John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

VIA ELECTRONIC MAIL ONLY

February 16, 2016

Bill Brooks
Centers for Medicare and Medicaid Services
Division of Medicaid and Children's Health Operations
Dallas Regional Office
1301 Young Street, Suite 833
Dallas, TX 75202

Dear Bill:

RE: LA SPA TN 15-0018 RAI Follow-up Response
Targeted Case Management Services – Adding Reimbursement for the Department of Children and Family Services – Eligible Foster Children

Please refer to our proposed amendment to the Medicaid State Plan submitted under transmittal number (TN) 15-0018 with a proposed effective date of July 1, 2015. The purpose of this SPA is to amend the provisions governing targeted case management (TCM) in order to provide reimbursement to the Department of Children and Family Services (DCFS) for TCM services rendered to Medicaid eligible foster children. We are providing the following in response to your request for additional information (RAI) dated November 23, 2015:

Coverage Questions

1. General: As discussed with the state on the November 16, 2015 call with CMS, CMS understands that pages 1a and 2 will be removed from the state plan amendment (SPA) submission as they duplicate information also submitted in the TCM template. Please confirm that this understanding is correct, and please remove the pages discussed.

   RESPONSE: The State would like to remove Attachment 3.1-A, Item 19, Pages 1a and 2. Please see attached request for a pen and ink change to the Form 179.

Bienville Building • 628 N. Fourth St. • P.O. Box 91030 • Baton Rouge, Louisiana 70821-9030
Phone: (888) 342-6207 • Fax: (225) 342-9508 • www.dhh.la.gov
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2. Supplement 1 to Attachment 3.1-A, Page 1C: Why has the state checked that services are "comparable?" We think that the section 1915(g) of the Social Security Act allows targeting of specific populations under the TCM benefit. Please check that the services are not comparable.

   RESPONSE: **The "*Services are not comparable in amount duration and scope (§1915(g)(1))*" box has been checked. Please see Supplement 1 to Attachment 3.1-A, Page 1C.**

3. Page 1C(1) and Page 1C(2): The state has amended the TCM template to include domestic violence and family functioning screenings (page 1C(1)) under "Comprehensive Assessments"; preparing cases for presentation to the multi-disciplinary team for consultation (page 1C(1)) under "Development of a specific care plan"; and exploration of all federal benefits for the child (page 1C(2)). From the language provided, CMS is unable to determine if these services constitute direct service provision, which case managers are not authorized to furnish under 42 CFR 441.18. Please explain the services listed above to determine if direct medical services are being furnished by TCM case managers.

   RESPONSE: **Comprehensive Assessments: The screenings are a part of the assessment process and are not direct services. The assessment tool is described as the Assessment of Family Functioning (AFF). There are several areas of focus included in the assessment process to include violence in the home and substance abuse. Screening questions related to domestic violence and family functioning are included throughout the assessment. Development of a Specific Care Plan: Cases may be presented to a multi-disciplinary team to assist in the assessment process which includes the assessment of the ability of the caretaker to meet the needs of the child, to assist in the assessment and recommendation for children who have special needs and children who are non-verbal; and to develop an appropriate service and treatment plan to reduce the risk of maltreatment. Referral and Related Activities: A referral is made to the Federal Benefits unit in the DCFS central office requesting exploration of federal benefits for children who enter the custody of the State. Direct services will not be included in the TCM rate and will be carved out through a direct services code in the Random Moment Time Study (RMTS).**

4. Please further describe the following questions regarding providers:

a. Page 1C, "Target Group": As discussed with the state on the November 16, 2015 call with CMS, the state has clarified that the target group will not include or furnish services to those with developmental disabilities or who have chronic mental illness. Please confirm that this understanding by CMS is correct.

RESPONSE: Children who are receiving targeted case management services from another provider due to developmental disability or chronic mental illness will be excluded from the Medicaid claim.

b. Response to question 6.b: The state has provided a list of agency qualifications required to furnish case management services. Please include these agency qualifications on the state plan amendment pages.

RESPONSE: The agency qualifications have been added to Supplement 1 to Attachment 3.1-A, page 1C(3)- 1C(4).

c. Response to question 7: The state has indicted that it will, "use its internal staff with experience and knowledge to work with this special population." In accordance with the free choice of provider regulation at 42 CFR 431.51, states many not limit providers and must ensure all qualified Medicaid providers are able to furnish services. The target group set forth by the state does not appear to meet a free choice of provider exception, nor has the state elected this exception in the TCM template. As a result, please remove the requirement that only internal DCFS staff may furnish case management services.

RESPONSE: The requirement has been removed.

d. General: The response to RAI does not clearly define how TCM providers are enrolled and trained if they are interested in furnishing TCM case management services. Please describe the provider enrollment process for TCM case managers from point of initial interest in becoming a case manager to being authorized to furnish case management services. Please also describe any educational, licensure, or certification requirements the state will be requiring TCM case managers to attain.

RESPONSE: The enrollment process applies to the agency as a whole, which enrolls with Medicaid Provider Enrollment. For the

educational, licensure and/or certification requirement for individual case managers, please refer to Supplement 1 of Attachment 3.1-A, Pages 1C(4)- 1C(5).

Financial Questions

5. 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)). Please explain how LA SPA 15-0018 justifies FFP in lieu of the statement above.

   RESPONSE: None of these activities will he included in the development of the interim rate for services. Please see the proposed RMS allocation matrix for those case manager activities that will be allocated to Medicaid Services, Medicaid Admin and other funding sources such as Title IV-E.

