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State/Territory Name: Montana

State Plan Amendment (SPA) #: MT-16-0002

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

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: 16-0002

2. STATE: Montana

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
04/01/2016

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:

42 CFR Part 440.169
42 CFR Part 441.18

7. FEDERAL BUDGET IMPACT:

a. FFY 16 (6 months): $ 0
b. FFY 17 (12 months): $ 0
c. FFY 18 (6 months): $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Supplement 1C to Attachment 3.1A
Service 19c, Individuals with Developmental Disabilities Age 16 and Over or Who Reside in a Children's DD Group Home
Pages 1-7 of 7

Supplement 1C to Attachment 3.1B
Service 19c, Individuals with Developmental Disabilities Age 16 and Over or Who Reside in a Children's DD Group Home
Pages 1-7 of 7

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Supplement 1C to Attachment 3.1A
Service 19c, Inviduals with Developmental Disabilities Age 16 and Over or Who Reside in a Children's DD Group Home
Pages 1-8 of 8

Supplement 1C to Attachment 3.1B
Service 19c, Individuals with Developmental Disabilities Age 16 and Over or Who Reside in a Children's DD Group Home
Pages 1-8 of 8

10. SUBJECT OF AMENDMENT:
The purpose of this amendment is to update the TCM DD State Plan language; no longer require the Montana Resource Allocation Tool (MONA) to be updated every 3 years, but only when there are significant changes in needed services; and replace the Cost Recovery Data Sheets (CRDS) with the electronic state-approved data system to record and calculate the units of services delivered for reimbursement.

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:
Single Agency Director Review

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME: Mary E. Dalton

14. TITLE: State Medicaid Director

15. DATE SUBMITTED: 3-30-16

16. RETURN TO:
Montana Department of Public Health and Human Services
Mary E. Dalton
Attn: Mary Eve Kulawik
PO Box 4210
Helena MT 59620

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: March 30, 2016

18. DATE APPROVED: June 16, 2016

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: April 1, 2016

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Mary Marchioni

22. TITLE: Acting ARA, DMCHO

23. REMARKS:

FORM HCFA-179 (07-92)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1961 Stout Street, Room 08-148
Denver, CO 80294

CENTERS FOR MEDICARE & MEDICAID SERVICES

Region VIII

June 16, 2016

Mary Dalton, Medicaid & CHIP Director
Montana Department of Public Health & Human Services
P.O. Box 4210
Helena, MT 59604

Re: SPA MT-16-0002

Dear Ms. Dalton:

We have reviewed the proposed State Plan Amendment (SPA) submitted under transmittal number MT-16-0002. The purpose of this amendment is to update the TCM DD State Plan language; no longer request the Montana Resource Allocation Tool (MONA) to be updated every 3 years, but only when there are significant changes in needed services, and replace the Cost Recovery Data Sheets (CRDS) with the electronic state-approved data system to record and calculate the units of services delivered for reimbursement.

Please be informed that this State Plan Amendment was approved June 16, 2016, with an effective date of April 1, 2016. We are enclosing the summary page and the amended plan page(s).

If you have any questions regarding this SPA please contact Michelle Baldi at (312) 353-0909.

Sincerely,

[redacted]

Mary Marchioni
Acting Associate Regional Administrator
Division for Medicaid & Children's Health Operations

cc: Richard Opper, Department Director
Duane Preshinger
Jo Thompson
Mary Eve Kulawik

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

TARGETED CASE MANAGEMENT SERVICES

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(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.]
Targeted case management (TCM) services are furnished to all eligible Medicaid individuals who have a developmental disability (DD) as defined under state statute and who are either under the age of 16 and reside in a children's DD group home or are ages 16 and older. Services are the same for those who are under the age of 16 and reside in a children's DD group home and for those who are ages 16 and older. This target group does not include individuals who reside in a Medicaid-certified Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or nursing facility, except for the time period required to assist in transition to community services. TCM services are coordinated with, and do not duplicate, activities provided as a part of developmental institutional services and discharge planning activities. The target group does not include individuals who receive case management services under a home and community-based waiver program authorized under Section 1915(c) of the Social Security Act.

_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.

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TARGETED CASE MANAGEMENT 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.]
  The Montana Resource Allocation Tool (MONA) is a web-based assessment of service levels in compliance with the Department's DD Program (DDP) rate reimbursement requirements. The case manager conducts the MONA when an individual is selected from the statewide waiting list for waiver services. The MONA is updated to reflect reassessments as recommended by the Personal Support Plan (PSP) team.

- **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**

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- **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.]**
      The case manager meets with the individual for a minimum of four face-to-face contacts per year.

