**Section 630.220 Outreach and Case Management**

a) Definitions. Outreach and case management are defined in Section 630.70.

1) "May" is used to indicate permitted outreach and case management activities.

2) "Must" is used to indicate required outreach and case management activities.

3) "Shall" is used to indicate required outreach and case management activities.

4) "Should" is used to indicate recommended outreach and case management activities.

5) "Advocacy" and "Advocate" mean that the case manager or case manager assistant will ensure, to the extent possible, that the participant receives needed services.

b) Agency Requirements.

1) Criteria for Certifying Agencies to Conduct Outreach and Case Management Activities.

A) Grantees of the Illinois Department of Public Health conducting outreach and case management activities must apply for certification as a case management agency. Certified agencies will enter into a written agreement with the Department or its designee to conduct these activities.

B) Application Process for Certification as a Case Management Agency.

i) The annual funding application must provide assurance that the applicant is in compliance with the requirements set forth in subsections (b)(2) and (3) and describe in detail how it will meet the program requirements set forth in subsection (b)(4) through (7) and describe in detail how it will provide services in accordance with the requirements set forth in subsection (c) through (f). Further, the agency must agree on a continuous basis to comply with this Part and all applicable Federal and State laws and regulations. (See Title XIX of the federal Social Security Act (42 U.S.C.A., Section 1396 et seq.) and the Illinois Public Aid Code [305 ILCS 5].

ii) The Department or its designee will notify successful applicants in writing. The Department or its designee shall provide technical assistance to applicants when requested.

C) Certification.

i) Provisional certification will be awarded for 180 days to successful applicants. During this period, the Department or its designee will conduct a management and fiscal review to ensure compliance with these rules. (See Section 630.20(e) and (f).)

ii) Full certification will be awarded for two years to agencies who successfully complete the review conducted during provisional certification. During this period, the Department or its designee will conduct a management and fiscal review to ensure compliance with these rules. Successful agencies (based on review findings) will be recertified for a two-year period. Unsuccessful agencies (based on review findings) will be given provisional certification. The Department or its designee may, based on review, change an agency's certification at any time, or terminate certification, pursuant to Section 630.200(h).

2) The agency must agree to help a program participant apply for benefits under the Medicaid program.

3) Physical facilities to be used for serving participants must be comfortable, safe, and clean, and must meet local requirements for fire safety, building construction, sanitation and health. The agency must be able to furnish proof upon request that all such local requirements have been met. In addition, a space for meetings with participants that is conducive to privacy should be available.

4) The agency must be capable of delivering services to the target population, demonstrate an understanding of the concept and delivery of case management services and demonstrate (by written agreements or other means such as letters of support) linkages to relevant service and health care agencies serving the target area.

5) The agency must conduct outreach activities to the target population and medical providers in the geographic area to be served.

6) Direct service staff for the program must meet the standards defined in subsection (c) and proof of licensure must be available upon request.

7) The agency must be able to provide services in medical, home and other settings such as schools and churches.

8) The agency must maintain an adequate and confidential participant records system. Documentation of all services provided is to be maintained in this system. (Refer to Section 630.90.)

c) Provider Qualifications.

1) The case manager must meet one of the following qualifications:

A) a registered professional nurse licensed pursuant to Section 12 of the Nurse Practice Act [225 ILCS 65] and

i) two years experience in community health or maternal and child health nursing, or

ii) a Bachelor of Science in Nursing (B.S.N.) degree from a recognized or accredited program and one year of experience in community health or maternal and child health nursing, or

iii) supervision by a registered professional nurse, licensed social worker or licensed clinical social worker with the length of experience described herein, until the case manager obtains the length of experience required in subsection (c)(1)(A)(i) or (c)(1)(A)(ii) of this Section.

B) a clinical social worker licensed pursuant to Section 9 or social worker licensed pursuant to Section 9A of the Clinical Social Work and Social Work Practice Act [225 ILCS 20] and 68 Ill. Adm. Code 1470 and:

i) one year of experience in providing services to families with young children, or

ii) supervision by a registered professional nurse, licensed social worker or licensed clinical social worker with the length of experience described herein until the case manager obtains the length of experience required in subsection (c)(1)(B)(i) of this Section.

