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Targeted Case Management Policy and Implementation Training

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Objectives

- Regulations and Authority
- Definition of Case Management/Targeted Case Management
- Target Groups
- BH Target Groups
- Provider Qualifications
- Covered and Non-Covered Activities
- Documentation Requirements



Regulatory Authority

- Targeted Case Management is under the case management regulation for the federal government
- "Targeted" refers to the ability to target specific populations when delivering the service



Regulatory Authority

- TCM is an optional service for Nevada Medicaid
- Deficit Reduction Act section 6052, effective January 1, 2005 (with an implementation date 90 days later) clarified case management services
- 42 CFR 440.169
- Medicaid Services Manual Chapter 2500
- Billing Manual Provider Type 54



Case Management

- Case management services are services which assist an eligible individual in gaining access to needed medical, social, educational and other supportive services and must include the following components:
 - Case Management Assessment
 - Development of a Person Centered Care Plan
 - Linkage/Referral and Related Activities
 - Monitoring/Follow-Up Activities



Target Groups

- There are nine target groups eligible to receive this service.
 These groups are:
 - Children and adolescents who are Non-Severely Emotionally Disturbed (Non-SED) with a mental illness;
 - Children and adolescents who are Severely Emotionally Disturbed (SED);
 - Adults who are Non- Seriously Mentally III (Non-SMI) with a mental illness;
 - Adults who are Seriously Mentally III (SMI);
 - Persons with intellectual disabilities or related conditions;
 - Developmentally delayed infants and toddlers under age three;
 - Juvenile Parole Population;
 - Juvenile Probation Services (JPS), and
 - Child Protective Services (CPS)



Behavioral Health Target Groups

- This training focuses on the four behavioral health target groups:
 - Non-SED
 - SED
 - Non-SMI
 - SMI



Admission Criteria

- Client has current (within one year) SMI/non-SMI or SED/non-SED determination made by a Qualified Mental Health Professional (QMHP)
- Client requires assistance in obtaining and coordinating medical, educational, social, and/or other support services
- Client has chosen TCM services and services are voluntary
- Client has not been required to participate in other services in order to receive TCM services
- There is no 'conflict of interest' between the case manager and the direct service providers listed on the care plan
- Client resides in the community or is transitioning (within 14 days) from a Residential Treatment Center (RTC) into a community setting



Continuing Stay Criteria

- Documentation reflects ...
 - Continues to meet admission criteria
 - Unmet TCM Needs: Client continues to require assistance in obtaining and/or coordinating medical, educational, social, and/or other support services
 - Progress towards achieving case management goals are identified on the Care Plan



Discharge/Exclusionary Criteria

- Documentation reflects ...
 - No longer meets criteria as Non-SED/SMI or SED/SMI
 - No longer meets admission and continuing stay criteria
 - TCM Care Plan goals have been achieved and there are sufficient supports in place to sustain stability
 - Client or their legal guardian chooses not to participate in the program or is noncompliant
 - Client requires institutional level of care



Provider Qualifications

Bachelor's degree in a health-related field,
Registered Nurse (RN), Master's level professional
(LSCW or LMFT), Advanced Practice Registered
Nurse (APRN) in mental health, psychologist, or
mental health professional who works under the
direct supervision of a person listed above.



TCM Services

- Assessment
- Care Plan Development
- Linkage/Referral
- Monitoring/Follow-Up
- Discharge Planning
- Note: TCM Services may be provided face-to-face or by telephonic means (Tele-TCM).



TCM Assessment

- Assessment and periodic reassessment of an individual needs to determine the need for any medical, educational, social or other services. The assessment activities include the following:
 - Taking client history
 - Identifying the needs of the individual 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 of the eligible recipient



Person-Centered Planning

- Working with a client to establish their goals, actions, and create a TCM Care Plan to respond to their assessed needs
- Individualized approach: Seeing each person as unique
- Seeking personal strengths
- With a client's approval and based on a signed release, working with other sources (i.e., family members, medical providers, therapists, social workers, educators, etc.) to establish goals and actions and create a TC
 Care Plan

Note: Case managers may not authorize or approve any direct delivery or Rehabilitative Mental Health services (e.g., BST, PSR, etc.).



TCM Care Plan

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



Goals and Actions

- Goals
 - Access needed medical, educational, social, and/or other support services
- Actions
 - Steps to achieve goals
 - What barriers exist that may prevent them from reaching their highest level of independent functioning?



Example of Care Plan

- Goal 1: "I want to find a low-cost apartment"
 - Action 1: Linkage/referral to public subsidized housing
 - Action 2: Linkage/referral to DPBH Residential Program
- Goal 2: "I want to get a job"
 - Action 1: Linkage/referral to Workforce Strategies seminar/training
 - Action 2: Linkage/referral and monitor/follow-up to Nevada JobConnect
 - Action 3: Linkage/referral and monitor/follow-up with Voc Rehab



Referral and Linkage

- Referral and Linkage
 - Referring or linking clients to needed medical, educational, social, and/or other support services as identified in the Care Plan.
 - Finding and researching referral sources (what services the organization/agency provides)
 - Referring clients to services and/or agencies (providing name/ contact information of the organization/person)
 - Determining how will the organization and/or individual service benefit the client
 - Phone calls to coordinate services with referral organizations/people
 - Scheduling appointments



Linkage

- The process of linking (connecting) clients to a specific organization and/or individual for a needed TCM service.
- Process is TCM initiated
- Process is more involved
 - e.g., the case manager arranges the first meeting, visit or appointment.
- Warm Handoff: Process of acquainting clients with the organizations and/or individuals you are linking them to.
 - Call (link) the person/organization while the client is with you whenever possible
 - Inform the client about the person and/or organization they are to meet/speak with; make sure to provide written contact information



Referral

- The process of referring clients to a specific organization and/or individual for identified needed TCM services
- Ensure client is able to independently follow through or has supports in place to complete this task
- Process is TCM facilitated but client initiated
 - e.g., Client arranges the first meeting, visit, or appointment



Documentation

- Referral and linkage to needed TCM services identified on the care plan
- Use the following action verbs (in DAP note description):
 - 'Referred John Smith to ...'
 - 'Linked John Smith with ...'



