DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1301 Young Street, Room 833
Dallas, Texas 75202

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Division of Medicaid & Children's Health, Region VI

April 16, 2010

Our Reference: SPA-LA-08-13

Mr. Don Gregory, Interim State Medicaid Director
Department of Health and Hospitals
Bienville Building
628 North 4th Street
Post Office Box 91030
Baton Rouge, LA 70821-9030

Dear Mr. Gregory:

We have reviewed the proposed amendment to your Medicaid State Plan submitted under Transmittal Number 08-13. This state plan amendment revises the reimbursement methodology for targeted case management to a 15 minute unit and clarifies coverage of case management services.

In the future, when the State submits a State Plan Amendment (SPA) that may impact Indians or Indian health providers, CMS will look for evidence of the State's tribal consultation process for that SPA. Pursuant to section 1902 (a) (73) of the Act added by section 5006 (e) of the Recovery and Reinvestment Act of 2009, the State must submit evidence to CMS regarding the solicitation of advice prior to submission of the SPA. This consultation must include all federally recognized tribes, Indian Health Service and Urban Indian Organizations within the state.

Transmittal Number 08-13 is approved with an effective date of May 1, 2008 as requested. A copy of the HCFA-179, Transmittal No. 08-13 dated June 25, 2008 is enclosed along with the approved plan pages.

If you have any questions, please contact Cheryl Rupley at (214) 767-6278.

Sincerely,

[redacted]

Bill Brooks
Associate Regional Administrator

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **08-13**

2. STATE: **Louisiana**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
~~May 21, 2008~~ May 1, 2008
See E-mail Dated 4-9-10

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.169
1915(g) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2008 **$0.00**
b. FFY 2009 **$0.00**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Item 19, Page 1a
* See E-mail Date 4-7-10

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
None (New page)
See E-mail Dated 4-7-10

10. SUBJECT OF AMENDMENT: **The purpose of this amendment is to revise the reimbursement methodology for targeted case management to provide for billing in 15 minute increments and to establish cost reporting requirements for targeted case management.**

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor does not review state plan material.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
Alan Levine

14. TITLE:
Secretary

15. DATE SUBMITTED:
June 25, 2008

16. RETURN TO:
State of Louisiana
Department of Health and Hospitals
628 N. 4th Street
PO Box 91030
Baton Rouge, LA 70821-9030

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
26 June, 2008

18. DATE APPROVED:
16 April, 2008

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
1 May, 2008

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
Bill Brooks

22. TITLE: Associate Regional Administrator
Div of Medicaid & Children's Health

23. REMARKS: Pen + Ink changes to Add + Remove Pages per State's E-Mail Dated 4-7-10.

FORM HCFA-179 (07-92)

Marks, Marsha L. (CMS/SC)

From:	Marks, Marsha L. (CMS/SC)
Sent:	Thursday, April 22, 2010 1:33 PM
To:	CMS CMSO_508_SPA
Cc:	Rupley, Cheryl A. (CMS/SC); Sampson, Tamara L. (CMS/CMCHO); Carter, Demetria (CMS/SC)
Subject:	Approval Pkg for 08-13
Attachments:	LA-08-13Approval.doc; Final Approval Package LA 08-13.pdf

State: Louisiana

Brief Description: Amendment revises reimbursement rates for target case management to a 15 minute unit and clarifies coverage of case management services. State indicated that non-federal share of payment will be funded through Medicaid Agency & the State .

