

Public notice

Notice of intent – OHA will amend the Medicaid State Plan to implement new coverage for incarcerated youth.

Date: Dec. 19, 2024

Contact: Jesse Anderson, State Plan manager

Comments due: 5 p.m. Tuesday, Jan. 7, 2025

Oregon Health Authority (OHA) intends to submit a State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services. The SPA will add screening, diagnostic and targeted case management service coverage for incarcerated youth with Oregon Health Plan coverage.

The estimated annual Total Fund cost is \$332,048.

Background

Section 5121 of the Consolidated Appropriations Act, 2023 requires states to provide this coverage to Medicaid and CHIP youth 30 days prior to release from incarceration, or no later than is practical after release.

Obtaining SPA language

The next pages show edits to existing State Plan language in the proposed SPA. You can also view the full State Plan, approved SPAs and proposed SPAs on [the OHA website](#).

How to comment:

OHA welcomes public review and input. Please send written comments by 5 p.m. Tuesday, Jan. 7, 2025, to jesse.anderson@oha.oregon.gov.



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OREGON

TARGETED CASE MANAGEMENT SERVICES FOR ELIGIBLE JUVENILES

Target Group (42 CFR 410.18(a)(8)(i) and 441.18(a)(9)):

Eligible juveniles as defined in §1902(nn) (individuals who are under 21 years of age and determined eligible for any Medicaid eligibility group, or individuals determined eligible for the mandatory eligibility group for former foster care children age 18 up to age 26, immediately before becoming an inmate of a public institution or while an inmate of a public institution) who are within 30 days of their scheduled date of release from a public institution following adjudication, and for at least 30 days following release. Target group also includes TCM services for 30 days post release for all age groups of Medicaid eligible individuals transitioning from a state or county carceral setting to the community.

Post Release TCM Period beyond 30 day post release minimum requirement:

State will provide TCM beyond the 30 day post release requirement. [ENTER TEXT]

Areas of state in which services will be provided:

Entire State

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management (TCM) services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services.

Targeted Case Management includes the following assistance:

- ❖ Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
 - Taking client history;
 - identifying the individual's needs and completing related documentation (medical, mental, substance use, housing, and other health-related social needs (HRSN), functional needs, and strengths and support resources); 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;

The periodic reassessment is conducted every (check all that apply):

1 month

- 3 months
- 6 months
- 12 months
- Other frequency **[explain]**:

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, mental, substance use, housing, social, educational, and other HRNS, functional needs, strengths and support resources services needed by the eligible individual;
- Includes activities such as ensuring the active participation of the eligible individual, 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, including referrals to appropriate care and services available in the geographic region of the home or residence of the eligible juvenile, where feasible (such as scheduling appointments for the individual) to help an eligible individual obtain needed services including:

- Activities that link an individual with medical, mental, substance use, housing social, educational providers or other health-related social needs (HRSN), functional needs and support programs and services that are capable of providing needed services, that are capable of providing needed support services (including but not limited to food vouchers, transportation, child care and housing assistance) to address identified needs and achieve goals specified in the care plan;
- Participating in a warm hand-off, as appropriate, from pre-release case managers who provided pre-release care management services prior to release. Warm handoff meeting must include the member.

Monitoring and follow-up activities:

Activities and contacts 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 individual's and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met: implemented;

- 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.

Frequency of additional monitoring:

Specify the type and frequency of monitoring (check all that apply)

- Telephonic. Frequency: [enter text].
- In-person. Frequency: [enter text].
- Other **[explain]**:

Case management includes contacts with non-eligible individuals, who 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. For instance, a case manager might also work with state children and youth agencies for children who are involved with the foster care system. (42 CFR 440.169(e))

If another case manager is involved upon release or for case management after the 30-day post release mandatory service period, states should ensure a warm hand off to transition case management and support continuity of care of needed services that are documented in the person-centered care plan. A warm handoff should include a meeting between the eligible juvenile, and both the pre-release and post-release case manager. It also should include a review of the person-centered care plan and next steps to ensure continuity of case management and follow-up as the eligible juvenile transitions into the community.

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Case managers will possess a combination of education and experience necessary to support case planning, referral and client monitoring to effectively engage individuals who are eligible for pre-release and post-release case management services under the 2023 Federal Consolidated Appropriations Act or Oregon's Reentry Section 1115 Demonstration waiver.

The department will authorize locally based agencies that are licensed or certified. Qualified Case Managers must meet the following qualifications as outlined in Oregon Administrative Rule:

1. Licensed Medical Providers, Qualified Mental Health Professionals, Qualified Mental Health Associates; or
2. Complete a Peer Services Training Program following a curriculum approved by the Authority's Addictions and Mental Health Division and be:-
 - a. A self-identified person currently or formerly receiving mental health services; or
 - b. A self-identified person in recovery from a substance use disorder, who meets the abstinence requirements for recovering staff in alcohol and other drug treatment programs; or
 - c. A family member of an individual who is a current or former recipient of addictions or mental health services
3. Work under the supervision of a clinical supervisor. The clinical supervisor shall:
 - a. Meet the requirements in Oregon administrative rule for alcohol and other drug treatment programs;
 - b. Be certified or licensed by a health or allied provider agency to provide addiction treatment; and
 - c. Possess one of the following qualifications:
 - i. Five years of paid full-time experience in the field of alcohol and other drug counseling; or

- ii. A Bachelor's degree and four years of paid full-time experience in the social services field with a minimum of two years of direct alcohol and other drug counseling experience; or
 - iii. A Master's degree and three years of paid full-time experience in the social services field with a minimum of two years of direct alcohol and other drug counseling experience;
4. Satisfy continuing education requirements as specified by the agency providing clinical supervision specific to reentry services; and
5. Work in compliance with Medicaid policies, procedures, and protocols.

Freedom of Choice (42 CFR 441.18(a)(1):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):

- The State assures the following:
- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
 - Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
 - Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.
 - Delivery of TCM and the policies, procedures, and processes developed to support implementation of these provisions are built in consideration of the individuals release and

will not effectuate a delay of an individual's release or lead to increased involvement in the juvenile and adult justice system.

Payment (42 CFR 441.18(a)(4)):

The state assures 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)):

The state assures 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:

The state assures that 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)).

State has additional limitations **[Specify any additional limitations.]**

Reimbursement Attachment 4.19-b

Payment for 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.

The fee schedule developed for the Targeted Case Management is designed for specific tasks related exclusively to case management functions for this target group. The fee schedule is constructed by

using the market value of the individual's time (the Bureau of Labor Statistics wage level) augmented by a margin for Program Related expenditures (supervisory staff, transportation, program supplies etc.), Employment Related expenditures (mandated and other benefits), and General and Administrative (Indirect). The assumptions from which the fees are developed are expressed in the service standards, and the fees are predicated on fifteen minute increments.

The program intends to establish and maintain a maximum number of fifteen minute increments which can be performed and billed for any single day. This maximum will be twenty four units (24 fifteen minute increments) in any given calendar day (midnight to midnight) which corresponds to an assumption that no more than six hours would ever be provided for the same client, by the same case manager in any twenty four hour calendar day.

The program will be utilizing an authorization methodology to monitor and control for this utilization limit.

The agency's rates were established as of 04/01/2008 and are effective for services on or after that date. All rates are published on the Agency's website.

State developed fee schedule rates are the same for governmental and private providers of HIV/AIDS Targeted Case Management services and the fee schedule and any annual/periodic adjustments to the fee schedule.

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