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Re-entry Targeted Case Management (RTCM) (S5190 U1) with Transition Coordination (S5190)

Definitions

Refer also to Appendix A for terms used in the Appendix.

“Face-to-Face" means the service component may be delivered via telemedicine if clinically appropriate. Refer to the Telehealth Services Supplement for the definition of telemedicine and requirements for service delivery through telemedicine.

“In-Person” means physically in the presence of the individual.

“Transition Coordination Meeting” means a meeting between the RTCM case manager and Managed Care Organization (MCO) care manager. The meeting is facilitated by the RTCM case manager and may also include the individual, caregiver, family or household members, and other service providers. The meeting serves as a warm hand-off from fee-for-service RTCM to MCO care management and appropriate managed care services. The purpose of the transitional meeting is to ensure that the individual has ongoing care management for all needed Medicaid services and is aware of the care management support provided by their health plan.

RTCM Level of Care Guidelines	
Service Definition	Re-entry Targeted Case Management (RTCM) is defined as a service to assist eligible individuals in gaining and coordinating access to needed medical, behavioral health, social, educational, and other services in the 30-day period prior to release from incarceration and for 60 days following release to help justice-involved youth transition to community living. Case management shall facilitate the coordination of services to ensure seamless, integrated support by reducing barriers, minimizing service fragmentation, and connecting individuals with appropriate resources. The objective of RTCM services is to promote comprehensive and continuous access to medical, psychiatric, psychological, social, educational, vocational, recovery, and other essential supports necessary to address the fundamental needs of each individual by strengthening pathways to community reintegration. RTCM does not include the provision of direct clinical or treatment services. RTCM includes the assessment, development of a person-centered Individual Service Plan (ISP), referral and care coordination with service providers and monitoring of the services provided pursuant to the ISP.

	The required features of RTCM are: 1) re-entry needs assessment, 2) person-centered care planning and the development of the ISP (including the review of health records provided by correctional providers and review or completion of a screening and diagnostic checklist), 3) referrals to community services (including any ongoing targeted case management services as well as the required transition coordination meeting when an individual enters a Cardinal Care Managed Care health plan), 4) and monitoring and follow-up activities. For individuals who meet criteria for Mental Health Case Management (MHCM) (H0023) or Substance Use Disorder Case Management (SUD-CM) (H0006) the RTCM case manager may coordinate the referral and transition to the appropriate case management service at any time following release based on the needs of the individual and availability of services.
Required Activities	The following service components and activities are required and shall be provided. Face-to-face contacts should be prioritized and audio-only/telephonic modality should only be used when significant barriers to face-to-face modalities exist. In-person contacts should also be offered and prioritized both pre- and post-release when in the same geographical area but are not required. **Re-entry Needs Assessment:** A Re-entry Needs Assessment must be completed by a qualified case manager to determine the need for services. The assessment should be conducted pre-release whenever feasible to determine the individual's needs for medical, educational, social, or other services and supports upon release. Information shall be gathered from other sources such as family members, medical providers, social workers, and educators (if necessary). If pre-release assessment is not feasible, the assessment shall take place as soon as possible post-release. • The case manager shall review files from the carceral provider documenting screenings, assessments, and services received during incarceration and identify additional screening and assessment needs based on Virginia's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) periodicity schedule and other key developmentally appropriate screenings and assessments.

	• The case manager shall gather information from carceral providers regarding pharmacy and medication needs at the time of discharge, to include medications to be provided at discharge and timing of need for follow up appointments in the community. • Case management assessments and intakes must be provided in accordance with the provider requirements defined in DBHDS licensing regulations (12VAC35-105) for case management services. The assessment serves as the basis for the ISP. The provider may complete a Comprehensive Needs Assessment (CNA) for this assessment (see Chapter 4 of the Mental Health Services Manual for additional information) but a CNA is not required for this service. • If facility release date changes by more than 60 days and the assessment has already been completed, an updated assessment should be completed when the individual is re-admitted to RTCM within 30 days of the updated release date. **Person-Centered Care Planning:** Using the results of the assessment and the stated goals of the individual, the case manager shall develop the ISP in a person-centered manner, in collaboration with the individual/family/caregiver. • The ISP shall describe the services and resources needed to meet the needs of the individual and to help access those services and essential supports during the transition from pre-release to 60 days post-release. • Such service planning shall not include performing medical and psychiatric assessment but shall include referrals for such assessments. • The ISP should specify any EPSDT screenings and assessments that the individual is due based on Virginia's EPSDT Periodicity schedule and the records reviewed. This can be completed by including any checklists completed by the carceral facility or by completing the checklist and including it in the ISP. • The ISP should specify medication management and prescription-related coordination needs (e.g., refills and prescriptions) based on the discharge plan of the facility and any specific medication needs, including oral and long-acting injectable medications for substance use disorder and mental health conditions, ensuring that access to prescribed medications is continuous during the transition from the carceral setting to the community.

