

**DEPARTMENT OF HEALTH AND SOCIAL SERVICES**  
**DIVISION OF MEDICAID AND MEDICAL ASSISTANCE**  
Statutory Authority: 31 Delaware Code, Section 512 (31 Del.C. §512)

**PROPOSED**

**PUBLIC NOTICE**

**Targeted Case Management for Children and Youth with Serious Emotional Disturbance**

In compliance with the State's Administrative Procedures Act (APA - Title 29, Chapter 101 of the Delaware Code), 42 CFR §447.205, and under the authority of Title 31 of the Delaware Code, Chapter 5, Section 512, Delaware Health and Social Services (DHSS) / Division of Medicaid and Medical Assistance (DMMA) is proposing to amend Title XIX Medicaid State Plan regarding Targeted Case Management (TCM) for Children and Youth with Serious Emotional Disturbance, specifically, *to establish coverage for targeted case management services for children and youth with serious emotional disturbance, mental health or substance use disorder or co-occurring mental health and substance use disorders meeting Department of Services to Children Youth and Their Families (DSCYF), Division of Prevention and Behavioral Health Services (DPBHS) eligibility criteria.*

Any person who wishes to make written suggestions, compilations of data, testimony, briefs or other written materials concerning the proposed new regulations must submit same to, Planning, Policy and Quality Unit, Division of Medicaid and Medical Assistance, 1901 North DuPont Highway, P.O. Box 906, New Castle, Delaware 19720-0906, by email to [Nicole.M.Cunningham@state.de.us](mailto:Nicole.M.Cunningham@state.de.us), or by fax to 302-255-4413 by 4:30 p.m. on December 1, 2017. Please identify in the subject line: Targeted Case Management for Children and Youth with Serious Emotional Disturbance.

The action concerning the determination of whether to adopt the proposed regulation will be based upon the results of Department and Division staff analysis and the consideration of the comments and written materials filed by other interested persons.

**SUMMARY OF PROPOSAL**

The purpose of this notice is to advise the public that Delaware Health and Social Services (DHSS)/Division of Medicaid and Medical Assistance (DMMA) is proposing to amend Title XIX Medicaid State Plan regarding Targeted Case Management (TCM) for Children and Youth with Serious Emotional Disturbance, specifically, *to establish coverage for targeted case management services for children and youth with serious emotional disturbance, mental health or substance use disorder or co-occurring mental health and substance use disorders meeting Department of Services to Children Youth and Their Families (DSCYF), Division of Prevention and Behavioral Health Services (DPBHS) eligibility criteria.*

**Statutory Authority**

- 42 CFR §447.201, *State plan requirements*
- 42 CFR §447.205, *Public notice of changes in statewide methods and standards for setting payment rates*
- 42 CFR §441.18, *Case management services, general provisions*
- 42 CFR §447.205, *Case management services, specific requirements*
- §1902(a)(23) of the Social Security Act, *Freedom of choice of qualified providers*
- §1902(a)(25) of the Social Security Act, *Third party liability*
- §1903(c) of the Social Security Act, *FFP for case management included in an individualized education program or individualized family service plan*
- §1915(g)(1) of the Social Security Act, *location and comparability of case management services*

**Background**

On July 20, 2017 The Centers for Medicare & Medicaid Services approved the Delaware State Plan Amendment (SPA) 16-011 to establish coverage and reimbursement methodologies for targeted case management services for individuals with intellectual disabilities. Case management is defined under section 1915(g)(2) of the Social Security Act (the Act) as "services which will assist individuals, eligible under the plan, in gaining access to needed medical, social, educational, and other services." Case management services are often used to foster the transitioning of a person from institutional care to a more integrated setting or to help maintain a person in the community. There are several ways that case management services may be furnished under the Medicaid program. Home and Community-Based Services (HCBS) Case Management may be furnished as a service under the authority of section 1915(c) when this service is included in an approved HCBS waiver. Persons served under the waiver may receive case management services while they are still institutionalized, for up to 180 consecutive days prior to discharge. This case management service may be provided under the optional Targeted Case Management (TCM) authority of section 1915(g)(2) of the Social Security Act. TCM, defined in

section 1915(g) of the Act, may be furnished as a service to institutionalized persons who are about to leave the institution, to facilitate the process of transition to community services and to enable the person to gain access to needed medical, social, educational and other services in the community. TCM may be furnished during the last 180 consecutive days of a Medicaid eligible person's institutional stay if provided for the purpose of community transition. States may specify a shorter time period or other conditions under which TCM may be provided.

