

TABLE OF CONTENTS

CHAPTER FORTY

OPTIONAL TARGETED CASE MANAGEMENT

RULE	TITLE	PAGE
560-X-40-.01	Definitions	1
560-X-40-.02	Eligibility	10
560-X-40-.03	Description of Covered Services, Limitations, and Exclusions – General	12
560-X-40-.04	Payment Methodology for Covered Services	13
560-X-40-.05	Third Party Liability	15
560-X-40-.06	Payment Acceptance	15
560-X-40-.07	Confidentiality	16
560-X-40-.08	Records	16

Chapter 40. Optional Targeted Case Management.

Rule No. 560-X-40-.01. Definitions.

(1) Optional Targeted Case Management Services - those services to mentally ill adults (Target Group 1), intellectually disabled adults (Target Group 2), disabled children (Target Group 3), foster children (Target Group 4), pregnant women (Target Group 5), AIDS/HIV-positive individuals (Target Group 6), adult protective service individuals (Target Group 7), and individuals who meet the eligibility criteria for the HCBS Technology Assisted Waiver for Adults (TAW) (Target Group 8), paid for by the Alabama Medicaid Agency to assist Medicaid-eligible persons in gaining access to needed medical, social, educational, and other services.

(2) Case Management Services Target Group 1 - Mentally Ill Adults - the population to be served consists of functionally limited individuals age 18 and over with multiple needs who have been found to require mental health case management. Such persons have a DSM-III-R diagnosis (other than mental retardation or substance abuse), impaired role functioning, and a documented need for access to the continuum of services offered through a Medicaid-enrolled mental health clinic services provider.

(3) Individual Case Managers for Mentally Ill Adults - professionals meeting the following qualifications:

- (a) At a minimum, Bachelor of Arts or a Bachelor of Science degree, preferably in a human services related field, or
- (b) A registered nurse, and
- (c) Training in case management curriculum provided or approved by the Department of Mental Health and the Alabama Medicaid Agency.

(4) Case Management Providers for Mentally Ill Adults - Regional Boards incorporated under Act 310 of the 1967 Alabama Acts and Comprehensive Community Mental Health Centers. Providers must be certified by and provide services through a contract with the Alabama Department of Mental Health.

(5) Case Management Services Target Group 2 - Intellectually Disabled Adults- the population to be served consists of individuals with a diagnosis of mental retardation who are 18 years of age or older. Diagnosis must be determined and must include a primary determination of both intellectual and adaptive behaviors indicating the individual's primary problems are due to mental retardation.

(6) Individual Case Managers for Intellectually Disabled Adults - professionals meeting the following qualifications:

- (a) At a minimum, Bachelor of Arts or Bachelor of Science degree, or
- (b) A registered nurse, and
- (c) Training in case management curriculum approved by the Alabama Medicaid Agency.

(7) Case Management Providers for Intellectually Disabled Adults - Regional Boards incorporated under Act 310 of the 1967 Alabama Acts who have demonstrated ability to provide targeted case management services directly, or the Alabama Department of Mental Health. Providers must be certified by the Department of Mental Health.

(8) Case Management Services Target Group 3 Disabled Children - the population to be served consists of individuals age 0-21 considered to be disabled as defined in the following six subgroups:

(a) Intellectually Disabled/related conditions: (Individuals in this subgroup will be age 0-17.)

1. Intellectually Disabled - diagnosis must be determined and must include a primary determination of both intellectual and adaptive behaviors indicating the individual's primary problems are due to intellectual disability.

2. Related conditions - individuals who have a severe chronic disability that meets all of the following

(i) It is attributable to:

(I) Cerebral palsy or epilepsy; or

(II) Any other condition, other than mental illness, found

to be closely related to intellectual disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of intellectually disabled persons, and requires treatment or services similar to those required for these persons.

(ii) It is manifested before the person reaches age 22.

(iii) It is likely to continue indefinitely.

(iv) It results in substantial functional limitations in three or more of the following areas of major life activity.

(I) Self-care,

(II) Understanding and use of language,

(III) Learning,

(IV) Mobility,

(V) Self-direction,

(VI) Capacity for independent living.

