STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Alaska

CASE MANAGEMENT SERVICES

A. Target Group: Medicaid-eligible substance-abusing adults and children for whom care coordination services have been found to be a treatment need in an intake assessment, during an evaluation or at a reassessment, and are certified as medically necessary in a treatment plan signed by supervising staff in, or the director of, a substance abuse treatment center.

B. Areas of State in which services will be provided:

X Entire State.

/ / Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

/ / 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.

D. Definition of Services:

Care coordination means those activities conducted by a substance abuse coordinator to identify necessary and appropriate services a recipient needs in order to successfully recover, and to assist the recipient in obtaining those services. The service must be separate from other reimburseable services.

E. Qualification of Providers:

Programs which are approved as providers of substance-abuse services by the Division of Alcoholism and Drug Abuse and hold a valid certificate under 7 AAC 29.010- 7 AAC 29.900.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Alaska

CASE MANAGEMENT SERVICES

A. Target Group: Medicaid-eligible mentally ill children and adults whose illness is severe enough that case management services are determined to be medically necessary and are specified in a written treatment plan which has been approved and signed by a physician or mental health professional clinician.

B. Areas of State in which services will be provided:

/X/ Entire State.

/ / Only in the following geographic areas (authority of section 1915(g)(1 of the Act is invoked to provide services less than Statewide:

C Comparability of Services

/ / 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.

D. Definition of Services: Family support (for children) and client support (for adults) services coordinate treatment services, facilitate access to appropriate/necessary services, monitor service delivery and progress, and advocate for appropriate services. Limited to treatment plan prescription, but not to exceed 15 hours per month, 180 hours per 12 months. Service must be rendered by a mental health clinical associate or professional clinician, and **cannot be a part of any other reimbursable service.**

E. Qualification of Providers:

Must be a "Community Mental Health Clinic", which means a program operating under the provisions of AS 47.30.520 -- AS 47.30.620 and headed by a physician, or by a psychologist or a mental health professional clinician under the general direction of a physician.

State/Territory: Alaska

F 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.

Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

CASE MANAGEMENT SERVICES

A. Target Group:

Infants and toddlers at risk for or currently experiencing developmental delays or with disabilities who are eligible for Alaska Infant Learning Program services under Alaska Administrative Code 07 ACC 23.080.

B. Areas of State in which services will be provided:

__X__ Entire State
___ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide.)

C. Comparability of Services:

___ 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.

D. Definition of Services:

Case management is provided to children in the target group to assist and enable the eligible child to gain access to needed medical, social, educational, developmental and other appropriate services. The case manager is responsible for coordinating all services across agency lines and serving as the single point of contact in helping child and family obtain the services and assistance they need. Case management may be delivered in person, electronically, or by telephone for the purpose of enabling the eligible child and family to obtain the needed services.

Case management services include:

Intake and Needs Assessment
Ongoing systematic, data collection to determine current status and identify needs in physical, environmental, psychosocial, developmental, educational, social, behavioral, emotional, and mobility areas. Data sources include family interviews, existing available records, and needs assessments.

Plan of Care: Development of Individualized Family Service Plan (IFSP)
The case manager (service coordinator) develops a case plan (IFSP), in conjunction with the family and other IFSP team members to identify goals, objectives and issues discovered through the assessment process. Case

CASE MANAGEMENT SERVICES

planning (IFSP) includes determining activities to be completed by the case manager, in support of the child and family. These activities include accessing appropriate health and mental health, social, educational, vocational, and transportation services to meet the child's needs.

Service Coordination and Monitoring

a. Linkages - establishing and maintaining a referral process with pertinent individuals and agencies which avoids duplication of services to the child and family.

b. Planning - Identifying needs, writing goals and objectives, and determining resources to meet those needs in a coordinated, integrated fashion with the family and other IFSP team members.

c. Implementation - Putting the plan (IFSP) into action and monitoring its status.

d. Support - Support is provided to assist the family to reach the goals of the plan; especially if resources are inadequate or the service delivery system is non-responsive.

Reassessment and Transition Planning

The case manager (service coordinator), in consultation with the family and other IFSP team members, determines whether or not the linked services continue to meet the child and family's needs, and if not, adjustments are made and new or additional referrals are made to adequately meet the defined child and family needs.

