge planners, health care providers and other service providers, including informal caregivers and other case managers, through case conferences to encourage exchange of clinical information and to assure:

1. the integration of clinical care plans throughout the case management process;
2. the continuity of service;
3. the avoidance of duplication of service (including case management services); and,]

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[4. the establishment of a comprehensive case management plan that addresses the medical, social, psychosocial, educational, and financial needs of the recipient.

- D. Implementation of the case management plan** includes: securing the services determined in the case management plan to be appropriate for a particular recipient through referral to those agencies or persons who are qualified to provide the identified services; assisting the recipient with referral and/or application forms required for the acquisition of services; advocating for the recipient with all providers of service; and developing alternative services to assure continuity in the event of service disruption.
- E. Crisis intervention** by a case manager or practitioner when necessary, includes: assessment of the nature of the recipient's circumstances; determination of the recipient's emergency service needs; and, revision of the case management plan, including any changes in activities or objectives required to achieve the established goal.
- F. Monitoring and follow-up** of case management services includes: assuring that quality services, as identified in the case management plan, are delivered in a cost-conscious manner; assuring that the recipient is adhering to the case management plan; ascertaining the recipient's satisfaction with the services provided and advising the preparer of the case management plan of the findings if the plan has been formulated by a practitioner; collecting data and documenting in the case record the progress of the recipient' making necessary revisions to the case management plan; making alternate arrangements when services have been denied or are unavailable to the recipient; and, assisting the recipient and/or provider of services to resolve disagreements, questions or problems with implementations of the case management plan.
- G. Counseling and exit planning** include: assuring that the recipient obtains, on an ongoing basis, the maximum benefit from the services received; developing support groups for the recipient, the recipient's family and informal providers of services; mediating amount the recipient, the family network and/or other informal providers of services when problems with]

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[service provision occur; facilitating the recipient's access to other appropriate care if and when eligibility for the targeted services ceases; and, assisting the recipient to anticipate the difficulties which may be encountered subsequent to discharge from or admission to facilities or other programs, including other case management programs.

PROCEDURAL REQUIREMENTS FOR PROVISION OF SERVICE

1. Assessments.

The case management process must be initiated by the recipient and case manager through a written assessment of the recipient's need for case management as well as medical, social, psychosocial, educational, financial and other services.

An assessment provides verification of the recipient's current functioning and continuing need for services, the service priorities and evaluation of the recipient's ability to benefit from such services. The assessment process includes those activities listed in paragraph B of **CASE MANAGEMENT FUNCTIONS**.

An assessment must be completed by a case manager within 15 days of the date of the referral or as specified in a referral agreement. The referral for the service may include a plan of care containing significant information developed by the referral source which should be included as an integral part of the case management plan.

An updated assessment of the recipient's need for case management and other services must be completed by the case manager every six months, or sooner if required by changes in the recipient's condition or circumstances.

2. Case management plan.

A written case management plan must be completed by the case manager for each recipient of case management services within 30 days of the date of referral or as specified in a referral agreement, and must include those activities outlined in paragraph C under **CASE MANAGEMENT FUNCTIONS**.]

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[The recipient's case management goals, with anticipated dates of completion, must be established in the initial case management plan, consistent with the recipient's service needs and assessment.

The case management plan must be reviewed and updated by the case manager as required by changes in the recipient's condition or circumstances, but not less frequently than every six months subsequent to the initial plan; and each time the case management plan is reviewed, the goals established in the initial case management plan must be maintained or revised, and new goals and new time-frames may be established with the participation of the recipient.

The case management plan must specify:

- a. those activities which the recipient is expected to undertake within given period of time toward the accomplishment of each case management goal;
- b. the name of the person or agency, including the individual and/or family members, who will perform needed tasks;
- c. the type of treatment program or service providers to which the recipient will be referred.
- d. the method of provision and those activities to be performed by a service provider or other person to achieve the recipient's related goal and objective; and
- e. the type, amount, frequency, duration and cost of case management and other services to be delivered or tasks to be performed.

3. Continuity of service.

Case management services must be ongoing from the time recipient is accepted by the case management agent for services to the time when: the coordination of services provided through case management is not required or is no longer required by the recipient; the recipient moves from the social services district to a district in which case management services are not provided; the long term goal has been reached; the recipient refuses to accept case management services; the recipient requests that his/her case be closed; the recipient is no longer eligible for services; or, the recipient's case is appropriately transferred to another case manager.]

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[Contact with the recipient or with a collateral source on the recipient's behalf must be maintained by the case manager at least monthly or more frequently as specified in the provider's agreement with New York State Department of Social Services.

LIMITATIONS TO THE PROVISION OF MEDICAID CASE MANAGEMENT SERVICES

Case management services:

1. must not be utilized to restrict the choice of a case management services recipient to obtain medical care or services from any provider participating in the Medical Assistance Program who is qualified to provide such care or services and who undertakes to provide such care or service(s) including an organization which provides such care or services or which arranges for the delivery of such care or services on a prepayment basis;
2. must not duplicate case management services currently provided under the Medical Assistance Program or under any other program;
3. must not be utilized by providers of case management to create a demand for unnecessary services or programs particularly those services or programs within their scope of authority; and,
4. must not be provided to persons receiving institutional care reimbursed under the Medical Assistance Program or to persons in receipt of case management services under a Federal Home and Community Based Services Waiver.

While the activities of case management services secure access to, including referral to and arrangement for, an individual's needed service, the activities of case management do not include:

1. the actual provision of the service;
2. Medicaid eligibility determinations/redeterminations;]

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3. Medicaid preadmission screening;
4. prior authorization for Medicaid services;
5. required Medicaid utilization review;
6. EPSDT administration;
7. activities in connection with "lock-in" provisions under 1915(a) of the Social Security Act;
8. institutional discharge planning as required of hospitals, SNF's, ICF's and ICF/MR's; and
9. client outreach.

LIMITATIONS SPECIFIC TO TARGET GROUP A

Case managers and case management staff with respect to any eligible child of an adolescent or adolescent in Target Group A for whom case management activities are being performed and the child(ren) of such adolescent, are prohibited from and do not have the authority to:

1. provide, authorize or purchase services or assistance reimbursable under Title XX of the federal Social Security Act or otherwise administered or funded by the social services district;
2. accept or deny any application for public assistance or for services or assistance reimbursable under Title XX of the federal Social Security Act or otherwise administered or funded by the social service district; or,
3. place the adolescent or his or her child(ren) in foster care, or remove the adolescent or his or her child(ren) from the home of his or her parent or guardian.

E. QUALIFICATIONS OF PROVIDERS

1. Providers

Case management services may be provided by social services agencies, facilities, persons and other groups possessing the capability to provide such services who are approved by the New York State Commissioner of Social Services based upon an approved proposal submitted to the New York State Department of Social Services. Providers may include:]

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- [a. facilities licensed or certified under New York State law or regulation;
- b. health care or social work professionals licensed or certified in accordance with New York State law;
- c. State and local governmental agencies; and
- d. home health agencies certified under New York State law.

2. Case Managers

The case manager must have two years experience in a substantial number of activities outlined under **CASE MANAGEMENT FUNCTIONS**, including the performance of assessments and development of care management plans. Voluntary or part-time experience which can be verified will be accepted on a pro-rata basis. The following may be substituted for this requirement:

- a. one year of case management experience and a degree in a health or human services field; or
- b. one year of case management experience and an additional year of experience in other activities with the target population; or
- c. a bachelor's or master's degree which includes a practicum encompassing a substantial number of activities outlined under **CASE MANAGEMENT FUNCTIONS**, including the performance of assessments and development of case management plans; or
- d. the individual meets the regulatory requirements for case manager of a State Department within New York State.

3. Qualifications of Providers Specific to Target Group A*

1. Providers

Providers of case management to the adolescents in Target Group A may be public or private agencies and organizations, whether operated on a profit-making or not-for-profit basis.

2. Case Managers

Case managers must have the education, experience, training and/or knowledge in the areas necessary to assess the needs and capabilities of, and to assist pregnant, parenting or at-risk adolescents access to services and assistance needed to maintain and strengthen]

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Supplement 1 to Attachment 3.1-A

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[family life, to attain or retain the capability for maximum self support and personal independence including, but not limited to the areas of adolescent development, adolescent sexuality, and effective interviewing techniques.

Primary responsibility for performing case management activities must be given to case managers. Para-professional and volunteers may be used as case management staff to assist the case managers and may perform those activities which are appropriate based on their training and experience.]

[* (18 NYCRR 361.0-361.13 NYS DSS Regulatory requirements for implementation of the New York State Teenage Services Act of 1984.)]

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Supplement 1 to Attachment 3.1-A

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Effective December 1, 2011, the State is terminating the optional reimbursement of Medicaid case management services provided through TASA — Target Group A described on pages 1-A1 through 1-A12.

TN #11-83
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES

A. Target Group:

See attached Target Group B.

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

Entire State.

Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

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

Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See attached

E. Qualification of Providers:

See attached

TN #89-16

Supersedes TN NEW

Approval Date July 27, 1990

Effective Date April 1, 1990

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

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

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

TN #89-16

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Approval Date July 27, 1990

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CASE MANAGEMENT SERVICES

A. TARGET GROUP B

Persons enrolled in Medical Assistance who:

- (1) Have a documented diagnosis of mental retardation or a developmental disability as defined in New York Mental Hygiene Law §1.03, and
- (2) Are in need of ongoing and comprehensive service coordination rather than incidental service coordination, and
- (3) Have chosen to receive the services, and
- (4) Do not reside in intermediate care facilities for the developmentally disabled; State operated Developmental Centers; Small Residential Unit (SRU); Nursing Facilities, or hospitals or any other medical assistance institutional settings that provide service coordination, and
- (5) Are not concurrently enrolled in any other comprehensive service coordination service funded under Medical Assistance.

B. AREAS OF STATE IN WHICH SERVICES WILL BE PROVIDED TO TARGET

Entire State

C. DEFINITION OF MEDICAID SERVICE COORDINATION TO TARGET GROUP B

Medicaid Service Coordination (MSC) for Target Group B is a service which assists persons with developmental disabilities in gaining access to necessary services and supports appropriate to the needs of the individual. MSC is provided by qualified service coordinators and uses a person-centered approach to planning, developing, maintaining, and monitoring an Individualized Service Plan (ISP) with and for a person with developmental disabilities. MSC promotes the concepts of choice, individualized services and supports and consumer satisfaction.

TN #00-07

Supersedes TN #89-16

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D. Medicaid Service Coordination Functions

General Service Description

Medicaid Service Coordination helps a person access necessary supports and services including medical, social, educational, psychosocial, employment, habilitation, rehabilitation, financial, residential and legal services available and in accordance with the person's valued outcomes as expressed in the Individualized Service Plan (ISP).

Medicaid Service coordination functions are:

- Enrollment ("Intake")
- Development of the Individualized Service Plan (ISP)
- Implementation of the ISP
- Maintenance of the ISP

Enrollment

The service coordinator assesses eligibility for MSC based on the criteria specified in A above. The service coordinator completes necessary enrollment documents.

Development of the Individualized Service Plan (ISP)

The Individualized Service Plan (ISP) is developed using a person-centered approach. The service coordinator helps the person plan by choosing personal valued outcomes, and developing a personal network of activities, supports and services. The plan identifies those supports and services chosen by the consumer with the service coordinator's assistance, as well as the entities that will supply them. The resulting planning information is written in the appropriate ISP format.

ISP development also includes the execution of a Service Coordination Agreement. This agreement, between the person served and the service coordinator, describes the service coordination activities the person wants and needs to meet his or her individualized goals as described in the ISP.

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Implementation of the Individualized Service Plan (ISP)

Using the ISP as a blueprint, the service coordinator works with the person to achieve his or her valued outcomes. Chosen activities, supports, and the full array of services are accessed as identified in the plan. The service coordinator uses knowledge of the community and available resources and employs specialized skills to successfully implement the ISP. The service coordinator:

- Locates or creates natural supports and community resources.
- Locates funded services, helps determine eligibility, completes referrals, facilitates visits and interviews.
- Helps arrange for transportation to the community activities and services as necessary.
- Assists in communicating the content of the ISP, including valued outcomes, to service providers and assists providers in designing and implementing services consistent with the ISP.

Maintenance of the ISP

This is the ongoing service provided by the service coordinator. It includes:

- Assessing the person's satisfaction with his or her ISP, including the Service Coordination Agreement, and making adjustments as necessary.
- Supporting the person towards achievement of valued outcomes.
- Establishing and maintaining an effective communication network with service providers.
- Keeping up to date with changes, choices, temporary setbacks and accomplishments relating to the ISP
- Managing through difficulties or problems or crises as they occur.
- Assisting the consumer in assuring that rights, protections and health and safety needs are met pursuant to state law and regulations.
- Keeping the ISP document, including the Service Coordination Agreement, current by adapting it to change.
- Reviewing the ISP at least semi-annually.

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Systemic Features and Functions

OMRDD centrally and through its local DDSOs will:

- Ensure access to the service for all eligible people.
- Assist people served in choosing a service coordination provider by making the full range of provider options known to the person and his/her family.
- Match individual needs of people with special provider capabilities and characteristics.
- Ensure uniformity in service coordinator and service coordinator supervisor basic training.
- Provide standardized curricula for service coordinators' ongoing training.
- Organize and schedule training and carry out training.
- Carry out functions necessary to ensure quality of service and proper management of the program.
- Monitor Service Coordination Agreements between the service coordinator and the person served to ensure service coordinator fulfillment of commitments according to the agreed upon time frame.
- Make referrals to other service coordination providers when a person is dissatisfied with the current service provider.
- Monitor complaints of persons served and their families to detect patterns of poor service quality.
- Require provider corrective action as necessary.
- Oversee provider terminations and necessary referrals to other service coordination providers as necessary.

E. LIMITATIONS ON THE PROVISION OF MEDICAID SERVICE COORDINATION

Medicaid service coordination will not:

1. Be utilized to restrict the choice of a service coordination consumer to obtain medical care or services from any provider participating in the Medical Assistance Program who is qualified to provide such care or services and who undertakes to provide such care or service(s), including an organization which provides such care or services or which arranges for the delivery of such care or services on a prepayment basis.
2. Duplicate case management services currently provided under the Medical Assistance Program or under any other program.

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December 16, 1999

3. Be utilized by providers of service coordination to create a demand for unnecessary services or programs particularly those services or programs within their scope of authority and
4. Be provided to persons receiving institutional care reimbursed under the Medical Assistance Program, except that Medicaid service coordination may be provided for up to 30 days to persons who are temporarily institutionalized, when the admission to the institution is initially expected to be 30 days or less.

While the activities of Medicaid Service Coordination secure access to an individual's needed service, the activities of service coordination do not include:

1. The actual provision of the service;
2. Medicaid eligibility determinations/redetermination;
3. Medicaid pre-admission screening;
4. Prior authorization for Medicaid services;
5. Required Medicaid utilization review;
6. EPSDT administration;
7. Activities in connection with "lock-in" provisions under §1915(a) of the Social Security Act;
8. Institutional discharge planning as required of hospitals, SNF's, and ICFs/MR and
9. Client outreach considered necessary for the proper and efficient administration of the Medicaid State Plan.

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F. **QUALIFICATIONS**

1. **Providers**

Pursuant to §1915(g)(1) of the Social Security Act, Medicaid service coordination will be provided by New York State OMRDD through a network of OMRDD employees and contractors.

2. **Service Coordinators**

Service coordinators must:

- (a) either;
 - (1) have experience providing OMRDD Comprehensive Medicaid Case Management (CMCM) or OMRHH Home and Community Based (HCBS) Waiver Service coordination or
 - (2) (i) be a registered nurse or have at least an associate's degree (or equivalent accredited college credit hours) in a health or human services field, and
 - (ii) have at least one year's experience working with persons with developmental disabilities or at least one year's experience providing service coordination to any population, and
- (b) attend professional development courses required by OMRDD.

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G. METHOD OF REIMBURSEMENT

The method of reimbursement shall be a monthly fee established by OMRDD in conjunction with the New York State Department of Health and approved by the New York State Division of the Budget.

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2. Case Managers

The case manager must have two years experience in a substantial number of activities outlined under CASE MANAGEMENT FUNCTIONS, including the performance of assessments and development of care management plans. Voluntary or part-time experience which can be verified will be accepted on a pro-rate basis. The following may be substituted for this requirement:

- a. one year of case management experience and a degree in a health or human service field; or
- b. one year of case management experience and an additional year of experience in other activities with the target population; or
- c. a bachelor's or master's degree which includes a practicum encompassing a substantial number of activities outlined under CASE MANAGEMENT FUNCTIONS, including the performance of assessments and development of case management plans; or
- d. the individual meets the regulatory requirements for case manager of a State Department within New York State.

3. Qualifications of Providers Specific to Target Group "B"

1. Providers

Providers of Comprehensive Medicaid Case Management to developmentally disabled persons in Target Group "B" shall only be the Borough/District Developmental Services Offices (B/DDSO) of CMRDD and voluntary non-profit agencies and organizations authorized by CMRDD as CMCM/CMRDD providers, and identified by CMRDD to SDSS.

2. Case Managers

Case managers serving Target Group "B" must meet the minimum qualifications described above.

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State Plan under Title XIX of the Social Security Act
State/Territory: New York

TARGETED CASE MANAGEMENT SERVICES
Target Group B – Medicaid Service Coordination (MSC)

Office of People With Development Disabilities (OPWDD) -
Individuals with Intellectual and Developmental Disabilities (II/DD)

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

Persons enrolled in Medical Assistance who:

- (1) Have a developmental disability as defined in New York Mental Hygiene Law §1.03, and
- (2) Are in need of the support of Care Manager to assist in coordinating the Medicaid-funded Long Term Supports that the person receives or would benefit from receiving, and
- (3) Have chosen to receive the services and not to receive comprehensive Health Home Care Management through the Health Home model, and
- (4) Reside in their own or family home, live in an OPWDD certified residence (Individualized Residential Alternative, Community Residence or Family Care Home). However, persons who receive Basic Home and Community-Based Services (HCBS) Plan Support and are receiving institutional care reimbursed under the Medical Assistance Program may continue to receive Basic HCBS Plan Support for up to 30 days when persons are temporarily institutionalized, and when the admission to the institution is initially expected to be 30 days or less.

 Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 0 (zero) 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):

- 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.
 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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Target Group B – Medicaid Service Coordination (MSC)

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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**
 - **Gathering pertinent individual and family 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;**

Assessment activities include taking the person's history, identifying needs of the individual, and completing related documentation. It also includes gathering information from other sources such as family members, medical providers, clinical assessments, educators, and other individuals/providers associated with the person, if necessary, to form a complete assessment (i.e., picture) of the person and his/her needs and goals. Re-assessment should occur when the care plan (known as an Individualized Service Plan (ISP) or Life Plan) is reviewed semi-annually or more frequently if necessary based on the changing needs of the person or his or her request for a reassessment. The Care Manager may recommend an individual seek more comprehensive services through the Health Home model if the needs of the individual require more frequent reviews and re-assessments than is available under this option. Basic HCBS Plan Support provides care management and does not provide the comprehensive, core services available through the Health Home model. The individual may choose to enroll in the Health Home service at any time. A request to change from between Basic HCBS Plan Support and Health Home Care Management may be submitted to the OPWDD Development Disabilities Regional Office (DDRO) which can authorize the new service for the first date of the following month.

- ❖ **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**

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❖ **Monitoring and follow-up activities:**

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

This is the service provided by the Care Manager. It includes direct contacts on a bi-annual or up to a quarterly basis:

- Assessing the person's satisfaction with his or her supports and services as identified within the care plan, known as an ISP or Life Plan, and making adjustments as necessary;
- Supporting the person towards achievement of valued outcomes;
- Establishing and maintaining an effective communication network with service providers;
- Keeping up to date with changes, choices, temporary setbacks;
- Accomplishments relating to the persons supports and services as reflected in the ISP or Life Plan;
- Managing through difficulties or problems or crises as they occur;
- Assisting the person in assuring that his or her rights, protections and health and safety needs are met pursuant to state law and regulations;
- Keeping the ISP or Life Plan document current by adapting it to change; and
- Reviewing the ISP or Life Plan at least semi-annually.

