D. **Definition of Services** (continued)

The above components of case management services must fall within the following parameters to be eligible for medical assistance ~~payment~~ coverage:

1. For clients in hospitals, NFs, or ICFs/~~MR~~ID, ~~payment~~ coverage for case management services is limited to the last 180 consecutive days before discharge in an effort to establish continuity of care and community-based services recommended by the discharge planning team. This 180-day coverage may not exceed more than six months in a calendar year.

Case management services will not duplicate those provided as part of the institution's discharge plan.

Case management services are not provided to individuals who are inmates of public institutions, or to individuals between the ages of 22 and 64 who are residing in an IMD.

2. A client's continued eligibility for case management services must be determined every 36 months by the local agency. The determination of whether the client continues to have a diagnosis of serious and persistent mental illness or severe emotional disturbance must be based on updating the client's diagnostic assessment or on the results of conducting a complete diagnostic assessment because the client's mental health status or behavior has changed markedly.

The following services are not eligible for ~~payment~~ coverage as case management services:

1. Diagnostic assessment.

2. Administration and management of a client's medications.

3. Legal services, including legal advocacy, for the client.

4. Information and referral services that are part of a county's community social service plan.

5. Outreach services including outreach services provided through the community support services program.

6. Services that are not adequately documented, as required under Minnesota Statutes ~~Rules, part 9520.0920, subpart 1~~.

Additional 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.

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.

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.

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

X Entire state.

_ Only in the following geographic areas (authority section 1915{g) (1) of the Act is invoked to provide services less than statewide).

B. **Comparability of services:**

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

X Services are not comparable in amount, duration, and scope.

Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

C. **Definition of services:**

Targeted case management services are activities that are coordinated on an individual recipient basis and are designed to help recipients to gain access to needed medical, social and recreational, educational, vocational, advocacy, legal, and other services necessary to meet the recipient's needs. It does not include therapy, treatment, legal, or outreach services.

Targeted case management services include:

1. Comprehensive ~~A~~assessment and periodic reassessment of a recipient's need for targeted case management services plus 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, and educators, to form a complete assessment of the individual.

2. Development, completion, and regular review and revision of a written individual service plan with the recipient and the recipient's legal representative, and others identified by the recipient, designed to help a recipient to gain access to needed medical, social and recreational, educational, vocational, advocacy, legal and other related services. The plan must be reviewed at least annually with the recipient and the recipient's legal representative. The plan must be revised when there is a change in the recipient's status.

D. **Definition of services:** (continued)

1. ~~If a recipient is a resident or inpatient of an inpatient hospital, nursing facility, or ICF/MRID, payment for services is limited to the last 180 consecutive days before discharge~~ Target group includes individuals transition to a community setting. Case management services will be made available for 180 consecutive days of a covered stay in a medical institution.

2. Case management services will not duplicate those provided as part of the facility's discharge plan.

3. Case management services are not provided to individuals who are inmates of public institutions, or to individuals between the ages of 22 and 64 who are residing in an IMD.

E. **Qualifications of providers:**

A provider of targeted case management services must be an enrolled medical assistance provider and:

1. a local social services agency; or

2. an entity under contract with the local social services agency.

Case managers must meet the following standards:

1. Demonstrated capacity and case management experience in providing case management services to coordinate and link community resources.

2. Administrative capacity and case management experience in serving the target population for whom it will provide services.

3. Administrative capacity to ensure quality of services in accordance with federal and state requirements.

4. A financial management system providing accurate documentation of services and costs under federal and state requirements.

5. Capacity to document and maintain individual case records in accordance with federal and state requirements.

6. Coordinate with local social services agencies responsible for planning for community social services, conducting adult protective investigations, and conducting prepetition screenings for commitments.

7. Coordinate with health care providers to ensure access to necessary health care services.

8. The designated case manager must have at least a bachelor's degree in social work, special education, psychology, nursing, human services, or other fields related to the education or treatment of persons with disabilities, and one year of experience in the education or treatment of persons with disabilities.

Except for screening and service planning development services, the county board may establish procedures permitting others than those identified in item 8 to assist in providing case management services under the supervision of a case manager who meets the qualifications in item 8.