Effective Date: 5/1/2008

Approval Date: 4/16/2010

Marsha Marks // Dept of Health & Human Services // Centers for Medicare & Medicaid Services // Dallas Regional Office // Division of Medicaid & Children's Health // Dallas Texas 75202 // 214-767-6280 // Fax 214-767-0322 // marsha.marks@cms.hhs.gov

Rupley, Cheryl A. (CMS/SC)

From: Close, Jean K. (CMS/CMSO)
Sent: Thursday, April 08, 2010 2:09 PM
To: Rupley, Cheryl A. (CMS/SC)
Cc: Cieslicki, Mary E. (CMS/CMSO); Sampson, Tamara L. (CMS/CMCHO); Jarosinski, Donna Y. (CMS/CMSO); Close, Jean K. (CMS/CMSO)
Subject: RE: LA 08-13 Clarification

Cheryl,
Thank you for sending the revisions for LA 08 13. Donna and I have no further questions or comments. The State made the requested changes to TCM coverage.
Thanks,
Jean

From: Rupley, Cheryl A. (CMS/SC)
Sent: Wednesday, April 07, 2010 3:17 PM
To: Close, Jean K. (CMS/CMSO); Cieslicki, Mary E. (CMS/CMSO); Sampson, Tamara L. (CMS/CMCHO); Jarosinski, Donna Y. (CMS/CMSO)
Subject: FW: LA 08-13 Clarification
Importance: High

Please see the revisions on LA 08-13. If there are additional questions, please let me know.

Cheryl

From: Allyson Lamy [mailto:ALLYSON.LAMY@LA.GOV]
Sent: Wednesday, April 07, 2010 2:06 PM
To: Rupley, Cheryl A. (CMS/SC)
Cc: Lou Ann Owen; Randy Davidson; Kyle Viator; Tara Disandro; Shirley Garland; Sandra Victor; Keydra Singleton
Subject: RE: LA 08-13 Clarification
Importance: High

Cheryl,
We have attached the responses to the additional questions. Per the conference call with CMS on 3/25/10, we have revised the pages for Attachment 3.1-A, Item 19, and the pages for Supplement 1 to Attachment 3.1-A. We also revised Attachment 4.9-B, Item 19 per CMS' e-mail on 3/26/10. Please substitute the attached pages for the pages previously submitted for this SPA.

Additionally, the blocks 8 and 9 of the Form 179 should read as follows. This revises the changes we submitted with the RAI response letter.

Attachment 3.1-A, Item 19, Pages 1, 2	Same (TN 99-17)
Attachment 3.1-A, Item 19, Page 1a	None (New Page)
Supplement 1 to Attachment 3.1-A, Page 1A	Same (TN 98-21)
Supplement 1 to Attachment 3.1-A, Pages 1A(1) - 1A(4)	None (New Pages)
Supplement 1 to Attachment 3.1-A, Page 1B	Same (TN 98-21)
Supplement 1 to Attachment 3.1-A, Pages 1B(1) – 1B(4)	None (New Pages)
Supplement 1 to Attachment 3.1-A, Page 1D	Same (TN 98-21)
Supplement 1 to Attachment 3.1-A, Pages 1D(1) – 1D(4)	None (New Pages)
Supplement 1 to Attachment 3.1-A, Page 1E	Same (TN 00-28)

Supplement 1 to Attachment 3.1-A, Pages 1E(1) – 1E(4)	None (New Pages)
Supplement 1 to Attachment 3.1-A, Pages 1F – 1F(4)	Same (TN 03-31)
Attachment 4.19-B, Item 19, Page 1	Same (TN 05-02)
Attachment 4.19-B, Item 19, Page 1a	None (New Page)
Remove the following pages:	
Attachment 3.1-A, Item 19, Page 3	(TN 99-06)
Attachment 3.1-A, Item 19, Page 4	(TN 04-19)
Attachment 3.1-A, Item 19, Page 5	(TN 00-28)
Attachment 3.1-A, Item 19, Pages 6, 7	(TN 03-31)

From: Rupley, Cheryl A. (CMS/SC) [mailto:Cheryl.Rupley@cms.hhs.gov]
Sent: Friday, March 26, 2010 12:23 PM
To: Allyson Lamy; Keydra Singleton
Cc: Sampson, Tamara L. (CMS/CMCHO); Close, Jean K. (CMS/CMSO)
Subject: LA 08-13 Clarification
Importance: High

Allyson,
Please see the following clarification from Central Office on the revision for TCM on the plan page:

Our TCM regulation does not specify that contacts must be "face to face". For example, telephone contacts are permissible. CMS suggests clarifying that contacts are on a one-to-one basis between a case manager and a participant or between a case manager and others when this contact is for the benefit of the participant.