- 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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Effective 07/01/2018, provider organizations will be known as CCO/HH. The following are the general provider qualifications under the Health Home model:

- CCO/HH providers must be enrolled (or be eligible for enrollment) in the NYS Medicaid program and agree to comply with all Medicaid program requirements and CCO/HH standards, requirements and guidance issued by the State.
- CCO/HH providers eligible to deliver Basic HCBS Plan Support must also be designated by NYSDOH and the OPWDD to deliver Health Home Care Management Services and Basic HCBS plan support.
- CCO/HH providers must also have:
 - the capacity to conduct IT-enabled planning services for the I/DD population; and
 - a Regional Network for referrals to developmental disability, health and behavioral health services.

Effective 07/01/2018, Care Managers will be regulated by the Health Home model. The following are the educational and experience qualifications a Care Manager employed by the CCO/HH:

- 1) A Bachelor's degree with two (2) years of relevant experience, OR
- 2) A License as a Registered Nurse with two (2) years or relevant experience, which can include any employment experience and is not limited to case management/service coordination duties OR
- 3) A Master's degree with one (1) year of relevant experience.

To support the transition to CCO/HH and Basic HCBS Plan Support services, the following special allowance is made for Care Managers who served as a MSC Service Coordinator and do not meet the above educational requirements.

- 1) Care Managers who served as an MSC Service Coordinators prior to July 1, 2018 are "grandfathered" to facilitate continuity for the individual receiving coordination. Documentation of the employee's prior status as an MSC Service Coordinator may include a resume or other record created by the MSC Agency or the CCO/HH demonstrating that the person was employed as an MSC Service Coordinator prior to July 1, 2018.
- 2) CCO/HHs will be required to provide the CCO/HH core services training for current MSC Service Coordinators transitioning to CCO/HH Care Management and who do not meet the minimum education and experience requirements. Such training will be provided by the CCO/HH within one (1) year of contracting with an MSC Service

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Coordinator. The CCO/HH will adjust training activities for Care Managers serving individuals enrolled in Basic HCBS Plan Support, but all Care Managers must be able to deliver both the Health Home Care Management service and Basic HCBS Plan Support.

Care Managers who serve Willowbrook Class members must be Qualified Intellectual Disabilities Professionals (QIDP).

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.

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

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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:

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

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

A CCO/HH is a Health Home that is tailored to meet the needs of individuals with intellectual and/or developmental disabilities (I/DD). CCO/HHs will be designated by the NYSDOH in collaboration with the NYS OPWDD. CCO/HHs and Care Managers provide person-centered care management, planning and coordination services that are tailored specifically to help people with I/DD and their families coordinate all services.

Effective 07/01/2018, entities must demonstrate they are controlled (at least 51 percent) by one or more non-profit organizations with a history of providing or coordinating developmental disability, health, and long-term care services to persons with I/DD, including MSC and/or I/DD long term supports and services (LTSS). New York State's expectation is that the governance structure and leadership of the I/DD Health Home (board members and officers) will have extensive experience coordinating care for individuals with I/DD in New York State; prior experience in overseeing and operating entities that have delivered MSC or I/DD HCBS waiver services to individuals with I/DD, and are in good standing with the State.

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §44[1]Q.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 §44[1]Q.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

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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))

While the activities of Care Managers secure access to an individual's needed services, the activities of care coordination do not include:

1. The actual provision of the service;
2. Medicaid eligibility determinations/redetermination;
3. Medicaid pre-admission screening;
4. Prior authorization for Medicaid services;
5. Required Medicaid utilization review;
6. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) administration;
7. Activities in connection with "lock-in" provisions under §1915(a) of the Social Security Act;
8. Institutional discharge planning as required of hospitals, Skilled Nursing Facilities (SNFs), and ICFs/IIDs; and
9. Client outreach considered necessary for the proper and efficient administration of the Medicaid State Plan.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES

A. Target Group:

See attached Target Group C

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

Entire State

Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Service

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

Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See attached

E. Qualification of Providers:

See attached

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- F. **The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.**
1. Eligible recipients will have free choice of the providers of case management services.
 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. **Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.**

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

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

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

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CASE MANAGEMENT SERVICES

A. Target Group C

This target group consists of any categorically needy or medically needy individual who meets one or more of the following criteria:

1. All HIV infected persons;
2. All HIV antibody positive infants up to age 3 years if seroconversion has not been firmly established; and
3. All high risk individuals for a temporary period of time not to exceed 6 months with transition to another appropriate case management program for individuals who are HIV negative or continued unknown status. High risk individuals as the term is used in the expanded target Group C AIDS CMCM population are those individuals who are members of the following category:

Men who have sex with men (MSM), substance abusers, persons with history of sexually transmitted diseases, sex workers, bisexual individuals, sexually active adolescents engaging in unprotected sex, and persons who engage in unprotected sex with HIV+ or high risk individuals.

Family members and coresidents (ie. collaterals) of the above targeted index clients may also receive case management services as necessary, to allow for the provision of necessary care and services to the targeted individual. Services for case collaterals shall be considered as one family unit in the case manager's caseload. Separate assessments and service plans are not required for collaterals, but may be incorporated into the case records of the primary client. Collaterals may have services arranged for by the case management provider. Case management services for collaterals should be limited to issues that directly affect the care of and services to the primary client.

The clients targeted under this proposal face enormous barriers to care, such as continuing drug and alcohol use, and their associated medical and social problems, domestic violence, mistrust of medical care and other services, fear of losing their children to foster care, fear of HIV infection and its consequences, lack of transportation and day care services, and lack of support in accessing care for their sexual partner and/or coresidents. These barriers to care can be overcome by the persistent efforts of indigenous community follow-up workers in cooperation with case managers. These workers must have special skills and strengths to deal with these problems, to win the trust and confidence of their clients in order to motivate them to return to care and to be continuously monitored thereafter. The magnitude of the effort required to accomplish this exceeds the capabilities of existing institutional bound and community case managers and requires the extensive frequent personal contact possible through an intensive case management program under Comprehensive Medicaid Case Management.

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B. AREAS OF THE STATE WHERE SERVICES MAY BE PROVIDED

Services to this target group may be provided statewide.

C. COMPARABILITY OF SERVICES

Services will only be provided to those individuals who meet one or more of the criteria set forth in Section A, Target Group, of this Supplement.

Case management services will be provided without limitation as to amount, duration or scope.

D. DEFINITION OF CASE MANAGEMENT UNDER THE COMMUNITY FOLLOW-UP PROGRAM (CFP)

Case management is a process which will assist persons eligible for Medical Assistance to access necessary services in accordance with goals contained in a written case management plan.

Case management is a multi-step process comprised of the following activities:

1. Intake
2. Assessment
3. Initial Care Plan Development
4. Initial Care Plan Implementation
5. Reassessment
6. Care Plan Update
7. Care Plan Update Implementation
8. Monitoring
9. Crisis Intervention Activities
10. Termination/Case Disposition Activities
11. Client Advocacy, Interagency Coordination and Systems Development Activities
12. Supervisory Review/Case Conferencing

The sections below describe the specific functions in detail.

1. Intake

The case manager should collect identifying information concerning the client, family, care givers and informal supports including the intake elements required on forms developed or approved by the State Department of Health. A list of family members, coresidents and children not currently living at home should be recorded including identification of the primary caregiver, primary contacts and legal guardian(s) of the child(ren). Client consent to case management, including home visitation, case conferencing, service acquisition and registration procedures, should be obtained and documented in the case records.

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Intake procedures should be initiated upon referral to the Community Follow-up Program provider and completed after the first visit. The Intake Procedures may be completed by the case manager, technician or the community follow-up worker. The intake includes confirmation that the case management program has been fully explained to the client. Clients have the right to choose care providers and, therefore, may choose whether or not to enroll in the case management program.

2. **Assessment**

Assessment is the collection of information about the client's medical, physical and psychosocial condition, resources, needs, and confirmation of eligibility for the program. The assessment process should include a home visit to evaluate the client's needs, informal supports, and general living conditions. All family members should be seen in the assessment interview(s), if possible. Direct caregivers and family members not able to be interviewed should be contacted by phone, if possible. The purpose of assessment is to identify the client's/family's problems and care needs, what care needs are being met and by whom, and what needs are not adequately met. The initial assessment will focus on immediate health and social services needs and address the client's history of underutilization of care, and the reasons for such underutilization. Assessments will be documented on forms required or approved by the State Department of Health, AIDS Institute.

Assessment activities should be completed following the second visit but no later than 15 days from the date of receipt of the referral. The assessment should be completed by the case manager with assistance from the case management technician.

3. **Initial Service Plan Development**

Development of the service plan is the translation of assessment information into specific goals and objectives, and specific services, providers and timeframes to reach each objective. The service plan is developed by the case manager, in coordination with the client, representative and other providers.

The service plan will reflect goals and services to be provided to the client and family members. If services actually provided differ, a note explaining the difference should be made. The costs and sources of payment for all services should be documented as required by Department of Social Services regulations 505.16. The client's response to the final plan, consent to case management and/or declination of any part of the plan by the client should be documented on forms approved by the Department of Health.

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It is the intent of New York State that case management in the Community Follow-up Program represent a fully integrated case management approach. The case manager coordinates all necessary services along the continuum of care – both institutional and community based by both directly accessing services and by establishing linkages with other service programs including those under the jurisdiction of the local department of social services. The role of the case manager is to reduce the barriers in crossing administrative boundaries to ensure that clients obtain needed services at the appropriate time from wherever the services are available. Services accessed for the client should include institutional and non-institutional medical and non-medical services, social and other support services and linkages to existing community resources. In so doing, the case manager will access and coordinate services with other case managers who may also serve the client. The service plan will be developed following the second client contact. Immediate needs should be addressed by the case manager and such services should be implemented immediately after the intake. Other assessed needs should be addressed as soon as possible but in no case later than 30 days from the date of receipt of the referral. The service plan is to be developed by the case manager with the assistance of the technician or community follow-up worker.

4. Initial Service Plan Implementation

In implementation of the service plan, or service acquisition, the case manager assists the client and family or coresidents as needed, in contacting the support persons and other service providers to negotiate the delivery of planned services. The service plan may be modified to accommodate the client, family members, coresidents, support persons, and service providers. Any changes from the original plan should be noted in the record. These activities may be accomplished by the case manager or a member of the case management team.

The case manager, case management technician or community follow-up worker will (in accordance with the client's assessed abilities):

- a. contact providers, including support persons, by phone, in writing or in person
- b. assist the client and family members or coresidents in making applications for services and entitlements, including basic needs such as transportation, child care, baby-sitting, etc.
- c. confirm service delivery dates with providers, and supports
- d. schedule multiple visits by family members on the same day to accommodate the needs of the family and children
- e. document services that aren't available or cannot be accessed

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- f. gain assurance from other care providers that services will be initiated, and confirm the delivery of these services
- g. decide, with the client and other providers, on the ongoing responsibilities of each provider
- h. give other service providers accurate and complete information about the service(s) they are expected to provide and the services provided by others.

Any changes to the service plan due to scheduling or availability of services will be documented. Service plan implementation should begin immediately after service needs are assessed and is an ongoing responsibility of the case manager. The case manager and support staff, in accordance with the client's assessed abilities, will assist the client by contacting providers and support persons when needs are identified. Assistance continues until the case manager or staff determines that the services have been arranged and received. Confirmation of need for, application for and receipt of services is required.

5. Reassessment

Reassessment is a scheduled or event generated formal re-examination of the client's situation, functioning, clinical and psychosocial needs, to identify changes which have occurred since the initial or most recent assessment. The reassessment should measure progress toward the desired goals outlined in the care plan and is used to prepare a new or revised service plan or confirm that current services remain appropriate. Reassessment is the responsibility of the case manager.

A formal reassessment under the program for clients who are receiving intensive case management is due within 90 days of admission and every 90 days thereafter or when a change in the client's status occurs which significantly effects the service plan. Significant changes in status include:

- a. death, illness or hospitalization of a family member or care giver(s), or a condition or circumstance which impairs the client's ability to provide for the family's physical and/or emotional needs,
- b. change in the client's clinical or functioning status,
- c. loss of domicile, entitlement, or service.
- e. document services that aren't available or cannot be accessed

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6. Service Plan Update

Updating the service plan means modification to or revision of the service plan based on reassessment. Update of the service plan may also occur as a result of changes in clients' needs, or information from monitoring contacts when changes are not significant as to require a formal reassessment. Update of the service plan includes all activities of service plan development, described above in subsection c, relative to new or changed needs and services. The service plan should be updated at every reassessment or when a change in client status occurs which significantly affects the service plan. The service plan may be updated by the case manager with assistance from the members of the case management team.

7. Service Plan Update Implementation

Implementation of the updated service plan includes the same activities as described for service plan implementation noted in subsection d, and may be the responsibility of the technician or community follow-up worker under the supervision of a case manager.

8. Monitoring

Monitoring is contact between the case manager or support staff and the client or representative. Support persons and service providers will also be contacted if necessary. The purpose of these contacts is to assure that services are being delivered according to the service plan. Contacts may include encounters in the agency, home, hospital or outpatient department, contacts by phone or in person. Any problems noted during monitoring contacts will be followed up immediately with the client, support person or provider, as needed, to address the problem.

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The case manager and case management team will also coordinate the medical monitoring of all persons who are HIV positive with the primary care physician, clinic or AIDS Center responsible for the medical monitoring of asymptomatic HIV disease. This service includes the ongoing monitoring of preclinical HIV infection (asymptomatic) to determine the appropriate stage to initiate active prophylactic and secondary treatment for opportunistic infections. This service applies to HIV positive persons prior to clinical manifestations or laboratory evidence of HIV illness. The case manager should assure that CD4 ((T4)) testing is done every three or six months as appropriate, and if symptoms of HIV illness are identified, therapies provided by a referral to an AIDS Center hospital or appropriate outpatient department be arranged. Periodic testing for persons at risk, when requested, or when high risk behavior is reported or suspected should also be arranged by the case manager and case management team.

For clients receiving intensive case management in the Community Follow-up Program, a minimum of 9 contacts is required every 90 days. A minimum of six of these contacts must be face to face with the client. A minimum of four of these contacts must be home visits. Greater frequency of contacts in all categories will be arranged on an as needed basis and are in fact encouraged and anticipated in an intensive case management program. The case manager must personally have two contacts with the primary client every 90 days. Case conferences will be held for families with multiagency service plans including agencies such as Certified Home Health Agencies, local child welfare or community based organizations. Conferences will take place within 90 days of initial care plan implementation and every 180 days thereafter.

9. **Crisis Intervention**

The purpose of crisis service is to provide assessment and intensive short term treatment of acute medical, social, physical or emotional distress. Crisis intervention should be made available to all Community Follow-up Program clients on an emergency 24 hour basis through subcontract with a 24 hour crisis agency, or via direct provision by the case manager, by a crisis hotline, use of mobile crisis teams, or through referral to the Community Follow-up Program Director or supervisor. Crisis services may be needed for a variety of reasons. The crisis may relate to an emergency medical need, drug use or drug overdose, domestic violence or child abuse, etc. Irrespective of the nature of the crisis, it is the responsibility of the case manager or provider agency to assist the client, family, coresident or lover in obtaining the appropriate response to the situation, keeping in mind the need to maintain the client's dignity and rights to privacy and confidentiality. In addition, the crisis intervention should be designed to decrease inappropriate utilization of emergency rooms by targeting the response more appropriately to the identified crisis.

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10. Exit Planning/Case Discontinuations

Exit planning procedures are initiated when the client:

- a. expires
- b. loses Medicaid or programmatic eligibility, though Medicaid eligibility is not required for eligibility in the CFP, or
- c. declines the case management services of CFP, or
- d. desires to be referred to a different CFP provider agency or to an existing case management program such as the Long Term Home Health Care Program, AIDS Home Care Program, or
- e. will be institutionalized for greater than 30 days if Medicaid is the payor for such hospitalization and discharge to community based care is not anticipated. For private pay and third party individuals, case management services may continue beyond the 30 day limit while hospitalized, or
- f. the client relocates out of the CFP providers' service area.

In all cases, except where the client expires, the provider must complete a referral process designed to link the client with appropriate ongoing case management and other vital services necessary to meet their care needs. The provider must refer the client to another eligible CFP provider if one exists within the geographic area in which the client resides. With the client's consent, a case summary should be prepared for referral to the new provider. A final assessment noting disposition and measures of progress toward identified goals should be prepared and placed in the final record. The local Department of Social Services should be notified of the case disposition and can assist in referral of the client to alternate case management providers. Exit planning is a responsibility of the case manager with assistance from the members of the case management team.

11. Patient Advocacy, Interagency Coordination and Systems Development

The function of the case manager is to be an advocate for services for the client with particular emphasis on self-sufficiency in the community and avoidance of premature or unnecessary institutionalization.

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12. Supervisory Review/Case Conferencing

An important component of the required quality assurance process for each CFP provider will be supervisory review of case management documentation, care plans and other products as well as peer review or case conferencing with other case managers. Therefore, for clients receiving case management, supervisory review of each client care plan by the designated supervisor or agency director will be conducted initially at the time of the development of the original service plan and every 90 days thereafter. In addition, each agency participating as a CFP provider will establish a peer review process wherein all case managers will present and discuss client specific case management plans with other case managers in the agency at least once annually. While we are requiring the supervisory function, we are not requiring a supervisory role. In this way agencies will have the flexibility to provide supervision with either in house staff or through an outside consultant.

Case managers will also be required to case conference with other agencies regarding specific clients at 90 days after service plan implementation and every 180 days thereafter, taking into consideration client consent, the client's need for confidentiality and privacy, as well as Department of Health Regulations on confidentiality. This would include contacts with discharge planners, case managers from other agencies, etc. Supervisory review and case conferencing are billable on a direct patient specific basis in the community Follow-up Program. Agency conferences that are not patient specific are not directly billable; however, projected costs for these activities may be included in the administrative budget submitted by each provider.

13. Program Limitations

Case Management under the Community Follow-up Program:

1. must not be utilized to restrict the choice of a case management services recipient to obtain medical care or services from any provider participating in the Medical Assistance Program that is qualified to provide such care or services and who undertakes to provide such care or service(s) including an organization which provides such care or services or which arranges for the delivery of such care or services on a prepayment basis;
2. must not duplicate certain case management services currently provided under the Medical Assistance Program or other funding sources such as the Long Term Home Health Care Program, AIDS, Home Care Program under Chapter 622 of the Laws of 1988, and the Care at Home Program (Katie Beckett Model Waivers).

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3. must not be utilized by providers of case management to create a demand for unnecessary services or programs, particularly those services or programs within their scope of authority; and
4. must not be provided to persons receiving institutional care for more than 30 days or when discharge to community based care is not anticipated and care is reimbursed under the Medical Assistance Program. Case management services may be provided for children and family members during this period of hospitalization.

While the activities of case management services secure access to, including referrals to and arrangements for, an individual's needed service, reimbursement for case management does not include:

1. the actual provision of the service;
2. Medicaid eligibility determinations/redeterminations;
3. Medicaid preadmission screening;
4. prior authorization for Medicaid services;
5. required Medicaid utilization review;
6. administration of Child-Teen Health Program Services;
7. activities in connection with "lock-in" provisions under 1915(a) of the Social Security Act;
8. institutional discharge planning as required of hospitals, SNFs, ICFs and ICF/MRs; and
9. client outreach.

