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

TARGETED CASE MANAGEMENT SERVICES

Ventilator Care Coordination

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 beneficiaries, birth through age 25, who require the use of mechanical ventilation and who are beneficiaries of the New Opportunities Waiver (NOW), Residential Options Waiver (ROW), Children's Choice (CC) Waiver, Early Steps program, or who qualify for Early Periodic Screening Diagnostic and Treatment (EPSDT) case management services. Ventilator care coordination may be received in lieu of case management services.

___ 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.

~~—~~Ventilator Care Coordination services include:

❖

- Technical medical expertise relative to mechanical ventilation;
- Intensive case management focusing on medical needs and addressing socioeconomic and environmental factors;

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- Conferring with beneficiary/family when medical concerns arise and acting accordingly (i.e., assess need for intervention via primary care physician and/or specialist, therapies, and hospital staff);
- Updating physicians on medical concerns/issues between hospitalizations to maximize patient care;
- Collaborating with skilled professionals to assess equipment needs for each beneficiary to ensure appropriateness;
- Advocating between the beneficiary/family, the supply/equipment vendor, and other providers when needed;
- Assessing beneficiary needs to have updated prescriptions for ventilator supplies and durable medical equipment;
- Working with the home health agency, family, and pharmacy to avoid the risk of medication reaction or error;
- Reviewing the home health agency's plan of care (POC) to determine the accuracy and appropriateness of the services provided; and
- Providing training and technical assistance to care providers and agencies that administer the provision of care (i.e., personal care assistant/respite, school nurses, home health agencies) to promote the health and safety of ventilator beneficiaries in their home, at school, and in the community.

❖ Comprehensive assessment and periodic reassessment of needs, to determine the need for any medical, educational, social or other services. These assessment activities include:

- Taking beneficiary history;
- Identifying the beneficiary'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 beneficiary;
- Verifying the beneficiary requires the use of mechanical ventilation; and
- Contacting the beneficiary's local energy provider for priority reinstatement during power outages, explaining that the medically fragile individual requires a power source to sustain life.

After the initial assessment of the beneficiary is completed, reassessments shall be conducted quarterly, at minimum, or 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:

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- Specifies the goals and actions to address the medical, social, educational, and other services needed by the beneficiary;
- Includes activities such as ensuring the active participation of the eligible beneficiary, and working with the beneficiary (or the beneficiary'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 beneficiary.

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

- Activities that help link the beneficiary 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.

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

❖ Monitoring and follow-up activities:

- Each beneficiary must receive at least one home visit per quarter and bi-weekly contact calls. If indicated in the beneficiary's comprehensive POC, more frequent home visits may be required.
- Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible beneficiary's needs, which may be with the beneficiary, family members including parents/authorized representatives, service providers, 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 adequate, appropriate, and being furnished in accordance with the beneficiary's -care plan;
    - Changes in the needs or status of the beneficiary are updated and reflected in the care plan;
    - A comprehensive assessment is provided; and
    - A meeting is held with home care providers to inform and educate them on any updated beneficiary needs and reinforce disease prevention protocols (i.e., hand hygiene, tracheostomy and gastrostomy tube 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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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 employ the following staff and each shall possess at least two years of experience working with individuals who require mechanical ventilation:

1. **Licensed registered nurse; and**
2. **Registered respiratory therapist.**

Ventilator Care Coordinators may not exceed a caseload of 25 patients.

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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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, and units of the case management services received and whether goals specified in the care plan have been achieved;
(v) Whether the individual has declined services in the care plan;
(vi) The need for, and occurrences of, coordination with other case managers;
(vii) A timeline for obtaining needed services; and
(viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §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.]