

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

TARGETED CASE MANAGEMENT SERVICES for Adults with Serious and Persistent
Mental Illness

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

Persons who are age twenty one (21) and older who have a serious and persistent mental illness, including adults with substance use disorders, who also have long-term limitations on their capacity to function in the community resulting solely from their mental illness or substance use disorder.

X Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 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; and,
 - the state reassess the individual's needs every ninety (90) days and at the same time the initial comprehensive assessment and individual plan of care for Targeted Case Management (TCM) services is reassessed in conjunction with the client's quarterly treatment plan progress review, or more often as individual client preference and need indicates.

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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; and,
 - the individual plan of care is reassessed every 90 days, or more often as individual client need indicates.

- ❖ 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.

- ❖ 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;
 - changes in the needs or status of the individual are reflected in the care plan; and,
 - Plan monitoring occurs quarterly (every 90 days), at a minimum, to assess client preferences and progress towards defined goals and to coordinate TCM activities with the client's comprehensive treatment plan.

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)):

Providers of TCM services are required to maintain current working knowledge of community resources, human service agencies, and strong ability to work collaboratively with other agencies. Targeted case managers are part of the client's care team and provide feedback to the team on progress and goals for TCM. TCM does not include the furnishing of direct services to the client.

Targeted Case Management Services may be provided by the following disciplines who are employed by or under contract with a Medicaid-enrolled community mental health or substance abuse treatment center that is certified by the State Mental Health and Substance Abuse Treatment Authority:

- ✓ Physician, Psychologist or Advanced Practice Nurse
- ✓ Licensed or Certified Mental Health or Substance Abuse Professionals to include:
 - Licensed Professional Counselor; Licensed Clinical Social Worker; Licensed Marriage and Family Therapist; Licensed Addictions Therapist; Provisionally licensed mental health or substance abuse practitioner practicing under the supervision of a qualified clinical supervisor as defined by the Mental Health Professions Licensing Board pursuant to Wyoming State Statute;
 - Certified Social Worker (CSW) or a Certified Mental Health Worker (CMHW) who is certified by the Mental Health Professions Licensing Board pursuant to Wyoming State Statute;
 - Certified Addictions Practitioner (CAP) who has received a baccalaureate degree in a human resource discipline or a baccalaureate level equivalency in addiction therapy and is certified by the Mental Health Professions Licensing Board pursuant to Wyoming State Statute; and,
- ✓ Mental Health Assistant (MHA) who has achieved a bachelor's degree in a human relations discipline and who is working under the documented, scheduled supervision of a licensed mental health professional.
- ✓ Certified Peer Specialist (CPS) who has a GED, a high school degree, or a higher degree in a discipline other than human relations, who is working under the documented, scheduled supervision of a licensed mental health professional, and who has completed a course of no less than thirty two (32) contact hours of standard training in addition to completing a Wellness Recovery Action Plan. The CPS must also participate in ongoing training annually to include at least fourteen (14) contact hours of routine training, participation in at least one (1) statewide, regional, or national training/conference with at least ten (10) contact hours of training, and participation in at least three (3) local trainings that each include at least one (1) contact hour related to the advancement of peer specialist proficiencies. The CPS will be further trained in the provision of TCM services.

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- ✓ Registered Nurse (R.N.), licensed in the State of Wyoming; who has at least two years of clinical experience after the awarding of the R.N.

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)):

X 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. This includes State certified community mental health and substance abuse treatment centers.

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.

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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))

The following mental disorders are not included in the definition of chronic mental illness for the purposes of determining client qualification to receive targeted case management services:

- A. A sole diagnosis of mental retardation or other developmental disability.
- B. A sole diagnosis of a substance abuse disorder.
- C. Mental disorders, due to a medical condition, for which supervision is the primary intervention need.

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

TARGETED CASE MANAGEMENT SERVICES

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9))
Individuals eligible for Medicaid who are being determined for eligibility for the Wyoming Adult Developmental Disabilities (DD) Waiver, the Child DD Waiver, Acquired Brain Injury Waiver, Comprehensive Waiver, or Supports Waiver must have collateral information or display characteristics, limitations, and/or behaviors suggesting a diagnosis of a developmental disability or an acquired brain injury to become a client for TCM services and apply for one of the waivers.