E. QUALIFICATIONS

1. Provider Qualifications

Provider agencies applying for participation in the Community Follow-up Program must meet one of the following requirements:

- (a) have 2 years demonstrated experience in the care of the clients with HIV related illnesses or in providing case management or other services to clients with HIV illness. Examples of eligible agencies will include: Article 28 facilities, Community Based Organizations (CBOs), Community Health Centers (CHCs), or Community Service Programs (CSPs), Certified Home Health Agencies (CHHAs), or
- (b) have 3 years demonstrated experience in the provision of maternal/pediatric services or in providing case management or care planning services to prenatal or post partum women and their children or families, or

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- (c) have 3 years demonstrated experience in the provision of drug abuse and/or drug treatment services, foster care preventive services or adult protective services including case management to clients and families that are at risk of foster care, including but not limited to local departments of social services, or
- (d) be a hospital that has a provider agreement with the New York State Department of Health to participate in the Department's Obstetrical HIV Counseling/Testing/Care Initiative.

2. **Staff Qualifications**

A. **Case Manager Qualifications**

To be eligible for reimbursement under this program, the case manager employed by the agency must meet the following required education/experience:

- 1. a Bachelor's or Master's Degree which includes a practicum encompassing case management practices or a major in Psychology, Sociology, Social Work, or related subjects, or
- 2. one year of qualified experience and an Associate Degree or 60 credit hours of college study from a regionally accredited college or university or one recognized by the New York State Education Department as following acceptable educational practices, or
- 3. two years of qualified experience and/or of case management experience, or
- 4. a degree in nursing or certification as a registered professional nurse or a licensed practical nurse with one year of qualified experience, or
- 5. qualifications meeting the regulatory requirements of a state agency for case manager.

Qualified Experience means verifiable full, part time or voluntary case management or case work with the following target populations:

- 1. persons with HIV related illnesses
- 2. women, children and families at risk of foster care
- 3. substance using families

B. **Case Management Technician Qualifications**

Case management technicians must have a high school diploma or equivalent or must be working towards a high school equivalency diploma (GED) at the time of employment, have one year of qualified experience and have received intensive training in the Case Management Technician curriculum developed by Hunter College, and shall work under the supervision of the case manager.

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C. Community Follow-up Worker Qualifications

The community follow-up worker, under the supervision of the case manager or case management technician, has no required educational or experiential requirements, but should have the following characteristics:

- a. maturity, emotional and mental stability
- b. ability to read and write, understand and carry out directions and instructions, record messages and keep simple records
- c. be a resident or at least familiar with the local community and have knowledge of services and resources that are available
- d. good physical health
- e. a sympathetic attitude towards providing services to persons with HIV illness
- f. fluency in local languages such as Spanish and Creole
- g. experience working in the community preferable

In addition, the agency shall have the responsibility of assuring that all case managers, technicians and community follow-up workers employed (including volunteers) receive a 2-3 day orientation training within the first month of employment in the agency. Each agency must maintain a training log to document the provision of training to all employees.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES

A. Target Group:

See attached Target Group "D"

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

Entire State.

Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

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

Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See attached

E. Qualification of Providers:

See attached

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

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

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

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CASE MANAGEMENT SERVICES

A. TARGET GROUP D

The targeted group consists of medical assistance eligibles who are served by the Office of Mental Health's Intensive Case Management Program and who:

- (i) are seriously and persistently (chronically) mentally ill and
- (ii) require intensive, personal and proactive intervention to help them obtain services, which will permit or enhance functioning in the community and
- (iii) either have symptomology which is difficult to treat in the existing mental health care system or are unwilling or unable to adapt to the existing mental health care system.

These individuals include:

- (1) high risk/heavy service users who are known to staff in emergency rooms, acute inpatient units, psychiatric centers as well as to providers of other acute and crisis service. May have multiple disabilities including drug abuse, alcohol abuse or developmental disabilities;
- (2) extended care state psychiatric center patients who could be discharged but are not because of the absence of needed support in the community;
- (3) mentally ill who are homeless and live on the streets or in shelters;
- (4) seriously mentally ill children and adolescents whose disability disrupts their ability to function in educational, social, vocational and interpersonal spheres and may, without intervention, be institutionalized, incarcerated or hospitalized.

The aim is to benefit these clients by reducing hospitalization and reliance on emergency psychiatric services, as well as increasing employment, encouraging better medication compliance and generally improving the individual's quality of life within the community.

B. AREAS OF STATE IN WHICH SERVICES WILL BE PROVIDED TO TARGET GROUP D

Entire State

D. DEFINITION OF COMPREHENSIVE MEDICAID CASE MANAGEMENT REIMBURSABLE UNDER MEDICAID

Case management is a process which will assist persons eligible for Medical Assistance to access necessary services in accordance with goals contained in a written case management plan.

BASIC PREMISES OF COMPREHENSIVE MEDICAID CASE MANAGEMENT

- 1. Case management services are those services which will assist persons eligible for Medical Assistance to obtain needed medical, social, psychosocial, educational, financial and other services.

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2. Case Management is a human services agency tool for the effective management of multiple resources for the benefit of individuals identified as high utilizers of service who have problems accessing care, or belonging to certain age, diagnosis or specialized program groups. Effective case management must address quality, adequacy and continuity of service, and balance a concern for affordable service with assuring that eligible individuals receive the services appropriate to their needs. Target groups consist of functionally limited persons with multiple needs or high vulnerability who require intensive and/or long term intervention by health and other human services providers.
3. Case management services enable Medicaid eligibles to exercise their freedom of choice by providing knowledge of services available to them, providing access to the most appropriate service to meet their needs and assisting them to achieve their maximum level of functioning and independence in the most appropriate environment.
4. Case management empowers individuals by involving them in the decision making process, and allowing them to choose among all available options as a means of moving to the optimum situation where these individuals and their support system can address their needs. Case management implies utilization and development of such support networks as will maximize the effectiveness, efficiency and accountability of support services on behalf of the individual.

DEFINITION OF CASE MANAGEMENT RELATED TO TARGET GROUP "D"

Case management for Target Group "D" means those activities performed by case management staff related to ensuring that the mentally disabled individual has full access to the comprehensive array of services and assistance which the individual needs to maintain community life and to attain or retain capability for maximum personal independence.

Case management for Target Group "D" requires referral to and coordination with medical, social, educational, psycho-social, employment, habilitation, rehabilitation, financial, environmental, and legal services available within the community appropriate to the needs of the mentally ill individual.

CASE MANAGEMENT FUNCTIONS

Case management functions are determined by the recipient's circumstances and therefore must be determined individually in each case. In no instance will case management include the provision of clinical or treatment services. A separate case record must be established for each individual recipient of case management services and must document each case management function provided.

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A. Intake and screening.

This function consists of: the initial contact to provide information concerning case management; exploring the recipient's receptivity to the case management process; determining that the recipient is a member of the provider's targeted population; and identifying potential payors for services.

B. Assessment and reassessment.

During this phase the case manager must secure directly, or indirectly through collateral sources, with the recipient's permission: a determination of the nature and degree of the recipient's functional impairment through a medical evaluation; a determination of the recipient's functional eligibility for services; information from other agencies/individuals required to identify the barriers to care and existing gaps in service to the recipient; assessment of the recipient's service needs including medical, social, psychosocial, educational, financial and other services; and a description of the recipient's strengths, informal support system and environmental factors relative to his/her care.

C. Case management plan and coordination.

The case management activities required to establish a comprehensive written case management plan and to effect the coordination of services include: identification of the nature, amount, frequency, and duration of the case management services required by a particular recipient; with the participation of the recipient, a cost-conscious selection of the nature, amount, type, frequency and duration of services to be provided to the recipient; identification of the recipient's informal support network and providers of services; specification of the long term and short term goals to be achieved through the case management process; collaboration with hospital discharge planners, health care providers and other services providers, including informal caregivers and other case managers. It also includes, through case conferences, an exchange of clinical information which will assure:

1. the integration of clinical care plans throughout the case management process;
2. the continuity of service;
3. the avoidance of duplication of service (including case management services); and,
4. the establishment of a comprehensive case management plan that addresses the interdisciplinary needs of the recipient.

D. Implementation of the case management plan.

Implementation of the plan includes securing the services determined in the case management plan to be appropriate for a particular recipient through referral to those agencies or to persons who are qualified to provide the identified services; assisting the recipient with referral and/or application forms required for the acquisition of services; advocating for the recipient with all providers of service; and developing alternative services to assure continuity in the event of service disruption.

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- E. **Crisis intervention.** Crisis intervention by a case manager or practitioner includes when necessary: assessment of the nature of the recipient's circumstances; determination of the recipient's emergency service needs; and, revision of the case management plan, including any changes in activities or objectives required to achieve the established goal.
- F. **Monitoring and follow-up.** As dictated by the client's needs and desires, case manager services include: assuring that quality services, as identified in the case management plan, are delivered in a cost-conscious manner; assuring the recipient's satisfaction with the services provided and advising the preparer of the case management plan of the findings; collecting data and documenting in the case record the progress of the recipient; making necessary revisions to the case management plan; making alternate arrangements when services have been denied or are unavailable to the recipient; and, assisting the recipient and/or provider of services to resolve disagreements, questions or problems with implementation of the case management plan.
- G. **Counseling and exit planning.** This function consists of: assuring that the recipient obtains, on an ongoing basis, the maximum benefit from the services received; developing support groups for the recipient, the recipient's family and informal providers of services; mediating among the recipient, the family network and/or other informal providers of services when problems with service provision occur; facilitating the recipient's access to other appropriate care if and when eligibility for the targeted services ceases; and, assisting the recipient to anticipate the difficulties which may be encountered subsequent to discharge from or admission to facilities or other programs, including other case management programs.

PROCEDURAL REQUIREMENTS FOR PROVISION OF SERVICES

- 1. **Assessments.** The case management process must be initiated by the recipient and case manager (or practitioner as appropriate) through a written assessment of the recipient's need for case management as well as medical, social, psychosocial, educational, financial and other services.

An assessment provides verification of the recipient's current functioning and continuing need for services, the service priorities and evaluation of the recipient's ability to benefit from such services. The assessment process includes, but is not limited to, those activities listed in paragraph B of **CASE MANAGEMENT FUNCTIONS**.

An assessment must be completed by a case manager within 15 days of the date of the referral or as specified in a referral agreement. The referral for service may include a plan of care containing significant information developed by the referral source which should be included as an integral part of the case management plan.

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An assessment of the recipient's need for case management and other services must be completed by the case manager every six months, or sooner if required by changes in the recipient's condition or circumstances.

2. Case management plan.

A written case management plan must be completed by the case manager for each recipient of case management services within 30 days of the date of referral or as specified in a referral agreement, and must include, but is not limited to, those activities outlined in paragraph C under **CASE MANAGEMENT FUNCTIONS**.

The recipient's case management goals, with anticipated dates of completion, must be established in the initial case management plan, consistent with the recipient's service needs and assessment.

The case management plan must be reviewed and updated by the case manager as required by changes in the recipient's condition or circumstances, but not less frequently than every six months subsequent to the initial plan. Each time the case management plan is reviewed the goals established in the initial case management plan must be maintained or revised, and new goals and new time frames may be established with the participation of the recipient.

The case management plan must specify:

- a. those activities which the recipient is expected to undertake within a given period of time toward the accomplishment of each case management goal;
- b. the name of the person or agency, including the individual and/or family members, who will perform needed tasks;
- c. the type of treatment program or service providers to which the recipient will be referred;
- d. the method of provision and those activities to be performed by a service provider or other person to achieve the recipient's related goal and objective; and
- e. the type, amount, frequency, and duration of services to be delivered or tasks to be performed.

3. Continuity of service.

Case management services must be ongoing from the time the recipient is accepted by the case management agency for services to the time when: the coordination of services provided through case management is not required or is no longer required by the recipient; the recipient moves from the social services district*; the long term goal has been reached; the recipient refuses to accept case management services; the recipient requests that his/her case be closed; the recipient is no longer eligible for services or, the recipient's case is appropriately transferred to another case manager.

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Contact with the recipient or with a collateral source on the recipient's behalf must be maintained by the case manager at least monthly or more frequently as specified in the provider's agreement with the New York State Department of Social Services.

* The criteria for discontinuance by a particular entity when a client moves are inaccessibility and the provider's incapability to provide adequate service to someone removed from their usual service area. Although equally qualified, each CMH entity is not capable of serving clients in all other parts of the State since serving this clientele requires frequent contact and an intimate knowledge of the support system in the client's community. The current case manager is responsible to help transition clients to case managers in their new location or, if a program is not available to the best substitute. Clients are free to choose among qualified providers within the State.

LIMITATIONS TO THE PROVISION OF MEDICAID CASE MANAGEMENT SERVICES

Case management services must not:

1. be utilized to restrict the choice of a case management services recipient to obtain medical care or services from any provider participating in the Medical Assistance Program who is qualified to provide such care or services and who undertakes to provide such care or service(s), including an organization which provides such care or services or which arranges for the delivery of such care or services on a prepayment basis;
2. duplicate case management services currently provided under the Medical Assistance Program or under any other program;
3. be utilized by providers of case management to create a demand for unnecessary services or programs particularly those services or programs within their scope of authority;
4. be provided to persons receiving institutional care reimbursed under the Medical Assistance Program or to persons in receipt of case management services under a federal Home and Community Based Services waiver.

While the activities of case management services secure access to an individual's needed service, the activities of case management do not include:

1. the actual provision of the service;
2. Medicaid eligibility determinations/redeterminations;
3. Medicaid preadmission screening;

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4. prior authorization for Medicaid services;
5. required Medicaid utilization review;
6. EPSDT administration;
7. activities in connection with "lock-in" provisions under 1915(a) of the Social Security Act;
8. institutional discharge planning as required of hospitals, SNF, ICFs and ICF/MRs; and
9. client outreach considered necessary for the proper and efficient administration of the Medicaid State Plan.

LIMITATIONS SPECIFIC TO TARGET GROUP "D"

In order to support an intensive, personal and proactive service, Intensive Case Managers will carry an average active case load of twelve clients. Active adult ICM clients are seen a minimum of four times during a month. Active seriously emotionally disturbed children in the ICM program must receive four contacts during a month, three face-to-face and the fourth face-to-face may be with either the client or a collateral. Collaterals are defined in 14 NYCRR Part 587.4(a)(2) as members of the patient's family or household, or significant others who regularly interact with the patient and are directly affected by or have the capability of affecting the patient's condition and are identified in the treatment plan as having a role in treatment and/or identified in the pre-admission notes as being necessary for participation in the evaluation and assessment of the patient prior to admission. Each Office of Mental Health Regional Office shall maintain a listing by name (roster) of individuals meeting the basic participation criteria. These individuals may be referred to the roster by various community agencies, mental health agencies, (including State psychiatric facilities), and human service agencies with whom the client has been in contact. From these prospective clients, the Intensive Case Manager will determine which are viable to become active (i.e. that the client can be engaged in activities directed at fulfilling a case plan based on the goals of the program.)

If an active client has fewer than the minimum required face-to-face meetings described above during a month for two continuous months, she/he will be evaluated for return to the roster. Clients returned to rostered status may be placed back into active status expeditiously when the need arises.

E. QUALIFICATIONS OF PROVIDERS

1. Providers

Case management services may be provided by social services agencies, facilities, persons and other groups possessing the capability to provide such services who are approved by the New York State Commissioner of Social Services based upon an approved proposal submitted to the New York State Department of Social Services. Providers may include:

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- a. facilities licensed or certified under New York State law or regulation;
- b. health care or social work professionals licensed or certified in accordance with New York State law;
- c. state and local governmental agencies; and
- d. home health agencies certified under New York State law.

2. Case Managers

The case manager must have two years experience in a substantial number of activities outlined under CASE MANAGEMENT FUNCTIONS, including the performance of assessments and development of care management plans. Voluntary or part-time experience which can be verified will be accepted on a pro-rata basis. The following may be substituted for this requirement:

- a. one year of case management experience and a degree in a health or human services field; or
- b. one year of case management experience and an additional year of experience in other activities with the target population; or
- c. a bachelor's or master's degree which includes a practicum encompassing a substantial number of activities outlined under CASE MANAGEMENT FUNCTIONS, including the performance of assessments and development of case management plans; or
- d. the individual meets the regulatory requirements for case manager of a State Department within New York State.

3. Qualifications of Providers Specific to Target Group "D"

1. Providers

The New York State Department of Social Services will authorize as ICM providers either employees of the New York State Office of Mental Health meeting the qualifications described below or employees of those organizations determined by OMH and certified to SDSS to have the capacity to provide specialized Intensive Case Management Services.

2. Case Manager

Minimum Qualifications for Appointment As An Intensive Case Manager

A bachelor's degree in a human service field* or a NYS teacher's certificate for which a bachelor's degree is required, and four years of experience in providing direct services to mentally disabled patients/clients or in linking mentally disabled patients/clients to a

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broad range of services essential to successfully living in a community setting, (e.g. medical, psychiatric, social, educational, legal, housing and financial services).

A master's degree in human services field* may be substituted for two years of the required experience.

Minimum Qualifications for Appointment As A Coordinator of Intensive Case Management Services

A master's degree in a human services field* and four years of experience in providing direct services to mentally disabled patients/clients or in linking mentally disabled patients/clients to a broad range of services essential to successfully living in a community setting (e.g. medical, psychiatric, social, education, legal, housing and financial services). Two years of this experience must have involved supervisory or managerial experience for a mental health program or major mental health program component.

* For purposes of qualifying for these titles a "Human Services Field" includes Social Work, Psychology, Nursing, Rehabilitation, Education, Occupational Therapy, Physical Therapy, Recreation or Recreation Therapy, Counseling, Community Mental Health, Child and Family Studies, Speech and Hearing, Sociology.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES

A. Target Group:

Target Group D1

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

Entire State.

Only in the following geographic area (authority of section 1915(g)(1)) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

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

Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See attached

E. Qualifications of Providers:

See attached

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

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

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

A. TARGET GROUP D1

The targeted group consists of medical assistance eligibles who are served by the Office of Mental Health's (OMH) Flexible Intensive Case Management Program and who:

- (i) are seriously and persistently (chronically) mentally ill and
- (ii) require intensive, personal and proactive intervention to help them obtain services, which will permit or enhance functioning in the community and
- (iii) either have symptomology which is difficult to treat in the existing mental health care system or are unwilling or unable to adapt to the existing mental health care system.

These individuals include:

- (1) high risk/heavy service users who are known to staff in emergency rooms, acute inpatient units, psychiatric centers as well as to providers of other acute and crisis service. They may also have multiple disabilities including drug abuse, alcohol abuse or developmental disabilities;
- (2) extended care state psychiatric center patients who could be discharged but are not because of the absence of needed support in the community;
- (3) mentally ill who are homeless and live on the streets or in shelters;
- (4) seriously mentally ill children and adolescents whose disability disrupts their ability to function in educational, social, vocational and interpersonal spheres and who might, without invention, be institutionalized, incarcerated or hospitalized.

The aim to benefit these clients by reducing hospitalization and reliance on emergency psychiatric services, as well as by increasing employment, encouraging better medication compliance and generally improving the individual's quality of life within the community.

B. AREAS OF STATE IN WHICH SERVICES WILL BE PROVIDED TO TARGET GROUP D1

Statewide

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C. DEFINITION OF COMPREHENSIVE MEDICAID CASE MANAGEMENT REIMBURSABLE UNDER MEDICAID

Case management is a process which will assist persons eligible for Medical Assistance to access necessary services in accordance with goals contained in a written case management plan.