6. The State has said that this is funded using certified public expenditures (CPEs). Is the State doing a rate for this? If so the State cannot CPE to a rate. This would have to be an interim rate and the State would have to cost settle to the rate. The State needs to demonstrate how the rate was constructed, which would include a random moment time study, and cost reports that all would have to be approved by CMS.

   RESPONSE: The State will cost settle at the end of each year using a DHH approved cost report and time study data to identify only those costs allowed by DHH and CMS. The time study has been approved by DHHS.

7. The State needs to show justification for the proposed rate of $884/month. Is this rate for a one time monthly face to face visit? Please itemize the services that are included in the rate of $884/month.

   RESPONSE: The services included in the rate are the costs allocated through the approved Public Assistance Cost Allocation Plan (PACAP) via the RMS allocation matrix attached. After the discussion with CMS on November 16,

2015, DCFS allocated eligible costs to Title IV-E which substantially reduced the $884 rate to $434.97.

8. Please tell us what activities in the Administrative rate are being changed to justify the medical match rate instead of the admin rate? If so, where is the historical cost data coming from to justify the cost?

   RESPONSE: Please reference the attached RMS allocation matrix. Medicaid Admin will continue to be claimed for Medicaid administrative activities such as eligibility and outreach. The historical cost data comes from those costs that are allocated on the basis of the Random Moment Sampling of the child welfare staff. The costs that are being transferred to Medicaid Services include those that are allocated based on three of the activity codes in the Sample. It is planned to move the non-IVE portion of the costs based on "Referral to Services" and "Case Management and Supervision Social Services" and all of the costs based on "Case Management and Supervision Medical and Behavioral" to Medicaid Services. The only cost planned for movement to Medicaid Services that is now being charged to Medicaid Administration is that based on the code for "Case Management and Supervision Medical and Behavioral". The other costs planned for movement to Medicaid Services are currently being charged to State Funds.

Please consider this a formal request to begin the 90-day clock. We trust that this additional information will be sufficient to result in the approval of the pending plan amendment. We look forward to negotiating with CMS to ensure approval.

As always, we appreciate the assistance of Ford Blunt in resolving these issues. If further information is required, you may contact Darlene A. Budgewater at Darlene.Budgewater@la.gov or by phone at (225) 342-3881.

Sincerely,

Jen Steele
Interim Medicaid Director

JS:DAB:JH
Attachments (7)

c: Ford Blunt
Darlene Budgewater
Tamara Sampson

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

TARGETED CASE MANAGEMENT SERVICES
Department of Children and Family Services (DCFS)
Medicaid Eligible Foster Children

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

- **The targeted population is Medicaid eligible recipients who are under age 21 and are the responsibility (custody) of the Department of Children and Family Services for foster care services and are currently residing in an in-home setting, a foster home, non-certified relative home, group home, residential care facility (excludes Institutions for Mental Disease as defined in 42 CFR 435.1010), or independent living situation.**

__X__ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to __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):
__X__ 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.
__X__ Services are not comparable in amount duration and scope (§1915(g)(1)).

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

- Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include, but are not limited to:
  - taking client history;
  - identifying the individual's needs and completing related documentation
  - 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;

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- completing a social history and assessment;
- obtaining the child's medical history, as well as immunization records;
- coordinating with other professionals regarding the needs of the child, family, and/or parent;
- completing a behavioral health screening within 15 days of the child entering foster care;
- completing a safety and risk assessment, and
- completing an assessment of family functioning, initial and on-going, to include trauma screening as well as screenings for mental health, domestic violence and substance use disorder (SUD) issues.

A case management needs assessment is initially performed to determine the recipients need for TCM services. Reassessments are performed at a minimum of every 180 days but may be performed as frequently as necessary based on a recipient's needs. Assessment and reassessment results in the initial development or revision of the individuals care plan.

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;
- identifies a course of action to respond to the assessed needs of the eligible individual;
- developing case plans and objectives with the family; and
- preparing cases for presentation to the multi-disciplinary team for consultation.

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

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TARGETED CASE MANAGEMENT SERVICES
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- activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan;
- arranging an initial medical, dental and communicable disease screening upon entry into foster care;
- providing a link to community resources for parents and children, including:
  - referrals to substance abuse;
  - mental health services;
  - domestic violence services;
  - daycare services;
  - the Early Steps program;
  - family resources center services;visit coaching and
  - skill building; and
  - exploring all federal benefits for the child (SSI, death benefits, etc).

❖ 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. The activities may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and includes 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;
  - 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;
  - continuously assessing the safety of the child and service needs of the child(ren) and families through interviews, observations and other information sources; and
  - providing supportive services for clients and arranging for the provision of services from community resources.

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Case management monitoring consists of regular contacts between the case manager and the recipient, family members, service providers, or other entities or individuals to determine if goals specified in the targeted case management care plan are being met. For this target group, it is also critical that regular monitoring occurs to ensure that problems are identified and resolved in a timely manner to determine if the recipient is successfully accessing needed services and meeting identified goals. Monitoring is performed in accordance with the frequency specified in the recipient's targeted case management service plan which is based on recipient needs. A minimum of one monthly face-to-face visit will be conducted for all in state placements.