      Reassessments that the case manager is required to conduct at least annually are: the Consumer Survey; Health Care Checklist and Risk Assessment Worksheet; and person-centered forms associated with completing the PSP document. The case manager and/or provider also complete assessments and reassessments with regard to physical, dental, hearing, vision, living, employment, developmental, educational, social/leisure, among other assessments, as necessary. These requirements are outlined in administrative rule, policy, and/or the procedural manual.

      If an individual is being assisted through a crisis, the case manager convenes the PSP team to discuss appropriate action, which could include: a behavior intervention plan, medical review, additional staff, or other response. If the individual's PSP team consists only of the individual and the case manager, the case manager refers the individual in crisis to an appropriate service provider. If there is suspected abuse, neglect, and/or exploitation of the individual, the case manager immediately reports the incident to: the Department's Adult Protective Services or Child and Family Services Division; appropriate state staff, if applicable; and the appropriate management staff of the service provider, if applicable. When institutional commitment is being sought, the case manager coordinates the provision of the individual's information with the appropriate people.

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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.]
A case manager must be employed by the Department's DDP or a case management provider contracting with the DDP. The following requirements are in addition to those contained in rule and statutory provisions generally applicable to Medicaid providers. A targeted case manager must meet the following criteria:

- *A bachelor's degree in social work or a related field from an accredited college and one year's experience in human services; or have provided case management services, comparable in scope and responsibility to that provided by case managers, to persons with DD for at least five years; and*
- *At least one year's experience in the field of DD; or have completed at least 40 hours of training in service delivery to persons with DD under a training plan reviewed by the Department within no more than three months of hire or designation as a case manager.*

All targeted case managers must participate in a minimum of 20 hours of training specific to the delivery of case management services each year. Ongoing documentation of the qualifications of case managers and completions of mandated training must be maintained by the case manager's employer.

New employee training requirements include completing:

- *Abuse prevention training;*
- *The first available MONA certification training;*
- *The first available PSP plan of care training;*
- *The first available Basic Individual Cost Plan (ICP) training; and*
- *The online "CMS Training for Case Managers-Improving the Quality of Home and Community Based Waiver Services."*

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Annual training requirements include:

- *Abuse prevention;*
- *Self-directed Services;*
- *Waiver Update; and*
- *Other approved advanced trainings.*

Additional provider qualifications include:

- *Case management activities will comply with DDPP policy, guidelines in the current version of the Case Manager Handbook, and current PSP guidelines;*
- *Providers will submit an annual list of: case manager names; FTE level; location; verification that each case manager has complied with requirements; and case managers' case load list, sorted by individuals in DDP services and those only on the DDP 1915 (c) waiver program waiting list for adult services only;*
- *As changes occur, the provider will inform the DDP Regional Manager and verify that each case manager is qualified;*
- *A case manager's maximum average caseload is 35 individuals (prorated for less than full time case managers), unless approved by the Regional Manager;*
- *A case manager supervisor's caseload cannot exceed 18 individuals (prorated for less than full time case manager supervisor), unless approved by the Regional Manager;*
- *Providers must offer the assurance that case managers are available to provide case management services to all eligible individuals in the counties for which they serve;*
- *Agencies that provide case management and other services in the same region will not be allowed to provide case management services to the same individuals who receive other services from that agency;*
- *Providers must offer the assurance that all members receiving services are residents of the State of Montana and present within the State when receiving services;*
- *A system for handling member grievances is in place;*
- *Protection of the confidentiality of client records must be evident; and*
- *Units of services delivered for reimbursement are recorded and calculated in an electronic state-approved data system.*

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.**

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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: [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.]**
Montana TCM services are provided by the Department's DDP and contracted non-governmental case management entities that specialize in providing services to individuals with DD. The non-governmental case management entity is contractually required to provide case management services in all small-town and rural areas in Montana, where historical experience has shown it is difficult for the Department's DDP to adequately staff case managers. The State assures all case managers are adequately trained to provide consistency in delivering TCM 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

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management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

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

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

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

[Specify any additional limitations.]
Unallowable targeted case management activities include: 1) counseling; 2) coordination of the investigation of any suspected abuse, neglect and/or exploitation cases; 3) transporting members; and 4) monitoring the member's personal financial status and goals.

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

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TARGETED CASE MANAGEMENT SERVICES

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(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.]
Targeted case management (TCM) services are furnished to all eligible Medicaid individuals who have a developmental disability (DD) as defined under state statute and who are either under the age of 16 and reside in a children's DD group home or are ages 16 and older. Services are the same for those who are under the age of 16 and reside in a children's DD group home and for those who are ages 16 and older. This target group does not include individuals who reside in a Medicaid-certified Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or nursing facility, except for the time period required to assist in transition to community services. TCM services are coordinated with, and do not duplicate, activities provided as a part of developmental institutional services and discharge planning activities. The target group does not include individuals who receive case management services under a home and community-based waiver program authorized under Section 1915(c) of the Social Security Act.