C) possess a master's degree or baccalaureate degree in a behavioral science, social science or health-related area; or a baccalaureate degree in any other area and one year of experience in child, family or community services; or an associate degree and two years experience in child, family or community services. Case managers meeting only this qualification must be supervised by a case manager meeting requirements of subsection (c)(1)(A) or (c)(1)(B) of this Section until they have a total of two years of supervised case management experience.

2) Exception process: The Department will use the following procedures when grantees' staff do not meet the qualifications listed above or when they are unable to recruit qualified staff.

A) Individuals employed by a grantee, at the time of the adoption of this Section, to conduct case management activities as described in this Section will be deemed qualified.

B) Grantees that can demonstrate an inability to recruit individuals who meet the qualifications listed above may request an exception. The Department or its designee will grant an exception if it is requested in writing and documents: the grantee's efforts to recruit qualified staff; the education and experience that the grantee proposes to require in filling the position; a justification of why the proposed education and experience are functionally equivalent to the above requirements; and a plan for bringing the individual into compliance within a two-year period.

3) Case Manager Assistants. Paraprofessionals and lay workers may be used to perform some case management functions under the supervision of the case manager. These functions may include intake, follow-up with participants or providers to ensure that participants are accessing needed services, and provision of support and assistance that participants may require to access services. The functions of assessment, service planning, referral, and reassessment of participant's needs are limited to the case manager. Paraprofessionals and lay workers may also be used to conduct outreach activities.

d) Clinical record. The participant's clinical record shall contain, but is not limited to:

1) identifying information including name, case number, address and telephone number, sex, race, hispanic origin, date of birth, marital status, and date of initial contact and initiation of case management services;

2) documentation of the participant's eligibility status for all payment mechanisms for medical care;

3) assessment and reassessment reports;

4) an individual care plan, progress reviews and notes;

5) documentation of missed appointments and attempts to follow up on missed appointments of those participants the case manager or physician have identified as noncompliant;

6) documentation of each service rendered by the case manager as described in subsection (e);

7) documentation of participant's authorization of the case manager to release information to providers of necessary services; and

8) documentation of the participant's primary care provider.

e) Case Management Process

1) Role of the Case Manager. One goal of the case management process is to help participants or their caregivers learn to accept responsibility for their own lifestyle and promote their own health. Another major goal of case management is to enhance the participants' or their caregivers' strengths and resources by teaching them skills for seeking out and using individuals and agencies in the community who are available to meet a wide variety of human needs. At first, the case manager will likely be responsible for most of these activities. As time passes, the participants or their caregivers will ideally participate more actively, while the case manager adopts a more supportive role. Successful case management relies on the education of participants, facilitation of access to services, coordination with service agencies, follow-up on services delivered, assistance with scheduling, and case management assessments to determine medical, psychosocial and environmental risks. The case management process includes the following activities:

A) assessment of needed health and social services;

B) development of an Individual Care Plan consistent with subsection (e)(2);

C) referral of participants to appropriate providers within the community for services identified in the Individual Care Plan;

D) on-going follow-up with participants or service providers to determine whether participants have accessed services. Follow-up should be continuous from initial identification through case closure;

E) periodic reassessment of participants' needs, as described in these rules;

F) advocacy to assist participants in accessing services;

G) procedures for terminating the professional relationship between the participant and the case manager when the participant no longer requires case management;

H) case management activities should be provided during a face-to-face contact with the program participant whenever possible; and

I) case managers may also perform outreach activities on a less than full-time basis.

2) Individual Care Plan. The case manager should utilize the recommendations from the primary care provider, other service providers as appropriate, and from the initial social and nutritional assessments to develop an individual care plan with each participant. Development of the individualized care plan may include discussions with other providers identified in the plan (provided that the participant has consented in writing to such discussions); and telephone calls to, face-to-face meetings with, or home visits to the participant. The individual care plan or clinical record must include, but is not limited to, the following:

A) verification of eligibility status for all payment mechanisms for medical services;

B) referral, if necessary, for physician services;

C) a list of all of the service providers involved with the participant;

D) a list of the agencies to which the participant will be referred;

E) a problem list and plans for problem resolution;

F) an assessment or assessments to determine the need for health, mental health, social, educational, vocational, substance abuse treatment, child care, transportation or other services, including:

i) a nutritional assessment (refer to Sections 630.30(b)(3)(F), 630.40(b)(1)(E), 630.50(a)(1)(F), and 630.60(a)(1)(F));

ii) a psychosocial assessment, including composition of family, evidence of parent-child bonding, parenting skills and education of parents;

iii) support systems available to parents or caregivers;

iv) social and health services currently used by the family, including sources of primary care and emergency care;

v) environmental assessment, including at least the condition of housing, availability of utilities (water, heat, light, cooking, refrigeration, sanitation, etc.) and risks of unintentional injury; and

vi) developmental assessment of infants and children.

