Supports Coordination/Targeted Case Management Models

Targeted Case Management (T1017)

- Provided to SMI, DD (Non-HSW), Co-Occurring and SED consumers
- Complex case with intense/multiple service needs
- Must have medical necessity for and be receiving **ALL** of the TCM service elements as follows:
  - Assessment
  - Planning
  - Linking
  - Advocacy
  - Coordination
  - Monitoring
- TCM expected on a short-term basis with transition to B3 Support and Service Coordination as medically necessary
- All services must be provided by the Case Manager

B3 Support and Service Coordination (T1016)

- Provided to SMI, DD (Non-HSW), Co-occurring or SED consumer
- Less intense case with single or multiple service needs
- Must meet medical necessity and be receiving any combination of **one or more** of the service elements as follows:
  - Assessment
  - Planning
  - Linking
  - Advocacy
  - Coordination
  - Monitoring
- May be expected long-term to monitor and maintain stability
- May use Assistants and brokers for service provision

Supports Coordination – HSW (T1016)

- DD HSW enrolled consumers only
- Intensity level equivalent to Targeted Case Management
- Must meet medical necessity for and be receiving **ALL** of the service elements as follows:
  - Assessment
  - Planning
  - Linking
  - Advocacy
  - Coordination
  - Monitoring
- Typically long-term considering the ongoing needs associated with HSW population
- May use assistants and brokers for service provision

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SECTION 13 – TARGETED CASE MANAGEMENT

Targeted case management is a covered service that assists beneficiaries to design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Services include assessment, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports developed through the person-centered planning process. Targeted case management is provided in a responsive, coordinated, effective and efficient manner focusing on process and outcomes.

Targeted case management services must be available for all children with serious emotional disturbance, adults with serious mental illness, persons with a developmental disability, and those with co-occurring substance use disorders who have multiple service needs, have a high level of vulnerability, require access to a continuum of mental health services from the PIHP, and/or are unable to independently access and sustain involvement with needed services.

Beneficiaries must be provided choice of available, qualified case management staff upon initial assignment and on an ongoing basis.

13.1 PROVIDER QUALIFICATIONS

Providers must demonstrate the capacity to provide all core requirements specified below and have a sufficient number of staff to meet the needs of the target population.

Providers must document initial and ongoing training for case managers related to the core requirements and applicable to the target population served.

Caseload size and composition must be realistic for the case manager to complete the core requirements as identified in the individual plan of service developed through the person-centered planning process.

13.2 DETERMINATION OF NEED

The determination of the need for case management must occur at the completion of the intake process and through the person-centered planning process for beneficiaries receiving services and supports. Justification as to whether case management is needed or not must be documented in the beneficiary's record.

13.3 CORE REQUIREMENTS

- Assuring that the person-centered planning process takes place and that it results in the individual plan of service.
- Assuring that the plan of service identifies what services and supports will be provided, who will provide them, and how the case manager will monitor (i.e., interval of face-to-face contacts) the services and supports identified under each goal and objective.
- Overseeing implementation of the individual plan of service, including supporting the beneficiary's dreams, goals, and desires for optimizing independence; promoting recovery; and assisting in the development and maintenance of natural supports.

SECTION 13 – TARGETED CASE MANAGEMENT continued

- Assuring the participation of the beneficiary on an ongoing basis in discussions of his plans, goals, and status.
- Identifying and addressing gaps in service provision.
- Coordinating the beneficiary's services and supports with all providers, making referrals, and advocating for the beneficiary.
- Assisting the beneficiary to access programs that provide financial, medical, and other assistance such as Home Help and Transportation services.
- Assuring coordination with the beneficiary's primary and other health care providers to assure continuity of care.
- Coordinating and assisting the beneficiary in crisis intervention and discharge planning, including community supports after hospitalization.
- Facilitating the transition (e.g., from inpatient to community services, school to work, dependent to independent living) process, including arrangements for follow-up services.
- Assisting beneficiaries with crisis planning.
- Identifying the process for after-hours contact.