F. **Freedom of Choice**

The provision of targeted case management services will not restrict a recipient's freedom of choice of provider in violation of 1902(a)(23) of the Act.

1. An eligible recipient will have free choice of the providers of targeted case management services.
2. An eligible recipient will have free choice of the providers of other medical care under the state plan.

D. **Definition of Services** (continued)

The above components of case management services must fall within the following parameters to be eligible for medical assistance ~~payment~~ coverage:

1. For clients in hospitals, NFs, or ICFs/~~MR~~ID, ~~payment~~ coverage for case management services is limited to the last 180 consecutive days before discharge in an effort to establish continuity of care and community-based services recommended by the discharge planning team. This 180-day coverage may not exceed more than six months in a calendar year.

Case management services will not duplicate those provided as part of the institution's discharge plan.

Case management services are not provided to individuals who are inmates of public institutions, or to individuals between the ages of 22 and 64 who are residing in an IMD.

2. A client's continued eligibility for case management services must be determined every 36 months by the local agency. The determination of whether the client continues to have a diagnosis of serious and persistent mental illness or severe emotional disturbance must be based on updating the client's diagnostic assessment or on the results of conducting a complete diagnostic assessment because the client's mental health status or behavior has changed markedly.

The following services are not eligible for ~~payment~~ coverage as case management services:

1. Diagnostic assessment.

2. Administration and management of a client's medications.

3. Legal services, including legal advocacy, for the client.

4. Information and referral services that are part of a county's community social service plan.

5. Outreach services including outreach services provided through the community support services program.

6. Services that are not adequately documented, as required under Minnesota Statutes ~~Rules, part 9520.0920, subpart 1~~.

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

X Entire state.

_ Only in the following geographic areas (authority section 1915{g) (1) of the Act is invoked to provide services less than statewide).

E. **Comparability of services:**

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

X Services are not comparable in amount, duration, and scope.

Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

F. **Definition of services:**

Targeted case management services are activities that are coordinated on an individual recipient basis and are designed to help recipients to gain access to needed medical, social and recreational, educational, vocational, advocacy, legal, and other services necessary to meet the recipient's needs. It does not include therapy, treatment, legal, or outreach services.

Targeted case management services include:

1. Comprehensive ~~A~~assessment and periodic reassessment of a recipient's need for targeted case management services plus 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, and educators, to form a complete assessment of the individual.

2. Development, completion, and regular review and revision of a written individual service plan with the recipient and the recipient's legal representative, and others identified by the recipient, designed to help a recipient to gain access to needed medical, social and

recreational, educational, vocational, advocacy, legal and other related services. The plan must be reviewed at least annually with the recipient and the recipient's legal representative. The plan must be revised when there is a change in the recipient's status.

D. **Definition of services:**

1. ~~If a recipient is a resident or inpatient of an inpatient hospital, nursing facility, or ICF/MR~~ID~~, payment for services is limited to the last 180 consecutive days before discharge~~ Target group includes individuals transition to a community setting. Case management services will be made available for 180 consecutive days of a covered stay in a medical institution.

2. Case management services will not duplicate those provided as part of the facility's discharge plan.

3. Case management services are not provided to individuals who are inmates of public institutions, or to individuals between the ages of 22 and 64 who are residing in an IMD.

E. **Qualifications of providers:**

A provider of targeted case management services must be an enrolled medical assistance provider and:

1. a local social services agency; or

2. an entity under contract with the local social services agency.

Case managers must meet the following standards:

1. Demonstrated capacity and case management experience in providing case management services to coordinate and link community resources.

2. Administrative capacity and case management experience in serving the target population for whom it will provide services.

3. Administrative capacity to ensure quality of services in accordance with federal and state requirements.

4. A financial management system providing accurate documentation of services and costs under federal and state requirements.

5. Capacity to document and maintain individual case records in accordance with federal and state requirements.

6. Coordinate with local social services agencies responsible for planning for community social services, conducting adult protective investigations, and conducting prepetition screenings for commitments.