3) Assignment of Participants. Each participating family should be assigned to one case manager.

4) Frequency. The case management agency must have face-to-face contact with the participating family as specified below and have as much additional contact as necessary to facilitate the family's access to services. Each contact must include the activities described in Section 630.220(e)(6). Whenever possible, the face-to-face contact should be made by the assigned case manager. In determining the appropriate frequency of face-to-face contacts with a family, priority must be given to the requirements for infants, then for pregnant women, then for all other family members.

A) For families with one or more infants, face-to-face contact at approximately two, four, six and twelve months of age.

B) For families with a pregnant woman, face-to-face contact once each trimester of pregnancy.

C) For families with one or more children over age one year, but without an infant or pregnant woman, face-to-face contact once each twelve months of program participation.

5) Referral and Advocacy. The case manager shall assure that any necessary referrals are made and advocate as necessary on the participant's behalf for services identified in the individual care plan.

6) Follow-up and Reassessment. Subsequent case management activities shall include, as necessary, a review of the implementation of the individualized care plan to date. The case manager should update the individual care plan using any additional information received from the physician or other service providers.

7) High-Risk Case Management

A) Content. High-risk case management includes all the service components of case management, including a review of the implementation of the individualized care plan to date, emphasizing compliance with recommendations regarding the high-risk condition(s). High-risk case management must be performed by the case manager.

B) Frequency. High-risk case management may be provided as frequently as needed.

C) Eligibility. High-risk case management may be provided when the participant is determined to be at high risk for medical complications by the primary care provider or by risk assessment. High-risk case management of infants and children may be provided by the case management agency when the infant or child has been identified through the Adverse Pregnancy Outcome Reporting System (APORS) (See 410 ILCS 525/3) and 77 Ill. Adm. Code 840.210), when the infant has been diagnosed with a serious medical condition after newborn discharge, when maternal alcohol or drug addiction has been diagnosed or when child abuse or neglect has been indicated based on investigation by the Illinois Department of Children and Family Services. Similarly, APORS infants or children whose conditions are minor and whose environments are stable may be transferred into the low-risk follow-up regime.

8) Home Visits. Case management activities shall be conducted in the participant's home as presented below.

A) At least once prenatally.

B) At least once during infancy, if a home visit was not completed during pregnancy.

C) At least once every 24 months of program participation to families that do not include a pregnant woman or an infant.

9) Case Closure:

A) Criteria for closure. Unless other family members are receiving case management, case closure may occur when:

i) the participant no longer meets age or income eligibility criteria for case management funding;

ii) the participant moves out of the grantee's service area;

iii) the participant dies; or

iv) the case management agency is no longer able to reach the participant.

B) Content. At the time of closure, the case manager should ensure that the following activities have been completed, as appropriate for the participant's circumstances:

i) the participant has located a medical care provider for continued care for himself or herself and his or her children;

ii) the participant is referred for family planning services;

iii) the participant is referred for postpartum WIC or Commodity Supplemental Food Program (CSFP) certification;

iv) the participant's children are referred for WIC or CSFP certification;

v) the children have begun or been referred for immunizations (if these are not contraindicated or declined by the parent);

vi) the participant has completed application for Medicaid for his or her children; and

vii) the participant has been given information regarding child restraint seats.

C) If the participant is moving to another area, the participant's case records may be transferred to the new case management agency if the participant's consent is obtained.

f) Case Management Coordination. Department grantees providing case management services should engage in activities (as described below) to coordinate with other agencies in the grantee's service area that provide case management services to the same types of persons as the grantee has agreed to serve. These activities are intended to avoid duplication of case management services at the local level and ensure that each participant has only one lead case manager at any given time.

1) The case management agency should ensure that every family enrolled in case management continues to utilize primary medical care, regardless of the lead case management agency working with the family.