These services:

a) Assist families of eligible children in gaining access to Infant Learning Program services and other medical or social services identified in the IFSP;
b) Coordinate Infant Learning Program services and other medical or social services (such as medical services for other than diagnostic and evaluation purposes) that the child needs or is being provided;
c) Assist families in identifying available medical and social service providers;
d) Coordinate and monitor the delivery of available medical or social services;
e) Inform families of medical/social service availability;
f) Maintain a record of case management activities in each child's file.

CASE MANAGEMENT SERVICES

E. Qualification of Case Managers (Service Coordinators)

Case managers (service coordinators) must be employees of the Alaska Infant Learning Program contracting or subcontracting agency and meet the relevant personnel standards. Service Coordinators must have demonstrated knowledge and understanding about:

a) The Alaska Infant Learning Program;
b) The nature and scope of Medicaid and other services available under the Alaska Infant Learning Program, the system of payments for services and other pertinent information.
c) Infants and toddlers eligible for this program

F. Qualifications of Provider Organizations

Provider organizations must be contractors or subcontractors with the Department of Health and Social Services for the provision of Infant Learning Program services under Alaska Administrative code 07 ACC 23.030.

G. 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 consumers will have free choice of the providers of case management services.
2. Eligible consumers will have free choice of the providers of other medical care under this plan.

H. Payment for Case Management services under the plan does not duplicate payments made to public or private entities under other program authorities for this same purpose.

CASE MANAGEMENT SERVICES

Section 1915(g) of the Social Security Act is the Authority for this Amendment.

A. Target Group

Targeted case management services are provided to all Medicaid eligible recipients under age 21 and who are currently residing in an in-home setting, a foster home, group home, residential care facility, or independent living situation under the responsibility of the Department of Health and Social Services.

B. Areas of State in which services will be provided:

/X/ Entire State.

/ / Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

/ / 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.

D. Definition of Services

Case management services include:

Assessment
After the need for targeted case management services has been determined, the case manager assesses the specific areas of concern, family strengths and resources, community resources and extended family resources available to resolve those identified issues. At assessment, the case manager makes preliminary decisions about needed medical, social, educational, or other services, and the level of agency intervention required.

Case Planning
The case manager develops a case plan in conjunction with the client and family to identify goals and objectives to resolve the issues of concern identified through the assessment process. Case planning involves outlining activities to be completed by the case manager, the family, and client. The case plan includes ways to access medical, social, educational, and other services to meet the client's needs.

Case Plan Implementation
The case manager links the client and family with appropriate agencies and medical, social, educational or other services by calling or visiting these resources. The case manager facilitates implementation of agreed-upon services by ensuring clients and providers fully understand how the services support their case plan and then assisting the client and family to access the services.

Case Plan Coordination
After these linkages have been completed, the case manager will evaluate, on an ongoing basis, the level of involvement of the client and family and whether or not the medical, social, educational, or other services are being provided and used as agreed upon. Coordination activities include, but are not limited to, personal, mail, email, and telephone contacts with providers, and well as meetings with the client and family.

Case Plan Reassessment
The case manager determines whether or not medical, social, educational or other services continue to adequately meet the goals and objectives identified in the case plan. Reassessment decisions include those to continue, change, or terminate those services. This may include assisting clients to access different medical, social, educational or other needed services beyond those already provided. Reassessment activities include, but are not limited to, staffings, and personal, email, mail, and telephone contacts with involved parties.

E. Qualifications of Case Managers

1. Completion of training in case management curriculum approved by the Department of Health and Social Services.

2. Basic knowledge of behavior management techniques, family dynamics, child development, family counseling techniques, emotional and behavioral disorders.

3. Skill in interviewing to gather data and complete needs assessment, in preparation of narratives/reports, in development of service plans, and in individual and group communication.

4. Ability to work with court systems, to learn state and federal rules, laws and guidelines relating to child welfare, and to gain knowledge about community resources.

F. Qualifications of Providers

Provider Organizations
Case management provider organizations must be certified as meeting the following criteria:

a) A minimum of three years experience of successful work with children and families, involving a demonstrated capacity to provide all core elements of case management, including Assessment, Case Planning, Case Plan Implementation, Case Plan Coordination, and Case Plan Reassessment.

b) A minimum of three years case management experience in coordinating and linking community medical, social, educational or other resources as required by the target population.

c) A minimum of three years experience working with the target population.