7. Coordinate with health care providers to ensure access to necessary health care services.

8. The designated case manager must have at least a bachelor's degree in social work, special education, psychology, nursing, human services, or other fields related to the education or treatment of persons with disabilities, and one year of experience in the education or treatment of persons with disabilities.

Except for screening and service planning development services, the county board may establish procedures permitting others than those identified in item 8 to assist in providing case management services under the supervision of a case manager who meets the qualifications in item 8.

F. **Freedom of Choice**

The provision of targeted case management services will not restrict a recipient's freedom of choice of provider in violation of 1902(a)(23) of the Act.

1. An eligible recipient will have free choice of the providers of targeted case management services.
2. An eligible recipient will have free choice of the providers of other medical care under the state plan.

19.a. Mental health targeted case management services as defined in, and to the group specified in Supplement 1a to Attachments 3.1-A/B (in accordance with 1905(a)(19) or section 1915(g) of the Act).

Payment is made on a monthly basis. Costs associated with mentoring, supervision and continuing education may be included in the monthly rate. Payment is limited to the components listed in Supplement 1 to Attachments 3.1-A/B, "Definition of Services."

1. The monthly rate for mental health targeted case management services provided by ~~state or~~ county staff is based on an aggregate of time spent performing all elements of case management services. There are separate rates for adults and children.
2. The rate for mental health targeted cases management services provided by a facility of the Indian Health Service (IHS) or by a 638 facility is made according to the encounter rate specified on page 1 of this Attachment.
3. The rate for mental health targeted case management services provided by entities under contract with a ~~county, a~~ facility of the IHS~~,~~ or a 638 facility is based on the monthly rate negotiated by ~~the county,~~ the IHS facility or the 638 facility. The negotiated rate must not exceed the rate charged by the entity for the same service to other payers.
4. The rate for mental health targeted case management services provided by entities under contract with a county is based on a standard caseload size derived from the estimated average number of hours that case management staff spend on recipients each month. Counties may request an adjustment to the standard caseload size and may request an additional adjustment for costs associated with the provision of culturally specific services.

~~a) If the service is provided by a team of contracted vendors, the county, the IHS facility or the 638 facility may negotiate a team rate with a vendor who is a member of the team. The team must determine how to distribute the rate among its members. No payment received contracted vendors will be returned to the county or the IHS facility, or the 638 facility, except to pay the county, the IHS facility or the 638 facility for advance funding provided by the county, IHS facility or the 638 facility to the vendor.~~

19.a. Mental health targeted case management services as defined in, and to the group specified in Supplement 1a to Attachments 3.1-A/B (in accordance with 1905(a)(19) or section 1915(g) of the Act).

~~b)~~ If the service is provided by a team that includes contracted vendors, IHS or 638 facility staff, and state or county staff, the costs for the state or county staff participation in the team must be included in the rate for county-provided services. In this case, the contracted vendor, the IHS or 638 facility and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, each entity must document, in the client's file, the need for team mental health targeted case management and a description of the roles of team members.

~~**Rate methodology for County and State Staff: July 1, 2000 through June 30, 2003**~~

~~Beginning July 1, 2000, a statistically valid random moment time study, Minnesota's Social Services Time Study (SSTS), is used to construct a monthly for mental health targeted case management services. The SSTS separates time of all direct services staff into a number of categories that constitute allowable mental health targeted case management activities and other unallowable activities. The proportion of allowable to total activities, when multiplied by the overall provider costs establishes the costs of mental health targeted case management activity.~~

~~The percentage of time spent by services staff on allowable mental health targeted case management services for children and adults is applied to the annual costs of providing social services and divided by twelve to arrive at the eligible cost per month. These figures are divided by the average number of children and adults who received mental health targeted case management services per month. The result is two separate, monthly payment rates for mental health targeted case management, one for children and one for adults.~~

19.a. Mental health targeted case management services as defined in, and to the group specified in Supplement 1a to Attachments 3.1-A/B (in accordance with 1905(a)(19) or section 1915(g) of the Act).