Please let me know if you have any questions.

Cheryl Rupley
Division of Medicaid and Children's Health
1301 Young St. Rm. 833
Dallas, TX 75202
Phone 214-767-6278
FAX 214-767-0322

AMOUNT DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

LIMITATIONS OF THE AMOUNT, DURATION, AND SCOPE OF CERTAIN ITEMS OF PROVIDED MEDICAL AND REMEDIAL CARE AND SERVICES ARE DESCRIBED AS FOLLOWS:

STATE LA
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CITATION 1915(g) of the Social Security Act

Medical and Remedial Care and Services
Item 19

I. Definition

Case management is defined as services provided to individuals to assist them in gaining access to the full range of needed services including medical, social, educational, and other support services. The Department utilizes a broker model of case management in which recipients are referred to other agencies for specific services they need. These services are determined by individualized planning with the recipient and/or the recipient's family, and other persons/professionals deemed appropriate and provided according to a written comprehensive plan of care which includes measurable person centered outcomes. All case management services must be provided by qualified staff. The provider must ensure that there is no duplication of payment, that there is only one primary case manager for each eligible recipient and that the recipient is not receiving other case management services from any other provider. Procedures are detailed in the Case Management Provider Manual.

II. Services To Be Provided

All Medicaid enrolled case management agencies are required to perform the core elements of intake, assessment, service planning, linkage, follow-up/monitoring, reassessment, transition/closure, and maintenance of records.

NOW Waiver Recipients
A minimum of one home visit per quarter to each recipient is required. More frequent home visits shall be required to be performed if indicated in the recipient's Comprehensive Plan of Care.

Infants and Toddlers with Special Needs
A minimum of one face-to-face meeting per quarter with each recipient's family is required. More frequent face-to-face meetings shall be required to be performed if indicated in the recipient's Individualized Family Service Plan (IFSP).

HIV Disabled Individuals
A minimum of one home visit per quarter to each recipient is required. More frequent home visits shall be required to be performed if indicated in the recipient's Comprehensive Plan of Care.

AMOUNT DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

LIMITATIONS OF THE AMOUNT, DURATION, AND SCOPE OF CERTAIN ITEMS OF PROVIDED MEDICAL AND REMEDIAL CARE AND SERVICES ARE DESCRIBED AS FOLLOWS:

EPSDT Recipients on the DD Request for Services Registry

A minimum of one face-to-face visit per quarter with each recipient (and their guardian) is required. More frequent face-to face visits shall be required to be performed if indicated in the recipient's Comprehensive Plan of Care. Additional face-to-face visits may be performed if needed to obtain services.

Nurse Family Partnership Program (First Time Mothers)

A minimum of one home visit per quarter to each recipient is required. More frequent home visits shall be required to be performed if indicated in the recipient's Comprehensive Plan of Care.

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AMOUNT DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

LIMITATIONS OF THE AMOUNT, DURATION, AND SCOPE OF CERTAIN ITEMS OF PROVIDED MEDICAL AND REMEDIAL CARE AND SERVICES ARE DESCRIBED AS FOLLOWS:

III. Selection of Case Management Agency

Recipients have the right to select the provider of their case management services from among those available agencies enrolled for participation.

IV. Standards For Participation

A. In order to participate as a case management services provider in the Medicaid Program, an agency must comply with licensure and certification requirements, provider enrollment requirements, case management manual, and when applicable, the specific terms of individual contractual agreements.

B. Separate enrollment is required for each population and DHH designated region that the agency plans to serve, as well as for each office site it plans to operate. The agency may provide services only in the parishes of the DHH region for which approval has been granted.

V. Discharge

Discharge from a case management agency must occur when the recipient no longer requires services, desires to terminate services, becomes ineligible for services, or chooses to transfer to another case management agency.