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

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

The organization providing case management services for Medicaid eligible foster children must meet the following requirements:

- A minimum of five years' experience of working successfully with children and families in the target population, including a demonstrated capacity to provide all components of case management.
- A minimum of five years' experience in responding successfully to the needs of children and families in the target population on a statewide 24 hours, seven days a week basis.
- A minimum of five years case management experience in accordance and linking community medical, social, educational, or other resources needed by the target population on a statewide basis.
- A minimum of five years working with the target population.
- A minimum of five years' experience in documenting and maintaining individual case records that is in accordance with all applicable state and federal requirements.
- A minimum of five years' experience of demonstrated capacity in meeting the case management service needs of the target population.

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Department of Children and Family Services (DCFS)
Medicaid Eligible Foster Children

- Demonstrated capacity to provide training and supervision to individual case managers, including training pertaining to Medicaid-covered services.
- Providers must have full access to all relevant records concerning the child's needs for services including records of the District Family and Juvenile Courts.

Individual case manager qualifications:

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

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

- Baccalaureate degree in social work, psychology, psychiatric nursing, psychiatry, mental health counseling, rehabilitation counseling, psychological counseling, criminal justice, sociology,applied sociology, human services counseling, education with a concentration in special education, family and consumer sciences with a concentration in child, family and social services, guidance and counseling, human development counseling, social services counseling, vocational rehabilitation, or human services; or
- A baccalaureate degree in a non-related field plus one year of professional social services experience; or
- A master's degree in social work or a non-related field.

Case managers must also meet the following conditions:

- Individuals occupying this job who are subject to state licensing or registration laws administered by the Louisiana State Board of Social Work Examiniers must possess and keep current the license or registration;
- Have the ability to work in and within the legal systems, including the court system;

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- Have the ability to learn state and federal rules, laws and guidelines relating to the target population and to gain knowledge about community resources.
- Complete the required training of provider agency.

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.

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TARGETED CASE MANAGEMENT SERVICES
Department of Children and Family Services (DCFS)
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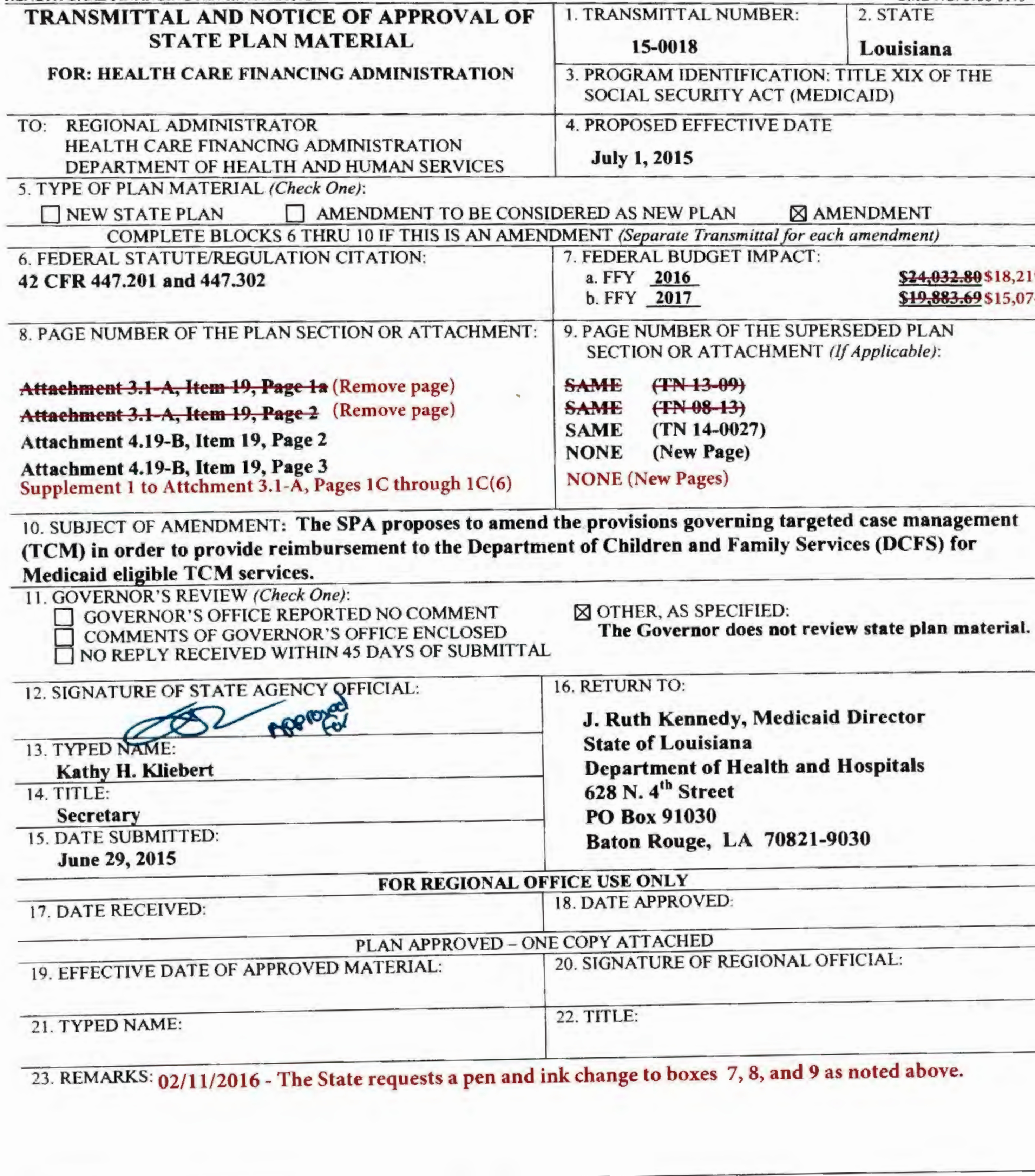
Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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