BASIC PREMISES OF COMPREHENSIVE MEDICAID CASE MANAGEMENT

1. Case management services are those services which will assist persons eligible for Medical Assistance to obtain needed medical, social, psychosocial, educational, financial and other services.
2. Case Management is a human services agency tool for the effective management of multiple resources for the benefit of individuals identified as high utilizers of service who have problems accessing care, or belonging to certain age, diagnosis or specialized program groups. Effective case management must address quality, adequacy and continuity of service, and balance a concern for affordable services while assuring that eligible individuals receive the services appropriate to their needs. Targeted groups consist of functionally limited persons with multiple needs or high vulnerability who require intensive and/or long term intervention by health and other human services providers.
3. Case management services enable Medicaid eligibles to exercise their freedom of choice by providing information regarding services available to them, providing access to the most appropriate service to meet their needs and assisting them to achieve their maximum level of functioning and independence in the most appropriate environment.
4. Case management empowers individuals by involving them in the decision making process, and allowing them to choose among all available options as a means of moving to the optimum situation where these individuals and their support systems can address their needs. Case management implies utilization and development of support networks that will maximize the effectiveness, efficiency and accountability of support services on behalf of the individual.

DEFINITION OF CASE MANAGEMENT RELATED TO TARGET GROUP "D1"

Case management for Target Group "D1" means those activities performed by case management staff related to ensuring that the mentally disabled individual has full access to the comprehensive array of services and assistance which the individual needs to maintain community life and to attain or retain capability for maximum personal independence.

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Case management for Target Group "D1" requires referral to and coordination with medical, social, educational, psycho-social, employment, habilitation, rehabilitation, financial, environmental, and legal services available within the community appropriate to the needs of the mentally ill individual.

CASE MANAGEMENT FUNCTIONS

Case management functions are determined by the recipient's circumstances and therefore must be determined individually in each case. In no instance will case management include the provision of clinical or treatment services. A separate case record must be established for each individual recipient of case management services and must document each case management function provided.

A. Intake and screening.

This function consists of: the initial contact to provide information concerning case management; exploring the recipient's receptivity to the case management process; determining that the recipient is a member of the provider's targeted population; and identifying potential payors for services.

B. Assessment and reassessment.

During this phase the case manager or case management team must secure directly, or indirectly through collateral sources, with the recipient's permission: a determination of the nature and degree of the recipient's functional impairment through a medical evaluation; a determination of the recipient's functional eligibility for services; information from other agencies/individuals required to identify the barriers to care and existing gaps in service to the recipient; assessment of the recipient's service needs including medical, social, psychosocial, educational, financial and other services; and a description of the recipient's strengths, informal support system and environmental factors relative to his/her care.

C. Case management plan and coordination.

The case management activities required to establish a comprehensive written case management plan and to effect the coordination of services include: identification of the nature, amount, frequency, and duration of the case management services required by a particular recipient; with the participation of the recipient, a cost-conscious selection of the nature, amount, type, frequency and duration of services to be provided to the recipient; identification of the recipient's informal support network and providers of services; specification of the long term and short term goals to be achieved through the case management process; collaboration with hospital discharge planners, health care providers and other service providers, including informal caregivers and other case managers. It also includes, through case conferences, an exchange of clinical information which will assure:

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1. the integration of clinical care plans throughout the case management process;
2. the continuity of service;
3. the avoidance of duplication of service (including case management services); and
4. the establishment of a comprehensive case management plan that addresses the interdisciplinary needs of the recipient.

D. Implementation of the case management plan.

Implementation of the plan includes securing the services determined in the case management plan to be appropriate for a particular recipient through referral to those agencies or to persons who are qualified to provide the identified services; assisting the recipient with referral and/or application forms required for the acquisition of services; advocating for the recipient with all providers of services; and developing alternative services to assure continuity in the event of service disruption.

E. Crisis intervention.

Crisis intervention by a case manager or practitioner includes when necessary: assessment of the nature of the recipient's circumstances, determination of the recipient's emergency service needs, and revision of the case management plan, including any changes in activities or objectives required to achieve the established goal.

F. Monitoring and follow-up.

As dictated by the client's needs and desires, case manager services include: assuring that quality services, as identified in the case management plan, are delivered in a cost-conscious manner; assuring the recipient's satisfaction with the services provided and advising the preparer of the case management plan of the findings; collecting data and documenting in the case record the progress of the recipient; making necessary revisions to the case management plan; making alternate arrangements when services have been denied or are unavailable to the recipient; and assisting the recipient and/or provider of services to resolve disagreements, questions or problems with implementation of the case management plan.

G. Counseling and exit planning.

This function consists of: assuring that the recipient obtains, on an ongoing basis, the maximum benefit from the services received; developing support groups for the recipient, the recipient's family and informal providers of services; mediating among the recipient, the family network and/or other

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informal providers of services when problems with service provision occur; facilitating the recipient's access to other appropriate care if and when eligibility for the targeted services ceases; and, assisting the recipient to anticipate the difficulties which may be encountered subsequent to discharge from or admission to facilities or other programs, including other case management programs.

PROCEDURAL REQUIREMENTS FOR PROVISION OF SERVICE

1. Assessments.

The case management process must be initiated by the recipient and case manager, case management team, or practitioners as appropriate, through a written assessment of the recipient's need for case management as well as medical, social, psychosocial, educational, financial and other services.

An assessment provides verification of the recipient's current functioning and continuing need for services, the service priorities and evaluation of the recipient's ability to benefit from such services. The assessment process includes, but is not limited to, those activities listed in paragraph B of CASE MANAGEMENT FUNCTIONS.

An assessment shall be initiated within fifteen days and must be completed by a case manager or case management team within 30 days or as specified in a referral agreement. The referral for services may include a plan of care containing significant information developed by the referral source which should be included as in integral part of the case management plan.

An assessment of the recipient's need for case management and other services must be completed by the case manager every six months, or sooner if required by changes in the recipient's condition or circumstances.

2. Case management plan.

A written case management plan must be completed by the case manager or case management team for each recipient of case management services within 30 days of the date of referral or as specified in a referral agreement, and must include, but is not limited to, those activities outlined in paragraph C under CASE MANAGEMENT FUNCTIONS.

The recipient's case management goals, with anticipated dates of completion, must be established in the initial case management plan, consistent with the recipient's service needs and assessment and must address those needs necessary to achieve

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and maintain stabilization. The case management plan must be reviewed and updated by the case manager or case management team as required by changes in the recipient's condition or circumstances, but not less frequently than every six months subsequent to the initial plan. Each time the case management plan is reviewed the goals established in the initial case management plan must be renewed or revised, and new goals and new time frames may be established with participation of the recipient.

The case management plan must specify:

- a. those activities which the recipient is expected to undertake within a given period of time toward the accomplishment of each case management goal;
- b. the name of the person or agency, including the individual and/or family members, who will perform needed tasks;
- c. the type of treatment program or service providers to which the recipient will be referred;
- d. those activities to be performed by a service provider or other person to achieve the recipient's related goal and objective; and the method by which those activities will be performed, and
- e. the type, amount, frequency, and duration of services to be delivered or tasks to be performed.

3. Continuity of service.

Case management services must be ongoing from the time the recipient is accepted by the case management agency for services to the time when: the coordination or services provided through case management is not required or is no longer required by the recipient; the recipient moves from the social services district; the long term goal has been reached; the recipient refuses to accept case management services; the recipient requests that his/her case be closed; the recipient is no longer eligible for services; or the recipient's case is appropriately transferred to another case manager.

Contact with the recipient or with a collateral source on the recipient's behalf must be maintained by the case manager or case management team at least monthly or more frequently as specified in the provider's agreement with the New York State Department of Health.

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LIMITATIONS TO THE PROVISION OF MEDICAID CASE MANAGEMENT SERVICES

Case management services must not:

1. be utilized to restrict the choice of a case management services recipient to obtain medical care or services from any provider participating in the Medical Assistance Program who is qualified to provide such care or services and who undertakes to provide such care or service(s), including an organization which provides such care or services or which arranges for the delivery of such care or services on a prepayment basis;
2. duplicate case management services currently provided under the Medical Assistance Program or under any other program;
3. be utilized by providers of case management to create a demand for unnecessary services or programs particularly those services or programs within their scope of authority;
4. be provided to persons receiving institutional care reimbursed under the Medical Assistance Program or to persons in receipt of case management services under a federal Home and Community Based Waiver except as provided for in July 25, 2000 HCFA letter to State Medicaid Directors (Olmstead Update No. 3) which informed the States that Targeted Case Management (TCM), defined in section 1915(g) of the Act, may be furnished as a service to institutionalized persons who are about to leave the institution, to facilitate the process of transition to community services and to enable the person to gain access to needed medical, social, educational and other services in the community.

While the activities of case management services secure access to an individual's needed service, the activities of case management do not include:

1. the actual provision of the service;
2. Medicaid eligibility determinations/redeterminations;
3. Medicaid preadmission screening;
4. prior authorization for Medicaid services;

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5. required Medicaid utilization review;
6. EPSDT administration;
7. activities in connection with "lock-in" provisions under 1915(a) of the Social Security Act;
8. institutional discharge planning as required of hospitals, SNF, ICFs and ICF/MRs; and
9. client outreach considered necessary for the proper and efficient administration of the Medicaid State Plan.

LIMITATIONS SPECIFIC TO TARGET GROUP "D1"

In order to support an intensive, personal and proactive service, Intensive Case Managers will carry an average active case load of twelve clients. Active adult ICM clients must be seen a minimum of two times during a month, but the program must provide in the aggregate a minimum of four visits times the number of Medicaid eligible clients per month per case manager. Active seriously emotionally disturbed children in the ICM program must be seen a minimum of two times during a month, but a maximum of one-quarter of the required total aggregate face-to-face contacts may be with collaterals as defined in 14 NYCRR Part 587. Individuals may be referred to the program by various community agencies, mental health agencies, (including State psychiatric facilities), and human service agencies with whom the client has been in contact. From these prospective clients, the Intensive Case Manager or Case Management team will determine which clients are suitable candidates for Intensive Case management (i.e., that the client can be engaged in activities directed at fulfilling a case plan based on the goals of the program.)

If an active client has fewer than the minimum required face-to-face meetings described above during a month for two continuous months, she/he will be evaluated for disenrollment. Clients ready for disenrollment may be placed into transitional status for a period not to exceed two months, and during that period the program/provider can bill for a maximum face to face contact of one visit per month. Clients who are disenrolled may be placed back into active status expeditiously when the need arises.

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E. QUALIFICATIONS OF PROVIDERS

1. Providers

Case management services may be provided by social services agencies, facilities, persons and other groups possessing the capability to provide such services who are approved by the New York State Office of Mental Health and certified to the Department of Health (DOH) to have the capacity to provide specialized Intensive Case Management Services, so that DOH can enroll the providers in the Medicaid program. Providers may include:

- a. facilities licensed or certified under New York State law or regulation;
- b. health care or social work professionals licensed or certified in accordance with New York State law;
- c. state and local governmental agencies; and
- d. home health agencies certified under New York State law.

2. Case Managers

The case manager must have two years experience in a substantial number of activities outlined under CASE MANAGEMENT FUNCTIONS, including the performance of assessments and development of case management plans. Voluntary or part-time experience which can be verified will be accepted on a pro-rata basis. The following may be substituted for this requirement:

- a. one year of case management experience and a degree in a health or human services field; or
- b. one year of case management experience and an additional year of experience in other activities with the target population; or

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- c. a bachelor's or master's degree which includes a practicum encompassing a substantial number of activities outlined under CASE MANAGEMENT FUNCTION, including the performance of assessments and development or case management plans; or
- d. the individual meets the regulatory requirements for case manager of a State Department within New York State.

3. **Qualification of Providers Specific to Target Group "D1"**

1. **Providers**

The New York State Office of Mental Health will authorize as ICM providers either employees of the New York State Office of Mental Health meeting the qualifications described below or employees of those organizations approved by OMH and certified to the Department of Health (DOH) to have the capacity to provide specialized Intensive Case Management Services, in order for the DOH to enroll the providers in the Medicaid program.

2. **Case Manager**

Minimum Qualifications for Appointment As An Intensive Case Manager

A bachelor's degree in a human services field* or a NYS teacher's certificate for which a bachelor's degree is required, and four years of experience in providing direct services to mentally disabled patients/clients or in linking mentally disabled patients/clients to a broad range of services essential to successfully living in a community setting, (e.g. medical, psychiatric, social, educational, legal, housing and financial services).

A master's degree in human services field* may be substituted for two years of the required experience.

Minimum Qualifications for Appointment As A Coordinator of Intensive Case Management Services

A master's degree in a human services field* and four years of experience in providing direct services to mentally disabled patients/clients or in linking mentally

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disabled patients/clients to a broad range of services essential to successfully living in a community setting (e.g. medical, psychiatric, social, educational, legal, housing and financial services). Two years of this experience must have involved supervisory or managerial experience for a mental health program or major mental health program component.

- * For purposes of qualifying for these titles a "Human Services Field" includes Social Work, Psychology, Nursing, Rehabilitation, Education, Occupational Therapy, Physical Therapy, Recreation or Recreation Therapy, Counseling, Community Mental Health, Child and Family Studies, Speech and Hearing, Sociology.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES

A. Target Group:

See attached Target Group D2

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

Entire State.

Only in the following geographic areas (authority of section 1915(g)(1)) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

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

Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See attached

E. Qualifications of Providers

See attached

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

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

G. Payment for case management services under the plan does not duplicate payments made to

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public agencies or private entities under other program authorities for this same purpose.

A. TARGET GROUP D2

The targeted group consists of medical assistance eligibles who are served by the Office of Mental Health’s Blended and Flexible Case Management Program and who:

- (i) are seriously and persistently (chronically) mentally ill, or seriously mentally ill and
- (ii) require intensive, personal and proactive intervention to help them obtain services, which will permit or enhance functioning in the community, or require personal and proactive intervention to help them obtain and maintain services, which will permit or enhance functioning in the community; and
- (iii) either have symptomatology which is difficult to treat in the existing mental health care system, or are unwilling or unable to adapt to the existing mental health care system, or need support to maintain their treatment connections and/or residential settings.

These individuals include:

- (1) high risk/heavy service users who are known to staff in emergency rooms, acute inpatient units, psychiatric centers as well as to providers of other acute and crisis service. May have multiple disabilities including drug abuse, alcohol abuse or developmental disabilities, or
- (2) persons with recent hospitalizations in either State psychiatric centers or acute care general hospitals, or
- (3) extended care state psychiatric center patients who could be discharged but are not because of the absence of needed support in the community; or
- (4) mentally ill who are homeless and live on the streets or in shelters; or
- (5) seriously mentally ill children and adolescents whose disability disrupts their ability to function in educational, social, vocational and interpersonal spheres and who may, without invention, be institutionalized, incarcerated or hospitalized, or
- (6) people in need of ongoing mental health support in order to maintain or enhance community tenure.

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The aim is to benefit these clients by reducing hospitalization and reliance on emergency psychiatric services, as well as by increasing employment, encouraging better medication compliance and generally improving the client's quality of life within the community.

B. AREAS OF STATE IN WHICH SERVICES WILL BE PROVIDED TO TARGET GROUP D2

Entire State

C. DEFINITION OF COMPREHENSIVE MEDICAID CASE MANAGEMENT REIMBURSABLE UNDER MEDICAID

Case management is a process which will assist persons eligible for Medical Assistance to access necessary services in accordance with goals contained in a written case management plan.

BASIC PREMISES OF COMPREHENSIVE MEDICAID CASE MANAGEMENT

1. Case management services are those services which will assist persons eligible for Medical Assistance to obtain needed medical, social, psychosocial, educational, financial and other services.
2. Case Management is a human services agency tool for the effective management of multiple resources for the benefit of individuals identified as high utilizers of service who have problems accessing care, or belonging to certain age, diagnosis or specialized program groups. Effective case management must address quality, adequacy and continuity of service, and balance a concern for affordable service while assuring that eligible individuals receive the services appropriate to their needs. Targeted groups consist of functionally limited persons with multiple needs or high vulnerability who require intensive and/or long term intervention by health and other human service providers.
3. Case management services enable Medicaid eligibles to exercise their freedom of choice by providing them with information regarding the services available to them, providing access to the most appropriate service to meet their needs and assisting them to achieve their maximum level of functioning and independence in the most appropriate environment.
4. Case management empowers individuals by involving them in the decision making process, and allowing them to choose among all available options as a means of

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moving to the optimum situation in which these individuals and their support system can address their needs. Case management implies utilization and development of such support networks as will maximize the effectiveness, efficiency and accountability of support services on behalf of the individual.

DEFINITION OF CASE MANAGEMENT RELATED TO TARGET GROUP "D2"

Case management for Target Group "D2" means those activities performed by case management staff related to ensuring that the mentally disabled individual has full access to the comprehensive array of services and assistance which the individual needs to maintain community life and to attain or retain capability for maximum personal independence.

Case management for Target Group "D2" requires referral to and coordination with medical, social, education, psycho-social, employment, habilitation, rehabilitation, financial, environmental, and legal services available within the community appropriate to the needs of the mentally ill individual.

CASE MANAGEMENT FUNCTIONS

Case management functions are determined by the recipient's circumstances and therefore must be determined individually in each case. In no instance will case management include the provision of clinical or treatment services. A separate case record must be established for each individual recipient of case management services which documents each case management function provided.

A. Intake and screening.

This function consists of: the initial contact to provide information concerning case management; exploring the recipient's receptivity to the case management process; determining that the recipient is a member of the provider's targeted population; and identifying potential payors for services.

B. Assessment and reassessment.

During this phase the case management team must secure directly, or indirectly through collateral sources, with the recipient's permission: a determination of the nature and degree of the recipient's functional impairment through a medical evaluation; a determination of the recipient's functional eligibility for services; information from other agencies/individuals required to identify the barriers to care and existing gaps in service to the recipient; assessment of the recipient's service needs including medical, social, psychosocial, educational, financial and other services; and a description of the recipient's strengths, informal support system and environmental factors relative to his/her care.

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C. Case management plan and coordination.

The case management activities required to establish a comprehensive written case management plan and to effect the coordination of services include: identification of the nature, amount, frequency, and duration of the case management services required by a particular recipient; with the participation of the recipient, a cost-conscious selection of the nature, amount, type, frequency and duration of services to be provided to the recipient; identification of the recipient's informal support network and providers of services; specification of the long term and short term goals to be achieved through the case management process; collaboration with hospital discharge planners, health care providers and other service providers, including informal caregivers and other case managers. It also includes, through case conferences, an exchange of clinical information which will assure:

1. the integration of clinical care plans throughout the case management process;
2. the continuity of service;
3. the avoidance of duplication of service (including case management services); and,
4. the establishment of a comprehensive case management plan that addresses the interdisciplinary needs of the recipient.

D. Implementation of the case management plan.

Implementation of the plan includes securing the services determined in the case management plan to be appropriate for a particular recipient through referral to those agencies or to persons who are qualified to provide the identified services; assisting the recipient with referral and/or application forms required for the acquisition of services; advocating for the recipient with all providers of service; and developing alternative services to assure continuity in the event of service disruption.

E. Crisis intervention.

Crisis intervention by a case management team includes when necessary: assessment of the nature of the recipient's circumstances; determination of the recipient's emergency service needs; and, revision of the case management plan, including any changes in activities or objectives required to achieve the established goal.

F. Monitoring and follow-up.

As dictated by the client's needs and desires, case manager services include: assuring that quality services, as identified in the case management plan, are delivered in a cost-conscious manner; assuring the recipient's satisfaction with the services provided and advising the preparer of the case

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management plan whether the recipient is satisfied; collecting data and documenting in the case record the progress of the recipient; making necessary revisions to the case management plan; making alternate arrangements when services have been denied or are unavailable to the recipient; and, assisting the recipient and/or provider of services to resolve disagreements, questions or problems with implementation of the case management plan.

G. Counseling and exit planning.

This function consists of: assuring that the recipient obtains, on an ongoing basis, the maximum benefit from the services received; developing support groups for the recipient, the recipient's family and informal providers of services; mediating among the recipient, the family network and/or other informal providers of services when problems with service provision occur; facilitating the recipient's access to other appropriate care if and when eligibility for the targeted services ceases; and, assisting the recipient to anticipate the difficulties which may be encountered subsequent to discharge from or admission to facilities or other programs, including other case management programs.