(b) Seriously emotionally disturbed - In order to meet the definition of seriously emotionally disturbed, at least one criterion from Section 1. or 2. and two from Section 3. below must be met:

1. Mental Health Treatment History:

(i) Has undergone mental health treatment more intensive than outpatient care (emergency services, inpatient services, etc.);

(ii) Has experienced structured, supportive residential treatment, other than hospitalization, for a total of at least two months in their lifetime;

(iii) Has been assigned to a program of psychotropic medication;

or

(iv) Has received mental health outpatient care for a period of at least six (6) months, or for more than twenty (20) sessions, or has been admitted for treatment on two or more occasions.

2. Indicators of Mental Health Treatment Needs:
(i) Family history of alcohol or drug abuse,
(ii) Family history of mental health treatment,
(iii) Failure to thrive in infancy or early development indicated in medical records,
(iv) Victim of child abuse, neglect or sexual abuse,
(v) Pervasive or extreme acts of aggression against self, others, or property (homicidal or suicidal gestures, fire setting, vandalism, theft, etc.), or
(vi) Runaway episode(s) of at least twenty-four (24) hours duration.

3. Current Functioning - problem areas of one year duration or substantial risk of over one year duration.
(i) Is not attending school (and has not graduated), is enrolled in a special education curriculum, or has poor grades;
(ii) Dysfunctional relationship with family and/or peers;
(iii) Requires help in basic, age-appropriate living skills;
(iv) Exhibits inappropriate social behavior; or
(v) Experiences serious discomfort from anxiety, depression, irrational fears, and concerns (indicated by serious eating or sleeping disorders, extreme sadness, social isolation, etc.).

(c) Sensory impaired:

1. Blind - One who after the best possible correction has no usable vision; therefore, must rely upon tactile and auditory senses to obtain information.

2. Partially sighted - One who has a visual acuity of 20/70 or less in the better eye with the best possible correction, has a peripheral field so restricted that it affects the child's ability to learn, or has a progressive loss of vision which may in the future affect the child's ability to learn.

3. Deaf - A hearing impairment which is so severe that the child is impaired in processing linguistic information through hearing, with or without amplification which adversely affects educational performance.

4. Blind multi- need - One who has a visual impairment (as defined in (c) 1. and (c) 2. above) and a concomitant handicapping condition.

5. Deaf multi- need - One who has a hearing impairment (as defined in (c) 3. above) and a concomitant handicapping condition.

6. Deaf-blind - One who has concomitant hearing and visual impairments, the combination of sensory impairments causing such severe communication and other developmental and educational problems that they cannot be properly accommodated in the educational programs by the Alabama School for the Blind or the Alabama School for the Deaf.

(d) Disabling health condition(s) - One which is severe, chronic and physical in nature, requiring extensive medical and habilitative/rehabilitative services:

1. Central nervous system dysraphic states, (such as spina bifida, hydranencephaly, encephalocele);

2. Cranio-facial anomalies, (such as cleft lip and palate, Apert's syndrome, Crouzon's syndrome);

3. Pulmonary conditions, (such as cystic fibrosis);

4. Neuro-muscular conditions, (such as cerebral palsy, arthrogryposis, juvenile rheumatoid arthritis);
5. Seizure disorders, (such as those poorly responsive to anticonvulsant therapy and those of mixed seizure type);
6. Hematologic/immunologic disorders, (such as hemophilia, sickle cell disease, aplastic anemia, agammaglobulinemia);
7. Heart conditions, (such as aortic coarctation, transposition of the great vessels);
8. Urologic conditions, (such as extrophy of bladder);
9. Gastrointestinal conditions, (such as Hirschsprung's Disease, omphalocele, gastroschisis);
10. Orthopedic problems, (such as clubfoot, scoliosis, fractures, poliomyelitis);
11. Metabolic disorders, (such as panhypopituitarism);
12. Neoplasms, (such as leukemia, retinoblastoma); and
13. Multisystem genetic disorders, (such as tuberous sclerosis, neurofibromatosis).