Assessment	The provider must have the capacity to perform an initial written comprehensive assessment addressing the beneficiary's needs/wants, barriers to needs/wants, supports to address barriers, and health and welfare issues. Assessments must be updated when there is significant change in the condition or circumstances of the beneficiary. The individual plan of services must also reflect such changes.
Documentation	The beneficiary's record must contain sufficient information to document the provision of case management, including the nature of the service, the date, and the location of contacts between the case manager and the beneficiary, including whether the contacts were face-to-face. The frequency of face-to-face contacts must be dependent on the intensity of the beneficiary's needs. The case manager must review services at intervals defined in the individual plan of service. The plan shall be kept current and modified when indicated (reflecting the intensity of the beneficiary's health and welfare needs). A beneficiary or his/her guardian or authorized representative may request and review the plan at any time. A formal review of the plan shall not occur less often than annually to review progress toward goals and objectives and to assess beneficiary satisfaction.
Monitoring	The case manager must determine, on an ongoing basis, if the services and supports have been delivered, and if they are adequate to meet the needs/wants of the beneficiary. Frequency and scope (face-to-face and telephone) of case management monitoring activities must reflect the intensity of the beneficiary's health and welfare needs identified in the individual plan of services.

Targeted case management may not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services.

13.4 STAFF QUALIFICATIONS

A primary case manager must be a qualified mental health or mental retardation professional (QMHP or QMRP); or if the case manager has only a bachelor's degree but without the specialized training or experience they must be supervised by a QMHP or QMRP who does possess the training or experience. Services to a child with serious emotional disturbance must be provided by a QMHP who is also a child mental health professional. Services to children with developmental disabilities must be provided by a QMRP.

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SECTION 17 – ADDITIONAL MENTAL HEALTH SERVICES (B3S)

17.3.L. SUPPORT AND SERVICE COORDINATION

Functions performed by a supports coordinator, supports coordinator assistant, services and supports broker, or otherwise designated representative of the PIHP that **include** assessing the need for support and service coordination, and assurance of the following:

- Planning and/or facilitating planning using person-centered principles
- Developing an individual plan of service using the person-centered planning process
- Linking to, coordinating with, follow-up of, advocacy with, and/or monitoring of Specialty Services and Supports and other community services/supports.
- Brokering of providers of services/supports
- Assistance with access to entitlements and/or legal representation
- Coordination with the Medicaid Health Plan, Medicaid fee-for-service, or other health care providers.

The role of the supports coordinator **assistant** is to perform the functions listed above, as they are needed, in lieu of a supports coordinator or case manager. A beneficiary would have only one of the three possible options: targeted case manager, supports coordinator, or supports coordinator assistant. When a supports coordinator assistant is used, a qualified supports coordinator or targeted case manager must supervise the assistant. The role and qualifications of the targeted case manager are described in the Targeted Case Management section of this chapter.

A services and supports broker is used to explore the availability of community services and supports, housing, and employment and then to make the necessary arrangement to link the beneficiary with those supports. The role of the supports coordinator or supports coordinator assistant when a services and supports broker is used is to perform the remainder of the functions listed above as they are needed, and to assure that brokering of providers of services and supports is performed.

Whenever independent services and supports brokers provide any of the supports coordination functions, it is expected that the beneficiary will also have a supports coordinator or case manager, or their assistant, employed by the PIHP or its provider network who assures that the other functions above are in place.

If a beneficiary has both a supports coordinator or supports coordinator assistant AND a services and supports broker, the individual plan of service must clearly identify the staff who is responsible for each function. The PIHP must assure that it is not paying for the supports coordinator (or supports coordinator assistant) and the services and supports broker to perform service brokering. Likewise, when a supports coordinator (or supports coordinator assistant) facilitates a person-centered planning meeting, it is expected that the PIHP would not "double count" the time of any services and supports broker who also attends. During its annual on-site visits, the MDCH will review individual plans of service to verify that there is no duplication of service provision when both a supports coordinator assistant and a services and supports broker are assigned supports coordination responsibilities in a beneficiary's plan of service.