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

- 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.
 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;
 - **Assisting the client to get necessary documents such as medical records, assessments, and other collateral information to determine waiver eligibility and eligibility for other resources available to the applicant.**
 - **Completing an annual level of care assessment for submission to the Division,**
 - **Arranging for a single initial psychological/neuropsychological evaluation for a new applicant to determine a diagnosis and clinical eligibility for the waiver.**

- **Arranging for a single initial Inventory for Client and Agency Planning Assessment, which is used to score functional limitations for the waiver, and arranging for one every five years thereafter if the person remains on the wait list for services.**
- ❖ 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,
 - **Develops the TCM plan of care for TCM service authorization.**
 - **Can be used for the development of the initial plan of care once the eligible person receives a funding opportunity for the waiver.**
- ❖ 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
 - **Advocacy: Advocacy on behalf of a specific client for the purpose of accessing needed services. Activities may include making and receiving telephone calls, and the completion of forms, applications and reports which assist the client in accessing needed services.**
 - **Linkage: Working with clients and/or service providers to secure access to needed services. Activities include communication with agencies to arrange for appointments or services following the initial referral process, and preparing clients for these appointments. Contact with hospitalized clients, hospital/institution staff, and/or collaterals in order to facilitate the client's application and entry into waiver services.**
- ❖ 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 planMonitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers

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))

A TCM Provider must have a:

- **Bachelor's degree in one (1) of the following related fields from an accredited college or university and one (1) year work experience in one (1) human services field. Fields include Counseling, Education (*will allow a school year instead of calendar year*), Gerontology, Human Services, Nursing, Psychology, Rehabilitation, Social Work, Sociology, or have a related degree, as approved by the Division.**

OR

- **Master's degree from an accredited college or university in one of the related fields listed above,**

OR

- **Associate's degree in a related field and four (4) years of work experience in a human services field.**

AND

- **Be certified by the Behavioral Health Division as an individual (not an agency)**
- **Obtain an NPI number in their name and submit a Medicaid enrollment application to the BHD.**
- **Keep current CPR and First Aid Certification**
- **Have a clean background check on file with his/her agency**
- **Complete training requirements as specified by the Division**

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

Individuals eligible for Medicaid who are being determined for eligibility for the Wyoming Adult Developmental Disabilities (DD) Waiver, the Child DD Waiver, Acquired Brain Injury Waiver, Comprehensive Waiver, or Supports Waiver must have collateral information or display characteristics, limitations, and/or behaviors suggesting a diagnosis of a developmental disability or an acquired brain injury to become a client for TCM services and apply for one of the waivers.

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))

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

TARGETED CASE MANAGEMENT SERVICES
NURSING FACILITY TRANSITION/DIVISION TARGETED CASE MANAGEMENT SERVICES

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):
Medicaid eligible individuals (consumers) who are residing or waiting to be placed, in a Medicaid certified acute care facility or nursing facility and express an interest in returning to the community rather than reside in a facility and qualify based on the targeted case manager's assessment as a good candidate for community living.

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

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;

Assessment Activities: Required services include screening and referral as well as comprehensive assessment of individual needs. Case managers must obtain and document information from all appropriate sources related to the client's need for services, type of services including amount and duration. The assessment will serve to assist the client, their family and their current facility in determining the appropriate services for the client. The assessment is comprehensive enough to determine a client's needs and preferences for case management and other services in order to

remain in the community. The assessment includes health, housing, daily living financial matters, social and transportation needs.

An initial assessment of all potential consumers is conducted to determine eligibility and needs and may be ongoing, as more information will be gathered regarding the consumer's needs and barriers.

- ❖ 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.

Monitoring/Follow-up: conducted prior to, during, and after a clients has transitioned/diverted to the community which will assist in determining the sufficiency of services and whether changes to the plan are needed. All clients shall have monitoring/follow-up by the by the case manager for a minimum of 3 months and a maximum of 12 months.

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)):

Qualifications of Providers of Targeted Case Management Services:

- ✓ Providers of Targeted Case Management Services may be individual, self-employed case managers, or employers of case managers.
- ✓ Providers must be certified by the state Medicaid agency to have:
 - Demonstrated capacity to provide all core elements of case management services; and
 - One year demonstrated experience in transition the client to the community and locating and engaging services related to transition or diversion; and
 - Sufficient resources to meet the case management service needs of the client(s) including travel to meet clients where they reside; and
 - An administrative capacity to insure quality of services in accordance with state and federal requirements; and
 - An Administrative capacity to provide documentation of services and costs; and
 - An administrative capacity to document and maintain individual case records in accordance with state and federal requirements.
- ✓ Case Mangers must have:
 - A Bachelor degree in social services or related field or equivalent education and/or work experience providing services to clients in a social services program; and
 - Knowledge of available community resources, skills necessary to work with and engage other agencies, and the ability to arrange appropriate service specific to each client.