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

Specify any additional limitations:



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: **15-0018**

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: **July 1, 2015**

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 447.201 and 447.302

7. FEDERAL BUDGET IMPACT:
a. FFY 2016 ~~$24,032.80~~ $18,219.66
b. FFY 2017 ~~$19,883.69~~ $15,074.16

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

~~Attachment 3.1-A, Item 19, Page 1a~~ (Remove page)
~~Attachment 3.1-A, Item 19, Page 2~~ (Remove page)
Attachment 4.19-B, Item 19, Page 2
Attachment 4.19-B, Item 19, Page 3
Supplement 1 to Attchment 3.1-A, Pages 1C through 1C(6)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

~~SAME (TN 13-09)~~
~~SAME (TN 08-13)~~
SAME (TN 14-0027)
NONE (New Page)
NONE (New Pages)

10. SUBJECT OF AMENDMENT: **The SPA proposes to amend the provisions governing targeted case management (TCM) in order to provide reimbursement to the Department of Children and Family Services (DCFS) for Medicaid eligible TCM services.**

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: [signature] Approved For

13. TYPED NAME: **Kathy H. Kliebert**

14. TITLE: **Secretary**

15. DATE SUBMITTED: **June 29, 2015**

16. RETURN TO:
J. Ruth Kennedy, Medicaid Director
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:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS: 02/11/2016 - The State requests a pen and ink change to boxes 7, 8, and 9 as noted above.

FORM HCFA-179 (07-92)

LA TITLE XIX SPA
TRANSMITTAL #: 15-0018
TITLE: Targeted Case Management Services Adding Reimbursement for DCFS
EFFECTIVE DATE: July 1, 2015

FISCAL IMPACT: Increase

	year	% inc.		fed. match	*# mos	range of mos.	dollars
1st SFY	2016			0.00%	12	July 1, 2015 - June 30,2016	$23,350,196
2nd SFY	2017	3.0%		0.00%	12	July 2016- June 2017	$24,050,702
3rd SFY	2018	3.0%		0.00%	12	July 2017 - June 2018	$24,772,223

*#mos-Months remaining in fiscal year

Total Increase in Cost FFY 2016

SFY	2016	$23,350,196	for	12	months	July 1, 2015 - June 30,2016			$23,350,196
SFY	2017	$24,050,702	for	12	months	July 2016- June 2017			
		$24,050,702	/	12 X	3	July 2016 - September 2016		=	$6,012,676
									$29,362,872

FFP (FFY 2016) = $29,362,872 X 62.05% = $18,219,662

Total Increase in Cost FFY 2017

SFY	2017	$24,050,702	for	12	months	July 2016- June 2017			
		$24,050,702	/	12 X	9	October 2016 - June 2016		=	$18,038,027
SFY	2018	$24,772,223	for	12	months	July 2017 - June 2018			
		$24,772,223	/	12 X	3	July 2017 - September 2017		=	$6,193,056
									$24,231,083

FFP (FFY 2017)= $24,231,083 X 62.21% = $15,074,157

RMS ALLOCATION MATRIX

Activity	Description	Current Funding Sources	Proposed Funding Sources	Allocation Method
500-Referral For Services	Includes contacting providers to determine the appropriateness and availability of services; contacting the client (and client's family, if applicable) to inform them of a new service to be provided; providing documentation required by the provider in order for clients to receive a service; and, response to information and referral requests.	Title IVE/State	IVE/Medicaid Services	Costs of this activity will be allocated through RMS to Title IVE based on the Title IVE penetration rate. The non- Title IVE portion of costs will be allocated to Medicaid Services
530-Case Management-Social Services	Includes following up with providers and clients after a referral for service is made; monitoring referrals to ensure client needs are being met; development of the case plan; monitoring the implementation of the case plan including discussions with the involved parties; monitoring supportive services to ensure compliance with the case plan to prevent negative outcomes; contacting family and collateral sources; reviewing case file, the presenting problem in the case and its associated circumstances in order to refer the client to make an impact on the case; making collateral contacts; monitoring school enrollment and progress; monitor the case by reviewing provider plans for the client; writing or amending the case plan; conferring with supervisory personnel in the actual development of the case plan and any other activities related to development and writing of the case plan; formal review of the case at a given time interval, including pre-placement, 30-day, multiple placements, TPR; formulation of revisions in the case plan based on the case staffing and-meeting with providers and/or other related agencies to assess the progress of the client; discussion of a specific case with a professional or expert concerning the progress or a discussion of alternative services in support of the Case Plan; making referrals for transportation in support of any of these case management activities	Title IVE/State	IVE/Medicaid Services	Costs of this activity will be allocated through RMS to Title IVE based on the Title IVE penetration rate. The non- Title IVE portion of costs will be allocated to Medicaid Services
531-Case Management-Medical and Behavioral health Services	Includes coordination and monitoring of referrals to medical/behavioral health services. This includes writing, reviewing or updating case notes; contracting for medical services; assistance with locating and coordinating medically necessary medical, dental and/or mental/behavioral health services; arrangement of transportation to any medical behavioral health appointments; and coordination with medical and behavioral health professionals.	Medicaid Admin/SSBG	Medicaid Services	
506- Medicaid Eligibility	Includes any activity which is necessary to determine or re-determine Medicaid eligibility.	Medicaid Admin	Medicaid Admin	