(e) Developmentally delayed -

1. A child age birth to three years who is experiencing developmental delays equal to or greater than 25 percent as measured by appropriate diagnostic instruments and procedures in one or more of the following areas:
 - (i) Cognitive development;
 - (ii) Physical development (including vision and hearing);
 - (iii) Language and speech development;
 - (iv) Psychosocial development; and
 - (v) Self-help skills.
2. One who has a diagnosed physical or mental condition which has a high probability of resulting in a development delays.

(f) Multi- need - An individual who has a combination of two or more handicapping conditions as described above. Each condition, if considered separately, might not be severe enough to warrant case management, but a combination of the conditions would be of such severity to adversely affect development.

(9) Individual Case Managers for Disabled Children - Professionals meeting the following qualifications:

- (a) At a minimum, a Bachelor of Arts or a Bachelor of Science degree, or
- (b) A registered nurse, and
- (c) Training in a case management curriculum approved by the Alabama Medicaid Agency.

(10) Case Management Providers for Disabled Children - Providers must meet the following criteria:

- (a) Demonstrated capacity to provide all core elements of case management:
 1. Assessment,
 2. Care/services plan development,

- 3. Linking/coordination of services, and
- 4. Reassessment/follow-up.
- (b) Demonstrated case management experience in coordinating and linking such community resources as required by the target population.
- (c) Demonstrated experience with the target population.
- (d) An administrative capacity to ensure quality of services in accordance with state and federal requirements.
- (e) A financial management system that provides documentation of services and costs.
- (f) Capacity to document and maintain individual case records in accordance with state and federal requirements.
- (g) Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider.
- (h) Demonstrated capacity to meet the case management service needs of the target population.

(11) Case Management Target Group 4 - Foster Children (Children in the Care, Custody or Control of the State or Receiving State Agency) - The population to be served consists of children age 0-21 who are receiving preventive, protective, family preservation or family reunification services from the State, or any of its agencies as a result of State intervention or upon application by the child's parent(s), custodian(s), or guardian(s); or children age 0-21 who are in the care, custody or control of the State of Alabama, or any of its agencies due to:

- (a) The judicial or legally sanctioned determination that the child must be protected by the State as dependent, delinquent, or a child in need of supervision as those terms are defined by the Alabama Juvenile Code, Title 12, Chapter 15, Code of Alabama 1975; or
- (b) The judicial determination or statutorily authorized action by the State to protect the child from actual or potential abuse under the Alabama Juvenile Code, Title 26, Chapter 14, Code of Alabama 1975, or other statute; or
- (c) The voluntary placement agreement, voluntary boarding house agreement, or an agreement for foster care, between the State and the child's parent(s), custodian(s), or guardian.

(12) Individual Case Managers for Foster Children - Professionals meeting the following qualifications:

- (a) At a minimum, a Bachelor of Arts or a Bachelor of Science degree, preferably in a human services field, or
- (b) A registered nurse, and
- (c) Training in a case management curriculum approved by the Alabama Medicaid Agency.

(13) Case Management Providers for Foster Children - Providers must meet the following qualifications:

- (a) Demonstrated capacity to provide all core elements of case management:

1. Assessment,
 2. Care/services plan development,
 3. Linking/coordination of services, and
 4. Reassessment/follow-up.
- (b) Demonstrated case management experience in coordinating and linking such community resources as required by the target population.
- (c) Demonstrated experience with the target population.
- (d) An administrative capacity to ensure quality of services in accordance with state and federal requirements.
- (e) A financial management system that provides documentation of services and costs.
- (f) Capacity to document and maintain individual case records in accordance with state and federal requirements.
- (g) Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider.
- (h) Demonstrated capacity to meet the case management service needs of the target population.

(14) Case Management Target Group 5 - Pregnant Women - The population to be served consists of Medicaid-eligible women of any age in need of maternity services.

(15) Individual Case Managers for Pregnant Women - Professionals meeting the following qualifications:

- (a) At a minimum, a Bachelor of Arts or a Bachelor of Science degree in social work from a school accredited by the Council on Social Work Education, or
- (b) A registered nurse, and
- (c) Training in a case management curriculum approved by the Alabama Medicaid Agency.