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SUPERSEDES: TN- 99-17

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TARGETED CASE MANAGEMENT SERVICES

NOW Waiver Recipients

Target Group *(42 Code of Federal Regulations 441.18(8)(i) and 441.18(9))*:
[Describe target group and any subgroups. If any of the following differs among the subgroups, submit a separate State plan amendment describing case management services furnished; qualifications of case management providers; or methodology under which case management providers will be paid.]

The targeted population consists of individuals with developmental disabilities who are participants the New Opportunities Waiver (NOW) program. The NOW waiver is a 1915(c) waiver and all participants meet the requirement of the waiver.

___ 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)*:
XX 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.
XX 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;

  [Specify and justify the frequency of assessments.]

  After the initial assessment is completed, reassessments are done annually and as needed when significant changes in circumstances occur.

SUPERSEDES: TN- 98-21

State Plan under Title XIX of the Social Security Act
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TARGETED CASE MANAGEMENT SERVICES

NOW Waiver Recipients

- 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:
  - 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. ***[Specify the type of monitoring and justify the frequency of monitoring.]***

      A minimum of one home visit per quarter to each recipient is required. More frequent home visits shall be required to be performed if indicated in the recipient's Comprehensive Plan of Care.

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TARGETED CASE MANAGEMENT SERVICES

NOW Waiver Recipients

___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)):
[Specify provider qualifications that are reasonably related to the population being served and the case management services furnished.]

Each Medicaid enrolled provider must ensure that all staff providing case management services meets the required qualifications prior to assuming any full caseload responsibilities.

Case Managers must meet one of the following minimum education and experience qualifications:

- **Bachelor's degree in a human service-related field such as psychology, education, rehabilitation counseling, or counseling from an accredited college or university and one year of paid experience in a human-service-related field providing direct services or case management services; or**
- **Licensed registered nurse with one year of paid experience as a registered nurse in public health or a human service- related field providing direct services or case management services; or**
- **Bachelor's or master's degree in social work from a social work program accredited by the Council on Social Work Education.**

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: ***[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.]***

SUPERSEDES: NONE - NEW PAGE

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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 §441.169 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 §441.169 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

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NOW Waiver Recipients

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))

[Specify any additional limitations.]

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SUPERSEDES: NONE - NEW PAGE

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TARGETED CASE MANAGEMENT SERVICES

Infants and Toddlers With Special Needs

Target Group *(42 Code of Federal Regulations 441.18(8)(i) and 441.18(9))*:
[Describe target group and any subgroups. If any of the following differs among the subgroups, submit a separate State plan amendment describing case management services furnished; qualifications of case management providers; or methodology under which case management providers will be paid.]

The targeted population consists of infants and toddlers from birth through age two inclusive (0 – 36 months) who meet the following conditions:

1. **A documented established medical condition determined by a licensed medical doctor. In the case of a hearing impairment, licensed audiologist or licensed medical doctor must make the determination; or**
2. **A developmental delay in one or more of the following areas:**
   - **Cognitive development;**
   - **Physical development, including vision and hearing eligibility must be based on a documented diagnosis made by a licensed medical doctor (vision) or a licensed medical doctor or licensed audiologist (hearing);**
   - **Communication development;**
   - **Social or emotional development;**
   - **Adaptive development**
3. **The case management services must be included on the recipient's Individualized Family Service Plan (IFSP).**

___ 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)*:
XX 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.
XX 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:

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TARGETED CASE MANAGEMENT SERVICES

Infants and Toddlers With Special Needs

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- 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;

  [Specify and justify the frequency of assessments.]

  After the initial assessment is completed, reassessments are done annually and as needed when significant changes in circumstances occur.

- 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:
  - 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. ***[Specify the type of monitoring and justify the frequency of monitoring.]***

      A minimum of one face-to-face meeting per quarter with each recipient's family is required. More frequent face-to-face meetings

SUPERSEDES: NONE - NEW PAGE

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TARGETED CASE MANAGEMENT SERVICES

Infants and Toddlers With Special Needs

shall be required to be performed if indicated in the recipient's Individualized Family Service Plan (IFSP).