DRAFT

Determination/Re-determination				
903-Medicaid Outreach	**Includes making public presentations to individuals or groups for the purpose of describing the nature of specific Medicaid programs and services offered: bringing persons into the Medicaid system for the purpose of determining eligibility and arranging for the provision of medical/health related services and related paperwork, clerical activities or staff travel required to perform these activities.**	**Medicaid Admin**	**Medicaid Admin**	
505-Title IV-E Eligibility Determination/Re-determination	Includes any activities which are necessary to determine or re-determine IV-E eligibility for services, including candidacy for Foster Care;	Title IVE/State	Title IVE/State	Costs of this activity will be allocated through RMS to Title IVE based on the Title IVE penetration rate. The non- Title IVE portion of costs will be allocated to State General Funds
510- Preparation/ Participation for Judicial Hearings	Includes telephone calling to verify and/or complete factual presentation to the court; drafting and review of reports; consultation with supervisory personnel, legal counsel and other involved parties during the report drafting process; interviewing relevant individuals in preparing court reports; participation in judicial hearings; and preparation of a TPR packet, and transporting parent/caretaker or child to court	Title IVE/State	Title IVE/State	Costs of this activity will be allocated through RMS to Title IVE based on the Title IVE penetration rate. The non- Title IVE portion of costs will be allocated to State General Funds
515-Placement/ Replacement of the Client (Adoptive or Foster Home)	Includes contacting potential care providers; consultation with supervisory personnel; processing of required legal and Departmental documentation; informing the current care provider of the details of the change of care placement; coordination among all parties involved for the date of transfer; conducting a pre-placement visit or conference (with or without the client) to the new provider; physical placement of the client with new care providers; replacement assessment; preparation for removal from current care provider; pre-placement visits; notification of custodian; emergency interim placement; and alternate placement; transporting child to placement or replacement;	Title IVE/State	Title IVE/State	Costs of this activity will be allocated through RMS to Title IVE based on the Title IVE penetration rate. The non- Title IVE portion of costs will be allocated to State General Funds
535-Counseling	Therapeutic counseling with a client, including problem identification and resolution; identification of a feasible goal; provision of emotional support and guidance; exploration with client of possible alternative behavior patterns; diagnosis and structured support groups, individual and family therapy focusing on specialized problems requiring intensive therapeutic counseling; and, surrender counseling.	Title IV-B	Title IV-B	
540- Fair Hearings	Activities related to the established procedure by which an individual claiming benefits is	Title	Title IVE/State	Costs of this activity will be allocated through RMS to

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and Appeals	entitled to a fair hearing before designated representatives of the department. This provision provides a method for addressing grievances of individuals who have been denied payment. The inadequate delivery of services, failure to provide required case plans, and problems with administrative reviews may also be addressed by such a hearing.	IVE/State		Title IVE based on the Title IVE penetration rate. The non- Title IVE portion of costs will be allocated to State General Funds
550-Recruitment & Certification/Re-certification of Homes	Includes identification of prospective foster care and adoptive parents; initial home study; interim monitoring of facilities; facility closures; initial certification; registration; re-certification; adoptive home studies. This code should be used for child specific recruitment, certification and re-certification of foster homes/facilities.	Title IVE/State	Title IVE/State	Costs of this activity will be allocated through RMS to Title IVE based on the Title IVE penetration rate. The non- Title IVE portion of costs will be allocated to State General Funds
560-Abuse/Neglect Investigation	Includes investigation of allegations of suspected child physical abuse; investigation of allegations of suspected child neglect; investigation of allegations of suspected child sexual abuse; investigation of allegations of suspected child emotional abuse and investigation of multiple allegations of suspected child abuse, neglect or exploitation. If a worker is taking a report of suspected child abuse and neglect and has determined that the report will go on to investigation, this code may be used.	Title IV-B	Title IV-B	
820-Recruitment and Certification of Homes/Facilities	Includes speaking to prospective foster care providers; participating in local forums or public service programs to inform the public of the need for foster care and adoptive parents; composing brochures or flyers, or distributing existing materials promoting the programs; other promotional or recruitment activities that are directly related to recruiting homes; initial home study; interim monitoring of facilities; facility closure; initial certification; registration; re-certification; and adoptive home studies. Use for non- child specific recruitment and certification.	Title IVE/State	Title IVE/State	Costs of this activity will be allocated through RMS to Title IVE based on the Title IVE penetration rate. The non- Title IVE portion of costs will be allocated to State General Funds
825- Foster Care and Adoptive Parent Training	Training of foster care and adoptive parents to facilitate interim and permanent placements.	Title IVE/State	Title IVE/State	Costs of this activity will be allocated through RMS to Title IVE based on the Title IVE penetration rate. The non- Title IVE portion of costs will be allocated to State General Funds
904- Non-Medicaid Outreach	Includes activities that inform individuals about Non-Medicaid program, including social (Food Stamps, Medicare, Child Welfare Services, SSI, TANF, WIC, day care, etc.), vocational and education programs, how to access them, any related paperwork and clerical	Title IV-B	Title IV-B	