PROCEDURAL REQUIREMENTS FOR PROVISION OF SERVICE

1. Assessments.

The case management process must be initiated by the recipient and case manager (or practitioner as appropriate) through a written assessment of the recipient's need for case management as well as medical, social, psychosocial, educational, financial and other services.

An assessment provides verification of the recipient's current functioning and continuing need for services, the service priorities and evaluation of the recipient's ability to benefit from such services. The assessment process includes, but is not limited to, those activities listed in paragraph B of CASE MANAGEMENT FUNCTIONS.

An assessment must be completed by a case management team within 30 days of the date of the referral or as specified in a referral agreement. The referral for service may include a plan of care containing significant information developed by the referral source which should be included as an integral part of the case management plan.

An assessment of the recipient's need for case management and other services must be completed by the case manager every six months, or sooner if required by changes in the recipient's condition or circumstances.

2. Case management plan.

A written case management plan must be completed by the

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case management team for each recipient of case management services within 30 days of the date of referral or as specified in a referral agreement, and must include, but is not limited to, those activities outlined in paragraph C under CASE MANAGEMENT FUNCTIONS.

The recipient's case management goals, with anticipated dates of completion, must be established in the initial case management plan, consistent with the recipient's service needs and assessment and must be address those needs necessary to achieve and maintain stabilization.

The case management plan must be reviewed and updated by the case management team as required by changes in the recipient's condition or circumstances, but not less frequently than every six months subsequent to the initial plan. Each time the case management plan is reviewed the goals established in the initial case management plan must be maintained or revised, and new goals and new time frames may be established with the participation of the recipient.

The case management plan must specify:

- a. those activities which the recipient is expected to undertake within a given period of time for purposes of accomplishing each case management goal;
- b. the name of the person or agency, including the individual and/or family members, who will perform needed tasks;
- c. the type of treatment program or service providers to which the recipient will be referred;
- d. the activities to be performed by a service provider or other person to achieve the recipient's related goal and objective; and the method by which such services shall be provided;
- e. the type, amount, frequency, and duration of services to be delivered or tasks to be performed; and
- f. whether the program plans to place a client into transitional status during the next six month period covered by the plan.

3. Continuity of service.

Case management services must be ongoing from the time the recipient is accepted by the case management agency for services to the time when: the coordination of services provided through case management is not required or is

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no longer required by the recipient; the recipient moves from the social services district; the long term goal has been reached; the recipient refuses to accept case management services; the recipient requests that his/her case be closed; the recipient is no longer eligible for services.

Contact with the recipient or with a collateral source on the recipient's behalf must be maintained by the case manager at least monthly or more frequently as specified in the provider's agreement with the New York State Office of Mental Health.

LIMITATIONS TO THE PROVISION OF MEDICAID CASE MANAGEMENT SERVICES

Case management services must not:

1. be utilized to restrict the choice of a case management services recipient to obtain medical care or services from any provider participating in the Medical Assistance Program who is qualified to provide such services and who undertakes to provide such care or service(s), including an organization which provides such care or services or which arranges for the delivery of such care or services on a prepayment basis;
2. duplicate case management services currently provided under the Medical Assistance Program or under any other program;
3. be utilized by providers of case management to create a demand for unnecessary services or programs particularly those services or programs within their scope of authority;
4. be provided to persons receiving institutional care reimbursed under the Medical Assistance Program or to persons in receipt of case management services under a federal Home and Community Based Waiver except as addressed in the July 25, 2000 HCFA letter to State Medicaid Directors which informed the States that Targeted case management (TCM), defined in section 1915(g) of the Act, may be furnished as a service to institutionalized persons who are about to leave the institution, to facilitate the process of transition to community services and to enable the person to gain access to needed medical, social, educational and other services in the community.

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While the activities of case management services secure access to an individual's needed service for the client, the activities of case management do not include:

1. the actual provision of the service;
2. Medicaid eligibility determinations/redeterminations;
3. Medicaid preadmission screening;
4. prior authorization for Medicaid services;
5. required Medicaid utilization review;
6. EPSCT administration;
7. activities in connection with "lock-in" provisions under 1915(a) of the Social Security Act;
8. institutional discharge planning as required of hospitals, SNF, ICFs and ICF/MRs; and
9. client outreach considered necessary for the proper and efficient administration of the Medicaid State Plan.

LIMITATIONS SPECIFIC TO TARGET GROUP "D2"

In order to support an intensive, personal and proactive service, Blended and Flexible Case Managers will carry case loads based on their designation as Intensive Case Managers or Supportive Case Managers. Intensive Case Managers are responsible to provide a minimum of 48 total monthly face to face contacts per manager. Supportive Case Managers are required to provide in the aggregate a minimum of twice the number of visits as the number of Supportive Case management clients. For children's programs, a maximum of 25% of the total aggregate visits can be face-to-face contacts with collaterals as defined in 14 NYCRR Part 587.

Individuals may be referred to case management by various community agencies, mental health agencies, (including State psychiatric facilities), and human service agencies with whom the client has been in contact. From these prospective clients, the Blended and Flexible Case Management Program will determine which clients are appropriate for case management services and at what level (i.e., that the client can be engaged in activities directed at fulfilling a case plan based on the goals of the program.)

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Clients who appear ready for disenrollment from the program can be placed into transitional status for a period not to exceed two months. During that time period the program can bill for the client as long as at least one face-to-face contact per month is provided. Clients who are disenrolled may be placed back into active status expeditiously when the need arises.

E. QUALIFICATIONS OF PROVIDERS

1. Providers

New York State Office of Mental Health (OMH) will authorize as Case Management providers either OMH employees meeting the qualifications approved below or employees of those organizations determined by OMH and certified to the DOH to have the capacity to provide specialized Case Management Services and having written agreements with appropriate mental health providers and other human service providers so that DOH can enroll the providers in the Medicaid program. Case management services may be provided by social services agencies, facilities, persons and other groups possessing the capability to provide such services that are approved by OMH. Providers may include:

- a. facilities licensed or certified under New York State law or regulation;
- b. health care or social work professionals licensed or certified in accordance with New York State law;
- c. state and local governmental agencies; and
- d. home health agencies certified under New York State law.

2. Case Managers

Intensive Case Managers:

The Intensive Case manager must have two years experience in a substantial number of activities outlined under CASE MANAGEMENT FUNCTIONS, including the performance of assessments and development of case management plans. Voluntary or part-time experience which can be verified will be accepted on a pro-rata basis. The following may be substituted for this requirement:

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- a. one year of case management experience and a degree in a health or human services field; or
- b. one year of case management experience and an additional year of experience in other activities with the target population; or
- c. a bachelor's or master's degree which includes a practicum encompassing a substantial number of activities outlined under CASE MANAGEMENT FUNCTIONS, including the performance of assessments and development or case management plans; or
- d. the individual meets the regulatory requirements for case manager of a State Department within New York State.

Supportive Case Managers:

Must have two years in providing direct services or in a substantial number of activities outlined under "Case Management Functions" to people who are mentally disabled, or homeless. The following may be substituted for this requirement:

- a. One year of case management experience and an associate degree in a health or human services field: or
- b. One year of case management experience and an additional year of experience in other activities with the target population; or
- c. A bachelor's or master's degree which includes a practicum encompassing a substantial number of activities with the target population; or
- d. The individual meets the regulatory requirements for case manager of a State Department within New York State.

Minimum Qualifications for Appointment As A Coordinator of Blended and Flexible Case Management Services

A master's degree in a human services field* and four years of experience in providing direct services to mentally disabled patients/clients or in linking mentally disabled patients/clients to a broad range of services essential to successfully living in a community setting (e.g. medical, psychiatric, social, educational, legal, housing

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Supplement 1 to Attachment 3.1-A

**New York
1-D34**

and financial services). Two years of this experience must have involved supervisory or managerial experience for a mental health program or major mental health program component.

- * For purposes of qualifying for these titles a "Human Services Field" includes Social Work, Psychology, Nursing, Rehabilitation, Education, Occupational Therapy, Physical Therapy, Recreation or Recreation Therapy, Counseling, Community Mental Health, Child and Family Studies, Speech and Hearing, Sociology.

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New York
1-E

[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES]

[A. Target Group:

See attached Target Group E

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

Entire State.

Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

Services to this target population may be provided to residents of Kings County (Zip Codes 11203, 11212, 11213, 11216, 11221, 11225, 11233 and 11235), Bronx County (Zip Codes 10454, 10455, 10451, 10474 and 10459), New York County (Zip Codes 10026, 10027, 10030, 10031, 10037, 10039)

C. Comparability of Services

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

Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See attached

E. Qualification of Providers:

See attached]

TN #15-0031

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New York
1-E1

[A. TARGET GROUP

This target group consists of any categorically needy or medically needy individual who meets the following criteria:

1. Women of child bearing age who are pregnant or parenting, and
2. Infants under 1 year of age.

One of the most serious public health problems we are facing today is that of infant mortality. The problem is especially severe in certain urban areas among poor minority groups where the infant mortality rate is up to 3 times that of the population at large. Other factors which contribute to this problem are women who receive late or no prenatal care. Recent changes to Federal and New York State Law have expanded eligibility benefits to pregnant women and infants. Case management programs are expected to identify women who are at risk and assist them in accessing health care and other resources which they need to assure positive birth outcomes.

In some areas of New York City almost twenty percent of the infants born to minority women are low birth weight babies who are vulnerable to infections and sudden infant death syndrome as well as complications related to low birth weight itself.

Certain upstate cities mirror these rates in their center city areas. Case management will assist in assuring that mothers in these areas can avail themselves of health and social services to properly care for their infants.

In the areas in question, about 20% of the births are to teenage mothers and up to 75% are out of wedlock. The mothers in question are often inexperienced at heading a family and do not have the social supports available in an intact family, and as such have a great need for case management services to assist them in obtaining needed services for themselves and their infants.

After years of steady decline, infant mortality rates have once again begun to climb since 1987. Much of this increase can be laid at the feet of increasing use of illegal drugs and alcohol on the part of poor women in urban areas. In births where toxicity for illegal drugs is found, in New York City, infant mortality is an astronomical 34 in 1,000.

New York State hopes to attack these problems in a site-specific manner using case managers to pull together both Title XIX services and services from other funding streams to meet the needs of pregnant women and infants.]

TN #15-0031

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New York
1-E1a

[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES]

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

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

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

TN #15-0031

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1-E2

[B. AREAS OF THE STATE WHERE SERVICES MAY BE PROVIDED

Services to this target population may be provided to residents of Kings County (Zip Codes: 11203, 11212, 11213, 11216, 11221, 11225, 11233 and 11238), Bronx County (Zip Codes: 10454, 10455, 10451, 10474 and 10459), New York County (Zip Codes: 10026, 10027, 10030, 10031, 10037 and 10039) and Onondaga County, New York.

C. COMPARIBILITY OF SERVICES

Services will only be provided to those individuals who meet one or more of the criteria set forth in Section A, Target Group, of this Supplement.

Case management services will be provided without limitation as to amount, duration or scope.

D. DEFINITION OF CASE MANAGEMENT SERVICES TO PREGNANT AND PARENTING WOMEN AND INFANTS

Case management is a process which will assist persons eligible for medical assistance to access needed medical, social, educational, and other services in accordance with a written case management plan.

Case management for this target group will be provided in the following fashion.

1. Referral

Referrals of Medicaid eligible women and infants who are part of the target population are made by prenatal and pediatric care providers in the areas involved. Other possible referral sources include alcohol and substance abuse services providers, schools, social agencies and local governmental agencies administering the Medicaid program, child protective and preventive services, programs under Title V of the Social Security Act and Section 17 of the Child Nutrition Act.

Hospitals in the target areas are encouraged to refer women who deliver at their facilities, who have received little or no prenatal care, test positive for illicit drugs or deliver low birth weight babies to case management agencies. Other women from the target areas will also be encouraged to participate because of the higher level of risk which they and their infants face.

The referral activity as outlined is included to add dimension to the problems faced by the target population and to show the degree to which existing service providers will be involved in the identification and referral of such clients. Successful case management for these clients depends in great part on the ability of the case manager to develop good working relationships with service providers. This includes becoming a recognized resource within the broader provider community i.e., a service to which clients may be referred.]

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New York
1-E3

[These referral activities are not a function of the case manager; begin prior to the receipt of case management services; and are not billed as Medicaid case management.

2. Engagement

Based on the referral from the hospital, prenatal care or other provider or local governmental agency, the case management agency attempts to interest the Medicaid eligible women/infant in case management services. Because women in high poverty areas, especially those who use illegal drugs or alcohol, are hard to engage for services, agencies are encouraged to make a number of attempts to contact the woman. If a woman accepts services, she is then enrolled by the case management agency. In areas where there are multiple agencies providing services, each agency will be required to explain to the woman that she has her choice of case management providers.

3. Assessment/Reassessment

Within 15 days of the acceptance of case management services, the case manager must complete an initial assessment. This will include an evaluation of the met and unmet needs of the woman and her children, her strengths and weaknesses, both formal and informal supports and identification of providers of service, including other case management resources.

It is anticipated that the initial assessment will concentrate on the immediate issues of the woman and her children's health and safety, substance abuse problems and family functioning. Subsequent reassessments (required at four month intervals) will likely deal with the family's longer term needs such as education, safe housing, training and employment for economic security.

4. Case Management Plan Development

Within 30 days of the acceptance of case management services; the case manager must complete development of an initial services plan for the woman and her family. Individuals residing together mutually impact upon each other in terms of their activities and their needs. To deliver effective case management, the family structure, whatever it may be, needs to be taken into account. Family supports and family stressors have a significant impact on the client. If a "parenting" woman (targeted) is having parenting problems with a 2 year old (non-targeted) or needs to arrange for child care in order to participate in a substance abuse treatment program, the case manager must address these needs in the woman's case management plan.

Case managers will not do assessments or case management plans for non-Medicaid eligible persons and will only assist non-Medicaid eligibles in obtaining services, when obtaining that service has a direct impact on the Medicaid eligible member of the target group.]

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New York
1-E4

[Medicaid funding will not be used to provide case management services to non-Medicaid eligible family members. Based on the assessment and developed in conjunction with the client, the services plan should include the type and frequency of services needed and the method of obtaining them. Also included in the plan should be timeframes for achieving the objectives and the anticipated frequency of case management.

As in the case of the initial assessment, the initial plan will likely focus on the immediate service needs to insure health and safety of the woman and her children. Once these objectives are achieved, longer term planning for improvements in housing, education and employment will become basic to the plan.

The services plan in question must indicate where and by whom each service is to be delivered; the case manager will be responsible for assuring the delivery of services outlined in the plan. Each woman will have only one Medicaid reimbursed case manager. The services plan should be signed by the women to show her agreement and willingness to participate.

5. Plan implementation

The case manager assists the woman in acquiring those services which have been identified in the plan as being necessary. In many instances this will required an advocacy role on the part of the case manager in attempting to obtain priorities for the woman and her children within services networks which are already seriously taxed.

The case manager might be required to escort the woman to appointments, at least initially, until she becomes familiar with the parties and processes involved in service provision.

Service acquisition to implement the case management plan will be crucial to the success of the program. It will be necessary to develop priority consideration for such services as clinic appointments, substance abuse services and day care for the program.

6. Monitoring

Monitoring includes assuring that the services were received and that they are appropriate and of acceptable quality and that the client is satisfied that they are meeting the needs of herself and her family. The primary source for obtaining this information is from the woman herself, but case managers should also maintain contact with service providers to assure that the client is making progress and utilizing services properly.

Certain services are dependent on other services. For instance, the case manager will want to be certain that a woman using child care is actually getting active drug or alcohol treatment during the times that the child is being cared for.]

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New York
1-E5

[7. Crisis Intervention

With a population which engages in substance abuse, does not respond to health needs until they become emergent and lives in dangerous, unsafe and unhealthy housing, the potential for crisis is measurably increased. For this reason, case management agencies should prepare a crisis plan for individual clients to advise them where to turn in an emergency, as well as having an agency plan to assist clients on a 24 hour a day basis, if necessary.

It is not essential that the case manager be available on a 24 hour basis, but only that the agency have a viable plan for dealing with after hour emergencies.

In addition, the agency must be prepared to revise the services plan almost immediately if the crisis has lasting repercussions or requires a change in the mix or intensity of services.

8. Counseling and Exit Planning

The best case management practices help build self-esteem and improve the client's ability to function more independently thus reducing or eliminating the need for further case management. As the case management becomes less intense, the client should be encouraged to participate in the development and implementation of her own plan objective.

When the case manager determines, in conjunction with the client, that case management is no longer necessary or if the woman loses program eligibility or moves to a different area or service system, the case manager should assist her in moving to new providers or sources of services. With the client's consent, a final assessment and case summary should be prepared and forwarded to the new case manager or services source.

E. QUALIFICATIONS

1. Provider Agency Qualifications

Agencies may be qualified in one of the following ways.

- a. One year of experience in providing case management services to pregnant or parenting women or infants.
- b. Two years of experience in providing health care or social services to pregnant or parenting women or infants.
- c. Two years of experience in providing drug or alcohol abuse treatment services to pregnant or parenting women.
- d. Two years of experience in providing protective services for children or services to prevent their placement in foster care.]

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New York
1-E6

[These qualifications may be met by the agency itself or may be met by an individual who has management experience in such an agency and assumes responsibility for the overall administration of the case management program.]

2. Staff Qualifications

a. Case Manager

An individual with a Bachelors or Masters degree in Nursing, Social Work, Health Education or a related field. If the degree is in a required field, one year of case management experience is required.

b. Associate Case Manager/Community Health Worker/Community Advocate

Associate Case Managers (ACM/Community Health Workers (CHW/Community Advocate (CA) describes persons residing in the community who assist case managers to monitor and reach clients who do not routinely access organized medical care or entitlements or who may be reluctant to access help from organizations. These individuals are not providers of case management, but are part of the team approach to case management encouraged by this program. They may assist case managers in locating individuals in the community, maintaining contact and gaining acceptance and cooperation for the program and it's goals.

These individual's must have two years of experience as case aides or similar experience with the target group. One year of this experience may be fulfilled by an intensive training program, approved by the State Medicaid Agency.]

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**New York
1-E7**

Effective December 1, 2011, the State is terminating the optional reimbursement of Medicaid case management services provided through CONNECT — Target Group E described on pages 1-E1 through 1-E6.

TN #11-83
Supersedes TN NEW

Approval Date August 7, 2012
Effective Date December 1, 2011

New York
1-F1

[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
CASE MANAGEMENT SERVICES]

[A. Target Group:

See attached Target Group F

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

[] Entire State.

[X] Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

City of Newburgh, Orange County
City of Fulton, Oswego County
Addison School District, Steuben County

C. Comparability of Services

[] Services are provided in accordance with section 1902(a)(10)(B) of the Act.

[X] Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See attached

E. Qualification of Providers:

See pages 1-F7 and 1-F8]

TN #15-0031

Supersedes TN #94-0029

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New York
1-F1a

[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES]

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

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

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

TN #15-0031

Supersedes TN #92-0068

Approval Date September 4, 2015

Effective Date April 1, 2015

New York
1-F2

[A. TARGETED GROUP

The targeted group consists of the categorically needy or medically needy who meet one or more of the following criteria.

