DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Region 10
2201 Sixth Avenue, MS/RX 43
Seattle, Washington 98121

NOV 2 2 2011

Douglas Porter, Director
Health Care Authority
Post Office Box 45502
Olympia, Washington 98504-5502

RE: Washington State Plan Amendment (SPA) Transmittal Number 10-014

Dear Mr. Porter:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of State Plan Amendment (SPA) Transmittal Number 10-014. This amendment implements the Targeted Case Management Program for recipients under age 21 and develops a reimbursement methodology for this population, in compliance with the companion letter issued for Transmittal Number 09-022.

This SPA is approved effective July 1, 2010.

If you have any additional questions or require any further assistance, please contact me, or have your staff contact Maria Garza at (206) 615-2542 or maria.garza@cms.hhs.gov.

Sincerely,

Carol J.C. Peverly
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **10-014**

2. STATE: **Washington**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2010 (P&I)

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2010 $1.37M
b. FFY 2011 $5.5 M

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Supplement 1-D to Attachment 3.1-A pgs. 1 – 4
Attachment 4.19-B pg .28b

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Supplement 1-D to Attachment 3.1-A pgs. 1 – 4
Attachment 4.19-B pg .28b

10. SUBJECT OF AMENDMENT:

Targeted Case Management for Recipients Under Age 21

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Exempt

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Susan N Dreyfus

13. TYPED NAME:
Susan N. Dreyfus

14. TITLE:
Secretary

15. DATE SUBMITTED:
9-22-10

16. RETURN TO:
Ann Myers
Department of Social and Health Services
Medicaid Purchasing Administration
626 8th Ave SE MS: 45504
POB 5504
Olympia, WA 98504-5504

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
SEPTEMBER 22 2010

18. DATE APPROVED:
NOV 2 2 2011

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL 0 1 2010

20. SIGNATURE OF REGIONAL OFFICIAL:
Carol Peverly

21. TYPED NAME:
Carol J.C. Peverly

22. TITLE:
Associate Regional Administrator
Division of Medicaid &
Children's Health

23. REMARKS:

9/22/2010 State authorized pen and ink changes to box 4.

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: WASHINGTON

TARGETED CASE MANAGEMENT SERVICES
[Target Group]

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):
[Describe target group and any subgroups. If any of the following differs among the subgroups, submit a separate State plan amendment describing case management services furnished; qualifications of case management providers; or methodology under which case management providers will be paid.]

All children under age 21 who have been removed, or are at risk of such removal, from his/her home into publicly funded care or supervision due to family crisis or dysfunction; and their caretakers (parents of such children, or persons serving in a parental capacity, excluding paid foster parents). Assistance to caretakers is provided for the direct benefit of the child.

___ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to ____ [insert a number; not to exceed 180] 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: [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.
_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;

  [Specify and justify the frequency of assessments.]
  Case management activities, including assessment, re-assessment, care plan development, and monitoring and revision of care plans, for the individuals identified in the target group will be based upon a Significant Encounters Model. Frequency of case management encounters must be no less than one contact per month. These encounters are identified as face-to-face visits with the child and parent/caretaker; phone calls, as needed during the month, of at least 15 minutes duration if related to linking child or parent/caretaker to needed medical, educational, social or other services. Significant encounters, as needed during the month, may include contact with service providers to ensure adequacy of services and client participation. Following assessment or re-assessment, the resulting plan of care will be recorded in the Individual Service and Safety Plan (ISSP), or other document that details the assessment or re-assessment of the individual's specific needs, a course of action to address those needs, and the progress of the individuals included in the target group relative to their specific plans of care.

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- 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;

  Development and periodic revision of a specific care plan will follow the same guidelines as those specified in the Significant Encounter model above. The progress of the individual with respect to goals identified in his or her care plan will be detailed and recorded in the Individual Service and Safety Plan (ISSP), or other detailed care plan document which specifies goals, actions, client participation and progress. The care plan will be reviewed and, if necessary, revised, no less frequently than every six months, or more frequently if needed.

- 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. [Specify the type of monitoring and justify the frequency of monitoring.]

  Monitoring using the Significant Encounter Model will include face-to-face visits with the child and parent/caretaker at least once per month; phone calls of at least 15 minutes duration, as needed during the month, if related to linking child or parent/caretaker to needed medical, educational, social or other services. This may include contact with service providers, as needed during the month, to ensure adequacy of services and client participation. This frequency (of no less than once per month) is the minimum necessary to monitor the adequacy of the individual's progress with the care plan, the adequacy of the care plan to address the individual's needs, and to determine if any adjustments should be made to the care plan to better serve the individual's needs. The progress of the care plan will be will be recorded in the Individual Service and Safety Plan (ISSP), or an equivalent detailed document.

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_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)):
[Specify provider qualifications that are reasonably related to the population being served and the case management services furnished.]

- *Any public or private entity licensed by the State as a child-placing agency.*
- *Providers will possess, at a minimum, a B.A. in Social Work or a closely allied field, and will have a minimum of one year's experience in working with children and families.*
- *TCM provider agencies: TCM case managers employed by the child-placing agency must meet the following requirements for education and/or experience: possess at least a B. A. in Social Work or a closely allied field from an accredited college or university, and one year of experience in performing case management duties working with children and families.*

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:

[Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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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 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 §441.169 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 §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))

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))

[Specify any additional limitations.]

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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XIII. Targeted Case Management Services (cont)

D. All children under age 21 who have been removed, or are at risk of such removal, from his/her home into publicly funded care or supervision due to family crisis or dysfunction, and their caretakers (parents of such children or persons serving in a parental capacity, excluding paid foster parents). Assistance to caretakers is provided for the direct benefit of the child.

Qualifications for contracted and governmental providers are described in Supplement D to Attachment 3.1-A.

Payments made for targeted case management services will not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

As noted below, state-developed fee schedule rates are not the same for governmental and private providers of the targeted case management services.

Contracted providers: payment is on a fee-for-service basis. The payment for services provided on a fee-for-service basis is based on a rate negotiated by the state Medicaid Agency.

- The Agency's fee schedule rate was set as of Oct. 1, 2009 and is effective for dates of services provided on and after that date. All rates are published on the Agency's fee schedule website at http://www.dshs.wa.gov/ca/partners/contractRates.asp
- The Agency requests providers to bill on a monthly basis using a daily rate. The billing must validate the total number of daily units of service provided during the month.
- Examples of the types of expenditures that are considered in the computation of the fee schedule rate are:
  - ✓ Targeted case management staff salary and other personnel expenses;
  - ✓ Supervisory salary and other personnel expenses in support of TCM services; and
  - ✓ Indirect expenses (general government service charges, worker's compensation, property insurance, etc.)

Governmental providers (state staff): payment is based on the actual statewide expenditures for the service.

- Expenditures include;
  - Targeted case management staff salary and other personnel expenses;
  - Supervisory salary and other personnel expenses in support of TCM services; and
  - Proportional indirect overhead expense.
- Cost for TCM provided by governmental providers (state staff) are accumulated and recognized after expenses are incurred. These costs are accumulated and allocated based on a CMS approved Random Moment Time Study (RMTS). As the cost recognition process is based on an allocation of employee salaries and actual expenditures for overhead expenses, there is no need for any interim payments nor reconciliation.