Care/Case Management Model Cover Sheet

Program Name: Developmental Disabilities Program—Targeted Case Management

Population Focus: Individuals with developmental disabilities enrolled in the 0208 1915(c) Waiver or individuals eligible for DDP-administered services who are age 16 years and over residing in the State of Montana. The target group excludes individuals who reside in a Medicaid-certified Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or nursing facility, except for the time-period required to assist in transition to community services.

Program Objectives: 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 (42 CFR 440.169).

Program Description:

Targeted case management includes the following:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;
- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and

- identifies a course of action to respond to the assessed needs of the eligible individual;

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

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

changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

The case manager meets with the individual for a minimum of three face-to-face contacts per year. These meetings focus on reviewing with the individual progress and satisfaction with activities and actions in the plan of care (POC), monitoring for changes of health and/or safety needs, and facilitating any necessary revisions to the POC.

It is the Department's expectation that some of the delivery of Case Management Services will occur in the individual's residence. If the individual chooses not to have the meeting in their residence, the Case Manager and individual must agree on a place to meet.

Case management must comply with the Center for Medicare and Medicaid Services (CMS) approved Targeted Case Management Services State Plan Supplement 1C to Attachment 3.1-A, Service 19c and Supplement 1C to Attachment 3.1B, Service 19c.

Unallowable targeted case management activities include: 1) counseling; 2) coordination of the investigation of any suspected abuse, neglect and/or

exploitation cases; 3) transporting members; and 4) monitoring the member's personal financial status and goals.

Writing or entering case notes for the member's case management file and transportation to and from member or member-related contacts are allowable, but not billable TCM activities.

Federal Statute/Regulation Citation: 42 CFR Part 440.169; 42 CFR Part 441.18

Required Care/Case Management Staff:

A case manager must be employed by the Department's DDP or a case management provider contracting with the DDP. The following requirements are in addition to those contained in rule and statutory provisions generally applicable to Medicaid providers. A targeted case manager must meet the following criteria:

- A bachelor's degree in social work or a related field from an accredited college and one year's experience in human services; or have provided case management services, comparable in scope and responsibility to that provided by case managers, to persons with DD for at least five years; and
- At least one year's experience in the field of DD; or have completed at least 40 hours of training in service delivery to persons with DD under a training plan reviewed by the Department within no more than three months of hire or designation as a case manager.

The following training/knowledge requirements apply:

- Reporting requirements for Adult and Child Protective Services and the DDP Incident Management Policy.
- Knowledge of case management methods, procedures and practices;
- Ability to assess and reassess continuing member need;
- Ability to develop and implement member plan and determine the services most appropriate to meet the assessed need(s);
- Ability to monitor and implement the POC;
- Ability to provide guidance to assist members in utilizing community services effectively and appropriately;
- Ability to promote members' self-determination; and
- Reporting requirements for Adult and Child Protective Services and the DDP Incident Management Policy.

Program Demographics

Monthly member count: 3213 Total: 811 members for State TCM, 2402 for contracted TCM (10/31/2018 Caseload Reports)

Average monthly program cost per member: $85.57 for contracted TCM

Average monthly total benefit cost per population member: Not sure what this is asking for.

Monthly provider count: 2 (State and Contractor)

Average # of members per provider:

775.6 members for State TCM, 2323.8 for contracted TCM (June, July, Aug, Sept, Oct 2018 Caseload Reports)

Average monthly provider program revenue:

$198,847.56 average for contracted provider (June – Oct 2018)

Program Measurements

0208 Comprehensive Waiver TCM Performance Measures:

Number and percent of contracted case management agencies that were in compliance with DDP requirements.

Number and percent of service coordinators who meet training requirements.

Number and percent of plans of care developed by state service coordinators that address individuals' assessed needs, either by the provision of waiver services or other means.

Number and percent of plans of care developed by contracted service coordinators that address individuals' assessed needs, either by the provision of waiver services or other means.

Number and percent of plans of care developed by state service coordinators that address individuals' personal goals, either by the provision of waiver services or other means.

Number and percent of plans of care developed by contracted service coordinators that address individuals' personal goals, either by the provision of

waiver services or other means.

Number and percent of plans of care that have been reviewed and updated at least annually by state service coordinators.

Number and percent of plans of care that have been reviewed and updated at least annually by contracted service coordinators.

Number and percent of plans of care that were reviewed and revised when warranted by changes in individual needs by state service coordinators.

Number and percent of plans of care that were reviewed and revised when warranted by changes in individual needs by contracted service coordinators.

Number and percent of individuals who received the services in their plan of care.

Number and percent of Freedom of Choice forms completed verifying that individuals were afforded choice among qualified providers.

Number and percent of Freedom of Choice forms completed verifying individuals were afforded choice between waiver services and institutional care.

Percent of waiver individuals (or families/legal guardians) who received information on how to report abuse, neglect, exploitation and unexplained death.

Number and percent of members who have an action in the PSP from the follow-up noted on the Healthcare Checklist and Risk Worksheet.