(16) Case Management Providers for Pregnant Women - Providers must meet the following qualifications:

- (a) Demonstrated capacity to provide all core elements of case management:
 1. Assessment,
 2. Care/services plan development,
 3. Linking/coordination of services, and
 4. Reassessment/follow-up.
- (b) Demonstrated case management experience in coordinating and linking such community resources as required by the target population.
- (c) Demonstrated experience with the target population.
- (d) An administrative capacity to ensure quality of services in accordance with state and federal requirements.
- (e) A financial management system that provides documentation of services and costs.
- (f) Capacity to document and maintain individual case records in accordance with state and federal requirements.

(g) Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider.

(h) Demonstrated capacity to meet the case management service needs of the target population.

(17) Case Management Target Group 6 - AIDS/HIV-Positive Individuals - The population to be served consists of Medicaid-eligible individuals of any age who have been diagnosed as having AIDS or being HIV-positive as evidenced by laboratory findings.

(18) Individual Case Managers for AIDS/HIV-Positive Individuals - Professionals meeting the following qualifications:

(a) At a minimum, a Bachelor of Arts or a Bachelor of Science degree in social work from a school accredited by the Council on Social Work Education, or

(b) A registered nurse, and

(c) Training in a case management curriculum approved by the Alabama Medicaid Agency.

(19) Case Management Providers for AIDS/HIV-Positive Individuals - Providers must meet the following qualifications:

(a) Demonstrated capacity to provide all core elements of case management:

1. Assessment,
2. Care/services plan development,
3. Linking/coordination of services, and
4. Reassessment/follow-up.

(b) Demonstrated case management experience in coordinating and linking such community resources as required by the target population.

(c) Demonstrated experience with the target population.

(d) An administrative capacity to ensure quality of services in accordance with state and federal requirements.

(e) A financial management system that provides documentation of services and costs.

(f) Capacity to document and maintain individual case records in accordance with state and federal requirements.

(g) Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider.

(h) Demonstrated capacity to meet the case management service needs of the target population.

(20) Case Management Target Group 7 - Adult Protective Service Individuals - The population to be served consists of individuals 18 years of age or older who are:

(a) At risk of abuse, neglect, or exploitation as defined in Section 38-9-2 Code of Alabama, 1975; or

(b) At risk of institutionalization due to his/her inability or his/her caretaker's inability to provide the minimum sufficient level of care in his/her own home.

(21) Individual Case Managers for Adult Protective Service Individuals - Professionals meeting the following qualifications:

- (a) At a minimum, a Bachelor of Science degree, preferably in a human services field, or
- (b) Eligible for state social work licensure or exempt from licensure, and
- (c) Training in a case management curriculum approved by the Alabama Medicaid Agency.

(22) Case Management Providers for Adult Protective Service Individuals - Providers must meet the following qualifications:

- (a) Demonstrated capacity to provide all core elements of case management:
 - 1. Assessment,
 - 2. Care/services plan development,
 - 3. Linking/coordination of services, and
 - 4. Reassessment/follow-up.
- (b) Demonstrated case management experience in coordinating and linking such community resources as required by the target population.
- (c) Demonstrated experience of at least ten years with the target population in investigating abuse, neglect, and/or exploitation in domestic settings and follow-up services to victims of abuse, neglect, and/or exploitation.
- (d) Authorized pursuant to Code of Alabama, 1975, Section 38-9-1 et seq to arrange for protective services for adults.
- (e) An administrative capacity to ensure quality of services in accordance with state and federal requirements.
- (f) A financial management system that provides documentation of services and costs.
- (g) Capacity to document and maintain individual case records in accordance with state and federal requirements.
- (h) Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider.
- (i) Demonstrated capacity to meet the case management service needs of the target population.

(23) Case Management Services Target Group 8 – Individuals who meet the eligibility criteria for the HCBS Technology Assisted Waiver for Adults.

(24) Individual Case Managers for individuals who meet the eligibility criteria for the HCBS Technology Assisted Waiver for Adults – professionals meeting the following qualifications:

- (a) At a minimum, Bachelor of Arts or Bachelor of Science degree, or
- (b) A registered nurse, and
- (c) Training in case management curriculum approved by the Alabama Medicaid Agency.