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

e) Financial management system which provides documentation of services and costs.

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

g) Demonstrated commitment to ensure a referral consistent with section 1902a(23), freedom of choice of providers.

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

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

H. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Additional Assurance

Payments for targeted case management will be made through the MMIS system. The state Medicaid agency assures that no case management administrative activities will be billed as targeted case management services. Department of Health and Social Services staff will utilize the approved Random Moment Time Sampling process to allocate case management administrative activities as separate costs, distinct from targeted case management services. Other providers of targeted case management must also provide assurances that they will not bill other federal programs. Payments for targeted case management will be made through the MMIS system to all qualified provider organizations. Use of this system assures that duplicate payments will not be made to more than one provider for targeted case management services provided to the same client.

CASE MANAGEMENT SERVICES

Section 1915(g) of the Social Security Act is the Authority for this Amendment.

A. Target Group

The target group consists of AI/AN served by health care facilities operated under the authority of 25 U.S.C. 450 - 458 bbb-2 (P.L. 93-638) which are located in the State of Alaska.
The target group includes elder care; individuals with diabetes; children and adults with health and social service care needs; and pregnant women. Services provided under this section are referred to as Tribal Targeted Case Management Services.

B. Areas of State in which services will be provided:

/X/ Entire State.

/ / Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

/ / 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.

D. Definition of Services

Tribal Targeted Case management services include:

1. Assessment
   After the need for tribal targeted case management services has been determined, the tribal case manager assesses the specific areas of concern, family strengths and resources, community resources and extended family resources available to resolve those identified issues. At assessment, the tribal case manager makes preliminary decisions about needed medical, social, educational, or other services and the level or direction tribal case management will take.

2. Case Planning
The tribal case manager develops a case plan, in conjunction with the client and family (where applicable), to identify the goals and objectives, which are designed to resolve the issues of concern identified through the assessment process. Case planning includes outlining activities to be completed by the tribal case manager, the family and client. The case planning activity includes accessing medical, social, educational, and other services to meet the clients' needs.

3. Case Plan Implementation
The tribal case manager links the client and family with appropriate agencies and medical, social, educational, or other services by calling or visiting these resources. The tribal case manager facilitates implementation of agreed-upon services by ensuring the clients and providers fully understand how the services support their case plan and then assisting the client and family to access them.

4. Case Plan Coordination
After these linkages have been established, the tribal case manager will perform an ongoing evaluation of whether or not the medical, social, educational, or other services are being provided and used as agreed. Coordination activities include, personal, mail and telephone contacts with providers and others identified by the case plan, and meetings with the client and family.

5. Case Plan Reassessment
The tribal case manager works with the individual to determine whether or not medical, social, educational or other services continue to be adequate to meet the goals and objectives identified in the case plan. Reassessment decisions include those to continue, change or terminate those services. Reassessment will also determine whether the case plan itself requires revision. This may include assisting clients to access different medical, social, educational or other needed services beyond those already provided. Reassessment activities include, staffing and mail, personal, and telephone contacts with involved parties.

E. Qualifications of Case Managers within Provider Organizations:

Completion of a case management training curriculum.

Basic knowledge of issues in the areas of behavior management techniques, family dynamics, child development, family counseling techniques, emotional and behavioral disorders, chronic disease, and aging.

Interviewing skills for gathering data and completing needs assessments to develop service and case plans and their related narratives/reports.

Skills in individual and group communication.

Ability to learn and work with state, federal and tribal rules, laws and guidelines relating to Native American child, adult and elder welfare and to gain knowledge about community resources and link tribal members with those resources.

F. Qualifications of Provider Organizations

A Tribal case management provider must be an organization certified as meeting the following criteria:

A. Minimum of three years experience of successful work with Native American children, families, and elders involving a demonstrated capacity to provide all core elements of tribal case management, including: Assessment, Case Planning, Case Plan Implementation, Case Plan Coordination, and Case Plan Reassessment.

B. Minimum of three years case management experience in coordinating and linking community medical, social, educational or other resources as required by the target population.

C. Administrative capacity to ensure quality of services in accordance with tribal, state, and Federal requirements.

D. Maintain a sufficient number of case managers to ensure access to targeted case management services.

F. Freedom of Choice

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 recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical

Care under the plan.