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.

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))

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

TARGETED CASE MANAGEMENT SERVICES
Children with Serious Emotional Disturbance

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

Children and youth ages four (4) through twenty-one (21) who meet the definition of having a serious emotional disturbance (per Federal Register, volume 58, no. 96, published May 20, 1993, pgs. 29422 through 29425)

X Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to **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;
 - facilitation and support for the youth and their family to gather information from, or, to access a Level of Care evaluation by a licensed mental health professional to obtain a current diagnosis and identify instances where the youth might meet Medicaid criteria for inpatient psychiatric care.
 - The evaluation must be completed annually and signed by a licensed mental health provider.
 - the individual plan of care indicating need for TCM services is updated every (180) days, or, more often if indicated.

- ❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that

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- 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;
 - identifies a course of action to respond to the assessed needs of the eligible individual; and
 - Development of the Individual Plan of Care for TCM.
- ❖ 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
 - based on the information gathered during the comprehensive assessment, provide assistance to the youth and their family to access the most appropriate community-based supports and resources that are for the direct and exclusive benefit of the youth.
- ❖ 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 assist 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 Plan of Care;
 - 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 High Fidelity Wraparound Family Care Coordinator responsible for the plan of care, in collaboration with the individual client and their child and family team, must update the plan of care at least every 180 days.

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)):

Provider of TCM services must comply with state requirements for obtaining initial credentialing as a High Fidelity Wrap Around provider and must recertify their credentials on an annual basis to ensure fidelity with the high fidelity wrap around model. The goal of this model is to facilitate the family's acquisition of skills and knowledge for self-efficacy, youth empowerment to achieve desired outcomes, and assist the family to develop and maintain an effective support system.

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The wraparound “facilitator” (FCC) is the family care coordinator who organizes, convenes, and coordinates this process in conjunction with the youth and their family. Family and youth peer support providers are integral to teams serving youth with behavioral health challenges and their families, and they are distinct from traditional mental health service providers in that they operate out of their personal experience and knowledge.

Every child and family team must include a Family Care Coordinator and participants can choose to include a Family Support Partner and/or a Youth Support Partner on their child and family team. The High Fidelity Wraparound Family Care Coordinator responsible for the plan of care, in collaboration with the youth and their child and family team, develops the goals and activities of TCM.

Family Care Coordinator (FCC)

1. Qualifications:
Bachelor’s degree in a human service area (or related field), or, two years work/personal experience in providing direct services or linking of services for youth experiencing serious emotional disturbance.
2. Skills:
 - a. Well developed interpersonal and relationship building skills;
 - b. Efficient time management and scheduling;
 - c. Small group meeting management skills;
 - d. Public speaking;
 - e. Familiarity with children’s services including child welfare, mental health, substance abuse, juvenile justice, and special education;
 - f. Ability to build trust with clients while recognizing, identifying and maintaining appropriate boundaries;
 - g. Knowledge and understanding of income supplements and entitlements;
 - h. Current knowledge of emotional and behavioral health disorders in children;
 - i. Knowledge and understanding of families’ rights and responsibilities in the mental health system, their rights in education settings, and the IEP process, and knowledge of other child-serving systems;
 - j. Knowledge of the system of care in the child’s community;
 - k. Effective written, oral, and interpersonal communication skills;
 - l. Ability to communicate, comprehend, and perform functions from written and oral instructions;
 - m. Must be organized with the ability to take direction and prioritize tasks;
 - n. Must have ability to maintain confidentiality; and,
 - o. Exhibits mature judgment and emotional stability.
3. Requirements:
 - a. Must be at least 21 years of age;
 - b. Complete all State required training components;
 - c. Posses a valid driver’s license, appropriate automobile insurance, and reliable car;

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- d. Maintain current CPR and First Aid Certification; and,
- e. Complete the High Fidelity Wrap Around credentialing processes as specified by Medicaid.

4. Role and Duties:

FCC's are responsible for implementing the phases and related activities of the HFWA process, advocating for and supporting the child/youth and family, and coordinating the child and family team meetings, documentation, and processes.

The FCC is primarily responsible for the following functions:

- a. Maintaining open lines of communication between all team members;
- b. Initiate and oversee completion of needed assessments and evaluations as identified by the team;
- c. Facilitate the development of the individualized plan;
- d. Locate, arrange, and refer child/youth and family to direct services as identified in the individualized plan; and,
- e. Identifying when objectives in the plan are not being met, or identification of barriers to achieving the objectives of the plans.