(25) Case Management Providers for individuals who meet the eligibility criteria for the HCBS Technology Assisted Waiver for Adults – Providers must meet the following criteria:

(a) Demonstrated capacity to provide all core elements of case management:

1. Assessment,
2. Care/services plan development,
3. Linking/coordination of services, and
4. Reassessment/follow up.

(b) Demonstrated case management experience in coordinating and linking such community resources as required by the target population.

(c) Demonstrated experience with the target population.

(d) An administrative capacity to ensure quality of services in accordance with state and federal requirements.

(e) A financial management system that provides documentation of services and costs.

(f) Capacity to document and maintain individual case records in accordance with state and federal requirements.

(g) Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider.

(h) Demonstrated capacity to meet the case management service needs of the target population.

(26) Discriminatory Practices - Any practice prohibited by Title VI of the Civil Rights Act of 1964 (Federal law that prohibits discrimination in supplying services to recipients on the basis of race, color, creed, national origin, age, or sex) or Section 504 of the Rehabilitation Act of 1973 (the Federal law that prohibits discrimination in the supplying of services to recipients on the basis of a handicap). All providers must comply with these requirements to prevent discriminatory practices.

(27) Third Party - any individual, entity or program other than the recipient or his/her responsible party that is, or may be, liable to pay all or part of the cost of injury, disease, or disability of an applicant or recipient of Medicaid.

(28) Fiscal Agent - an agent under contract with Medicaid to receive and adjudicate Medicaid claims.

(29) Medicaid - The Alabama Medicaid Agency.

(30) DMH- The Alabama Department of Mental Health.

(31) CMSP - Case management service provider.

(32) Noninstitutional Provider Agreement - the contract between a CMSP and Medicaid that specifies conditions of participation, funding arrangements, and operating mechanisms.

(33) Individual Plan of Care for All Target Groups - a document developed by the case manager listing the client's needs for service and assistance consistent with Rule No. 560-X-40-.03.

(34) Collateral - the case manager working with the Medicaid-eligible client, immediate family and/or guardians; Federal, State, or local service agencies (or agency representatives); and local businesses.

(35) Medicaid-eligible - persons eligible for Medicaid services under the Alabama State Plan as evidenced by a current, valid, Medicaid card.

(36) Regional 310 Boards - mental health boards established pursuant to Sections 22-55-1 through 22-51-14, Alabama Code, 1975 (Act 310,1967).

(37) Total Care Environments - ICF/MR facilities, ICF/MR 15-bed or less nursing facilities, residential programs, and hospitals.

Author: Latonda Cunningham, Administrator, Long Term Care Division

Statutory Authority: Section 1915 (g), Social Security Act; State Plan for Medical Assistance, Attachment 3.1-A, Supplement 1; OMB NO: 0939-0193.

History: Rule effective July 12, 1988. **Amended:** Effective November 10, 1988; April 17, 1990. **Emergency rule** effective June 1, 1990. **Amended:** Effective October 13, 1990; December 12, 1991; October 13, 1992; January 13, 1993; June 14, 1994; May 11, 1998; February 10, 1999; March 12, 2001; May 16, 2003; September 15, 2003; May 14, 2004. **Amended:** Filed March 13, 2012; Effective April 17, 2012.

Rule No. 560-X-40-.02. Eligibility.

(1) Providers of case management services must meet the following requirements:

(a) CMSP for the mentally ill must be certified by the Department of Mental Health as meeting the qualifications for enrollment as a case management provider under the provision of 560-X-40-.01 (6);

(b) CMSP for intellectually disabled adults must meet the qualifications for enrollment as a case management provider under the provision of 560-X-40-.01(7);

(c) CMSP for disabled children, foster children, pregnant women, and AIDS/HIV-positive individuals, adult protective service individuals, and individuals who meet the eligibility criteria for the HCBS Technology Assisted Waiver (TAW) for Adults must meet the following criteria:

1. Demonstrated capacity to provide all core elements of case management:

- a. Assessment,
- b. Care/services plan development,
- c. Linking/coordination of services, and
- d. Reassessment/follow-up.