	• The individual and their family/caregiver as appropriate shall be involved in the ISP development and in all reviews and updates to the ISP. • The case manager shall collaborate closely with the releasing institution and other involved parties in preparation of the ISP. • The ISP shall be completed within 14 calendar days of assessment and shall document a plan to address all identified medical, social, behavioral health, educational, and other re-entry related needs. • Verbal agreement for the ISP from the individual may be documented when physical or electronic signatures are not able to be obtained due to documented barriers to in-person contact or ability to obtain an electronic signature. • The case manager shall review and update the ISP every 30 days thereafter or more frequently if needs change. The ISP shall reflect the current needs of the individual prior to the transition coordination meeting. **Referrals, Care Coordination with Service Providers and Transition Coordination Meeting with MCO:** The case manager shall: • Link the individual to needed services and supports in the geographic region of their home and residence specified in the ISP. Activities shall include linking and scheduling appointments for the individual with medical, behavioral health, social, educational providers or other programs and services to address identified needs and achieve goals specified in the ISP. This includes ensuring continuous access to prescribed medications, including medication treatment for substance use disorder and mental health conditions (including long-acting injectable medications) during the transition period. • Coordinate services and service planning with other agencies and providers involved with the individual. • Enhance community integration by contacting other entities to arrange community access and involvement including opportunities to learn community living skills, and use vocational, civic, and recreational services. • Ensure that the individual has a primary care provider or pediatrician through referral and care coordination. If the individual already has a primary care provider or pediatrician, document attempts to notify the primary care provider or

	pediatrician of the individual's engagement in case management services. • Arrange a Transition Coordination meeting with the MCO care manager once the individual enrolls into a Cardinal Care Managed Care health plan to ensure that the individual and caregivers are aware of care management services they are entitled to through their health plan as well as the name and contact information for their MCO care manager. **Monitoring and Follow-Up Activities:** The case manager shall: • Continuously monitor the appropriateness of the individual's ISP and make revisions as indicated by the changing support needs of the individual. • Ensure that services are provided in accordance with the ISP and adequately address the individual's needs through monitoring and follow-up activities, including continuous access to prescribed medications and behavioral health services. • Monitor service delivery as needed through contacts with service providers as well as periodic site visits and home visits to ensure that services are being furnished in accordance with the individual's ISP. • Communicate with collateral contacts to promote implementation of the service plan and community integration and • Revise the ISP whenever the amount, type, or frequency of services rendered by the individual service providers change.
RTCM Medical Necessity Criteria	
Admission Criteria	All individuals who are in the target population ("eligible juveniles" as defined in Section 5121 of the Consolidated Appropriations Act of 2023) are eligible to receive the service: 1. Children and youth under 21 years of age and determined eligible for any Medicaid eligibility group; children determined eligible for FAMIS; and individuals determined eligible for the mandatory eligibility group for former foster care children age 18 up to age 26 and

	2. Who are within 30 days of their scheduled date of release from a public institution following adjudication, and 60 days following release. Public institutions include: ▪ Department of Corrections facilities, including institutions and special programs (e.g., community corrections alternative programs) ▪ Department of Juvenile Justice facilities, including corrections, detention, and community placement programs ▪ Local and regional jails
Continued Stay Criteria	Not Applicable; this is a time limited service, limited to the 30 days pre-release and the 60 days post-release or until the Transition Coordination Meeting has occurred.
Discharge Criteria	The individual shall be discharged at the end of the 60-day period following release or at the time of the Transition Coordination Meeting. For individuals who meet criteria and are transitioning to Mental Health Case Management (MHCM) (H0023) or Substance Use Disorder-Case Management (SUD-CM) (H0006) discharge from RTCM may occur after 30 days post-release to enroll in MHCM or SUD-CM based on the needs of the individual.
Exclusions and Service Limitations	The monthly case rate (S5190 U1) for RTCM cannot be billed the same calendar month as Mental Health Case Management (MHCM) (H0023), Substance Use Disorder - Case Management (SUD-CM) (H0006) or any other targeted case management service.
RTCM Provider Participation Requirements	
Provider Qualifications Requirements	The reentry targeted case management provider must be: 1. A Community Services Board (as established in § 37.2-500); and 2. Licensed by DBHDS as a provider of MH Case Management Service for Adults (16-004) or MH Case Management Service for Children and Adolescents (16-005); and 3. Enrolled with DMAS as provider class type (PCT) 156 or 456 with provider specialty (PS) 923.
Staff Qualification Requirements	Providers may bill Medicaid for RTCM only when the services are provided by qualified case managers. Qualified case managers providing RTCM services must have knowledge of: 1. Services, systems, and programs available in the community including primary health care, support services, eligibility criteria and intake processes, generic community resources, and mental health, developmental disability, and substance use treatment programs including medication for substance