Certain individuals residing in area of New York State designated as underserved and economically distressed through the State's Neighborhood Based Alliance (NBA) initiative. Under Chapter 657 of the Laws of 1990, the NBA is targeting state money, resources and services to designated areas in order to alleviate the pervasive and detrimental effects of poverty, lack of access to services and lack of services. Case management targeted individuals are those residents of the NBA area who are experiencing chronic or significant individual or family dysfunctions which might be ameliorated through effective case management referral and monitoring of service provision. Such dysfunctions are assessed as chronic or significant by the case manager in accordance with an assessment tool approved by the State Department of Social Services. The assessment will determine chronic or significant dysfunction of the following categories or characteristics:

- (i) school dropout
- (ii) low academic achievement
- (iii) poor school attendance
- (iv) foster care placement
- (v) physical and/or mental abuse or neglect
- (vi) alcohol and/or substance abuse
- (vii) unemployment/underemployment
- (viii) inadequate housing or homelessness
- (ix) family court system involvement
- (x) criminal justice system involvement
- (xi) poor health care
- (xii) family violence or sexual abuse

B. AREAS OF STATE IN WHICH SERVICES WILL BE PROVIDED TO TARGET GROUP F

City of Newburgh, New York Addison School District, New York City of Fulton, New York

C. DEFINITION OF COMPREHENSIVE MEDICAID CASE MANAGEMENT REIMBURSABLE UNDER MEDICAID

Case management is a process which will assist persons eligible for Medical Assistance to access necessary services in accordance with goals contained in a written case management plan.

DEFINITION OF CASE MANAGEMENT RELATED TO TARGET GROUP "F"

Case managers will assess, and refer the target population to the existing services including these newly available resources and services concentrated in the defined NBA community.]

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Supersedes TN #94-0029

Effective Date April 1, 2015

New York
1-F3

[Case management for Target Group "F" means linkage and referral activities performed by case management staff for individuals who are struggling with the effects of multiple problems compounded by poverty and poor access to services. Through case management, clients will have improved access to the comprehensive array of services and assistance available in the community. Individual needs of the client will be assessed and a case management plan developed.

Case management for Target Group "F" requires referral to and coordination with medical, social, educational, psychosocial, employment, habilitation, rehabilitation, financial, environmental, and legal services available within the community for the purpose of increasing the client's ability to function independently in the community. The ultimate purpose is to increase the client's level of self-sufficiency.

Case management services to individuals who are not Medicaid eligible will be supported by public and private grant funds. A sliding fee scale for clients based on income level will also be established. Case management will be the means to linking clients to the health, social, economic and educational resources of the community.

CASE MANAGEMENT FUNCTIONS

Case management functions are determined by the recipient's circumstances and therefore must be determined specifically in each case. In no instance will case management include the provision of clinical or treatment services. A separate case record must be established for each individual recipient of case management services and must document each case management function provided, including but not limited to:

A. Intake and screening.

This function consists of: the initial contact to provide information concerning case management; exploring the recipient's receptivity to the case management process; determining that the recipient is a member of the provider's targeted population; and identifying potential payers for services.

B. Assessment and reassessment.

During this phase the case manager will determine what services the individual needs to access. This determination requires the case manager to secure, as appropriate to the presenting problem, either directly, or indirectly through collateral sources, with the recipient's permission: a determination of the nature and degree of the recipient's functional impairment through a medical evaluation; a determination of the recipient's functional eligibility for services; information from other agencies/individuals required to identify the barriers to care and existing gaps in service needs including medical, social, psychosocial, educational, financial and other services; and a description of the recipient's strengths, informal support]

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New York
1-F4

[system and environmental factors relative to his/her care. Medical/psychological evaluations shall be obtained indirectly through collateral sources with the permission of the recipient and are not a compensated component of case management.

C. Case management plan and coordination.

The activities required to establish a comprehensive written case management plan and to effect the coordination of services include: identification of the nature, amount, type, frequency and duration of services to be provided to the recipient with the participation of the recipient; identification of the recipient's informal support network and providers of services; specification of the long term and short term goals to be achieved through the case management process; collaboration with other service providers, including informal caregivers and other case managers. It also includes through case management conferences an exchange of clinical information which will assure:

1. case management plans throughout the case management process;
2. the continuity of service;
3. the avoidance of duplication of service (including case management services); and,
4. the establishment of a comprehensive case management plan that addresses the interdisciplinary needs of the recipient.

D. Implementation of the case management plan.

Implementation of the plan means assisting clients in gaining access to necessary services. Case managers must secure the services determined in the case management plan appropriate for a particular recipient through referral to those agencies or to persons who are qualified to provide the identified services. Implementation may mean assisting the recipient with referral and/or application forms required for the acquisition of services; advocating for the recipient with all providers of service; and developing a plan to access alternative services to assure continuity in the event of service disruption.

E. Crisis intervention.

Crisis intervention by a case manager or practitioner includes when necessary: assessment of the nature of the recipient's circumstances; determination of the recipient's emergency service needs; and revision of the case management plan, including any changes in activities or objectives required to achieve the established goal.

F. Monitoring and follow-up.

The case manager is responsible for: assuring that quality services, as identified in the case management plan, are delivered by the provider to whom referral was made; assuring the recipient's satisfaction with the services provided and, if the plan has been formulated by a practitioner]

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New York
1-F5

[advising the preparer of the case management plan of the findings; collecting data and documenting the progress of the recipient in the case record; making necessary revisions to the case management plan; making alternate arrangements when services have been denied or are unavailable to the recipient; and, assisting the recipient and/or provider of services to resolve disagreements, questions or problems with implementation and continuation of the case management plan.

PROCEDURAL REQUIREMENTS FOR PROVISION OF SERVICE

1. Assessments.

The case management process must be initiated by the recipient and case manager (or practitioner as appropriate) through a written assessment of the recipient's need for case management as well as medical, social, psychosocial, educational, financial and other services.

An assessment provides verification of the recipient's current functioning and continuing need for services, the service priorities and evaluation of the recipient's ability to benefit from such services. The assessment process includes those activities listed in paragraph B of **CASE MANAGEMENT FUNCTIONS**.

An assessment must be completed by a case manager within 15 days of the date of the referral or as specified in a referral agreement. The referral for service may include a plan of care containing significant information developed by the referral source which should be included as an integral part of the case management plan.

An updated assessment of the recipient's need for case management and other services must be completed by the case manager every six months, or sooner if required by changes in the recipients condition or circumstances.

2. Case management plan.

A written case management plan must be completed by the case manager for each recipient of case management services within 30 days of the date of referral or as specified in a referral agreement, and must include those activities outlined in paragraph C under **CASE MANAGEMENT FUNCTIONS**.

The recipient's case management goals, with anticipated dates of completion, must be established in the initial case management plan, consistent with the recipient's service needs and assessment.

The case management plan must be reviewed and updated by the case manager as required by changes in the recipient's condition or circumstances, but not less frequently than every six months subsequent to the initial plan. Each time the case management plan is reviewed the goals established in the initial case management plan must be maintained or revised, and new goals and new time frames may be established with the participation of the recipient.]

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New York
1-F6

[The case management plan must specify:

- a. those activities which the recipient is expected to undertake within a given period of time toward the accomplishment of each case management goal;
- b. the name of the person or agency, including the individual and/or family members, who will perform needed tasks;
- c. the type of treatment program or service providers to which the recipient will be referred;
- d. the method of provision and those activities to be performed by a service provider or other person to achieve the recipient's related goal and objective; and
- e. the type, amount, frequency, duration and cost of case management and other services to be delivered or tasks to be performed.

3. Continuity of service.

Case management services must be ongoing from the time the recipient is accepted by the case management agency for services to the time when: the coordination of services provided through case management is not required or is no longer required by the recipient; the recipient moves from the target area; the long term goal has been reached; the recipient refuses to accept case management services; the recipient request that his/her case be closed; the recipient is no longer eligible for services; or, the recipient's case is appropriately transferred to another case manager.

Contact with the recipient or with a collateral source on the recipient's behalf must be maintained by the case manager at least monthly or more frequently as specified in the provider's agreement with the New York State Department of Social Services.

LIMITATIONS TO THE PROVISION OF MEDICAID CASE MANAGEMENT SERVICES

Case management services must not:

1. be utilized to restrict the choice of a case management services recipient to obtain medical care or services from any provider participating in the Medical Assistance Program who is qualified to provide such care or services and who undertakes to provide such care or services or which arranges for the delivery of such care or services on a prepayment basis;
2. duplicate case management services currently provided under the Medical Assistance Program or under and other program;
3. be utilized by providers of case management to create a demand for unnecessary services or programs particularly those services or programs within their scope of authority.]

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New York
1-F7

[While the activities of case management services secure access to an individual's needed service, the activities of case management do not include:

1. the actual provision of the service;
2. Medicaid eligibility determinations/redeterminations;
3. Medicaid preadmission screening;
4. prior authorization for Medicaid services;
5. required Medicaid utilization review;
6. EPSDT administration;
7. activities in connection with "lock-in" provisions under 1915(a) of the Social Security Act;
8. institutional discharge planning as required of hospitals, NF's;
9. client outreach considered necessary for the proper and efficient administration of the Medicaid State Plan.

Contact with the client or with a collateral source on the client's behalf must be maintained by the case manager at least monthly, or more frequently as specified in the proposal document submitted for each site.

E. Qualifications of Providers

1. Providers

Under New York State Regulations (18 NYCRR 505.16) case management services may be provided by social services agencies, facilities, persons and other groups possessing the capabilities to provide such services who are approved by the New York State Commissioner of Social Services based upon approved proposal submitted to the New York State Department of Social Services.

2. Case Managers

The case manager must have two years experience in a substantial number of activities outlined under **CASE MANAGEMENT FUNCTIONS**, including the performance of assessments and development of case management plans. Voluntary or part-time experience which can be verified will be accepted on a pro-rata basis. The following may be substituted for this requirement:

- a. one year of case management experience and a degree in a health or human services field; or]

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New York
1-F8

- [b. one year of case management experience and an additional year of experience in other activities with the target population; or
- c. a bachelor's or master's degree which includes a practicum encompassing a substantial number of activities outlined under **CASE MANAGEMENT FUNCTIONS**, including the performance of assessments and development of case management plans; or
- d. the individual meets the regulatory requirements for case manager of a State Department within New York State.

Provider Qualifications Specific to Target Group "F"

1. Providers

The State Department of Social Services designation of providers for this target group will be based upon a proposal document demonstrating the capacity to provide the described services to the target population. The proposal document must be submitted to SDSS, Division of Health and Long Term Care (HLTC) by the local social services district in which an NBA site is located. Qualified agencies will be enrolled as case management providers to serve target populations within the NBA service area.

The NBA lead agencies will provide case management themselves and/or solicit new case managers from community agencies with additional special expertise in the targeted subpopulations. New case managers solicited by the lead agency must meet all provider qualifications, must execute separate provider agreements with the State and must bill the Medicaid program in their own right. The NBA lead agencies are responsible for identification of clients needing case management and referral to the appropriate case management agency. Lead agencies will be responsible for recordkeeping and Medicaid claim preparation only for the case management services they themselves render.

2. Case Managers

Case managers will meet the general qualifications described in Item E.2.

Additionally, the staff recruited to work for the case management and crisis intervention program in both a supervisory and direct service capacity will be individuals who are highly committed to the community network concept and have experience working with the variety of cultural and ethnic groups represented in the community. A variety of educational, experiential, and cultural backgrounds will be sought.]

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**New York
1-F9**

Effective December 1, 2011, the State is terminating the optional reimbursement of Medicaid case management services provided through NBA — Target Group F described on pages 1-F1 through 1-F8.

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New York
1-G1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES

A. Target Group: G

See attached.

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

Entire State.

Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than statewide:

C. Comparability of Services

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

Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See attached

E. Qualification of Providers:

See attached

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A. TARGET POPULATION G

The target group consists of any categorically needy or medically needy eligibles

1. who are infants or toddlers from birth through age two years who have or are suspected of having a developmental delay or a diagnosed physical or mental condition that has a high probability of resulting in developmental delay, such as, Down Syndrome or other chromosome abnormalities, sensory impairments, inborn errors of metabolism, or fetal alcohol syndrome.
2. who have been referred to the municipal early intervention agency and are known to the New York State Department of Health.
3. who are in need of ongoing and comprehensive rather than incidental case management.

Developmental delay means that a child has not attained developmental milestones expected for the child's chronological age, as measured by qualified professionals (a multidisciplinary team) using appropriate diagnostic instruments and/or procedures and informed clinical opinion, in one or more of the following areas of development: cognitive, physical (including vision and hearing), communication, social/emotional, or adaptive development. A developmental delay is a delay that has been documented as:

1. a twelve month delay in one functional area, or
2. a 33% delay in one functional area or a 25% delay in each of two areas, or,
3. if appropriate standardized instruments are individually administered in the evaluation process, a score of at least 2.0 standard deviations below the mean in one functional area or a score of at least 1.5 standards deviations below the mean in each of two functional areas, or
4. if because of a child's age, condition or type of diagnostic instruments available in specific domains, a standardized score is either inappropriate or cannot be determined, a child may be deemed eligible by the informed clinical opinion of the multidisciplinary team. Criteria such as functional status, recent rate of change in development, prognosis for change in the future based on anticipated medical/health factors and other factors relevant to the needs of that child and family shall also be considered.

B. AREAS OF STATE IN WHICH SERVICES WILL BE PROVIDED TO TARGET GROUP G

Entire State

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D. DEFINITION OF CASE MANAGEMENT RELATED TO TARGET GROUP "G"

Case management for Target Group "G" means those initial and ongoing activities performed by case management staff related to ensuring that developmentally delayed infants and toddlers are provided access to services allowing them to:

1. resolve problems which will interfere with their independence or self-sufficiency;
2. resolve problems which will interfere with attainment or maintenance of self support or economic independence;
3. maintain themselves in the community rather than reside in, or return to an institution; or
4. prevent institutionalization from occurring.

Case management is a process which will assist Medicaid eligible infants and toddlers and their families to access necessary medical, social, psychological, educational, financial and other services in accordance with the goals contained in a written individualized family services plan (IFSP).

CASE MANAGEMENT FUNCTIONS

Case Management functions are determined by the recipient's circumstances and therefore must be determined specifically in each case. In no instance will case management include the provision of clinical or treatment services. A separate case record must be established for each individual recipient of case management services and must document each case management service provided.

1. Intake.

This function consists of: the initial contact to provide information concerning case management and early intervention to the parent of an eligible child or a child thought to be eligible for early intervention services at a time and place convenient to the family; exploration of the family's receptivity to the early intervention program and the case management process; determine that the recipient is a member of the targeted population; ascertain if the child and family are presently receiving case management services or other services from public or private agencies, identification of potential payers for services; and review of due process rights concerning mediation and impartial hearing.

2. Assessment.

The case manager must secure directly, or indirectly through collateral sources, with the family's permission: a determination of the nature and degree of the recipient's developmental status; must assist the family in accessing screening and evaluation services; review evaluation reports with the family; assist the family to identify their priorities, concerns, and resources; explore options and assist the family's investigation of these options; inform the family of other program and services that may be of benefit and assist

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in making referrals; assist the recipient in obtaining interim early intervention services when it is determined that the child has an obvious, immediate need and prepare an interim family services plan.

3. Case management plan and coordination.

For purposes of early intervention, the case management plan will be known as the individualized family services plan (IFSP). Development of the IFSP is the translation of specific goals and objectives, and specific services, providers and timeframes to reach each objective. The case manager shall convene a meeting at a time and place convenient to the family with 45 days of the child's referral to early intervention agency except under exceptional documented circumstances. Participants shall include: parent(s); early intervention official; case manager; the designated contact from the evaluation team; and other individuals the family invite or give consent to attend.

The IFSP shall be in writing and include the following:

- a. A statement of the child's levels of functioning in each of the following domains: physical development; cognitive development; communication development; social or emotional development; and adaptive development.
- b. A physician's order pertaining to early intervention services, which includes a diagnostic statement and purpose of treatment.
- c. With parental consent, a statement of the family's strengths, priorities, concerns that relate to enhancing the development of their child.
- d. A statement of the major outcomes expected to be achieved and for the child and family, including timelines, and criteria and procedures that will be used to determine whether progress toward achieving the outcomes is being made and whether modifications or revisions of the outcomes and services is necessary.
- e. A statement of specific early intervention services necessary to meet the unique needs of the child and family, including the frequency, intensity, location and the method of delivering services.
- f. A statement of the natural environments in which early intervention services will be provided
- g. When early intervention services are to be delivered to a recipient in a group setting without typically developing peers, the IFSP shall document the reason(s).
- h. A statement of other services, including medical services, that are not required under the early intervention program but are needed by the child and the family and the payment mechanism for these services.
- i. A statement of other public programs under which the child and family may be eligible for benefits, and a referral, where indicated.

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- j. The projected dates for initiation of services and the anticipated duration of these services.
- k. The name of the case manager who will be responsible for the implementation of the IFSP.
- l. If applicable, steps to be taken to support the potential transition of the recipient to special education or other services.
- m. The IFSP shall reflect the family's response to the plan, consent to case management and/or declination of any part of the plan by the family must be documented.

4. Implementation of the IFSP.

In implementing the service plan, the case manager must assist the recipient and family, as needed, in securing the services determined in the plan to be appropriate through referral to agencies or to persons who are qualified to provide identified services; assist the family in making applications for services and entitlements; confirm service delivery dates with providers and supports; assist with family scheduling needs; advocate for the family with all service providers; document services that are not available or cannot be accessed; and developing alternatives services to assure continuity in the event of service disruption.

5. Reassessment and IFSP update.

Reassessment is a scheduled or event generated formal reexamination of the client's situation, functioning, clinical and psychosocial needs, to identify changes which have occurred since the initial or most recent assessment. The IFSP for a child and the child's family must be reviewed at six months intervals and evaluated annually, or more frequently if conditions warrant, or if a parent requests such a review.

6. IFSP update implementation.

The case manager is responsible for the implementation of the updated plan. Such implementation will include the same activities as described in subsection 4 above.

7. Crisis intervention.

Crisis intervention by a case manager includes when necessary: assessment of the nature of the recipient's circumstances; determination of the recipient's emergency needs; and revision of the IFSP, including any changes in activities and objectives required to achieve the established goal.

8. Monitoring and follow-up.

The case manager is responsible for:

- a. assuring that quality services, as identified in the IFSP, are delivered in a cost-conscious manner;
- b. assuring the family's satisfaction with the services provided;
- c. collecting data and documenting the progress of the recipient in a case record;
- d. making necessary revisions to the plan in conjunction with the family, early intervention official, the designated representative of the evaluation team and the service provider(s);

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- e. making alternate arrangements when services have been denied or are unavailable; and
- f. assisting both the family and providers of service to resolve disagreements, questions or problems relating to the implementation of the IFSP.

9. **Counseling and exit planning.**

The case manager must assure that the recipient obtains, on an ongoing basis, the maximum benefit from the services received; developing support groups for the recipient, the recipient's family and informal providers of service; mediating among the recipient, the family network and/or other informal providers when problems with service delivery occur; facilitating the recipient's access to other appropriate care when eligibility for targeted services ceases; and assisting the family to anticipate difficulties which may be encountered subsequent to from the early intervention program or admission to other programs, including other case management programs.

10. **Supervisory Review/Case Conferencing.**

An important component of the required quality assurance process for each case management provider will be supervisory review of case management documentation. IFSPs and other products as well as peer review or case conferencing with other case managers.

PROCEDURAL REQUIREMENTS FOR PROVISION OF SERVICE

1. **Assessments.**

The case management process must be initiated by the family and the case manager through a written assessment of the child and family's need for case management and early intervention services including medical, social, psychosocial, educational, financial and other services.

An assessment provides verification of the recipient's current functioning and continuing need for services, the service priorities and evaluation of the child's ability to benefit from such services. The assessment process includes, but is not limited to, those activities listed in paragraph 2 of **CASE MANAGEMENT FUNCTIONS**.

The case manager shall promptly arrange a contact with the family at a time, place and manner reasonably convenient for the parent(s) consistent with applicable timeliness requirements and initiate the assessment process. Information developed by the referral source should be included as an integral part of the case management plan.

An assessment of the recipient's need for case management and early intervention services must be completed by the case manager every six months, or sooner if required by changes in the child's condition or circumstances.