Monitoring and follow-up

 Activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual



Monitor and Follow-Up

 Activities and contacts that are necessary to ensure that the needed service or services meet the desired goals and/or actions in the care plan.

Note: During monitor and follow-up, you may need to contact your client, the referring agency, anyone who helped you with the assessment and/or care plan. Be sure you have signed HIPPA compliant releases.



Documentation

- Monitor and follow-up on the effectiveness of referrals
 - Were goals and actions specified in the plan achieved?
 - Were the client's needs satisfied?
 - Does the care plan require changes?
 - Has the client declined services listed in the care plan?
 - The need for and occurrences of coordination with case managers of other programs.
 - Ensure documented coordination of care with other providers.
- Use the following action verbs (under Description):
 - 'Monitored care plan progress on goals X and X ...'
 - 'Followed-up with XXX ...'



Discharge Planning

- Helps clients transition from TCM services to other services and/or independent functioning
- Begins when you first meet with the client and is ongoing
- Ensures client has access to needed aftercare services
- Includes transition plan: What happens after TCM services end?



Case Management

Lead Case Manager

- Recipients should only have a single case manager.
- Those who fall into multiple target groups need to have the case managers determine who will be able to best serve the recipient and meet their needs.
- Though they may coordinate in needed services, only one provider may bill for the services.



TCM Services Review

- Services are being furnished based on the individual's assessed TCM needs an in accordance with their Care Plan.
- Services in the Care Plan must be adequate to meet the individual's goals.
- Services may change based on the individual's needs or status and include making necessary adjustments in the Care Plan and service arrangements with providers.



General Documentation Requirements

- A case record documentation shall be maintained for each recipient and shall contain the following items:
 - The name of the individual receiving services, the dates of case management services, the name of the provider agency and person chosen by the recipient to provide services.
 - The nature, content and units of case management services received.
 Units, for documentation purposes, are further defined as actual case management activities performed.
 - If paid per unit, document date, time, number of units and activities completed.
 - If paid per monthly cap rate, document date, time and activities completed.
 - Whether the goals specified in the care plan have been achieved.
 - If an individual declines services listed in the care plan, this must be documented in the individual's case record.
 - Timelines for providing services and reassessment.
 - The need for and occurrences of coordination with case managers of other programs.



General Documentation Requirements

 The case manager shall make available to Nevada Medicaid or Medicaid's Quality Improvement Organization (QIO-like vendor), upon request, copies of the medical record, progress notes, care plan, case record or summary documents which reflect the ongoing need for case management services and support any additional services requested.



- Case management services not reimbursable under the Nevada Medicaid Program include, but are not limited to:
 - The actual or direct provision of medical services or treatment. Examples include, but are not limited to:
 - Training in daily living skills;
 - Training in work skills and social skills;
 - Grooming and other personal services;
 - Training in housekeeping, laundry, cooking;
 - Transportation services;
 - Individual, group or family therapy services;
 - Crisis intervention services; and/or
 - Diagnostic testing and assessments.



- Services which go beyond assisting individuals in gaining access to needed services. Examples include, but are not limited to:
 - Paying bills and/or balancing the recipient's checkbook;
 - Completing application forms, paper work, evaluations and reports including applying for Medicaid eligibility;
 - Escorting or transporting recipients to scheduled medical appointments; and/or
 - Providing child care so the recipient can access services.



- Traveling to and from appointments with recipients.
- Traveling to and from appointments (without recipients).
- Case management services provided to recipients between 22 and 64 years of age who are in an Institution for Mental Disease (IMD).
- Using case management codes for billing, when the recipient does not meet the criteria for the target group.
- Recipient Outreach Outreach activities in which a state agency or other provider attempts to contact potential recipients of a service do not constitute case management services.



- The direct delivery of foster care services and therapeutic foster care services. The following activities are not considered to qualify as components of Medicaid case management services:
 - 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 and attendance at court appearances.
 - Home investigations.
 - Providing transportation.
 - Administering foster care subsidies.
 - Making placement arrangements.
 - Training, supervision, compensation for foster care parents.



- If the case manager also provides other services under the plan, the State must ensure that a conflict of interest does not exist that will result in the case manager making self-referrals. Individuals must be free to choose their case management provider from among those that have qualified to participate in Medicaid and are willing to provide the service.
- Services provided as "administrative case management," including Medicaid eligibility determination, intake processing, preadmission screening for inpatient care, utilization review and prior authorization for Medicaid services are not reimbursable.
- Administrative functions for recipients under the Individuals with Disabilities Education Act (IDEA) such as the development of an Individual Education Plan and the implementation and development of an Individual Family Service Plan for Early Intervention Services are not reimbursable as case management services.



Questions?

Contact Us at behavioralhealth@dhcfp.nv.gov



References

- Medicaid Services Manual (MSM), Chapter 2500 (Case Management)
- MSM Addendum
- Division of Public and Behavioral Health Policy, Behavioral Health Outpatient (BHO) Service Coordination, BHO-006