## Summary of Proposal

### *Purpose*

The purpose of this proposed regulation is to add Targeted Case Management (TCM) for Children and Youth with Serious Emotional Disturbance to the Delaware Medicaid State Plan under the authority of §1915(g)(1). Delaware does not currently offer Targeted Case Management to children and youth with serious emotional disturbance under the State Plan.

### *Summary of Proposed Changes*

Effective for services provided on and after October 1, 2017 Delaware Health and Social Services/Division of Medicaid and Medical Assistance (DHSS/DMMA) proposes to amend Title XIX Medicaid State Plan to add Targeted Case Management services for children and youth with serious emotional disturbance.

### *Public Notice*

In accordance with the *federal* public notice requirements established at Section 1902(a)(13)(A) of the Social Security Act and 42 CFR 447.205 and the state public notice requirements of Title 29, Chapter 101 of the Delaware Code, Delaware Health and Social Services (DHSS)/Division of Medicaid and Medical Assistance (DMMA) gives public notice and provides an open comment period for thirty (30) days to allow all stakeholders an opportunity to provide input on the proposed regulation. Comments must be received by 4:30 p.m. on December 1, 2017.

### *Centers for Medicare and Medicaid Services Review and Approval*

The provisions of this state plan amendment (SPA) are subject to approval by the Centers for Medicare and Medicaid Services (CMS). The draft SPA page(s) may undergo further revisions before and after submittal to CMS based upon public comment and/or CMS feedback. The final version may be subject to significant change.

### *Provider Manuals Update*

Also, upon CMS approval, the applicable Delaware Medical Assistance Program (DMAP) Provider Policy Specific Manuals will be updated. Manual updates, revised pages or additions to the provider manual are issued, as required, for new policy, policy clarification, and/or revisions to the DMAP program. Provider billing guidelines or instructions to incorporate any new requirement may also be issued. A newsletter system is utilized to distribute new or revised manual material and to provide any other pertinent information regarding manual updates. DMAP provider manuals and official notices are available on the Delaware Medical Assistance Provider Portal website: <https://medicaid.dhss.delaware.gov/provider>

## Fiscal Impact

No fiscal impact is projected for the Division of Medicaid and Medical Assistance (DMMA). The Division of Prevention and Behavioral Health Services has been providing care coordination services through its division staff, Child and Family Care Coordination, as well as contracting with a provider for high-fidelity wraparound services also called intensive care coordination. Currently, a limited amount of time is reimbursable through the DSCYF Cost Allocation Plan, this will be discontinued and replaced by Targeted Case Management, at which the funds used to employ staff and contract with providers will be redirected to Targeted Case Management.

## AMENDED

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
STATE/TERRITORY: **DELAWARE**

TARGETED CASE MANAGEMENT SERVICES FOR

Children and Youth with Serious Emotional Disturbance, or Co-occurring Mental Health and Substance Use Disorders meeting DPBHS Eligibility Criteria

### A. Target Group:

1. Meets the eligibility criteria for services provided by the Division of Prevention and Behavioral Health Services (DPBHS):

2. Is in a federal eligibility category for Delaware Medical Assistance, which governs the determination of eligibility for Delaware Medical Assistance Program. Services shall be provided to children and adolescents under 18 years of age diagnosed with a serious emotional disturbance, mental health or substance use disorder, or co-occurring mental health and substance use disorders, according to the current Diagnostic and Statistical Manual of the American Psychiatric Association.
3. Meets at least two of the following conditions:
  - a. Is not linked to behavioral health, health insurance, or medical services;
  - b. Lacks basic supports for education, income, shelter, and food;
  - c. Needs care coordination services to obtain and maintain community-based treatment and services; or
  - d. Is receiving services through DPBHS.
4.  Target group includes individuals currently living in the community or individuals transitioning to a community setting. Regarding individuals transitioning, targeted case management services will be made available for up to 60 consecutive days of covered stay in an inpatient medical institution (the Medicaid certified facility in which the recipient is currently residing). The target group does not include individuals between ages 22 and 64 who are serviced in institution for Mental Disease or individuals who are inmates of public institutions (State Medicaid Directors Letter (SMDL), July 25, 2000).