Supports strategies will incorporate the principles of empowerment, community inclusion, health and safety assurances, and the use of natural supports. Supports coordinators will work closely with the beneficiary to assure his ongoing satisfaction with the process and outcomes of the supports, services, and available resources.

Supports coordination is reported only as a face-to-face contact with the beneficiary; however, the function includes not only the face-to-face contact but also related activities that assure:

- The desires and needs of the beneficiary are determined

- The supports and services desired and needed by the beneficiary are identified and implemented
- Housing and employment issues are addressed
- Social networks are developed
- Appointments and meetings are scheduled
- Person-centered planning is provided, and independent facilitation of person-centered planning is made available
- Natural and community supports are used
- The quality of the supports and services, as well as the health and safety of the beneficiary, are monitored
- Income/benefits are maximized
- Activities are documented
- Plans of supports/services are reviewed at such intervals as are indicated during planning

While supports coordination as part of the overall plan implementation and/or facilitation may include initiation of other coverage and/or short-term provision of supports, it may not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services.

The supports coordination functions to be performed and the frequency of face-to-face and other contacts are specified in the beneficiary's plan. The frequency and scope of supports coordination contacts must take into consideration the health and safety needs of the individual.

Qualifications of Supports Coordinators	A minimum of a Bachelor's degree in a human services field and one year of experience working with people with developmental disabilities if supporting that population; or a Bachelor's degree in a human services field and one year of experience with people with mental illness if supporting that population.
Qualifications of Supports Coordinator Assistants and Services and Supports Brokers	Minimum of a high school diploma and equivalent experience (i.e., possesses knowledge, skills and abilities similar to supports coordinator qualifications) and functions under the supervision of a qualified supports coordinator. Independent services and supports brokers must meet these qualifications and function under the guidance and oversight of a qualified supports coordinator or case manager.

SECTION 15 – HABILITATION SUPPORTS WAIVER FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

Beneficiaries with developmental disabilities may be enrolled in Michigan's Habilitation Supports Waiver (HSW) and receive the supports and services as defined in this section. HSW beneficiaries may also receive other Medicaid state plan or additional/B3 services. A HSW beneficiary must receive at least one HSW service per month in order to retain eligibility. Medical necessity criteria should be used in determining the amount, duration, and scope of services and supports to be used. The beneficiary's services and supports that are to be provided under the auspices of the PIHP must be specified in his individual plan of services developed through the person-centered planning process.

HSW beneficiaries must be enrolled through the MDCH enrollment process completed by the PIHP. The enrollment process must include annual verification that the beneficiary:

- Has a developmental disability (as defined by Michigan law);

- Is Medicaid-eligible;
- Is residing in a community setting;
- If not for HSW services, would require ICF/MR level of care services; and
- Chooses to participate in the HSW in lieu of ICF/MR services

The enrollment process also includes confirmation of changes in the beneficiary's enrollment status, including termination from the waiver, changes of residence requiring transfer of the waiver to another PIHP, and death. Termination from the HSW may occur when the beneficiary no longer meets one or more of the eligibility criteria specified above as determined by the PIHP, or does not receive at least one HSW service per month, or withdraws from the program voluntarily, or dies. Instructions for beneficiary enrollments and annual re-certification may be obtained from the MDCH Bureau of Community Mental Health Services. (Refer to the Directory Appendix for contact information.)

The PIHP shall use value purchasing for HSW services and supports. The PIHP shall assist beneficiaries to examine their first- and third-party resources to pursue all reimbursements to which they may be entitled, and to make use of other community resources for non-PIHP covered activities, supports or services.

Reimbursement for services rendered under the HSW is included in the PIHP capitation rate.