2. Demonstrated case management experience in coordinating and linking such community resources as required by the target population.
3. Demonstrated experience with the target population.
4. Administrative capacity to ensure quality of services in accordance with state and federal requirements.
5. A financial management system that provides documentation of services and costs.
6. Capacity to document and maintain individual case records in accordance with state and federal requirements.
7. Demonstrated ability to assure a referral process consistent with Section 1902a(23), freedom of choice of provider.
8. Demonstrated capacity to meet the case management service needs of the target population.

(d) Shall be in full compliance with Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973;

(e) Shall be in full compliance with applicable Federal and State laws and regulations.

(2) Eligibility is limited to:

(a) Medicaid-eligible individuals age 18 and over who have a diagnosis of mental illness as established in Rule No. 560-X-40-.01.

(b) Medicaid-eligible individuals age 18 and over who have a diagnosis of intellectually disabilities as established in Rule No. 560-X-40-.01.

(c) Medicaid-eligible individuals age 0-21 who are considered to be disabled as established in Rule No. 560-X-40-.01.

(d) Medicaid-eligible individuals age 0-21 who are in the care, custody, or control of the State of Alabama as established in Rule No. 560-X-40-.01.

(e) Medicaid-eligible women of any age in need of maternity services as established in Rule No. 560-X-40.01.

(f) Medicaid-eligible individuals of any age who have been diagnosed as having AIDS or being HIV-positive as established in Rule 560-X-40-.01.

(g) Medicaid-eligible individuals age 18 and over who are at risk of abuse, neglect, or exploitation as established in Rule 560-X-40-.01.

(h) Medicaid-eligible persons who meet the eligibility criteria for the HCBS Technology Assisted Waiver (TAW) for Adults as outlined in the scope of service definition in the approved waiver document as established in Rule 560-X-40-.01.

(3) Persons applicable in one of the targeted groups may reside in their own home, the household of another, in a supervised residential setting or in total care environments, such as nursing facilities, hospital, and residential programs.

(4) Targeted Case Management services will be provided to recipients in a hospital, skilled nursing facility, ICFs/MR, and ICFs/MR 15 beds or less. In the HIV/AIDS and Related Illnesses Waiver, case management activities are available to assist recipients interested in transitioning from an institution into a community setting. Case management activities to facilitate the transition 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. (See Chapter 107 of the Medicaid Provider Manual Section 107.5.4 for place of service codes.)

(5) Medicaid recipients receiving case management services through a waiver are not eligible for targeted case management, unless the individual is at risk of abuse, neglect, exploitation or incapable of adequately caring for him or herself or may cause serious consequences to other.

(6) Targeted case management services for all target groups will be available in all areas of the state.

Author: Latonda Cunningham, Administrator, Long Term Care Division

Statutory Authority: 42 C.F.R. §435; § 1915 (g), Social Security Act, Title XIX; State Plan for Medical Assistance, Attachment 3.1-A, Supplement 1; OMB NO: 0939-0193.

History: Rule effective July 12, 1988. **Amended:** Effective April 17, 1990. **Emergency rule** effective June 1, 1990. **Amended:** October 13, 1990; June 14, 1994; March 12, 2001; May 16, 2003; September 15, 2003; May 14, 2004; November 16, 2007.

Amended: Filed March 13, 2012; Effective April 17, 2012.

Rule No. 560-X-40-.03. Description of Covered Services, Limitations, and Exclusions. (General)

(1) Reimbursement is made only for services rendered pursuant to mentally ill adults, intellectually disabled adults, disabled children, foster children, pregnant women, AIDS/HIV-positive individuals, adult protective service individuals, and individuals who meet the eligibility criteria for the HCBS Technology Assisted Waiver (TAW) for Adults as defined in Rule No. 560-X-40-.01. Case management services are those services which will assist Medicaid-eligible individuals in gaining access to needed medical, social, educational, and other services. The case manager shall accomplish these services through telephone contact with clients, face-to-face contact with clients, telephone contact with collaterals, and/or face-to-face contact with collaterals. The core elements of the service shall include the following:

(a) Needs assessment - a written comprehensive assessment of the person's assets, deficits, and needs. The following areas must be addressed when relevant:

1. Identifying information.
2. Socialization/recreational needs,
3. Training needs for community living,
4. Vocational needs,
5. Physical needs,
6. Medical care concerns,
7. Social/emotional status,
8. Housing, physical environment, and
9. Resource analysis and planning.