	use disorders and long-acting injectable medications for mental health and substance use disorders; 2. The nature of justice-involvement for youth, emotional and behavioral health disorders, developmental disability, and substance use, including clinical and developmental issues; 3. Different types of assessments, including functional assessments, and their uses in service planning; 4. Treatment modalities and intervention techniques, such as behavior management, independent living skills training, supportive counseling, family education, crisis intervention, discharge planning, and service coordination; 5. The service planning process and major components of a service plan; 6. The use of medications in the care or treatment of mental health and substance use disorders when present in the population served; and 7. All applicable federal and state laws, regulations, and local ordinances. Qualified case managers providing case management services must have skills in: 1. Identifying and documenting an individual's needs for resources, services, and other supports; 2. Using information from assessments, evaluations, observation, and interviews to develop Individual Service Plans; 3. Identifying services and resources within the community and establishing service systems to meet the individual's needs and documenting how resources, services, and natural supports, such as family, can be utilized to achieve an individual's personal habilitative, rehabilitative, and life goals; and 4. Coordinating the provision of services by public and private providers. Qualified case managers providing case management services must have abilities to:

	1. Work with team members, maintaining effective inter- and intra-agency working relationships; 2. Work independently, performing position duties under general supervision; and 3. Engage and sustain ongoing relationships with individuals receiving services.
RTCM Service Authorization and Utilization Review	
Service Authorization	**Re-entry Targeted Case Management (S5190 U1)** Providers must submit a registration to the FFS service authorization contractor within one business day of admission for S5190 U1. If a provider does not submit within the one business day requirement, the start date of the registration shall be changed to the date of the submission. **Transition Coordination (S5190)** Providers must submit a separate registration to the FFS service authorization contractor prior to billing S5190. Registration for S5190 should not be completed until the transition coordination meeting has been scheduled and the assessment and ISP have been completed. At time of registration for S5190, providers answer a question as to whether they were able to receive the carceral records for the completion of the checklist and the development of the ISP. Providers may contact the FFS service authorization contractor directly for more information.
Documentation and Utilization Review	Refer to Chapter IV and VI of the Mental Health Services Manual for additional documentation and utilization review requirements that apply to providers of RTCM. In addition: 1. Case management records must include the individual's name, dates of service, name of the provider, nature of the services provided, achievement of stated goals, if the individual declined services, and a timeline for reevaluation of the ISP. There must be documentation that notes all contacts made by the case manager related to the ISP and the individual's needs. 2. Case management records must include information regarding specific barriers to in-person contacts and face-to-face telemedicine contacts if these contacts were not made. 3. For behavioral health services initiated post-release, the case management record must include ISPs from rendering service providers.

RTCM (S5190 U1) and Transition Coordination (S5190) Billing Requirements

S5190 U1 Billing Details

1. A billing unit is one calendar month

2. RTCM may be billed each month that a case management activity occurs during the allowable time frame (30 days pre-release and 60 days post-release), per release episode. There may be circumstances where months billed are not consecutive due to changes in release dates that are less than 60 days. If first and final months are partial months, a total of four months may be billed.

3. If facility release date changes by more than 60 days and the pre-release month has already been billed, then the individual shall be discharged from RTCM and then re-admitted when the new release date is within 30 days including an updated assessment.

4. Billing can be submitted for RTCM for months in which direct or individual-related contacts, activity, or communications occur and that fall into the allowable time frame. These activities must be documented in the clinical record and related to the ISP. The provider shall bill for the specific date of the contact or service provided. S5190 U1 shall not be billed the same calendar month as mental health or SUD case management services or any other targeted case management.

5. See Chapter V for additional billing instructions.

S5190 Billing Details

One unit of Transition Coordination (S5190) may be billed at the time of the Transition Coordination meeting, whether the meeting occurs during the same calendar month RTCM (S5190 U1) is billed or after the three-month RTCM period has ended. Transition Coordination (S5190) may be billed the same calendar month as targeted case management and is not duplicative with these services.

General Requirements

1. Federal regulation 42 CFR § 441.18 prohibits providers from using case management services to restrict access to other services. An individual cannot be compelled to receive case management if the individual is receiving another service, nor can an individual be required to receive another service if they are receiving case management. For example, a provider cannot require that an individual receive case management if the individual also receives medication management services.

2. Providers must follow the requirements for the provision of telemedicine described in the “Telehealth Services Supplement” including the use of the GT

modifier for units billed for services provided through telemedicine.