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

TARGETED CASE MANAGEMENT SERVICES
Sustained Family Support Home Visiting Program

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):
The Strong Families Vermont (SFVT) Sustained Family Support Home Visiting Program will provide Targeted Case Management (TCM) services to Medicaid eligible pregnant and parenting people, infants, and children through five years of age. The Strong Families Vermont (SFVT) Sustained Family Support Home Visiting Program uses an internationally known evidenced based home visiting model known as Parents as Teachers (PAT). Risk factors of target population include:

- Families with pregnant individuals who have not attained age 21
- "Low income" families, i.e., are unemployed, or below poverty guidelines
- Families experiencing homelessness
- Families living in rural areas
- Families/children who have witnessed crime, including domestic violence
- Wards of the State
- Families with a history of child abuse and neglect or have had interactions with child protection services
- Immigrant, Migrant, and New American families
- Indigenous families
- Families at-risk due to prenatal, maternal, newborn or child health conditions, e.g., maternal mental health and substance misuse; pre-term birth, low birth weight infant, infant mortality due to neglect, infants/children who have been exposed to toxic substances during pregnancy
- Children, and their families, experiencing health needs and/or delayed development
- Families that have users of tobacco products in the home
- Families that are or have children with low student achievement
- Eligible families that include individuals who are serving or formerly served in the Armed Forces, including such families that have members of the Armed Forces who have had multiple deployments outside of the United States

Referral and eligibility determination for this service will occur through Vermont's established early childhood system of care referral and intake consultation process in partnership with the family.

_N/A__ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to _____ **[insert a number; not to exceed 180]** consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):

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_X_ Entire State
___ Only in the following geographic areas: **[Specify areas]**

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
_X_ Services are not comparable in amount duration and scope (§1915(g)(1)).

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

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
  - taking client history;
  - identifying the individual's needs and completing related documentation; and
  - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;
  - Assessments are conducted at least every six months and annually, or more frequently based on the client's needs and progress. Ongoing comprehensive assessments and reassessments are performed in a time-specific manner based on the evidence-based home visiting model requirements and expectations. Developmental screenings, depression, substance use, and family strengths assessments are also performed at specific time intervals determined by the model and when needed, as determined by the homes visitor and based on clinical judgment and on-going review with client and client's team as to need, progress, and goal completion.

❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;

❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including

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- activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

❖ Monitoring and follow-up activities:
- activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
  - services are being furnished in accordance with the individual's care plan;
  - services in the care plan are adequate; and
  - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.
- Care planning and monitoring is an integral component to each home visit, where goal planning and review of progress and barriers is built into model implementation. The family support home visitor, in partnership with the parent, develops, documents, and reviews the needs and strengths, goals and aspirations, and progress as outlined in the care plan. This is accomplished within the first thirty days and then reviewed and revised monthly or more frequently if the client's situation changes.

_**X**_ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

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

Family Health Educator	Education required: • Minimum of a bachelor's degree in a human services-related field (i.e. Social work, Counseling, or Early Care and Education)	Skills, Knowledge, and Experience Required: • Must be trained in and maintain the evidence-based home visiting certification as a Parents as Teachers (PAT) Certified Parent Educator; • Screening, assessments, and evaluation; • Knowledge of child development; • Knowledge of family-centered care; • Knowledge of cultural competence and culturally sensitive care;

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		• Demonstrated capacity to provide all core elements of case management services including: ○ Comprehensive client assessment ○ Comprehensive care/service plan development ○ Linking/coordination of services ○ Monitoring and follow-up of services ○ Reassessment of the client's status and needs • Demonstrated case management experience in coordinating and linking such community resources as required by the target population; and • Demonstrated experience with the target population.

In addition the organization providing the SFVT Sustained Family Support Home Visiting Program must have:

1. A sufficient number of staff to meet the case management service needs of the target population
2. An administrative capacity to ensure quality of services in accordance with state and federal requirements.
3. A financial management capacity and system that provides documentation of services and costs.
4. The capacity to document and maintain individual case records in accordance with state and federal requirements.
5. The demonstrated ability to meet all state and federal laws governing the participation of providers in the state Medicaid program.

Freedom of choice (42 CFR 441.18(a)(1)):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

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

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Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
__N/A__ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:
[Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

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

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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))