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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.

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TARGETED CASE MANAGEMENT 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.]
  The Montana Resource Allocation Tool (MONA) is a web-based assessment of service levels in compliance with the Department's DD Program (DDP) rate reimbursement requirements. The case manager conducts the MONA when an individual is selected from the statewide waiting list for waiver services. The MONA is updated to reflect reassessments as recommended by the Personal Support Plan (PSP) team.

- **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**

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- **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.]**
      The case manager meets with the individual for a minimum of four face-to-face contacts per year.

      Reassessments that the case manager is required to conduct at least annually are: the Consumer Survey; Health Care Checklist and Risk Assessment Worksheet; and person-centered forms associated with completing the PSP document. The case manager and/or provider also complete assessments and reassessments with regard to physical, dental, hearing, vision, living, employment, developmental, educational, social/leisure, among other assessments, as necessary. These requirements are outlined in administrative rule, policy, and/or the procedural manual.

      If an individual is being assisted through a crisis, the case manager convenes the PSP team to discuss appropriate action, which could include: a behavior intervention plan, medical review, additional staff, or other response. If the individual's PSP team consists only of the individual and the case manager, the case manager refers the individual in crisis to an appropriate service provider. If there is suspected abuse, neglect, and/or exploitation of the individual, the case manager immediately reports the incident to: the Department's Adult Protective Services or Child and Family Services Division; appropriate state staff, if applicable; and the appropriate management staff of the service provider, if applicable. When institutional commitment is being sought, the case manager coordinates the provision of the individual's information with the appropriate people.

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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.]
A case manager must be employed by the Department's DDP or a case management provider contracting with the DDP. The following requirements are in addition to those contained in rule and statutory provisions generally applicable to Medicaid providers. A targeted case manager must meet the following criteria:

- *A bachelor's degree in social work or a related field from an accredited college and one year's experience in human services; or have provided case management services, comparable in scope and responsibility to that provided by case managers, to persons with DD for at least five years; and*
- *At least one year's experience in the field of DD; or have completed at least 40 hours of training in service delivery to persons with DD under a training plan reviewed by the Department within no more than three months of hire or designation as a case manager.*

All targeted case managers must participate in a minimum of 20 hours of training specific to the delivery of case management services each year. Ongoing documentation of the qualifications of case managers and completions of mandated training must be maintained by the case manager's employer.

New employee training requirements include completing:

- *Abuse prevention training;*
- *The first available MONA certification training;*
- *The first available PSP plan of care training;*
- *The first available Basic Individual Cost Plan (ICP) training; and*
- *The online "CMS Training for Case Managers-Improving the Quality of Home and Community Based Waiver Services."*

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Annual training requirements include:

- *Abuse prevention;*
- *Self-directed Services;*
- *Waiver Update; and*
- *Other approved advanced trainings.*

Additional provider qualifications include:

- *Case management activities will comply with DDPP policy, guidelines in the current version of the Case Manager Handbook, and current PSP guidelines;*
- *Providers will submit an annual list of: case manager names; FTE level; location; verification that each case manager has complied with requirements; and case managers' case load list, sorted by individuals in DDP services and those only on the DDP 1915 (c) waiver program waiting list for adult services only;*
- *As changes occur, the provider will inform the DDP Regional Manager and verify that each case manager is qualified;*
- *A case manager's maximum average caseload is 35 individuals (prorated for less than full time case managers), unless approved by the Regional Manager;*
- *A case manager supervisor's caseload cannot exceed 18 individuals (prorated for less than full time case manager supervisor), unless approved by the Regional Manager;*
- *Providers must offer the assurance that case managers are available to provide case management services to all eligible individuals in the counties for which they serve;*
- *Agencies that provide case management and other services in the same region will not be allowed to provide case management services to the same individuals who receive other services from that agency;*
- *Providers must offer the assurance that all members receiving services are residents of the State of Montana and present within the State when receiving services;*
- *A system for handling member grievances is in place;*
- *Protection of the confidentiality of client records must be evident; and*
- *Units of services delivered for reimbursement are recorded and calculated in an electronic state-approved data system.*

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.**

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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: [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.]**
Montana TCM services are provided by the Department's DDP and contracted non-governmental case management entities that specialize in providing services to individuals with DD. The non-governmental case management entity is contractually required to provide case management services in all small-town and rural areas in Montana, where historical experience has shown it is difficult for the Department's DDP to adequately staff case managers. The State assures all case managers are adequately trained to provide consistency in delivering TCM 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 §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))

[Specify any additional limitations.]
Unallowable targeted case management activities include: 1) counseling; 2) coordination of the investigation of any suspected abuse, neglect and/or exploitation cases; 3) transporting members; and 4) monitoring the member's personal financial status and goals.

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