**B. Areas of State in which services will be provided:**

Entire State.

Only in the following geographic areas (authority of section 1915(g)(1) of Act is invoked to provide services less than Statewide:

**C. Comparability of Services:**

Services are provided in accordance with section 1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

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**D. Definition of Services:**

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, which includes responsibility for locating, coordinating and monitoring appropriate services for an individual. Targeted Case Management includes the following:

1. 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 strengths and completing related documentation; and
  - Gathering and reviewing documentation/information from other sources such as family members, medical providers, social workers, and educators (if necessary), need to form a complete and comprehensive assessment of the eligible individual.

The Targeted Case Manager will use a child and youth assessment tool designated by the Department or its designee to:

- To the initial assessment and to reassess at a minimum of every 3 months;
- Record information that may relate to the individual's mental health, social, familial, educational, cultural, medical, and other areas to evaluate the extent and nature of the individual needs and strengths and assist in the development of the Plan of Care (POC); and
- Coordinate and facilitate child and family team meetings (e.g., family members, friends, caretakers, providers, educators, and others, as appropriate) that:
  - Identify a team meeting location that is suitable for the child and family's needs; and

- : Convene at least once every 3 months, or more frequently, as clinically necessary or indicated in the Plan of Care.

2. Development (and periodic revision) of the Plan of Care based on the information obtained through the initial comprehensive assessment that includes the following:

- : Specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible 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 individual.

3. 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, education providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals in the care plan).

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4. Monitoring and follow-up activities, including activities and contacts as necessary to ensure that the Plan of Care is effectively implemented and adequately addresses the needs of the eligible individual and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including regular (at least one annually) 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;
  - : There are changes in the needs or status of the eligible individual are reflected in the Plan of Care. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.
- : Complete a periodic review of the progress that the individual has made on the Plan of Care goals and objective and the appropriateness and effectiveness of services being provided;
- : Provide ongoing follow up on service referrals and monitoring of service provision to ensure that the agreed upon services are provided, meet the individual's needs and goals, and ensure the quality, quantity, and effectiveness of services are appropriate and in accordance with the Plan of Care; and
- : Revise, continue, or terminate of the Plan of Care, if no longer appropriate.

Targeted case management includes contacts with non-eligible individuals who are directly related to identifying the individual's needs and care, for the purposes of helping the eligible individual access services, identify 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)).

E. Qualification of Providers:

A targeted case manager must be employed by DSCYF or a targeted case manager provider agency contracting with DSCYF. A targeted case manager must meet the following criteria:

- : Bachelor's degree or higher in Behavioral or Social Science or related field;
- : Certification in the State of Delaware to provide the service, which includes criminal and professional background checks, and completion of state-required training in wraparound philosophy and policies within six months of employment;
- : Maintain certification through state approved continuing education/professional development annually;
- : Six months experience in case management which includes assessing, planning, developing, implementing, monitoring, and evaluating options and services to meet an individual's needs;

- Six months experience in making recommendations as part of a client's service plan, such as, clinical treatment, counseling, or determining eligibility for health or human services/benefits;

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- Six month experience in interpreting laws, rules, regulations, standards, policies and procedures; and
- Six months experience in narrative report writing.

A highly qualified targeted case manager must be employed by DSCYF or a targeted case manager provider agency contracting with DSCYF. A targeted case manager must meet the following criteria:

- Bachelor's degree, Master's degree preferred, in social work, psychology, counseling, nursing, occupational therapy, vocation rehabilitation, therapeutic recreation, or human resources and two years of experience working with special population groups in a direct care setting or a master's degree in one of the fields listed above;
- Successful completion of the approved wraparound certification training, or be classified as "provisionally certified," which means one must successfully complete the Wraparound Certification training within nine months of beginning to provide case management;
- Maintain wraparound certification status by attending an approved wraparound recertification training at least once every two years;
- Basic knowledge of behavior management techniques;
- Skill in interviewing to gather data and complete needs and strengths assessment in preparation of narratives/ reports, in development of service plans, and in individual and group communication;
- Knowledge of state and federal requirements related to behavioral health; and
- Ability to use community resources.