~~The two rates represent one month's work of eligible mental health targeted case management activity. Only one claim per client is allowed per calendar month for mental health targeted case management services provided county and state staff. The rate is the same for medical assistance-eligible and non-medical assistance eligible clients. All of the following conditions must be met in order for a claim to be made:~~

- ~~the client must be eligible for medical assistance;~~
- ~~the client received mental health targeted case management services in that month; and~~
- ~~all documentation requirements are met.~~

~~The rate is reviewed and updated annually, using the most current, available data.~~

~~**Rate Formula:**~~

~~**CP** = Average monthly social services cost pool for the most recent year for that class of providers~~

P = Percentage of eligible mental health targeted case ~~management time as identified on the most recent year of the SSTS for that class of providers~~

~~**N** = Monthly average number of clients receiving mental health targeted case management services for that class for providers using the most recent year's work of data~~

~~**(CP x P)** = Monthly costs of proving mental health targeted case management services for that class of providers~~

~~**(CP x P)/N** = Mental health targeted case management monthly rate for that class of providers~~

19.a. Mental health targeted case management services as defined in, and to the group specified in Supplement 1a to Attachments 3.1-A/B (in accordance with 1905(a)(19) or section 1915(g) of the Act).

Rate Methodology for Services Provided by County ~~and State~~ Staff: ~~July 1, 2003~~

The Minnesota Social Services Time Study (SSTS) is used to construct a monthly rate for: (1) mental health targeted case management services for children; and (2)(a) mental health targeted case management services for adults and (b) targeted case management services for the group specified in Supplement 1c to Attachments 3.1-A/B. The SSTS separates time of all direct services staff into a number of categories that constitute: (1) allowable mental health targeted case management activities for children; (2) allowable mental health targeted case management activities for adults and allowable targeted case management activities for the group specified in Supplement 1c; and (3) other, unallowable activities.

The proportion of allowable to total activities, when multiplied by the overall provider cost, establishes the costs of: (1) mental health targeted case management activity for children; and (2) mental health targeted case management activity for the adults and targeted case management activity for the group specified in Supplement 1c.

The percentage of time spent by service staff on allowable: (1) mental health targeted case management services for children; and (2) mental health targeted case management services for adults and targeted case management services for the group specified in Supplement 1c is applied to the annual costs of providing social services and divided by twelve to arrive at the eligible cost per month. For children, these figures are divided by the average number who received mental health targeted case management services per month. For adults, these figures are divided by the average number received mental health targeted case management services and targeted case management services listed in Supplement 1c to Attachments 3.1-A/B per month.

The result is two separate, monthly payment rates, one for children and one for adults.

19.a. Mental health targeted case management services as defined in, and to the group specified in Supplement 1a to Attachments 3.1-A/B (in accordance with 1905(a)(19) or section 1915(g) of the Act).

The two rates represent one month's worth of eligible mental health targeted case management activity. Only one claim per client is allowed per calendar month for mental health targeted case management services provided county ~~and state~~ staff. The rate is the same for medical assistance-eligible and non-medical assistance eligible clients. All of the following conditions must be met in order for a claim to be made:

- the client must be eligible for medical assistance;
- the client received mental health targeted case management services in that month; and
- all documentation requirements are met.

County Rate Formula for Children:

~~The formula described on page 57b.~~

CP = Average monthly social services cost pool for the most recent year for that class of providers

P = Percentage of eligible mental health targeted case management time as identified on the most recent year of the SSTS for that class of providers

N = Monthly average number of clients receiving mental health targeted case management services for that class for providers using the most recent year's worth of data

(CP x P) = Monthly costs of proving mental health targeted case management services for that class of providers

(CP x P)/N = Mental health targeted case management monthly rate for that class of providers

19.a. Mental health targeted case management services as defined in, and to the group specified in Supplement 1a to Attachments 3.1-A/B (in accordance with 1905(a)(19) or section 1915(g) of the Act).

County Rate Formula for Adults:

CP = Average Monthly Social Services Cost Pool for the most recent year for that class of providers

P = Percentage of eligible: (1) mental health targeted case management time; and (2) targeted case management (described in Supplement 1c to Attachments 3.1-A/B) time as identified on the most recent year of the SSTS for that class of providers

N = Monthly Average number of clients receiving either mental health targeted case management services or targeted case management services listed in Supplement 1c for that class of providers using the most recent year's worth of data

(CP x P) = Monthly costs of providing targeted case management for that class of providers

(CP x P)/N = Targeted case management monthly rate for that class of providers

19.a. Mental health targeted case management services as defined in, and to the group specified in Supplement 1a to Attachments 3.1-A/B (in accordance with 1905(a)(19) or section 1915(g) of the Act).