Family Support Partner (FSP)

1. Qualifications:

- a. High school diploma or GED equivalent;
- b. Must be a parent or caregiver of a child with behavioral health needs or have two years experience working closely with children with serious emotional/behavioral challenges and their families;
- c. Minimum two years experience in the behavioral health field; and,
- d. Completion of credentialing requirements as specified by Medicaid.

2. Skills:

- a. Knowledge and understanding of income supplements and entitlements;
- b. Ability to build trust with clients while recognizing, identifying and maintaining appropriate boundaries;
- c. Current knowledge of emotional and behavioral health disorders in children;
- d. Knowledge and understanding of families' rights and responsibilities in the mental health system, their rights at school, and the IEP process, and knowledge of other child-serving systems;
- e. Knowledge of the system of care in the community and ability to assist the family in accessing the local system of care; and,
- f. Effective written, oral, and interpersonal communication skills including:
 - i. Ability to communicate, comprehend, and perform functions from written and oral instructions

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- ii. Must be organized, able to take direction and prioritize tasks; and,
 - iii. Must have the ability to maintain confidentiality.
 - g. Exhibits mature judgment and emotional stability.
3. Requirements:
- a. Must be at least 21 years of age;
 - b. Must successfully pass all background screens as required by Medicaid; and,
 - c. Completion of all Medicaid required training components.

4. Roles and Duties:

The FSP is a formal member of the wraparound team whose role is to serve the family, and help them engage and actively participate on the team, and make informed decisions and drive the process. The FSP does not provide clinical services, but rather the unique peer to peer support on their lived experience of raising and/or 2 years of work experience in programs serving populations with a child or youth with emotional, behavioral (including substance use), and mental health challenges.

The FSP should be well versed in the community, continuum of care, and the social contexts affecting wellness. The FSP may function as a mediator, facilitator, or bridge between families and agencies. FSPs ensure each family is heard and that their individual needs are being addressed and met. The FSP communicates with and educates child and family team members on wraparound principles, including family voice and choice, to ensure fidelity to the process.

The FSP service must be provided by a parent/family organization or through direct hire by the Medicaid Provider agency.

Youth Support Partner (YSP)

1. Degree and/or experience:
- a. High school diploma or GED equivalent;
 - b. Must be a youth with behavioral health needs or have experience overcoming various systems and obstacles related to mental and behavioral health;
 - c. Must successfully pass all background screens as required by Medicaid; and,
 - d. Completion of credentialing as specified by Medicaid.
2. Skills:
- a. Interpersonal and relationship building skills;
 - b. Familiarity with children's services including child welfare, mental health, substance abuse, juvenile justice, and special education; and,
 - c. Ability to build trust with clients while recognizing, identifying and maintaining appropriate boundaries.
3. Requirements:
- a. Must be 18-26 years of age; and,
 - b. Complete all Medicaid required training components

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4. Roles and Duties:

YSPs are young adults with personal experience participating in the system of care (mental health, special education, child welfare, juvenile justice) as a youth with behavioral health needs. YSP's may have experience overcoming various systems and obstacles related to seeking and maintaining recovery from their own behavioral health disorders. YSPs have the skills, training, and experience to perform the functions of their role.

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)):

X 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:

FCC's, family peer and youth peer support providers must complete initial and ongoing training and certification as defined by the State as part of the provider credentialing process. Training, credentialing, and supervision must provide and support a basic set of competencies that are necessary to perform the TCM functions with fidelity to the high fidelity wraparound model. Failure to maintain credentials appropriate to the provider's role will result in suspension and/or disenrollment from the Medicaid program.

The high fidelity wraparound approach is a form of intensive care coordination for children with significant mental health conditions. It is a team-based, collaborative process for developing and implementing individualized care plans for children and youth with complex needs and their families. The wraparound "facilitator" (FCC) is the family care coordinator who organizes, convenes, and coordinates this process in conjunction with the youth and their family. Family and youth peer support providers are integral to teams serving youth with behavioral health challenges and their families, and they are distinct from traditional mental health service providers in that they operate out of their personal experience and knowledge.

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))

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Additional Limitations:

While targeted case management services can be used to provide more services beyond those required by an institution's discharge plan to facilitate the person's transition into the community, targeted case management services should not be used to supplement the duties of a covered institution to conduct discharge planning.

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