State Plan under Title XIX of the Social Security Act
State/Territory: South Carolina

TARGETED CASE MANAGEMENT SERVICES

Individuals with Sensory Impairments

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

Medicaid eligible non-institutionalized individuals between the ages 0 to 64 year diagnosed as legally blind, visually impaired, deaf, hard of hearing or multi-handicapped by a qualified specialist in the area of vision or hearing.

_**X**_ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 90 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):
_**X**_ Entire State
___ Only in the following geographic areas:

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
_**X**_ Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;
    - Assessments shall be conducted at least every 180 days, but may occur more frequently when significant changes occur or new needs are identified.

- 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;

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- 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 following monitoring requirements must be performed and documented in the record as follows:
        - Face-to-Face with the eligible individual at least once every 180 days to ensure appropriateness of continued services.; and at least one visit in the individual's natural environment to ensure appropriateness of services; and
        - Face-to-face or telephone contact with eligible individual, family member, authorized representative, or provider at least every sixty (60) days to ensure appropriateness, utilization and continued need for services.

__**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))

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Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
TCM Provider Qualifications

The provider agency/entity must have:

- An established system to coordinate services for Medicaid eligible individuals who may be covered under another program which offers components of case management or coordination similar to TCM (i.e., Managed Care, Child Welfare Services, as well as State waiver programs.);
- Demonstrated programmatic and administrative experience in providing comprehensive case management services and the ability and capability to differentiate Targeted Case Management services to be provided to the target group;
- Staff with case management qualifications; and
- Established referral systems, demonstrated linkages, and referral ability with essential social and health service agencies;
- A minimum of three years providing comprehensive case management services to the target group;
- Demonstrated administrative capacity to ensure quality services in accordance with state and federal requirements;
- Complied with all State licensing and practice requirements, under Title 40 of the S.C. Code of Laws, that apply to the service.
- Demonstrated financial management capacity and system that provides documentation of services and costs in accordance with OMB A-87 principles;
- Established system to document and maintain individual case records in accordance with state and federal requirements;
- Demonstrated ability to meet state and federal requirements for documentation, billing and audits;
- Demonstrated ability to evaluate the effectiveness, accessibility, and quality of TCM services on a community-wide basis; and,
- Been recognized as a business or non-profit in good standing by local municipality or the State of South Carolina; and
- Must secure and store all records in-state or within 25 miles of the South Carolina Border.

The Targeted Case Manager Supervisor Qualifications:

- Possess a Bachelor's degree in health or human Services from an accredited college or university and have two years of supervisory experience and two years of case management experience; and
- Be employed by the TCM Provider and not be on any State's or the Office of the Inspector General's Medicaid Exclusion List; and
- Be familiar with the resources for the service community.

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The Targeted Case Manager must at a minimum:

1. Be employed by the TCM enrolled provider and not be on any State's or the Office of the Inspector General's Medicaid Exclusion List;
2. Possess baccalaureate or graduate degree from an accredited college or university in a health or human services field that promotes the physical, psychosocial, and/or vocational well-being of the individual being served and documentation of at least one year of experience working with the target population. The degree must be from an institution that is accredited by a nationally recognized educational accrediting body;
3. Have the ability to access multi-disciplinary staff when needed;
4. Have documented experience, skills, or training in:
    a. Crisis Intervention;
    b. Effective Communication; and,
    c. Cultural diversity and competency.
5. Possess knowledge of community resources; and,
6. Possess a working knowledge of families and/or systems theory.

Freedom of choice (42 CFR 441.18(a)(1):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

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.

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

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

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

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

Case management does not include:

- Activities to clients participating in any waiver program that includes case management services (unless prior authorized);
- Program activities of the agency itself that do not meet the definition of TCM;
- Diagnostic and/or treatment services;
- Restricting or limiting access to services, such as through prior authorization;

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- Activities that are an essential part of Medicaid administration, such as outreach; intake processing, eligibility determination, or claims processing; and,
- Services that are an integral part of another service already reimbursed by Medicaid.