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	activities or, staff travel require to perform these activities.			
925- Child Welfare Related Staff Development and Training	Participation in IV-E related and approved training, conferences, seminars and workshops. Staff will be informed of any training time that is appropriate to record under this code.	Title IVE/State	Title IVE/State	Costs of this activity will be allocated through RMS to Title IVE based on the Title IVE penetration rate. The non- Title IVE portion of costs will be allocated to State General Funds
926-Other Staff Development and Training	Participation in general training, conferences, seminars and workshops.	Redistributed	Redistributed	
945- General Administrative Functions	Includes retrieval or completion of administrative forms and documents (not case specific), such as time sheets, professional reading, unit meetings, etc.	Redistributed	Redistributed	
950-Breaks, Personal Business	Includes activities of a personal nature	Redistributed	Redistributed	
965-Sheltering	This code may be used when staff are activated to work at shelters during a disaster or participated in planning activities in the event of disaster. Any time spent in meeting or on-site preparing for sheltering activities should be record here.	State	State	
966-All Other Activities	All other activities	State	State	
996-Leave	Paid absence, for example, sick, vacation, personal leave or jury duty.	Redistributed	Redistributed	
998-Employee Not Scheduled to Work	Employee not scheduled to work at time of sample (i.e., schedule change, flextime)	Invalid	Invalid	

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	July	August	September	October	November	December	January	February	March	April	May	June	Close	TOTAL	MONTHLY AVG.
CW Administrative Expenditures	$9,169,269	$11,516,831	$9,400,598	$12,499,441	$12,356,838	$10,346,451	$10,101,687	$9,237,981	$8,642,292	$12,401,514	$10,860,732	$10,075,839	$2,012,934	$128,622,407	
Total Allocable Hits	1819	1819	1901	1901	1901	1854	1854	1854	1843	1843	1843	1824	1824		
531 - Case Management & Supervision Medical & Behavioral	43	43	29	29	29	32	32	32	52	52	52	30	30		
% Medical CM	2.36%	2.36%	1.53%	1.53%	1.53%	1.73%	1.73%	1.73%	2.82%	2.82%	2.82%	1.64%	1.64%		
$ Medical CM	$216,756	$272,251	$143,407	$190,681	$188,505	$178,580	$174,355	$159,447	$243,841	$349,907	$306,434	$165,721	$33,107	$2,622,992	

Targeted Case Management and Managed Care Collaborative Plan

In order to implement a collaborative approach between Targeted Case Management (TCM) and Managed Care Organizations (MCO's), and to offer the broadest care possible to clients/members, the Department of Children and Family Services (DCFS) will be required to enter into a Memorandum of Understanding (MOU) with each MCO. These MOUs will serve to define the respective responsibilities and necessary coordination between the TCM and the MCO as well as provide assurance that claims for TCM do not duplicate claims for managed care.

This document serves to define protocols to follow when entering into an MOU between DCFSs and MCOs in order to avoid duplication of services and activities. These protocols serve as the basis for this coordination that shall be used by DCFS when entering into the required MOUs.

Case Management

While both managed care organizations (MCOs) and TCM programs provide case management, there is a distinction between case management provided by TCM programs and by MCOs. The MCO primarily focuses on member medical needs in providing case management as the primary provider of client medical care. This may include management of acute or chronic illness.

In contrast, the TCM program focuses on the management of the whole client, including referring clients to providers to address medical issues, as appropriate. However, the TCM program is not a provider of medical services and does not include the provision of direct services.

Case management services, as defined in Title 42 CFR Section 440.169, include the following four service components:

1. Assessment and periodic reassessment;
2. Development of a specific Care Plan;
3. Referral and related activities; and
4. Monitoring and follow-up activities.

The four component requirement applies to both TCM and MCO case management. TCM services do not include the direct delivery of underlying medical, social, educational, or other services to which an individual has been referred.

Roles

Managed Care Organizations

MCOs will partner with DCFS to ensure that members receive the appropriate level of case management services. The collaborative process will ensure that there is no duplication of services.

The MCO will oversee the delivery of primary health care and related care coordination. MCOs are responsible for providing all medically necessary health care identified in the care plan including medical education that the member may need as well as any necessary medical referral authorizations. Case management for member medical issues and linkages to MCO covered health services will be the responsibility of the MCO.

MCOs will provide members with linkage and care coordination for any necessary social support need identified by the MCO that do not need medical case management.

DCFS TCM Program

For TCM, the DCFS will provide TCM services for medical, social, educational, and other services needing case management. For client medical issues needing case management, the DCFS TCM program will refer MCO members with open TCM cases to the MCOs when identified by the TCM Case Manager.

Contacts

Contact parties will be designated at both the MCO and the DCFS to facilitate the required coordination and to address any and all issues as they arise.

The MCO will designate a contact responsible for facilitating coordination with DCFS, including identifying the appropriate MCO contacts to the DCFS and resolving all related operational issues. The MCO primary care provider (PCP), Case Manager, or plan designee, as determined by each MCO, will serve as the contact person for member MCO case management.

The DCFS will designate a contact responsible for facilitating coordination with MCOs, including identifying the appropriate MCO contacts to the DCFS, and resolving all related operational issues. The TCM Case Manager or DCFS designee will serve as the contact person for all clients receiving TCM.

Client Identification

To facilitate proper coordination between the MCO and the DCFS, the Department of Health and Hospitals (DHH) will provide each MCO with electronic information identifying MCO clients receiving TCM services within the last three months.

MCOs will notify the member's PCP and/or any Case Manager that the member is receiving TCM services along with the appropriate DCFS contact information.

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Additionally, the MCO will notify the DCFS when the member is receiving TCM services and is also receiving complex case management from the MCO, either in batch or client-by-client basis monthly, and/or additionally, on request from the DCFS.

In addition, the DCFS will receive electronic information identifying to which MCO each client is assigned. DCFS will also query all TCM clients to determine if they are assigned an MCO for their primary medical care. Additionally, DCFS may request access to client managed care status and provider information via existing DHH provider eligibility information access systems.