2. **Case management plan.**

A written IFSP must be completed by the case manager for each child eligible for early intervention services within 45 days of referral to the municipal early intervention agency and must include, but is not limited to, those functions outlined in paragraph 3 under **CASE MANAGEMENT FUNCTIONS**.

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3. Continuity of service.

Case management services must be ongoing from the time the child is referred to the local early intervention agency for services to the time when: when the coordination of services provided through case management is not required or is no longer required by the child and his/her family; the child moves from the local social services district*; the long term goal has been reached; the family refuses to accept case management services; the family requests that its case be closed; the child is no longer eligible for services; or the child's case is appropriately transferred to another case manager.

Contact with the child, his or her family or with a collateral source on the child's behalf must be maintained by the case manager at least monthly or more frequently as specified in the provider's agreement with the New York State Department of Social Services.

* The criteria for discontinuance by a particular entity when a client moves are inaccessibility and the provider's incapability to provide adequate service to someone removed from their usual service area due to a lack of intimate knowledge of the support system in the family's new community. The current case manager is responsible to help transition the family to a case manager in their new location. Clients are free to choose among the case managers qualified to provide early intervention case management services.

LIMITATIONS TO THE PROVISION OF MEDICAID CASE MANAGEMENT SERVICES

Case management services for Target Group "G":

1. must not be utilized to restrict the choices of the case management services recipient to obtain medical care or services from any provider participating in the Medical Assistance Program who is qualified to provide such care or services and who undertakes to provide such care or service(s), including an organization which provides such care or services on a prepayment basis;
2. must not duplicate certain case management services services currently provided under the Medical Assistance Program or under any other funding sources;
3. must not be utilized by providers of case management to create a demand for unnecessary services or programs particularly those services or programs within their scope of authority;
4. must not be provided to persons receiving institutional care for more than 30 days or when discharge to community based care is not anticipated and care is reimbursed under the Medical Assistance Program or to persons in receipt of case management services under a federal Home and Community Based Services waiver or the Care At Home model waiver program.

While the activities of case management services secure access to, including referrals to and arrangements for, services for the Target Group, reimbursement for case management does not include:

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1. the actual provision of the service;
2. Medicaid eligibility determinations and redeterminations;
3. Medicaid preadmission screening;
4. prior authorization for Medicaid services;
5. required Medicaid utilization;
6. administration of the Child/Teen Health Program services;
7. activities in connection with "lock-in" provisions under 1915(a) of the Social Security Act;
8. institutional discharge planning;
9. client outreach.

E. QUALIFICATIONS OF PROVIDERS SPECIFIC TO TARGET GROUP "G"

1. Provider qualifications

Public or private agencies applying for participation in the Early Intervention Program must demonstrate the following:

- a. character and competence, including fiscal viability;
- b. the capacity to provide case management services;
- c. availability to provide qualified personnel as defined in subsection 2 below;
- d. adherence to applicable federal and state laws and regulations;
- e. the capacity and willingness to ensure case managers participate in inservice training;
- f. the assurance that all case managers will participate in training sponsored by the New York State Department of Health or another State early Intervention agency within the first twelve months of employment;
- g. completion of an approved Medicaid provider agreement.

2. Case manager qualifications

Early Intervention case managers may be located within either public or private agencies, or may be individual qualified personnel. All case managers shall meet the following qualifications:

- a. a minimum of one of the following educational or case management experience credentials:
 - i. two years experience in case management activities (voluntary or part-time experience which can be verified will be accepted on a pro rata basis); or
 - ii. one year of case management experience and an additional year of experience in a service setting with infants and toddlers with developmental delays or disabilities; or

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- iii. one year of case management experience and an associates degree in a health or human service field; or
- iv. a bachelors degree in a health and human services field.
- b. demonstrated knowledge and understanding in the following areas:
 - i. infants and toddlers who are eligible for early intervention services;
 - ii. State and federal laws and regulations pertaining to the Early Intervention Program;
 - iii. principles of family centered services;
 - iv. the nature and scope of services available under the Early Intervention Program and the system of payments and services in the State; and,
 - v. other pertinent information.

3. Individual case managers

Qualified personnel with appropriate licensure, certification, or registration shall apply to the State Department of Health for approval to provide case management services. In addition to the qualifications listed in subsection 2. above, the following factors are required for individuals not associated with a public or private agency in order to provide case management services:

- a. current licensure, certification or registration in a discipline eligible to deliver services to children;
- b. adherence to applicable federal and State laws and regulations;
- c. the capacity and willingness to attend in-service training programs sponsored by the Department of Health and State early intervention agencies;
- d. the assurance that all approved individual case managers will participate in the case manager training sponsored by the Department of Health or State early intervention agencies within the first twelve months of program participation;
- e. completion of an approved Medicaid provider agreement.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES

A. Target Group: H

See attached.

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

Entire State.

Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than statewide:

C. Comparability of Services

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

Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See attached

E. Qualification of Providers:

See attached

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

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

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

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A. TARGET GROUP H

The targeted group consists of Medical Assistance eligibles who are served by the Office of Mental Health's Supportive Case Management Program who:

- (i) are seriously mentally ill, and,
- (ii) require personal and proactive intervention to help them obtain and maintain services, which will permit or enhance functioning in the community; and,
- (iii) either have symptomology which is difficult to treat in the existing mental health care system or need support to maintain their treatment connections and/or residential settings.

These individuals include:

- (1) heavy service users who are known to staff in emergency rooms, acute inpatient units, psychiatric centers as well as to providers of other acute and crisis service. May have multiple disabilities including drug abuse, alcohol abuse or developmental disabilities, or,
- (2) persons with recent hospitalization in either state psychiatric centers or acute care general hospital; or,
- (3) mentally ill who are homeless and live on the streets or in shelters; or,
- (4) seriously emotionally disturbed children and adolescents whose disability disrupts their ability to function in educational, social, vocational and interpersonal spheres and may, without intervention, be institutionalized, incarcerated or hospitalized; or,
- (5) people in need of ongoing mental health support in order to maintain or enhance community tenure.

The aim is to benefit these recipients by reducing hospitalization and reliance on emergency psychiatric services, as well as increasing employment, encouraging better medication compliance and generally improving the individual's quality of life within the community.

Supportive Case Management will address the needs and desires of those persons in Target Group "H". Target Group "H" persons will be identified through the screening and intake process. The eligibility determination will be made based on individual factors in each person's life. Factors which will be considered during this process include: status of mental illness, case management options available in the community, residential situation and available options, current linkage to mental health services (including type of service, frequency and duration), linkage or lack thereof to the health care system and/or the Social Services system, the role of the criminal justice system in a person's life, as well as the individual's personal needs and goals. If

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an individual is generally not engaged in at least one of these service systems, he/she may be better served in an Intensive Case Management program and the SCM program will make the appropriate referral and work toward linking that person into ICM. Those persons determined to be in need of Intensive Case Management but who cannot be served due to lack of capacity in ICM program will be served by the SCM until the individual circumstances change or the ICM program has space available for the individual.

B. AREAS OF STATE IN WHICH SERVICES WILL BE PROVIDED TO TARGET GROUP H

Entire State

C. DEFINITION OF COMPREHENSIVE MEDICAID CASE MANAGEMENT REIMBURSABLE UNDER MEDICAID

Case management is a process which will assist persons eligible for Medical Assistance to access necessary services in accordance with goals contained in a written case management plan.

DEFINITION OF CASE MANAGEMENT RELATED TO TARGET GROUP "H"

Case management for Target Group "H" means those activities performed by case management staff related to ensuring that the individuals diagnosed with mental illness have full access to the comprehensive array of services and assistance which the individual needs to maintain community life and to attain or retain capability for maximum personal independence.

Case management for Target Group "H" requires referral to and coordination with medical, social, educational, psychosocial, employment, habilitation, rehabilitation, financial, environmental, and legal services available within the community appropriate to the needs of the person diagnosed with mental illness.

Supportive case management establishes programming directed toward a comprehensive person-centered view of recovery from mental illness. The Office of Mental Health has designed the SCM initiative to extend the personalized planning, linking, monitoring, and advocacy available through the Intensive Case Management Program target group "D" toward a wider group of persons in need. Called Supportive Case Management, this new program will be available to persons living in the community, homeless persons and persons in community support programs. The intent of the program is to provide for these individuals a comprehensive approach toward meeting their treatment, rehabilitation and support needs.

CASE MANAGEMENT FUNCTIONS

The case manager will assist the recipient in gaining access to each individual's specific area of need (ie. medical, social, education or other service). The case manager will perform needs assessments, develop a plan of care to meet the recipient's needs and interests,

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assist the recipient in accessing the services and perform monitoring and follow-up functions. In no instance will case management include the provision of clinical or treatment services. A separate case record must be established for each individual recipient of case management services and must document each case management function provided.

A. Intake and screening.

This function consists of: the initial contact to provide information concerning case management; exploring the recipient's receptivity to the case management process; determining that the recipient is a member of the provider's targeted population; and identifying potential payors for services.

B. Assessment and reassessment.

During this phase the case manager must secure directly, or indirectly through collateral sources, with the recipient's permission: a determination of the nature and degree of the recipient's functional impairment through a medical evaluation; a determination of the recipient's functional eligibility for services; information from other agencies/individuals required to identify the barriers to care and existing gaps in service to the recipient; assessment of the recipient's service needs including medical, social, psychosocial, educational, financial and other services; and a description of the recipient's strengths, informal support system and environmental factors relative to his/her care.

C. Case management plan and coordination.

The case management activities required to establish a comprehensive written case management plan and to effect the coordination of services include: identification of the nature, amount, frequency, and duration of the case management services required by a particular recipient; with the participation of the recipient, selection of the nature, amount, type, frequency and duration of services to be provided to the recipient; identification of the recipient's informal support network and providers of services; specification of the long term and short term goals to be achieved through the case management process; collaboration with hospital discharge planners, health care providers and other service providers, including informal caregivers and other case managers. It also includes, through case conferences, an exchange of clinical information which will assure:

1. the integration of clinical care plans throughout the case management process;
2. the continuity of service;
3. the avoidance of duplication of service (including case management services); and
4. the establishment of a comprehensive case management plan that addresses the interdisciplinary needs of the individual.

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D. Implementation of the case management plan.

Implementation of the plan includes securing the services determined in the case management plan to be appropriate for a particular recipient through referral to those agencies or to persons who are qualified to provide the identified services; assisting the recipient with referral and/or application forms required for the acquisition of services; advocating for the recipient with all providers of service; and developing alternative services to assure continuity in the event of service disruption.

E. Crisis intervention.

Crisis intervention by a case manager or practitioner includes when necessary: assessment of the nature of the recipient's circumstances; determination of the recipient's emergency service needs; and, revision of the case management plan, including any changes in activities or objectives required to achieve the established goal.

F. Monitoring and follow up.

As dictated by the client's needs and desires, case manager services include: assuring that quality services, as identified in the case management plan, are delivered; assuring the recipient's satisfaction with the services provided and advising the preparer of the case management plan of the findings; collecting data and documenting in the case record the progress of the recipient; making necessary revisions to the case management plan; making alternate arrangements when services have been denied or are unavailable to the recipient; and, assisting the recipient and/or provider of services to resolve disagreements, questions or problems with implementation of the case management plan.

G. Counseling and exit planning.

This function consists of: assuring that the recipient obtains, on an ongoing basis, the maximum benefit from the services received; developing linkages to support groups for the recipient, the recipient's family and informal providers of services; coordinating among the recipient, the family network and/or other informal providers of services when problems with service provision occur; facilitating the recipient's access to other appropriate care if and when eligibility for the targeted services ceases; and, assisting the recipient to anticipate the difficulties which may be encountered subsequent to discharge from or admission to facilities or other programs, including other case management programs.

PROCEDURAL REQUIREMENTS FOR PROVISION OF SERVICE

1. Assessments.

The case management process must be initiated by the recipient and case manager (or practitioner as appropriate) through a written assessment of the recipient's need for case management as well as medical, social, psychosocial, educational, financial and other services.

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An assessment provides verification of the individual's current functioning and continuing need for services, the service priorities and evaluation of the individual's ability to benefit from such services. The assessment process consists of those activities listed in paragraph B of **CASE MANAGEMENT FUNCTIONS**.

An assessment must be completed by a case manager within 15 days of the date of the referral or as specified in a referral agreement. The referral for service may include a plan of care containing significant information developed by the referral source which should be included as an integral part of the case management plan.

An assessment of the individual's need for case management and other services must be completed by the case manager every six months, or sooner if required by changes in the recipient's condition or circumstances.

2. Case management plan.

A written case management plan must be completed by the case manager for each individual receiving case management services within 30 days of the date of referral or as specified in a referral agreement, and must include those activities outlined in paragraph C, under **CASE MANAGEMENT FUNCTIONS**.

The individual's case management goals, with anticipated dates of completion, must be established in the initial case management plan, consistent with the recipient service needs and assessment.

The case management plan must be reviewed and updated by the case manager as required by changes in the individual's condition or circumstances, but not less frequently than every six months subsequent to the initial plan. Each time the case management plan is reviewed the goals established in the initial case management plan must be maintained or revised, and new goals and new time frames may be established with the participation of the recipient.

The case management plan must specify:

- a. those activities which the individual is expected to undertake within a given period of time toward the accomplishment of each case management goal;
- b. the name of the person or agency, including the individual and/or family members, who will perform needed tasks;
- c. the type of treatment program or service providers to which the individual will be referred;
- d. the method of provision and those activities to be performed by a service provider or other person to achieve the individual's related goal and objective; and
- e. the type, amount, frequency, and duration of services to be delivered or tasks to be performed.

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3. Continuity of service.

Case management services must be ongoing from the time the individual is accepted by the case management agency for services to the time when: the coordination of services provided through case management is not required or is no longer required by the individual; the recipient moves from the social services district*; the long term goal has been reached; the individual refuses to accept case management services; the individual requests that his/her case be closed; the individual is no longer eligible for services; or, the individual's case is appropriately transferred to another case manager. Contact with the individual or with a collateral source on the individual's behalf must be maintained by the case manager at least monthly or more frequently as specified in the provider's agreement with the New York State Department of Social Services.

* The criteria for discontinuance by a particular entity when a client moves are inaccessibility and the provider's incapability to provide adequate service to someone removed from their usual service area. Although equally qualified, each OMH entity is not capable of serving individuals in all other parts of the State since serving this clientele requires frequent contact and an intimate knowledge of the support system in the client's community. The current case manager is responsible to help transition clients to case managers in their new location or, if a program is not available, to the best substitute. Clients are free to choose among qualified providers within the State.

LIMITATIONS TO THE PROVISION OF MEDICAID CASE MANAGEMENT SERVICES

Case management services must not:

1. be utilized to restrict the choice of a case management services recipient to obtain medical care or services from any provider participating in the Medical Assistance Program who is qualified to provide such care or services and who undertakes to provide such care or service(s), including an organization which provides such care or services or which arranges for the delivery of such care or services on a prepayment basis;
2. duplicate case management services currently provided under the Medical Assistance Program or under any other program;
3. be utilized by providers or case management to create a demand for unnecessary services or programs particularly those services or programs within their scope of authority;
4. be provided to persons receiving institutional care reimbursed under the Medical Assistance Program or to persons in receipt of case management services under a federal Home and Community Based Services waiver.

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While the activities of case management services secure access to an individual's needed service, the activities of case management do not include:

1. the actual provision of the service;
2. Medicaid eligibility determinations/redeterminations;
3. Medicaid preadmission screening;
4. prior authorization for Medicaid services;
5. required Medicaid utilization review;
6. EPSDT administration;
7. activities in connection with "lock in" provisions under 1915 (a) of the Social Security Act;
8. institutional discharge planning required of hospitals, SNFS, ICFs and ICF/MRs;
9. client outreach considered necessary for the proper and efficient administration of the Medicaid State Plan; and
10. representative payee services.

LIMITATIONS SPECIFIC TO TARGET GROUP "H"

In order to support a personal and proactive service, Supportive Case Managers will carry an average active case load of between 20-30 clients. Supportive Case Managers will see active clients a minimum of two times during a month. SCM employs a team approach to the provision of case management service. The inclusion of the SCM program in the service target group H will assure that the nature and intensity of services vary with individuals changing needs. These individuals may be referred to the SCM by various community agencies, mental health agencies, (including State psychiatric facilities), and human services agencies with whom the client has been in contact.

D. QUALIFICATIONS OF PROVIDERS SPECIFIC TO TARGET GROUP "H"

1. Providers

The New York State Office of Mental Health (OMH) will authorize as Case Management providers either employees of OMH meeting the qualifications described below or employees of those organizations determined by OMH and certified to the Department of Health (DOH) to have the capacity to provide specialized Case Management Services and

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having written agreements with appropriate mental health providers and other human service providers so that DOH can enroll the providers in the Medicaid program.

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SCM Teams will vary in size and composition and may consist of one individual who may be a paraprofessional with adequate clinical supervision. Each supportive case manager must meet the minimum qualifications for Supportive Case Manager whether they serve a maximum 20 client caseload or a maximum 30 client caseload. The qualifications for Supportive Case Manager whether they serve a maximum 20 client caseload or a maximum 30 client caseload are the same. While supportive case management programs may provide services to individuals with only one staff member and a supervisor in the program, the more common model will utilize a team approach. The team may be comprised of professionals and paraprofessionals. All members of the team must meet the minimum qualifications for the SCM and will receive professional supervision, as detailed in this document. SCM teams will have a professional supervisor with both clinical and supervisory experience.

2. Case Managers

Minimum Qualifications for Supportive Case Manager:

Two years of experience in providing direct services or in a substantial number of activities outlined under CASE MANAGEMENT FUNCTIONS to people who are mentally disabled, or homeless. The following may be substituted for this requirement:

- a) one year of case management experience and an associates degree in a health or human services field; or
- b) one year of case management experience and an additional year of experience in other activities with the target population; or
- c) a bachelor's or master's degree which includes a practicum encompassing a substantial number of activities with the target population; or
- d) the individual meets the regulatory requirements for case manager of a State Department within New York State.

Minimum Qualifications for Coordinator of Supportive Case Management Services:

Education:

- 1. a master's degree in one of the below listed fields*
- or 2. a master's degree in public administration, business administration, health care or hospital administration and a bachelor's degree in one of the below listed fields*;
- or 3. NYS licensure and registration as a Registered Nurse plus a master's degree in 1 or 2 above

AND

Experience:

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Four years of experience:

1. in providing direct services to persons diagnosed with mental disabilities**;
- or
2. in linking persons diagnosed with mental disabilities** to a broad range of services essential to successfully living in a community setting (e.g., medical, psychiatric, social, educational, legal, housing and financial services)

Two years of this experience must have involved:

1. supervisory or managerial experience for a mental health program or major mental health program component;
- or
2. service as an Intensive Case Manager in a NYS Office of Mental Health registered ICM program.

* Qualifying education includes degrees in social work, psychology, nursing, rehabilitation, education, occupational therapy, physical therapy, recreation or recreation therapy, counseling, community mental health, child and family studies, sociology, speech and hearing.

** The term "mental disabilities" refers to persons properly diagnosed with mental illness, mental retardation, alcoholism or substance abuse.

Minimum Qualifications for a Clinical Professional:

Clinical professional staff are individuals who are qualified by credentials, training and experience to provide supervision and direct service related to the treatment of mental illness and shall include: a credentialed alcoholism counselor; registered or certified creative arts therapist; certified nurse practitioner; licensed occupational therapist, physician, psychiatrist, psychologist, or registered professional nurse; registered physician's assistant or specialist's assistant; rehabilitation counselor with a Master's Degree in this field or current certification, pastoral counselor with a Master's Degree or equivalent in this field, certified social worker currently licensed or with a Master's Degree in this field, therapeutic recreation specialist who is registered or has a Master's Degree in this field.

Minimum Supervision Standard for Supportive Case Management Teams:

Supervision of the SCM team will be provided by the SCM Team Coordinator, or an appropriate clinical professional.