(b) Case planning - the development of a systematic, client-coordinated plan of care which lists the actions required to meet the identified needs of the client.

The plan is developed through a collaborative process involving the recipient, his family or other support system, and the case manager.

(c) Service arrangement - through linkage and advocacy, the case management provider will interface the client with the appropriate person and/or agency through calling and/or visiting these persons or agencies on the client's behalf.

(d) Social Support - the case management service provider will, through interviews with the client and significant others, determine that the client possesses an adequate personal support system. If this personal support system is inadequate or nonexistent, the case management service provider will assist the client in expanding or establishing such a network through advocacy and linking the client with appropriate persons, support groups and/or agencies.

(e) Reassessment/Follow-up - the case management service provider will evaluate through interviews and observations the progress of the client toward accomplishing the goals listed in the case plan at intervals of six months or less. In addition, the persons and/or agencies providing services to the client will be contacted and the results of these contacts, together with the changes in need shown in the reassessments, will be utilized to accomplish any needed revisions to the case plan.

(f) Monitoring - the case management provider ascertains on an ongoing basis what services have been delivered and whether they are adequate to meet the needs of the client. Adjustments in the plan of care may be required as a result of monitoring.

Author: Latonda Cunningham, Administrator, Long Term Care Division

Statutory Authority: 42 C.F.R., §433; § 1915 (g), Social Security Act; State Plan for Medical Assistance, Attachment 3.1-A, Supplement 1; OMB NO: 0939-0193.

History: Rule effective July 12, 1988. **Amended:** Effective April 17, 1990; December 12, 1991; October 13, 1992; January 13, 1993; June 14, 1994; March 12, 2001; May 16, 2003; September 15, 2003; May 14, 2004. **Amended:** Filed March 13, 2012; Effective April 17, 2012.

Rule No. 560-X-40-.04. Payment Methodology for Covered Services.

(1) Governmental providers will be paid on a negotiated rate basis which will not exceed actual costs and which will meet all requirements of OMB Circular A-87. Nongovernmental providers will be reimbursed on a negotiated rate basis which will not exceed the upper limitations of 42 C.F.R. Section 447.325. The following documentation must be maintained in the recipient's record when billing for services:

(a) There must be a current comprehensive service plan which identifies the medical, nutritional, social, educational, transportation, housing and other service needs which have not been adequately accessed and a time frame to reassess service needs.

(b) Services must consist of at least one of the following activities:

1. Establishment of the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the recipient;

2. Assisting the recipient in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan;

3. Monitoring the recipient and service providers to determine that the services received are adequate in meeting the identified needs; or

4. Reassessment of the recipient to determine services needed to resolve any crisis situation resulting from changes in the family structure, living conditions, or other events.

(2) For target group 4 (Foster Children) and target group 7 (Adult Protective Service Individuals), reimbursement will be as follows:

(a) Reimbursement rates will be established based on cost as determined by the quarterly Social Services Work Sampling Study. Rates will be adjusted annually based on the results of the previous four quarters. Random Moment Sampling may not be used as a method of documenting services provided to recipients. The Work Sampling Study must provide an audit trail that identifies each client whose case is included in the data used for rate formulation and identifies that at least one of the services listed above in (b) 1, 2, 3, or 4 has been provided.

(b) A maximum of one unit of case management services will be reimbursed per month for each eligible recipient receiving case management services. A unit of case management service is defined as at least one telephone or face to face contact for the purpose of providing at least one of the services listed above in (b) 1, 2, 3, or 4 with the recipient, a family member, significant other, or agency from which the client receives or may receive services. All contacts must be documented in the client's record and must be for the coordination or linkage of services for a specific identified recipient.