Coordination

MCOs and DCFS will share client/member care plans with one another upon request from either party for MCO members with open TCM cases. MCOs and the DCFS TCM program will communicate regarding client/member status for open medical and related social support issues to ensure that there is no duplication of service and to ensure that the member receives the optimal level of case management services. Both the MCOs and the DCFS TCM program will comply with Health Insurance Portability and Accountability Act (HIPAA) requirements when sharing medical information between MCOs and the DCFS TCM program.

For any client/member with an open TCM case needing medical case management, the responsible MCO and DCFS will communicate at least once every six months to ensure that the client/member is receiving the appropriate level of care. The coordination between the MCO and the DCFS will include, at a minimum, all medical issues and all social support related issues identified by the MCO and/or by the DCFS TCM program.

The detailed protocols below shall be used to ensure this coordination takes place in a manner serving all clients' needs and to ensure continuity of care.

Client Health Insurance Portability and Accountability Act Consents

Both the MCOs and the DCFS TCM Program will pursue obtaining HIPAA consents from both MCO members and DCFS TCM clients to allow sharing of medical information between them.

Assessment and Care Plan Protocol

DCFS TCM Programs

TCM services will be provided to clients which will assist them in gaining access to needed medical, social, educational, or other services per Title 42 CFR Section 440.169.

- DCFS will be responsible for creating all TCM assessments, and for the

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development and revision of care plans related to TCM services. The assessment shall determine the need for any medical, educational, social, or other service. This includes the required semi-annual reassessments.

- DCFS will share TCM care plans with MCOs if requested by the MCO.
- Based on the assessment, the TCM care plan will specify the goals for providing TCM services to the eligible individual, and the services and actions necessary to address the client's medical, social, educational, or other service needs.
- All clients with open TCM cases will be referred to the MCO by the TCM Case Manager if client is in need of MCO case management for medical issues.

The TCM assessment extends further than the MCO assessment as it includes all medical, social, educational, and any non-medical aspects of case management, including those social support issues that may be related to a medical need. Non-medical issues may include, but are not limited to, life skills, social support, or environmental barriers that may impede the successful implementation of the MCO care plan.

Any client qualifying for TCM either through the DCFS or the MCO will have a TCM assessment and care plan created as described above. The care plan will include any need identified by the MCO. The DCFS TCM Case Manager will coordinate with the MCO when the DCFS TCM Case Manager determines, at a minimum, that:

- The MCO has identified that the client/member receives complex case management from the MCO, and the TCM Case Manager assesses that the client/member is not medically stable.
- The client/member indicates (self-declaration of receiving complex case management) that they are receiving assistance and/or case management for their needs from a Case Manager or other MCO professional.
- The TCM Case Manager assesses that the client may have an acute or chronic medical issue, and is not medically stable.
- The TCM Case Manager assesses that the client's medical needs require case management.
- The TCM Case Manager assesses that the client may have social support issues that may impede the implementation of the MCO care plan.

The method and frequency of TCM coordination will be dictated by the level of the client's medical and related social support needs. The DCFS will determine what coordination options are appropriate for the client's level of need in order to provide the same level of coordination with the MCO. The DCFS will also provide any corresponding documentation to the MCO PCP/Case Manager. This coordination will include, but not limited to, the following:

- The DCFS TCM Case Manager will obtain and review the client/member MCO care plan.

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- The DCFS TCM Case Manager will contact the MCO PCP/Case Manager to discuss the client/member medical issues and/or related social support issues.
- The DCFS TCM Case Manager will notify the MCO via an agreed medium (e.g. specific form, email to PCP), that the client/member is receiving TCM services and has identified a social support issue(s) that may impede the implementation of the MCO care plan.

The above procedures must be followed by DCFS TCM providers unless the client has an urgent medical situation needing immediate case management intervention.

MCO Members Needing Immediate Medical Case Management Intervention

The TCM Case Manager shall provide all necessary assessments, and care plans, medical or otherwise, to the MCO as soon as possible to address the client's/member's immediate medical need.

Managed Care Organizations

MCOs will provide health assessments and care plans for all members as needed.

- MCOs will assess all member medical needs and shall identify medically necessary social support needs, including required annual reassessments.
- MCOs will be responsible for the development and revision of member care plans related to all assessed client medical needs and services related to the medical diagnosis as needed.
- MCOs will share care plan information with the member's DCFS TCM program as they determine necessary to coordinate member medical issues. In addition, MCOs will share care plans if requested by the DCFS TCM program.
- MCO PCPs and Case Managers, when assigned, will communicate with the appropriate DCFS TCM program contact to discuss client needs and/or coordinate as deemed necessary by either the MCO PCP/Case Manager or the DCFS TCM Case Manager.

Referral, Follow Up, and Monitoring Protocol

DCFS TCM Programs

TCM Case Managers will provide referral, follow-up, and monitoring services to help members obtain needed services, and to ensure the TCM care plan is implemented and adequately addresses the client's needs per Title 42 CFR Section 440.169.

- The TCM Case Manager will refer the client to services and related activities that help link the individual with medical, social, educational providers. The TCM Case Manager will also link the client to other programs deemed necessary, and provide follow-up and monitoring as appropriate.

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- The TCM Case Manager will contact the MCO directly as needed to ensure the MCO, PCP, or Case Manager is aware of the client/member, and the client/member is receiving the proper care.