2) Case Management Coordination Agreements. Grantees of the Department's Division of Family Health should enter into written agreements with other agencies with the same geographic service area (in whole or in part) and with comparable scope of case management activities regarding coordination of case management services. These agreements must at least specify each grantee's target group for services; referral procedures; procedures to obtain informed consent for services and protection of participant's privacy; and procedures to determine the agency most appropriate to provide case management services.

3) Determination of the Agency or Program most appropriate for the delivery of case management services. Following the assessments of a participant's service needs, the case manager, other involved service providers, and the participant (and the participant's parent(s) or legal guardian(s), depending upon the participant's ability to consent for services) should determine the one agency or program most appropriate to take a lead role in providing case management services if any of the criteria listed below are met. Only those providers for which the participant has given written consent may participate in the determination of the most appropriate agency or program to provide case management. The criteria requiring such a determination are:

A) the participant's most important problem requires expertise for case management that the grantee's staff does not possess;

B) the participant's most important problem requires expertise for case management that another agency's staff does possess;

C) the participant's problems are so complex as to require the close collaboration of several agencies for successful case management; and

D) the participant prefers to obtain case management services from another agency.

g) Allowable Cost for Outreach and Case Management Activities.

1) Federal financial participation in outreach and case management is provided through the Medicaid program for coordination of medical and medically-related services for the health and well-being of the participant.

2) Allowable Costs for Outreach. Costs incurred for outreach activities as defined in Section 630.70 are allowed. However, health, general education, or other social service activities may not be included as outreach.

3) Allowable Costs for Case Management. Salary and other expenses for staff conducting outreach and case management activities must be supported by documentation, as described in subsection (h). Expenses incurred for the provision of any other direct service (including patient teaching) by staff conducting outreach and case management activities must be excluded. If program staff provide other direct services in addition to outreach and case management, the grantee's time and activity reporting system must distinguish between allowable and excluded costs.

4) The agency must make its clinical and time reporting records available for inspection by authorized representatives of the Department, the Illinois Department of Public Aid and the Centers for Medicare and Medicaid Services.

h) Time and Activity Data to be Collected. The following time, activity and participant information must be recorded by each outreach worker, case manager and case manager assistant on his or her daily activities and the participants served. Specific data entry codes for each item will be specified by the Department. Each report must be signed by the outreach worker, case manager or case manager assistant making the report, and signed or stamped by the outreach worker's, case manager's or case manager assistant's supervisor. A time study must be performed each quarter of the State fiscal year for at least one pay period or ten working days, whichever is longer. The time study period for each quarter will be specified by the Department and communicated to the case management agency in writing. During the remainder of each quarter of the State fiscal year, each case manager, case manager assistant or outreach worker must record and report only the information specified in subsection (h)(1), (h)(2), (h)(3), (h)(4), (h)(5)(A), (h)(5)(B), (h)(7), (h)(8), (h)(9), (h)(10), (h)(11) and (h)(12). This requirement applies to case management agencies that are serving clients who do not reside in the service area for the Medicaid Managed Care Demonstration program implemented by the Illinois Department of Public Aid under a waiver from the U.S. Centers for Medicare and Medicaid Services.

1) Identification of the agency conducting the outreach or case management activity.

2) Identification of the staff person conducting the outreach or case management activity.

3) The date on which the activity was conducted.

4) The Medicaid Case Identification Number and the Medicaid Recipient Identification Number. These numbers are assigned by the Illinois Department of Healthcare and Family Services. These numbers must be recorded if the participant's medical care is being paid for through the Medicaid program.

5) Activity. This item describes the outreach worker's, case manager's or case manager assistant's activity. At a minimum, categories must identify case management; outreach; administration of outreach and case management; accrued benefit time; and other direct services, as follows:

A) intake interview, assessment or reassessment of participant's needs; development or revision of the Individual Care Plan; referral or advocacy for services; follow-up with the participant or the provider's case closure; and travel;

B) outreach/case finding;

C) administration of outreach and case management activities. This includes administrative activities not attributable to a specific client such as the development of monthly or annual program plans or budgets; planning project activities; developing linkage agreements or referral arrangements with community service providers; supervision of staff; preparation of routine correspondence; preparation of travel vouchers, telephone logs and similar activity records (except case notes and client tracking); staff supervision; and preparation of case notes and reports;

D) staff training and evaluation. Time spent in continuing education, in-service or other training programs, and time spent in performance evaluation;

E) accrued benefit time (sick leave, vacation, compensatory time, etc.);

F) health education. Time spent directly providing health education to the participant;

G) counseling. Time spent directly providing counseling to the participant; and

H) other direct services to participants not involving outreach or case management.