15.1 WAIVER SUPPORTS AND SERVICES

Supports Coordination	Supports coordination involves working with the waiver beneficiary and others that are identified by the beneficiary, such as family member(s), in developing a written individual plan of services (IPOS) through the person-centered planning process. Functions performed by a supports coordinator, coordinator assistant, or supports broker include an assurance of the following: • Planning and/or facilitating planning using person-centered principles. • Developing an IPOS using the person-centered planning process. • Linking to, coordinating with, follow-up of, advocacy with, and/or monitoring of Habilitation Supports Waiver, other mental health services and community services/supports. • Brokering of providers of services/supports • Assistance with access to entitlements and/or legal representation. • Coordination with the Medicaid Health Plan, Medicaid fee-for-service, or other healthcare providers. The role of the supports coordinator assistant is to perform the functions listed above, as they are needed, in lieu of a supports coordinator. When a supports coordinator assistant is used, a qualified supports coordinator must supervise the assistant. The beneficiary may select an independent supports broker to serve as personal agent and perform supports coordination functions. However, parents of a minor-aged beneficiary, spouse or legal guardian of an adult beneficiary may not provide supports broker services to the beneficiary. The primary roles are to assist the beneficiary in making informed decisions about what will work best for him, are consistent with his needs and reflect the beneficiary's circumstances. The supports broker helps the beneficiary explore the availability of community services and supports, housing, and employment and then makes the necessary arrangements to link the beneficiary with those supports. Supports brokerage services offer practical skills training to enable beneficiaries to remain independent, including the provision of information on recruiting/hiring/managing workers, effective communication and problem solving. Whenever independent supports brokers perform any of the supports coordination functions, it is expected that the beneficiary will also have a supports coordinator or supports coordinator assistant employed by the PIHP or its provider network that assures the other functions above are in place, and that the functions assigned to the supports broker are being performed. The IPOS must clearly identify which functions are the responsibility of the supports coordinator, the supports coordinator assistant and the supports broker. The independent supports broker must work under the supervision of a qualified supports coordinator.

The PIHP must assure that it is not paying for the supports coordinator or supports coordinator assistant and the supports broker to perform the same function. Likewise, when a supports coordinator or supports coordinator assistant facilitates a person-centered planning meeting, it is expected that the PIHP would not "double count" the time of any supports broker who also attends. During its on-site visits, MDCH will review the IPOS to verify that there is no duplication of service provision when both a supports coordinator or supports coordinator assistant and a supports broker are assigned supports coordination responsibilities in a beneficiary's plan of service.

Supports strategies will incorporate the principles of empowerment, community inclusion, health and safety assurances, and the use of natural supports. Support coordinators will work closely with the beneficiary to assure his ongoing satisfaction with the process and outcomes of the supports, services, and available resources.

Supports coordination is reported only as face-to-face contact with the beneficiary; however, the function includes not only the face-to-face contact but also related activities (e.g., making telephone calls to schedule appointments or arrange supports) that assure:

- The desires and needs of the beneficiary are determined.
- The supports and services desired and needed by the beneficiary are identified and implemented.
- Persons chosen by the beneficiary are involved in the planning process.
- Housing and employment issues* are addressed.
- Social networks are developed.
- Appointments and meetings are scheduled.
- Person-centered planning is provided and independent facilitation of person-centered planning is made available.
- Natural and community supports are used.
- The quality of the supports and services, as well as the health and safety of the beneficiary, is monitored.
- Income/benefits are maximized.
- Information is provided to assure the beneficiary (and his representative(s), if applicable) is informed about self-determination.

- Monitoring of individual budgets (when applicable) for over- or under-utilization of funds is provided.
- Activities are documented.
- Plans of supports/services are reviewed at such intervals as are indicated during planning.

Additionally, the supports coordinator coordinates with the qualified mental retardation professional (QMRP) on the process of evaluation and reevaluation of beneficiary level of care (e.g., supply status and update information, summarize input from supports providers, planning committee members, etc.).

While supports coordination as part of the overall plan implementation and/or facilitation may include initiation of other coverages and/or short-term provision of supports, it may not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services.

The supports coordination functions to be performed and the frequency of face-to-face and other contacts are specified in the beneficiary's plan. The frequency and scope of supports coordination contacts must take into consideration health and safety needs of the beneficiary.

* Supports coordination does not include any activities defined as Out-of-Home Non-Vocational Habilitation, Prevocational Services, Supported Employment, or CLS.