- TCM Case Managers will refer client to MCOs:
    - For all medically necessary services, and authorization for any out-of-network medical services.
    - When a medical need develops or escalates after an MCO assessment and notification of any related medically necessary support issues.
    - When the client needs assistance with medical related services.
        - Examples:
            - Scheduling appointments with PCP.
            - Delays in receiving authorization for specialty health services.

- Prior to referral for TCM, the MCO will identify the social, educational, and/or other non-medical issues the member has that require case management.
    - If the DCFS determines that the client needs or qualifies for TCM, the TCM Case Manager will assess and specifically identify the issue for which the member was referred as well as all other case management needs and develop a care plan as described in the "Assessment and Care Plan Protocol" section.
    - The TCM Case Manager will provide linkage and referrals as needed, and will monitor and follow-up as appropriate.
    - The DCFS may obtain and review the MCO's client care plan to assist in assessing the referred issue.
    - The TCM client case shall remain open until the issue referred by the MCO has been resolved, and no other TCM service is determined to be necessary by the DCFS. The DCFS will notify the MCO when the referred issues have been resolved.
    - When an MCO refers a member to the DCFS for TCM services for any medically necessary or social support needs, coordination will take place as frequently as either the MCO or the TCM Case Manager deems necessary, but no less than quarterly.

- When a member is not referred to a TCM program by an MCO and enters the health system through the DCFS, the DCFS will refer the member to an MCO as needed to provide and document MCO case management services. These services include:

    1) Coordination of care
    2) Medical referrals
    3) Continuity of care
    4) Follow-up on missed appointments
    5) Communication with specialists

The above procedures must be followed by DCFS TCM providers unless the client has

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an urgent medical situation needing immediate case management intervention.

MCO Members Needing Immediate Medical Case Management Intervention

The TCM Case Manager shall provide all necessary referrals as appropriate, medical or otherwise, to the MCO as soon as possible to address the client's/member's immediate medical need.

Managed Care Organizations

MCOs will refer members for the following services in executing their responsibilities to members for the delivery of primary health care and related care coordination:

- Medical Services
- Non-Medical Services
- Basic Social Support Needs
  - MCOs will provide referrals for basic social support needs when an intensive level of case management is not needed, and does not require follow-up or monitoring.
    Examples:
      - Member seen by a MCO Case Manager and the member needs directions to the local Food Bank. The simple act of assisting the member with linking him/her to the Food Bank would not constitute the need for TCM services.
      - MCO Case Manager provides a member with driving directions to the nearest vocational trade school. This would not constitute the need for TCM services.
- TCM Case Management for Non-Medical Needs.
  - MCOs will refer members to the DCFS for TCM services when the individual falls into one of the identified target populations, has undergone an MCO case management assessment, and meets any of the following criteria:
    1. Member is determined to be in need of case management services for non-medical needs.
    2. MCO has determined that the member has demonstrated an on-going inability to access MCO services.
    3. MCO has determined that member would benefit from TCM face-to-face case management.
    4. The MCO has concerns that the member has an inadequate support system for medical care.
    5. The MCO has concerns that the member may have a life skill, social support, or an environmental issue affecting the member's health and/or successful implementation of the MCO care plan.
  - The MCO shall share information with the TCM Case Manager

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that informs the DCFS TCM Case Manager of the issue for which the referral was made.

- Referral does not automatically confirm enrollment into a TCM program.

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LA TCM RATE DETERMINATION - SFY 2015

	July	August	September	October	November	December	January	February	March	April	May	June	Close	TOTAL
CW Administrative Expenditures	$9,169,269	$11,516,831	$9,400,598	$12,499,441	$12,356,838	$10,346,451	$10,101,687	$9,237,981	$8,642,292	$12,401,514	$10,860,732	$10,075,839	$2,012,934	$128,622,407
Total Allocable Hits	1819	1819	1901	1901	1901	1854	1854	1854	1843	1843	1843	1824	1824	
TCM Activity Hits														
500 - Referral to Services	58	58	51	51	51	56	56	56	57	57	57	58	58	
Penetration Rate	44.93%	45.01%	45.41%	44.87%	44.35%	45.04%	44.20%	44.62%	45.36%	45.87%	45.31%	45.42%	45.57%	
500 - Referral to Services (Non-IVE)	31.94	31.89	27.84	28.12	28.38	30.78	31.25	31.01	31.14	30.85	31.17	31.66	31.57	
530 - Case Management & Supervision Social Services	498	498	526	526	526	492	492	492	445	445	445	473	473	
530 - Case Management & Supervision Social Services (Non IVE)	274.25	273.85	287.14	289.98	292.72	270.40	274.54	272.47	243.15	240.88	243.37	258.16	257.45	
531 - Case Management & Supervision Medical & Behavioral	43	43	29	29	29	32	32	32	52	52	52	30	30	
TCM Activity Total	349.19	348.74	343.98	347.10	350.10	333.18	337.78	335.48	326.29	323.73	326.54	319.82	319.02	
TCM Activity % of Allocable Hits	19.20%	19.17%	18.09%	18.26%	18.42%	17.97%	18.22%	18.10%	17.70%	17.57%	17.72%	17.53%	17.49%	
TCM Activity Expenditures	$1,760,203	$2,208,043	$1,701,030	$2,282,250	$2,275,715	$1,859,352	$1,840,447	$1,671,618	$1,530,069	$2,178,391	$1,924,311	$1,766,696	$352,068	$23,350,196
Foster Care Cases	4341	4419	4483	4482	4414	4429	4407	4421	4503	4561	4613	4609		53,682
Rate														