Rate Methodology for Service Providers under Contract with a County

The monthly rate is determined according to caseload size and includes the following cost and adjustment factors:

i. Wage Factor – Hourly wages for employees providing targeted case management services directly to recipients;

ii. Taxes and Benefits Factor – Employee-related taxes, insurance, and fringe benefits;

iii. Direct Care Hours Factor – The estimated number of direct care hours spent per recipient per month;

iv. Absence Factor – Adjustment for the average amount of billable time that becomes unbillable due to recipient absences;

v. Distribution of Time (Productivity) Factor – Adjustment for time that program staff must spend on non-reimbursable activities;

vi. Training and Paid Time Off Factor – Adjustment for hours that program staff are not available to provide direct services;

vii. Administration Factor – Adjustment for allowable administrative costs associated with service delivery;

viii. Program Support Factor – Adjustment for allowable costs supporting the delivery of services; and

ix. Supervisor Control Factor – Adjustment reflecting the number of direct care workers overseen by one supervisor.

19.a. Mental health targeted case management services as defined in, and to the group specified in Supplement 1a to Attachments 3.1-A/B (in accordance with 1905(a)(19) or section 1915(g) of the Act).

Adult mental health rates for providers under county contract

Caseload Size	Payment Rate	Culturally Specific Rate
4-8	$1,781	$1,932
9-13	$971	$1,053
14-18	$668	$724
19-23	$508	$551
Standard	$411	$446
29-33	$344	$373
34-38	$297	$322
39-43	$260	$282
44-48	$232	$252
49-53	$210	$227

Children's mental health rates for providers under county contract

Caseload Size	Payment Rate	Culturally Specific Rate
3-7	$2,137	$2,318
8-12	$1,068	$1,159
Standard	$712	$772
18-22	$534	$579
23-27	$427	$463
28-32	$356	$386
33-37	$306	$331
38-42	$267	$290
43-47	$237	$257
48-52	$214	$232

The wage and benefit components of the rates are based on the most recent data available from the Bureau of Labor Statistics (BLS). The BLS values are projected to the mid-point of the Medicaid rate year using the Medicare Economic Index. The wage and benefit values will be updated annually, and the rates will be adjusted accordingly. New rates will be effective January 1 of each rate year and published on the Department's website 180 days prior to the start of the year.

19.a. Mental health targeted case management services as defined in, and to the group specified in Supplement 1a to Attachments 3.1-A/B (in accordance with 1905(a)(19) or section 1915(g) of the Act).

Counties may request an adjustment to the standard caseload size. The Direct Care Service Hours Factor used to compute the rate in item (iii) may be adjusted to accommodate variations in caseload size that result when increasing or decreasing the average number of direct care hours provided to recipients. Adjustments to the standard value for caseload size must be preapproved by the Department and must be based on the needs of the specific population of recipients.

Counties may request a rate adjustment for the provision of culturally specific services. The adjustment will provide for an increase to the standard values for the Wage Factor described in item (i) and the Absence Factor in item (iv). Adjustments for culturally specific services must be preapproved by the Department and must be based on the needs of individuals from particular linguistic, racial, ethnic or social backgrounds.

Counties may request adjustments for caseload size and adjustments for the provision of culturally specific services separately or together.

Providers contracting with counties identified below will be paid an adjusted rate for services provided from July 1, 2022 through December 31, 2023. Providers will receive one adjusted rate for the first six month period and a different adjusted rate for the subsequent twelve month period. Effective January 1, 2024, providers contracting with the identified counties will be paid one-hundred percent of the standard rate. At that time, counties may request an adjustment for caseload size and/or the provision of culturally specific services.