___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)):
[Specify provider qualifications that are reasonably related to the population being served and the case management services furnished.]

Each Medicaid enrolled provider must ensure that all case management services are provided by qualified individuals who meet the following licensure, education, and experience requirements

1. **Bachelor's or master's degree in a health or human service-related field from an accredited college or university; and**
2. **Two years post bachelor's/master's degree experience in a health or human services field, (master's degree in social work, or special education with certification in noncategorical preschool handicapped or other certified areas with emphasis on infants, toddlers and families may be substituted for the required two years of experience); or**
3. **Nurse registered and licensed in the state; and**
4. **Two years experience in pediatric, public health or community nursing.**

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: ***[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.]***

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TARGETED CASE MANAGEMENT SERVICES

Infants and Toddlers With Special Needs

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 §441.169 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 §441.169 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

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Infants and Toddlers with Special Needs

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))

[Specify any additional limitations.]

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TARGETED CASE MANAGEMENT SERVICES

HIV Disabled Individuals

Target Group *(42 Code of Federal Regulations 441.18(8)(i) and 441.18(9))*:
[Describe target group and any subgroups. If any of the following differs among the subgroups, submit a separate State plan amendment describing case management services furnished; qualifications of case management providers; or methodology under which case management providers will be paid.]

The targeted population consists of HIV disabled individuals as follows:

- **The recipient must have reached, as documented by a licensed physician, a level 70 on the Karnofsky scale at some time during the course of HIV infection.**

___ 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)*:
XX 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.
XX 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;

  [Specify and justify the frequency of assessments.]

  After the initial assessment is completed, reassessments are done annually and as needed when significant changes in circumstances occur.

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- 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:
  - 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. ***[Specify the type of monitoring and justify the frequency of monitoring.]***

      A minimum of one home visit per quarter to each recipient is required. More frequent home visits shall be required to be performed if indicated in the recipient's Comprehensive Plan of Care.

___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))

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HIV Disabled Individuals

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
[Specify provider qualifications that are reasonably related to the population being served and the case management services furnished.]

Each Medicaid enrolled provider must ensure that all staff providing case management services meets the required qualifications prior to assuming any full caseload responsibilities.

Additionally, providers must have one or more documented years providing case management services to HIV disabled individuals and sign a notarized letter of assurance that the requirements of Louisiana Medicaid will be met.

The provider of case management must satisfactorily complete a one-day training approved by the Department's HIV program office.

Case Managers must meet one of the following minimum education and experience qualifications:

- **Bachelor's degree in a human service-related field such as psychology, education, rehabilitation counseling, or counseling from an accredited college or university and one year of paid experience in a human-service-related field providing direct services or case management services; or**
- **Licensed registered nurse with one year of paid experience as a registered nurse in public health or a human service- related field providing direct services or case management services; or**
- **Bachelor's or master's degree in social work from a social work program accredited by the Council on Social Work Education.**

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: ***[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.]***

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TARGETED CASE MANAGEMENT SERVICES

HIV Disabled Individuals

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 §441.169 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 §441.169 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

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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))

[Specify any additional limitations.]

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TARGETED CASE MANAGEMENT SERVICES

EPSDT Recipients on the DD Request for Services Registry

Target Group *(42 Code of Federal Regulations 441.18(8)(i) and 441.18(9))*:
[Describe target group and any subgroups. If any of the following differs among the subgroups, submit a separate State plan amendment describing case management services furnished; qualifications of case management providers; or methodology under which case management providers will be paid.]