6) Time Spent. The amount of time spent on each activity.

7) Case Number. The participant's case number assigned by the Department's Case Management Information System or other software provided by the Department for this purpose.

8) Participant's name.

9) Medicaid Status. The participant's eligibility status for the Medicaid program. At a minimum, the participant must be classified as:

A) ineligible. This includes participants who are ineligible for the Medicaid program; or

B) active. The participant is eligible for the Medicaid program at the time case management activities are conducted; or

C) the participant is in the process of applying for the Medicaid program. This includes discussing the participant's potential eligibility for Medicaid, as well as assistance provided while the participant's Medicaid application is pending; or

D) "Healthy Start" (Medicaid Presumptive Eligibility) − The participant has been presumed eligible for the Medicaid Program by an agency qualified to make that determination; or

E) Spend-down. The participant has been placed on spend-down status by the Illinois Department of Healthcare and Family Services as defined in 89 Ill. Adm. Code 120.60(d) and 120.384.

10) Program. The grant program or programs through which the participant is receiving case management.

11) Case Type. The participant's eligibility for case management on the basis of age or pregnancy.

12) Site of Contact. Where the contact between the case manager and the participant or provider occurred. At a minimum, this must be classified as: the participant's home; the case manager's office; or off site, including transporting participants.

13) Method of Contact. How contact between the case manager and the participant or provider occurred. At a minimum, this must be classified as: individual, face-to-face contact; group contact; telephone contact; home visit; or unsuccessful home visit.

14) Service. Describes the predominant service provided to, discussed with, or arranged for a participant during a specific activity. At a minimum, the following services must be recorded as appropriate:

A) Services covered by the Illinois Medicaid Plan.

B) Services not covered by the Illinois Medicaid Plan.

15) Whether a referral was made, refused or not possible for needed service.

16) The agency to which the participant was referred for a needed service.

17) The date on which the referral for a needed service was completed.

i) Agency Staff Expenses to be Reported. The following information must be reported by each agency applying, provisionally certified or certified under subsection (b). The information must be provided on a monthly basis, and the report must be signed and dated by an authorized official of the agency. This requirement applies to case management agencies that are serving clients who do not reside in the service area for the Medicaid Managed Care Demonstration Program implemented by the Illinois Department of Healthcare and Family Services under a waiver from the U.S. Centers for Medicare and Medicaid Services. The information must include:

1) The name, actual gross pay and actual paid hours for each full or part-time direct service staff person conducting outreach or case management activities;

2) the full-time equivalence as agency employees for the direct services staff;

3) the name, actual gross pay and proportion of time spent on the case management grant programs for each clerical, secretarial or other staff person supporting the direct service staff;

4) the name and actual gross pay for the staff who supervise direct service staff full time;

5) the name and actual gross pay for agency administrative staff;

6) the length of the agency's regular workday (in hours);

7) the agency's fringe benefit rate; and

8) the total number of full-time equivalent agency employees.

j) Agency Operating Expenses to be Reported. The following actual operational expenses for the entire agency which is applying, provisionally certified or certified to conduct outreach and case management activities under subsection (b) must be reported. This data must be submitted on a monthly basis, and the report signed and dated by an authorized official of the agency. This requirement applies to case management agencies that are serving clients who do not reside in the service area for the Medicaid Managed Care Demonstration Program implemented by the Illinois Department of Healthcare and Family Services under a waiver from the U.S. Centers for Medicare and Medicaid Services. Operating expenses must include the following:

1) Rent;

2) Maintenance;

3) Utilities;

4) Telephone;

5) Photocopying;

6) Office Supplies;

7) Postage;

8) Insurance;

9) Dues, Subscriptions and Registration Fees;

10) Travel;

11) Depreciation on Building;

12) Equipment;

13) Depreciation on Equipment;

14) Contractual Services; and

15) The total of items listed in subsections (j)(1) through (j)(14).

(Source: Amended at 18 Ill. Reg. 4384, effective March 5, 1994)