(3) Reimbursement for services provided by other governmental agencies will be based on actual costs as follows:

(a) Agencies will submit an annual cost report not later than sixty (60) days following the close of their fiscal year. This report will indicate not only the costs associated with providing the service but also statistical data indicating the units of service provided during the fiscal year.

(b) Cost reports will be reviewed for reasonableness and an average cost per unit of service will be computed.

(c) The average cost, trended for any expected inflation, will be used as the reimbursement rate for the succeeding year.

(d) If the cost report indicates any underpayment or overpayments for services during the reporting year, a lump sum adjustment will be made.

(e) New rates will be effective as of January 1 of each year.

(4) The Medicaid reimbursement for each service provided by a case management service provider shall not exceed the maximum allowable amount established by Medicaid as found in 42 C.F.R. Section 447.304.

(5) Actual reimbursement will be based on the rates in effect on the date of service.

Author: Dittra Skipper, Administrator, Project Development/Policy Unit, Long Term Care Division

Statutory Authority: 42 C.F.R., Section 447.325; OMB Circular A-87; Section 1915 (g); Social Security Act, State Plan for Medical Assistance Attachment 3.1-A, Supplement 1; OMB NO: 0939-0193.

History: Rule effective July 12, 1988. Amended June 14, 1994 and October 12, 1995. Amended: Filed December 18, 2000; effective March 12, 2001.

Rule No. 560-X-40-.05. Third Party Liability.

The CMSP shall make all reasonable efforts to determine if there is a liable third party source, including Medicare, and in the case of a liable third party source, utilize that source for payments and benefits prior to filing a Medicaid claim. Third party payments received after billing Medicaid for service for a Medicaid recipient shall be refunded to the Alabama Medicaid Agency.

Authority: 42 C.F.R. Part 433; Section 1915 (g), Social Security Act, State Plan for Medical Assistance, Attachment 3.1-A, Supplement 1; OMB NO: 0939-0193. Rule effective July 12, 1988. Date of this amendment April 17, 1990.

Rule No. 560-X-40-.06. Payment Acceptance.

(1) Payment made by the Alabama Medicaid Program to a CMSP shall be considered payment in full for covered services rendered.

(2) No Medicaid recipient shall be billed for covered Medicaid services.

(3) No person or entity, except a potential third party source, shall be billed for covered Medicaid services.

Authority: 42 C.F.R. Section 447.15; Section 1915 (g), Social Security Act, State Plan for Medical Assistance, Attachment 3.1-A, Supplement 1; OMB NO: 0939-0193. Rule effective July 12, 1988.

Rule No. 560-X-40-.07. Confidentiality.

The CMSP shall not use or disclose, except to duly authorized representatives of Federal or State agencies, any information concerning an eligible recipient, except upon the written consent of the recipient, his attorney, or his guardian, or upon subpoena from a court of appropriate jurisdiction.

Authority: 42 C.F.R. Section 431.300, et. seq.; Section 1915 (g), Social Security Act, State Plan for Medical Assistance, Attachment 3.1-A, Supplement 1; OMB NO: 0939-0193. Rule effective July 12, 1988. This amendment is effective April 17, 1990.

Rule No. 560-X-40-.08. Records.

(1) The CMSP shall make available to the Alabama Medicaid Agency at no charge, all information describing services provided to eligible recipients and shall permit access to all records and facilities for the purpose of claims audit, program monitoring, and utilization review by duly authorized representatives of Federal and State agencies. Complete and accurate medical/psychiatric and fiscal records which fully disclose the extent of the service shall be maintained by the CMSP. Said records shall be retained for the period of time required by State and Federal laws.

- (2) CMSP records must contain documentation of:
- (a) Name of recipient
 - (b) Dates of services
 - (c) Name of provider agency and person providing services
 - (d) Nature, extent or units of services provided
 - (e) Places of service.

Authority: 42 C.F.R. Part 433; Section 1915 (g), Social Security Act, State Plan for Medical Assistance, Attachment 3.1-A, Supplement 1; OMB NO: 0939-0193. Rule effective July 12, 1988.