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

TARGETED CASE MANAGEMENT SERVICES

NOW Waiver Beneficiaries

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 intellectual or developmental disabilities who are participants in 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;

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[Specify and justify the frequency of assessments.]

After the initial assessment is completed, reassessments are done on a quarterly basis, at a minimum, 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 home visit per quarter to each beneficiary is required. More frequent home visits shall be required to be performed if indicated in the beneficiary's Comprehensive Plan of Care.

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Allow two quarterly visits that are not the initial or annual plan of care visit, to be conducted virtually when the following conditions are met:

1. **The beneficiary/family is in agreement that a virtual visit is in the best interest of the beneficiary;**
2. **The support coordinator is in agreement that a virtual visit is in the best interest of the beneficiary;**
3. **The provider agencies are in agreement that a virtual visit is in the best interest of the beneficiary;**
4. **The legally responsible individual or family members living in the home are not paid caregivers;**
5. **Technology is available to complete the visit with direct observation of the beneficiary and the home;**
6. **There is evidence that the requirements for the quarterly visit can be met virtually; and**
7. **There have been no critical instances in the last two years including:**
   a. **Discovery by the support coordinator or reported by a provider of an incident, accident, or injury that meets Critical Incident Review criteria;**
   b. **Lack of desired personal outcomes such as education, employment, and community engagement;**
   c. **Unsafe living conditions, lack of sanitation, or lack of food supply;**
   d. **Change in involvement of natural supports;**
   e. **Medication issues; and**
   f. **Changes in behavior, medical status, or appearance (such as weight gain or weight loss).**

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___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:

1. **Bachelor's degree or master's degree in a human service-related field, which includes psychology education, counseling, social services, sociology, philosophy, family and consumer sciences, criminal justice, rehabilitation services, child development, substance abuse, gerontology, and vocational rehabilitation; or**
2. **Currently licensed registered nurse; or**
3. **A bachelor's degree in liberal arts or general studies with a concentration of at least 16 hours in one of the fields listed in number 1; or**
4. **Bachelor or master's degree in social work from a program accredited by the Council on Social Work Education; or**
5. **Bachelor's or master's degree in a field other than those listed above, if approved by Office for Citizens with Developmental Disabilities (OCDD) and Bureau of Health Services Financing (BHSF).**

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

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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 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

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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.]