County	MH TCM	7/1/22 – 12/31/22	1/1/23 – 12/31/24
Clay	Children	75% of standard rate	88% of standard rate
Itasca	Children	65% of standard rate	80% of standard rate
Itasca	Adults	85% of standard rate	95% of standard rate
Olmsted	Adults	115% of standard rate	105% of standard rate
St. Louis	Adults	115% of standard rate	105% of standard rate

19.b. Child welfare-targeted targeted case management services as defined in, and to the group specified in Supplement 1a to Attachments 3.1-A/B (in accordance with 1905(a)(19) or section 1915(g) of the Act).

The monthly rate is based on an aggregate of time spent forming all elements of case management services.

Payment is based on:

a. A face-to-face contact, either in person or by interactive video, at least once per month between the case manager and the recipient or the recipient's family, primary caregiver, legal representative, or other relevant person identified as necessary to the development or implementation of the goals of the individual service plan in regard to the status of the recipient, the individual service plan, or goals for the recipient.
b. A telephone contact, for Minnesota recipients placed outside the county of financial responsibility in an excluded time facility under Minnesota Statutes, section 260.~~851~~93, and the placement in either case is more than 60 miles beyond the county boundaries. The telephone contact must be between the case manager and the recipient or the recipient's family, primary caregiver, legal representative, or other relevant person identified as necessary to the development or implementation of the goals of the individual service plan in regard to the status of the recipient, the individual service plan, or goals for the recipient. There must be at least one contact per month and not more than two consecutive months without a face-to-face contact as described in item (a) above.

Encounter Rate Methodology for IHS or Tribal 638 Providers

~~Payment is $178 per encounter. This amount~~ The rate is one half of the average ~~of the~~ monthly child welfare targeted case management rate ~~in~~ paid to counties within the tribe's Contract Health Service Delivery Area ~~of federally recognized reservations divided by two encounters per month~~. The rate is ~~will be~~ recalculated annually.

19.b. Child welfare-targeted targeted case management services as defined in, and to the group specified in Supplement 1a to Attachments 3.1-A/B (in accordance with 1905(a)(19) or section 1915(g) of the Act).

An encounter is defined as a face-to-face contact, either in person or by interactive video, or a telephone contact occurring within a 24-hour period ending at midnight, as follows:

a. A face-to-face contact, either in person or by interactive video, between the case manager and the recipient or the recipient's family, primary caregiver, legal representative, or other relevant person identified as necessary to the development or implementation of the goals of the individual service plan in regard to the status of the recipient, the individual service plan, or goals for the recipient.

b. A telephone contact between the case manager and the recipient or the recipient's family, primary caregiver, legal representative, or other relevant person identified as necessary to the development or implementation of the goals of the individual service plan in regard to the status of the recipient, the individual service plan, or goals for the recipient.

   This applies to a recipient placed outside the county of financial responsibility or to a recipient served by tribal social services placed outside the reservation, in an excluded time facility under Minnesota Statutes, section 256G.02, subdivision 6, or through the Interstate Compact on the Placement of Children under Minnesota Statutes, section 260.~~851~~93. The placement must be more than 60 miles beyond the county or reservation boundaries.

To be eligible for payment, there must be at least one contact per month.

Only one contact within a 24-hour period will paid, except that encounters with more than one case manager in the same 24-hour period are payable if one case manager from a tribe and one case manager from the county of financial responsibility or a tribal-contracted vendor determine that dual case management is medically necessary and documentation of the need and the distinctive services provided by each case manager is maintained in the individual service plan.

19.b. Child welfare-targeted targeted case management services as defined in, and to the group specified in Supplement 1a to Attachments 3.1-A/B (in accordance with 1905(a)(19) or section 1915(g) of the Act).

Rate Methodology for Entities Under Contract with ~~a County or~~ Tribal Social Services

The monthly rate for child welfare targeted case management services provided by entities under contract with ~~a county or~~ tribal social services is based on the monthly rate negotiated by ~~the county or~~ tribal social services. The negotiated rate must not exceed the rate charged by the entity for the same service to other payers.