A Targeted Case Management Provider Agency must have:

- A contract with the State of Delaware with requisite expertise in supporting individuals with serious emotional disturbance, substance use disorder or co-occurring disorder and their families;
- Demonstrated ability to coordinate and link community resources required through at least three years of prior experience;
- At least three years of experience with the targeted group;
- Sufficient staff and/or agreements with community organizations to have the administrative capacity to ensure quality of services in accordance with state and federal requirements;
- A financial management system which provides documentation of services and costs;
- Capacity to document and maintain individual case records in accordance with state and federal requirements;
- Demonstrated ability to assure referrals consistent with section 1902(a)(23), freedom of choice of providers;
- Ability to provide linkage with other case managers to avoid duplication of case management services;
- Ability to determine that the client is included in the target group; and
- Ability to access systems to track the provision of services to the client.

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**F. 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.

G. Freedom of Choice Exception (§ 1915(q)(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.]

The State will limit providers of targeted case management to the Department of Services for Children, Youth and Their Families (DSCYF). DSCYF may sub-contract for this service. This limitation is in compliance with Section 4302.2, paragraph D. of the State Medicaid Manual.

H. 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:

- a. Targeted case management services will not be used to restrict an individual's access to other services under the plan;
- b. Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition of receipt of other Medicaid services on receipt of targeted case management services; and
- c. Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

I. Payment 42 CFR 441.18(a)(4)

Payment for targeted case management services under the Medicaid State Plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

J. Case Records (42 CFR 441.18(a)(7))

Providers maintain case records that document the following for all individuals receiving case management:

- a. The name of the individual;
- b. The dates of targeted case management services;
- c. The name of the provider agency (if relevant) and the person providing the case management service;
- d. The nature, content, and units of the targeted case management services received and whether goals specified in the Plan of Care have been achieved;
- e. Whether the individual has declined in functioning;

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- f. The need for and occurrences of coordination with other case managers;
- g. A timeline for obtaining needed services; and
- h. A timeline for reevaluation of the plan.

K. Limitations

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for services as defined in 440.169 when 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 is not available in expenditures for services as defined in 440.169 when case management activities constitute the direct delivery of underlying medical, education, 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, assessment of adoption placements, recruitment or interviewing of potential foster care parents, serving of legal papers, home investigations, providing transportation, administration of foster care subsidies, or arrangements of placements (42

CFR 441.18(c).

FFP is only available for targeted case management services if there are no other third parties liable to pay for such services, including 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).

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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
STATE/TERRITORY: **DELAWARE**

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Children and Youth with Serious Emotional Disturbance, or Co-occurring Mental Health and Substance Use Disorders meeting DPBHS Eligibility Criteria

Reimbursements for services are based upon a Medicaid fee schedule established by the Delaware Medical Assistance Program (DMAP).

The fee development methodology built fees considering each component of provider costs as outlined below. These reimbursement methodologies produced rates sufficient to enlist enough providers so that services under the State Plan are available to beneficiaries at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act and 42 CFR 447.200, regarding payments and are consistent with economy, efficiency, and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. The Medicaid fee schedule is equal to or less than the maximum allowable under the same Medicare rate, where there is a comparable Medicare rate. Room and board costs are not included in the Medicaid fee schedule.

The fee development methodology will primarily be composed of provider cost modeling, through Delaware provider compensation studies, cost data, and fees from similar State Medicaid programs may be considered, as well. The following list outlines the major components of the cost model to be used in fee development:

- Staffing Assumptions and Staff Wages
- Employee-Related Expenses - Benefits, Employer Taxes (e.g., Federal Insurance Contributions Act (FICA), unemployment, and workers compensation)
- Program-Related Expenses (e.g., supplies)
- Provider Overhead Expenses
- Program Billable Units.

The fee schedule rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units. A unit of service is defined according to Healthcare Common Procedure Coding System (HCPCS) approved code set unless otherwise specified.

Except as otherwise noted in the State Plan, the State-developed fee schedule is the same for both governmental and private individual providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the *Delaware Register of Regulations*.

The Agency's fee schedule rate was set as of July 1, 2016 and is effective for services provided on or after that date. All rates are published on the Delaware Medical Assistance Program (DMAP) website at <http://www.dmap.state.de.us/downloads/feeschedules.html>.

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