The targeted population consists of EPSDT recipients between the ages of zero (0) and twenty-one (21) who meet one of the following criteria:

1. **On the DD Request for Services Registry on or after October 20, 1997, and have passed the Office for Citizens with Developmental Disabilities (OCDD) Diagnosis and Evaluation (D&E) process by the later of: October 20, 1997 or the date they were placed on the DD Request for Services Registry; or**
2. **On the DD Request for Services Registry on or after October 20, 1997, but who did not have a D&E by the later of: October 20, 1997or the date they were placed on the DD Request for Services Registry. Those in this group who subsequently pass or passed the D&E process are eligible for these targeted case management services. Those who do not pass the D&E process, or who are not undergoing a D&E may still receive case management services if they meet the definition of a person with special needs. Special needs is defined as a documented, established medical condition, as determined by a licensed physician, that has a high probability of resulting in a developmental delay or that gives rise to a need for multiple medical, social, educational and other services. In the case of a hearing impairment, the determination of special needs must be made by a licensed audiologist or physician.**

___ 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)*:
XX 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.
XX Services are not comparable in amount duration and scope (§1915(g)(1)).

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EPSDT Recipients on the DD Request for Services Registry

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;

  [Specify and justify the frequency of assessments.]

  After the initial assessment is completed, reassessments are done annually and as needed when significant changes in circumstances occur.

- 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:
  - 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

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- 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. ***[Specify the type of monitoring and justify the frequency of monitoring.]***

  A minimum of one face-to-face visit per quarter with each recipient (and their guardian) is required. More frequent face-to face visits shall be required to be performed if indicated in the recipient's Comprehensive Plan of Care. Additional face-to-face visits may be performed if needed to obtain services.

___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)):
[Specify provider qualifications that are reasonably related to the population being served and the case management services furnished.]

Each Medicaid enrolled provider must ensure that all staff providing case management services meets the required qualifications prior to assuming any full caseload responsibilities.

~~1.~~ **Case Managers must meet one of the following minimum education and experience qualifications:**

- **Bachelor's degree in a human service-related field such as psychology, education, rehabilitation counseling, or counseling from an accredited college or university and one year of paid experience in a human-service-related field providing direct services or case management services; or**
- **Licensed registered nurse with one year of paid experience as a registered nurse in public health or a human service- related field providing direct services or case management services; or**
- **Bachelor's or master's degree in social work from a social work program accredited by the Council on Social Work Education.**

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.

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EPSDT Recipients on the DD Request for Services Registry

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: ***[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 §441.169 when the case management

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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 §441.169 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))

[Specify any additional limitations.]

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TARGETED CASE MANAGEMENT SERVICES

Nurse Family Partnership Program

Target Group *(42 Code of Federal Regulations 441.18(8)(i) and 441.18(9))*:
[Describe target group and any subgroups. If any of the following differs among the subgroups, submit a separate State plan amendment describing case management services furnished; qualifications of case management providers; or methodology under which case management providers will be paid.]

The Nurse Family Partnership program is a program of prenatal and infancy visits which begin during pregnancy and continue until 60 days post partum. The targeted population consists of Medicaid recipients who are pregnant with their first child and are not beyond the 28th week of pregnancy. The recipient must reside in the service delivery area. The recipient must attest that she meets one of the following definitions of a first time mother in order to receive case management services:

1. **Is expecting her first live birth and has never parented a child;**
2. **Has previously been pregnant, but experienced a stillbirth, miscarriage, or had an abortion;**
3. **Is expecting her first live birth, but has parented stepchildren or younger siblings;**
4. **Had previously delivered a child, but her parental rights were legally terminated within the first six months of that child's life; or**
5. **Has delivered a child, but the child died within the first six months of life.**

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

DHH Region II – Ascension, East Baton Rouge, East Feliciana, Iberville, Pointe Coupee, West Baton Rouge, West Feliciana Parishes

DHH Region III – Assumption, Lafourche, St. Charles, St. James, St. John, St. Mary, Terrebonne Parishes

DHH Region IV - Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, Vermillion Parishes

DHH Region V – Allen, Beauregard, Calcasieu, Cameron, Jefferson Davis Parishes

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Nurse Family Partnership Program

DHH Region VI – Avoyelles, Catahoula, Concordia, Grant, LaSalle, Rapides, Vernon, Winn Parishes

DHH Region VII - Bienville, Bossier, Caddo, Claiborne, Desoto, Natchitoches, Red River, Sabine, Webster Parishes

DHH Region VIII – Caldwell, East Carroll, Franklin, Jackson, Lincoln, Madison, Morehouse, Ouachita, Richland, Tensas, Union, West Carroll Parishes

Comparability of services *(§§1902(a)(10)(B) and 1915(g)(1))*

___ Services are provided in accordance with §1902(a)(10)(B) of the Act.

XX 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;

  [Specify and justify the frequency of assessments.]