~~a) If the service is provided by a team of contracted vendors, the county, the IHS facility or the 638 facility may negotiate a team rate with a vendor who is a member of the team. The team must determine how to distribute the rate among its members.~~

~~b)~~ If the service is provided by a team that includes contracted vendors, IHS or 638 facility staff, and state or county staff, the costs for the state or county staff participation in the team must be included in the rate for county-provided services. In this case, the contracted vendor, the IHS or 638 facility and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, each entity must document, in the client's file, the need for team mental health targeted case management and a description of the roles of team members.

Rate Methodology for <u>Services Provided by</u> County Staff:

A statistically valid random moment time study, Minnesota's Social Services Time Study (SSTS), is used to construct a monthly for child welfare targeted case management services. The SSTS separates time of all direct services staff into a number of categories that constitute allowable mental health targeted case management activities and other unallowable activities. The proportion of allowable to total activities, when multiplied by the overall provider costs establishes the costs of mental health targeted case management activity.

19.b. Child welfare-targeted targeted case management services as defined in, and to the group specified in Supplement 1a to Attachments 3.1-A/B (in accordance with 1905(a)(19) or section 1915(g) of the Act).

Rate Methodology for Service Providers under Contract with a County

The monthly rate is determined according to caseload size and includes the following cost and adjustment factors:

i. Wage Factor – Hourly wages for employees providing targeted case management services directly to recipients;

ii. Taxes and Benefits Factor – Employee-related taxes, insurance, and fringe benefits;

iii. Direct Care Hours Factor – The estimated number of direct care hours spent per recipient per month;

iv. Absence Factor – Adjustment for the average amount of billable time that becomes unbillable due to recipient absences;

v. Distribution of Time (Productivity) Factor – Adjustment for time that program staff must spend on non-reimbursable activities;

vi. Training and Paid Time Off Factor – Adjustment for hours that program staff are not available to provide direct services;

vii. Administration Factor – Adjustment for allowable administrative costs associated with service delivery;

viii. Program Support Factor – Adjustment for allowable costs supporting the delivery of services; and

ix. Supervisor Control Factor – Adjustment reflecting the number of direct care workers overseen by one supervisor.

The wage and benefit components of the rates are based on the most recent data available from the Bureau of Labor Statistics (BLS). The BLS values are projected to the mid-point of the Medicaid rate year using the Medicare Economic Index. The wage and benefit values will be updated annually, and the rates will be adjusted accordingly. New rates will be effective January 1 of each rate year and published on the Department’s website 180 days prior to the start of the year.

19.b. Child welfare-targeted targeted case management services as defined in, and to the group specified in Supplement 1a to Attachments 3.1-A/B, in accordance with 1905(a)(19) or section 1915(g) of the Act.

Caseload Size	Payment Rate	Culturally Specific Rate
3-7	$2,137	$2,318
8-12	$1,068	$1,159
13-17	$712	$772
18-22	$534	$579
Standard	$427	$463
28-32	$356	$386
33-37	$306	$331
38-42	$267	$290
43-47	$237	$257
48-52	$214	$232

Counties may request an adjustment to the standard caseload size. The Direct Care Service Hours Factor used to compute the rate in item (iii) may be adjusted to accommodate variations in caseload size that result when increasing or decreasing the average number of direct care hours provided to recipients. Adjustments to the standard value for caseload size must be preapproved by the Department and must be based on the needs of the specific population of recipients.

Counties may request a rate adjustment for the provision of culturally specific services. The adjustment will provide for an increase to the standard values for the Wage Factor described in item (i) and the Absence Factor in item (iv). Adjustments for culturally specific services must be preapproved by the Department and must be based on the needs of individuals from particular linguistic, racial, ethnic or social backgrounds.

Counties may request adjustments for caseload size and adjustments for the provision of culturally specific services separately or together.

Providers contracting with Itasca County will be paid an adjusted rate for services provided from July 1, 2022 through December 31, 2023. Providers will receive 75% of the standard rate for the first six month period (through December 31, 2022) and 88% of the standard rate for the subsequent twelve month period. Effective January 1, 2024, providers in Itasca County will be paid one-hundred percent of the standard rate. At that time, the county may request an adjustment for caseload size or for the provision of culturally specific services.