(a) When an individual is served through an approved Section 1915(b) waiver, the terms of that waiver will govern freedom of choice of the providers of other medical care under the plan.

G. Payment

Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

TARGETED CASE MANAGEMENT SERVICES
Long Term Services and Supports

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

The target group includes individuals who reside in the community or are transitioning as described in the following paragraph who meet or are in the process of determining whether they meet one of the following institutional levels of care:

a. long-terms care hospital or nursing facility;
b. intermediate care facility for individuals with intellectual disabilities;
c. institution providing psychiatric services for individuals under twenty-one (21) years of age; or
d. institution for mental diseases (IMD) for individuals age sixty-five (65) and over.

☒ Target group includes individuals transitioning to a community setting. Case management services will be made available for up to 60 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 served in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter, July 25, 2000)

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

☒ Entire State
☐ Only in the following geographic 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.
☐ 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 shall occur at least annually to ensure the participant has adequate supports. Assessments may occur more frequently than annually, up to monthly, when requested by the participant, or the care coordinator, a service provider, or the state identifies an issue.

- 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
  - 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:
  - The support plan includes a segment for the individual's personal goal(s). Development of the support plan requires that goals are identified and services are requested that match those goals. The person-centered support plan documents the outcomes of a structured discussion that addresses the participant's personal goals, needs, including health care needs, and preferences and how services and other supports will help achieve those goals.
  - 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.

    Monitoring shall occur at least annually to ensure the participant has adequate supports. The amount of monitoring is contingent upon the amount that the individual requested within the support plan. The individual may contact the care coordinator at any time for assistance.

☒ 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)):

A targeted case management provider must be certified as a provider of care coordination services under 7 AAC 130.220 (b) (2), meet the requirements of 7 AAC 130.238 and 7 AAC 130.240.

1) Requirements for certification:
   a) Care coordinators shall be at least eighteen (18) years of age and qualified through experience and education in a human services field or setting.
   b) Required education and additional experience or alternative to formal education for care coordinators, includes
      i) bachelor of arts, bachelor of science, or associate of arts degree from an accredited college or university in social work, psychology, rehabilitation, nursing, or a closely related human services field and one year of full-time, or equivalent part-time, experience working with human services recipients; or
      ii) two years of course credits from an accredited college or university in social work, psychology, rehabilitation, nursing, or a closely related human services field, and one year of full-time, or equivalent part-time, experience working with human services recipients; or
      iii) three years of full-time, or equivalent part-time, experience working with human services recipients in social work, psychology, rehabilitation, nursing, or a closely related human services field or setting; or
      iv) certification as a rural community health aide or practitioner and one year of full-time, or equivalent part-time, experience working with human services recipients.
   c) In addition to meeting education and experience requirements, care coordinators must possess, or develop before providing program services, the knowledge base and skills necessary to carry out the case management process.
      i) The care coordination knowledge base must include:
         (a) the medical, behavioral, habilitative, and rehabilitative conditions and requirements of the population to be served by the care coordinator;
         (b) the laws and policies related to senior and disabilities services programs;
         (c) the terminology commonly used in human services fields or settings;
         (d) the elements of the case management process; and
         (e) the resources available to meet the needs of participants.
      ii) The care coordinator skill set must include:
         (a) the ability to evaluate the needs and preferences of the participant and to develop a support plan, which meets the needs and preferences of the participant and complies with the requirements of the applicable Medicaid program;
         (b) the ability to organize, evaluate, and present information orally and in writing; and
         (c) the ability to work with professional and support staff.
   d) Training
      i) An individual who seeks certification to provide case management services, must:
         (a) enroll in the Department of Health and Social Services (department) approved beginning course for care coordinators;

(b) demonstrate comprehension of course content through examination; and
(c) provide proof of successful completion of the course when submitting an application for certification.

ii) A certified care coordinator, must:
(a) enroll in at least one department approved care coordination training course during the individual's one or two year period of certification; and
(b) provide proof of successful completion of that course when submitting an application for recertification; and
(c) demonstrate an understanding of the Medicaid State Plan services.

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

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

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

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

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

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

The State assures the following:

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

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; and
(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).

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))

Additional Limitations:

None.