  After the initial assessment is completed, reassessments are conducted as needed when significant changes in circumstances occur.

- 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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Nurse Family Partnership Program

- 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. ***[Specify the type of monitoring and justify the frequency of monitoring.]***

A minimum of one home visit per quarter to each recipient is required. More frequent home visits shall be required to be performed if indicated in the recipient's Comprehensive Plan of Care.

___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)):
[Specify provider qualifications that are reasonably related to the population being served and the case management services furnished.]

Each Medicaid enrolled provider must ensure that all staff providing case management services meets the required qualifications prior to assuming any full caseload responsibilities.

Case managers and supervisors providing services to this targeted population must meet the following educational qualifications:

1. **Possession of a license or temporary permit to practice professional nursing in the state of Louisiana; and**
2. **Certification of training in the Nurse Family Partnership Program (formerly the David Olds Prenatal and Early Childhood Nurses Home Visit Model).**

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Nurse Family Partnership Program

In addition, a supervisor must have one year of professional nursing experience. A master's degree in nursing or public health may be substituted for the required one year of professional nursing experience for the supervisor.

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: ***[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

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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 §441.169 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 §441.169 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))

[Specify any additional limitations.]

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES--OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

CITATION
42 CFR
447.201
447.302

Medical and Remedial Care and Services
Item 19 (cont)

OPTIONAL TARGETED CASE MANAGEMENT SERVICES

REIMBURSEMENT METHODOLOGY

Targeted case management services are reimbursed at a prospective rate for each approved unit of service provided to the recipient. One quarter hour (15 minutes) is the standard unit of service which covers both service provision and administrative costs. Contacts are on a one-to-one basis between a case manager and a participant or between a case manager and others when this contact is for the benefit of the participant. All services must be prior authorized.

Reimbursement for Targeted Case Management is based on cost using an independent cost model approach to rate setting. In this approach, a model of the costs providers incur in delivering a particular service is constructed. In constructing the models, the primary cost drivers include the following:

- Direct service staff wages;
- Direct service staff employee related expenses (ERE);
- The productivity of direct service staff, i.e. the amount of a direct service staff's time in each workday that can be billed;
- Supervisory costs;
- Key Staff costs;
- Travel and office space costs;
- Program support costs; and
- Administrative expenses.

Case management agencies shall provide annual cost reports based on the state fiscal year, starting with the state fiscal year July 1, 2008 through June 30, 2009. Completed reports are due within 90 calendar days after the end of each fiscal year.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of case management and the fee schedule and any annual/periodic adjustments to the fee schedule are published on the agency's provider website at www.lamedicaid.com. The agency's fee schedule rate was set as of May 21, 2008 and is effective for services provided on or after that date. All rates are published on the agency's website.

Payments made to targeted case management providers do not duplicate payments for the same or similar services furnished by other providers or under other authority as an administrative function or as an integral part of a covered service.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES--OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

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Medical and Remedial Care and Services
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OPTIONAL TARGETED CASE MANAGEMENT SERVICES

REIMBURSEMENT METHODOLOGY (continued)

Reimbursement is not available for case management services that are furnished to recipients without charge by any other agency or entity. With the statutory exceptions of case management services included in Individualized Educational Programs (IEP'S) or Individualized Family Service Plans (IFSP'S) and services furnished through Title V public health agencies, payment for case management services cannot be made when another third party payor is liable, nor may payments be made for services for which no payment liability is incurred by the recipient.

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