Routine review of tasks performed by the SCM team members will focus on enrollment, planning, and service linkage and advocacy. An SCM team meeting for case review will take place monthly or more frequently, if needed. Supervision of the SCM team members with paraprofessional job titles will be provided by a professional, who will be available at all times for consultation with the SCM and will provide direct supervision at frequent intervals to assure that recipient needs are being addressed. Supervision of a paraprofessionals by a professional staff member will occur on a bi-weekly basis at a minimum and more frequently, if needed.

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Additionally, the coordinator will review each recipient case record with the SCM team members on a semi-annual basis at a minimum and more frequently, as needed. The SCM Coordinator will post a progress note in the record at the time of the case record review.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CASE MANAGEMENT SERVICES

A. Target Group: I

See attached Target Group

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

Entire State.

Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than statewide:

C. Comparability of Services

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

Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See attached

E. Qualification of Providers:

See attached

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- F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a) (23) of the Act.**
1. Eligible recipients will have free choice of the providers of case management services.
 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.**

See Attached

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CASE MANAGEMENT SERVICES
SERVICE COORDINATION FOR CHILDREN WITH DISABILITIES

A. TARGET GROUP I:

Children 3 through 21 years old who are federally eligible Medical Assistance Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) recipients and for whom free and appropriate education is provided under the Individuals with Disabilities Education Act (IDEA) or Section 504 of the Rehabilitation Act of 1973.

A child is eligible to receive the case management services, called Service Coordination for Children with Disabilities under New York's Medical Assistance Program Comprehensive Medicaid Case Management regulations 18 NYCRR 505.16, when all of the following requirements are met:

1. It is determined through an assessment, in accordance with the New York State Education law and regulations for assuring a free, appropriate education for all students with disabilities, that:
 - a. the child has temporary or long-term needs arising from cognitive, emotional, or physical factors, or any combination of these, which affects the child's ability to learn, and
 - b. the child's ability to meet general education objectives is impaired to a degree whereby the services available in the general education program are inadequate in preparing the child to achieve his or her educational potential.
2. A multi-disciplinary team, called a Committee on Special Education (CSE) or Committee on Preschool Special Education (CPSE) in the New York State Department of Education regulations for Programs for Students with Disabilities, or Multi-Disciplinary Team (MDT) for programs and activities under §504 of the Rehabilitation Act of 1973 determines that the recipient is a child with disabilities who:
 - a. Is eligible for special education and/or related services that are provided through two school Medicaid programs; the Preschool Supportive Health Services Program (PSHSP) for children age 3 and 4 and the School Supportive Health Services Program (SSHSP) for children age 5 through 21, and
 - b. Needs an Individualized Education Program (IEP) under Part B (IDEA) or an Accommodation Plan (AP) under Section 504 of the Rehabilitation Act of 1973.
3. The child elects, or the child's parent or other responsible individual elects on the child's behalf, to receive Service Coordination for Children and Disabilities; and
4. The child is not receiving similar case management services under another Medical Assistance Program authority.

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D. DEFINITION OF SERVICES:

Service Coordination for Children with Disabilities means those case management services which will assist children with or suspected of having disabilities in gaining access to evaluations and the services recommended in a child's IEP or AP.

The New York Medical Assistance Program reimburses for the following services under Service Coordination for Children with Disabilities, when the following case management services have been documented as necessary and appropriate:

1. Initial IEP or AP

- a. A unit of service for the initial IEP or AP is defined as:
 - (1) The activities leading up to and including writing a completed initial IEP or AP prepared by members of the CSE/CPSE/MDT, the multi-disciplinary team. An initial IEP is a written recommendation identifying the handicapping condition, a description of the child's strengths and weaknesses, a list of goals and objectives that the child should reach in a years time, and an identification of the types of programs and services that the child will receive. An AP is a written document that describes the nature of the problem, evaluations completed, the basis for determining that the child has a disability, and the list of recommended accommodations; and
 - (2) At least one contact by the child's service coordinator or CSE/CPSE/MDT, in person or by telephone with the child or the child's parent or other responsible individual, on the child's behalf, relating to the development of the initial IEP or AP.
- b. The covered services include convening and conducting the CSE/CPSE/MDT conference to develop an initial IEP or AP. The conference will result in all of the following:
 - (1) A statement of the child's special education needs, and/or related services needs or accommodation needs and services, including the need for medical, physical, mental health, social, financial assistance, counseling, and other support services;
 - (2) A statement of measurable annual goals and measurable short-term objectives for the child;
 - (3) A statement of the specific special education and related services to be provided to the child;

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- (4) The projected dates for initiation of services and the anticipated duration of service;
 - (5) Appropriate objective criteria and evaluation procedures for determining, on at least an annual basis, whether the objectives set forth in the IEP or AP are being achieved; and
 - (6) Parental notification of the recommendation.
- d. Administrative, directive, supervisory, and monitoring services are included as part of the service.

2. Triennial Evaluation – IEP

- a. A triennial evaluation may occur every three years to provide current assessment information on children in special education pursuant to IDEA. A unit of service is defined as:
- (1) The activities leading up to a recommendation based on an appropriate reexamination of each child with a disability by a physician, a school psychologist, and to the extent required by the CSE, by other qualified appropriate professionals; and
 - (2) At least one contact by the child's service coordinator or CSE, in person or by telephone with the child or the child's parent or other responsible individual, on the child's behalf, relating to updating the IEP.
- b. The covered services include convening and conducting the CSE conference to review the results of the triennial evaluation, assessment and revising the IEP, as necessary, that will result in:
- (1) A statement of the child's special education needs and/or related service needs, including the need for medical, mental health, social, financial assistance, counseling, and other support services;
 - (2) A statement of measurable annual goals and measurable short-term objectives for the child;
 - (3) A statement of the specific special education and/or related services to be provided to the child;
 - (4) The projected dates for initiation of services and the anticipated duration of service;

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- (5) Appropriate objective criteria and evaluation procedures for determining, on at least an annual basis, whether the objectives set forth in the IEP or AP are being achieved; and
- (6) Parental notification of the recommendation.
- c. Administrative, directive, supervisory, and monitoring services are included as part of the service.

3. Annual IEP or AP Review

- a. An annual review is required CSE/CPSE/MDT meeting which must occur every year to determine whether the existing IEP or AP, is appropriately meeting the child's needs. A unit of service is defined as follows:
 - (1) A CSE/CPSE/MDT meeting to discuss yearly progress and make recommendations to continue, change or terminate the program, and
 - (2) At least one contact by the child's service coordinator or CSE/CPSE/MDT, in person or by telephone with the child or the child's parent or other responsible individual, on the child's behalf, relating to updating the IEP or AP.
- b. The covered services include convening and conducting the CSE/CPSE/MDT conference to revise the IEP or AP, as necessary, that will result in:
 - (1) A statement of the child's special education needs and/or related service needs or accommodation needs and services, including the need for medical, mental health, social, financial assistance, counseling, and other support services;
 - (2) A statement of measurable annual goals and measurable short-term objectives for the child;
 - (3) A statement of the specific special education and/or related services to be provided to the child;
 - (4) The projected dates for initiation of services and the anticipated duration of service;
 - (5) Appropriate objective criteria and evaluation procedures for determining whether the objectives set forth in the IEP or AP are being achieved; and
 - (6) Parental notification of the recommendation.
- c. Administrative, directive, supervisory, and monitoring services are included as part of the

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service.

4. Requested IEP or AP (Interim) Review

- a. Regulations of the New York State Department of Education require that a child's IEP or AP be reviewed and, if appropriate, revised on an interim basis upon the request of the professionals on the CSE/CPSE/MDT or the request of the child's parent(s) or other responsible individual.
- b. A unit of service for IEP or AP review is defined as:
 - (1) Reconvening the CSE/CPSE/MDT, and
 - (2) At least one contact by the service coordinator or CSE/CPSE/MDT in person or by telephone with the child or the child's parent or other responsible individual, on the child's behalf, relating to review of the IEP or AP.
- c. The covered services include convening and conducting a CSE/CPSE/MDT meeting to review and revise, as necessary, the child's IEP or AP. The meeting will result in a review and parental notification, of the following:
 - (1) The statement of the child's special education needs and/or related service needs or accommodation needs and services, including the need for medical, mental health, social, financial assistance, counseling, and other support services;
 - (2) The statement of measurable annual goals and measurable short-term objectives for the child;
 - (3) The statement of the specific special education and/or related services to be provided to the child;
 - (4) The projected dates for initiation of services and the anticipated duration of service; and
 - (5) The appropriate objective criteria and evaluation procedures to determining whether the objectives set forth in the IEP or AP are being achieved.
- d. Administrative, directive, supervisory, and monitoring services are included as part of the service.

5. Ongoing Service Coordination

- a. Ongoing service coordination is rendered subsequent to implementing a child's IEP or AP by the service coordinator employed by or under contract to a school district.

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b. A unit of service for ongoing service coordination includes:

- (1) At least two documented contacts per month by the service coordinator relating to the child's ongoing service coordination, and
- (2) The provision of all other necessary covered services under ongoing service coordination.

c. These services may include:

- (1) Acting as a central point of contact relating to IEP or AP services for a child,
- (2) Maintaining contact with direct service providers and with a child and the child's parent or other responsible individual through home visits, office visits, school visits, telephone calls, and follow-up services as necessary,
- (3) Assisting the child in gaining access to services specified in the IEP or AP, and providing linkage to agreed-upon direct service providers,
- (4) Discussing with direct service providers that the appropriate services are being provided, following up to identify any obstacles to a child's utilization of services, coordinating the service delivery, and performing ongoing reviews to determine whether the services are being delivered in a consolidated fashion as recommended in the IEP or AP and meet the child's current needs,
- (5) Providing a child and a child's parent or other responsible individual with information and direction that will assist them in successfully accessing and using the services recommended in the IEP or AP, and
- (6) Informing a child's parent or other responsible individual of the child's and the family's rights and responsibilities in regard to specific programs and resources recommended in the IEP or AP.

d. Administrative, directive, supervisory, and monitoring services are included as part of the service.

E. Qualifications of Providers of Service Coordination for Children with Disabilities:

1. A provider of Service Coordination for Children with Disabilities shall be a school district within the State that:
 - a. Operates and contracts for programs with special education and/or related services/accommodations for children with disabilities, in accordance with Article 89 of Education Law, Section 504 of the Rehabilitation Act of 1973 and Programs for Students

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with Disabilities. (8 NYCRR 200); and

- b. Is enrolled in MMIS as a SSHSP or PSHSP provider.

F. Qualifications of Service Coordinators:

- 1. An individual recommended as a child's service coordinator shall be:
 - a. Employed by or under contract to a school district;
 - b. Chosen by the CSE/CPSE/MDT, taking into consideration the:
 - (1) Primary disability manifested by the child;
 - (2) Child's needs, and
 - (3) Services recommended in the IEP or AP.
- 2. A service coordinator must be appropriately licensed or certified and could include an audiologist, school counselor, rehabilitation counselor, registered nurse, practical nurse, occupational therapist, physical therapist, psychologist, social worker, speech therapist, speech pathologist, teacher, school administrator, or school supervisor.

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

Reimbursement for the development of the IEP or AP is available even if the child's condition is reviewed and not classified, or the parent, on the child's behalf, does not consent to the recommendation and the services are not provided.

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Supplement 1 to Attachment 3.1-A

**New York
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The New York State Department of Health (NYSDOH) School Supportive Health Services Program (SSHSP) Targeted Case Management (TCM) for Target Group I, which became effective October 3, 1996, will be terminated on July 1, 2010.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York

TARGETED CASE MANAGEMENT SERVICES
For First-time Mothers and Newborns

Target Group: M – First-time Mothers and their Newborn

The primary target group consists of low-income, pregnant women who will be first-time mothers and their newborn children up to each child's second birthday. A woman must be enrolled in the targeted case management program during pregnancy, as early as possible, but no later than twenty-eight weeks gestation.

The goals of this program are to improve pregnancy outcomes by providing comprehensive case management services including: 1) assessment of each woman's need for medical, educational, social and other services; 2) development of a care plan for each woman with goals and activities to help the woman engage in good preventive health practices; and 3) referral, follow-up and assistance in gaining access to needed services including obtaining prenatal care, improving diets, reducing use of cigarettes, alcohol and illegal substances, improving each child's health and development and reducing quickly recurring and unintended pregnancies.

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

___ Entire State.

X Only in the following geographic areas (authority of section 1915(g)(1) of the-Act is invoked to provide services less than Statewide:

New York City, Monroe, Albany, Erie, Cayuga, Chautauqua, Nassau, Niagara, Chemung, Westchester, and Onondaga Counties

TN # 16-0021

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Comparability of Services (Sections 1902(a)(10)(B) and 1915(g)(1))

- [] Services are provided in accordance with Section 1902(a)(10)(B) of the Act.
- [X] Services are not comparable in amount, duration, and scope. (Section 1915(g)(1)). By enrolling in this targeted case management program, first-time mothers and their newborns will be receiving comprehensive case management services that are not comparable to the amount, duration and scope of services provided to all Medicaid eligible pregnant women.

Definition of Services (42 CFR 440.169):

Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. This targeted case management program for first-time mothers and their newborns offers a comprehensive set of case management services through home visits by trained registered nurses. Case management services provided include the following:

1. Comprehensive assessment and period reassessment of the first-time pregnant woman and her newborn to determine the need for medical, educational, social or other services. These assessment activities include:

- a) taking the woman's history and assessing her risk for poor birth outcomes;
- b) identifying the needs of the first-time mother and her newborn and completing related documentation; gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment.

2. Development (and periodic revision) of a specific care plan.

A care plan will be developed based on the comprehensive assessment conducted of the first-time mother. A written care plan must be completed by the case manager within 30 days of the date of the woman's referral to the targeted case management program and must include, but not be limited to, the following activities:

- i. identification of the nature, amount, frequency and duration and cost of the case management services required by a particular recipient;
- ii. Selection of the long-term and short-term goals to be achieved through the case management process;

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- iii. Specification of the long-term and short-term goals to be achieved through the case management process;
- iv. Collaboration with health care and other formal and informal service providers, including discharge planners and other case managers as appropriate, through case conferences to encourage exchange of clinical information and to assure:
 - a. the integration of clinical care plans throughout the case management process;
 - b. the continuity of service;
 - c. the avoidance of duplication of services (including case management services) and
 - d. the establishment of a comprehensive case management plan that addresses the medical, social, psychosocial, educational and financial needs of the recipient.

The care plan will state:

- a) goals and actions to address the medical, social, educational, and other services needed by the woman and child;
- b) activities to ensure the active participation of the first-time mother (or the woman's authorized health care decision maker) and others to develop the goals;
- c) a course of action identified to respond to the assessed needs of the first-time mother and child;
- d) an agreed upon schedule for re-evaluating goals and course of action.

The plan will be reviewed and updated by the case manager as required by changes in the recipient's condition or circumstances, but not less frequently than every six (6) months subsequent to the initial plan. Each time the care plan is reviewed, the goals established in the initial plan will either be maintained or revised, and new goals and time frames established.

3. Referral and related activities (such as scheduling appointments for the mother and child) to help the first-time mother and newborn obtain needed services including:

- a.) activities that help link the mother and child with medical, social, educational providers or other program and services in the community that are capable of providing needed services to address identified needs, and achieve goals as specified in the care plan.

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4. **Monitoring and follow-up activities**

Monitoring and follow-up activities may be with the first-time mother, other family members or providers. Home visits and other contacts that are necessary to ensure that the care plan is implemented and adequately addresses the mother and newborn's needs will be conducted as frequently as necessary, or at least bi-weekly to determine whether the following conditions are met:

- services are being furnished in accordance with the care plan;
- services in the care plan are adequate and
- if there are changes in the needs or status of the woman and/or her child, then, necessary adjustments in the care plan and service arrangements with providers are made.

X Case management includes contacts with non-eligible individuals (such as the newborn's father) who are directly related to identifying the needs and care, for the purposes of helping the first-time mother and her child access services; identifying needs and supports to assist the mother and child in obtaining services; providing case managers with useful feedback and altering case managers to changes in the mother or child's needs (42 CFR 440.169(e)).

Qualifications of Providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

1. Provider Agencies

Providers of targeted case management to first-time mothers and their children in the target groups may be public or private agencies and organizations, whether operated on a profit-making or not-for profit basis.

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Case management services may be provided by agencies, facilities, persons and other groups possessing the capability to provide services that are approved by the Commissioner of the New York State Department of Health (DOH), the single state Medicaid agency, based upon an approved proposal submitted to the New York State DOH. Providers may include:

- a) facilities licensed or certified under New York State law or regulation as Licensed Home Care Services Agencies (LHCSA) or Certified Home Health Agencies (CHHA);
- b) a county health department, including the health department of the City of New York;

2. Case Managers

Case managers must have the education, experience, training and/or knowledge in the areas necessary to conduct case management services including: assess the needs and capabilities of the pregnant or parenting woman and her child; develop a care plan based on the assessment; assist the first-time mother/child in obtaining access to medical, social, educational and other services; make referrals to medical, social, educational and other providers; and monitor activities to ensure that the care plan is effectively implemented and addresses the assessed needs. Case managers under this program are required to be registered nurses with BSN degrees; and be licensed as professional nurses with the New York State Department of Education. In limited circumstances, an RN who does not have a BSN degree but is competent in a foreign language may be hired as a case manager in the First-time Mothers/Newborn program to provide TCM services to first-time mothers and their newborns who speak a language other than English (including, but not limited to Spanish, Chinese or Russian). There are specific criteria for this exception:

- The RN must be fluent in English and a foreign language (such as Spanish, Chinese etc.) and should work exclusively with participants who speak that same target language;
- The RN must be enrolled in a Bachelor's degree program in nursing at an accredited institution of higher learning; and
- The RN must sign a memorandum of understanding with the provider agency which stipulates the expected completion date for obtaining the BSN degree. The provider agency will inform the county and the New York State Department of Health when the BSN degree is obtained.

Certification by a nationally-recognized organization, with an evidence-based program in nurse home visits and case management for high risk, first-time mothers and their newborn is preferred.

Case managers in this targeted case management program will meet or exceed the standards set by the single State Medicaid Agency. The case manager must have two years experience in a substantial number of case management activities. Voluntary or part-time experience which can be verified will be accepted on a pro-rata basis.

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The two years of experience may be substituted by:

- a) one year of case management experience and a degree in a health or human services field;
- b) one year case management experience and an additional year of experience in other activities with the target population; or
- c) a bachelor's or master's degree which includes a practical encompassing a substantial number of activities with the target population.

As a single state Medicaid agency, criteria for case managers is stated in Administrative Directive 89 ADM-29 for case management provider entities and case management staff under section D entitled Provider Qualifications and Participation Standards.

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 recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.
- 2. Eligible recipients will have free choice of the providers of other medical care under the plan.

Freedom of Choice Exception (Section 1915(g)(1) and 42 CFR 441.18(b)):

- [] Target group consists of eligible individuals with development disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan;

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- 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 services under the plan does not duplicate payment made to public agencies or private entities under other program authorities for this same purpose.

Case management providers are paid on a unit-of-service basis that does not exceed 15 minutes. A detailed description of the reimbursement methodology identifying the data used to develop the rate is included in Attachment 4.19B.

Case Records (42 CFR.18(a)(7)):

Providers maintain case records that document for all recipients receiving targeted case management services 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 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) The timeline for obtaining needed services; and (viii) A timeline for reevaluation of the plan.

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Limitations

Case Management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in Section 441.169 when the case management activities are an integral and inseparable component of another 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 Section 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)). First-time mothers who are in foster care or under the jurisdiction of the juvenile justice system or the criminal justice system will not be eligible for targeted case management services under this program.

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 Section 1903(c) of the Act. (Sections 1902(a)(25) and 1905(c)).

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