19.d. Targeted case management services for persons not receiving services pursuant to a §1915(c) waiver who are vulnerable adults or adults with developmental disabilities or related conditions as defined in Supplement 1c, to Attachments 3.1-A/B (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

~~(1)~~ Payment is made on a monthly basis. Payment is based on at least one contact per month between the case manager and the recipient or the recipient's family, primary caregiver, legal representative, or other relevant person identified as necessary to the development or implementation of the goals of the individual service plan. This contact may occur via telephone, interactive video, or in person.

~~(2) The monthly rate for targeted case management services provided by entities under contract with a county is based on the monthly rate negotiated by the county. The negotiated rate must not exceed the rate charged by the entity for the same service to other payers.~~

~~a) If the service is provided by a team of contracted vendors, the county may negotiate a team rate with the vendor who is a member of the team. The team must determine how to distribute the rate amongst its members. No payment received by contracted vendors will be returned to the county except to pay the county for advance funding provided by the county to the vendor.~~

~~b)~~ If the service is provided by a team that includes contracted vendors and county staff, the costs of county staff participation in the team must be included in the rate for county-provided service. In this case, the contracted vendor and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, each entity must document, in the client’s file, the need for team case management and a description of the roles of the team members.

19.d. Targeted case management services for persons not receiving services pursuant to a §1915(c) waiver who are vulnerable adults or adults with developmental disabilities or related conditions as defined in Supplement 1c, to Attachments 3.1-A/B (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

Rate Methodology for services provided by County Staff:

The rate ~~will be~~ is the same as the county rate in effect for mental health targeted case management for adults (item 19.a).

Rate Methodology for Service Providers under Contract with a County

The monthly rate is determined according to caseload size and includes the following cost and adjustment factors:

i. Wage Factor – Hourly wages for employees providing targeted case management services directly to recipients;

ii. Taxes and Benefits Factor – Employee-related taxes, insurance, and fringe benefits;

iii. Direct Care Hours Factor – The estimated number of direct care hours spent per recipient per month;

iv. Absence Factor – Adjustment for the average amount of billable time that becomes unbillable due to recipient absences;

v. Distribution of Time (Productivity) Factor – Adjustment for time that program staff must spend on non-reimbursable activities;

vi. Training and Paid Time Off Factor – Adjustment for hours that program staff are not available to provide direct services;

vii. Administration Factor – Adjustment for allowable administrative costs associated with service delivery;

viii. Program Support Factor – Adjustment for allowable costs supporting the delivery of services; and

ix. Supervisor Control Factor – Adjustment reflecting the number of direct care workers overseen by one supervisor.

19.d. Targeted case management services for persons not receiving services pursuant to a §1915(c) waiver who are vulnerable adults or adults with developmental disabilities or related conditions as defined in Supplement 1c, to Attachments 3.1-A/B.

Caseload Size	Payment Rate	Culturally Specific Rate
4-8	$1,781	$1,932
9-13	$971	$1,053
14-18	$668	$724
19-23	$508	$551
24-28	$411	$446
29-33	$344	$373
Standard	$297	$322
39-43	$260	$282
44-48	$232	$252
49-53	$210	$227

The wage and benefit components of the rates are based on the most recent data available from the Bureau of Labor Statistics (BLS). The BLS values are projected to the mid-point of the Medicaid rate year using the Medicare Economic Index. The wage and benefit values will be updated annually, and the rates will be adjusted accordingly. New rates will be effective January 1 of each rate year and published on the Department's website 180 days prior to the start of the year.

Counties may request an adjustment to the standard caseload size. The Direct Care Service Hours Factor used to compute the rate in item (iii) may be adjusted to accommodate variations in caseload size that result when increasing or decreasing the average number of direct care hours provided to recipients. Adjustments to the standard value for caseload size must be preapproved by the Department and must be based on the needs of the specific population of recipients.

Counties may request a rate adjustment for the provision of culturally specific services. The adjustment will provide for an increase to the standard values for the Wage Factor described in item (i) and the Absence Factor in item (iv). Adjustments for culturally specific rates must be preapproved by the Department and must be based on the needs of individuals from particular linguistic, racial, ethnic or social backgrounds.

Counties may request adjustments for caseload size and adjustments for the provision of culturally specific services separately or together.