

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
CASE MANAGEMENT SERVICES

A. Target Group:

The target group consists of categorically needy women whose pregnancies are deemed to be "at risk" (see Supplement 1 to Attachment 3.1-A, page 2, #1 for definition of "at risk").

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

X  Entire state

Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide.)

C. Comparability of Services:

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

X  Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Case management for pregnant women consists of care coordination services that are defined as an active, ongoing process of assisting the individual to identify, access, and utilize community resources and coordinating services to meet individual needs. Care coordination services include locating service sources, making appointments for services, arranging transportation to services, and following up to verify appointments or reschedule appointments for Medicaid-eligible women whose pregnancies are at risk for low birth weight or poor pregnancy outcome. Care Coordinators, and in some cases, Community Health Workers (CHW) provide these case management services in order to encourage the use of cost-effective medical and community resources while helping to reduce infant mortality and low birth weight.

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The activities to be undertaken by a care coordinator for pregnant women are:

1. Risk Assessment - The care coordinator will complete a risk assessment based on the client's medical and social needs as reported by the client and her medical service provider(s). This is done by means of the Prenatal Risk Assessment Form, a checklist that contains absolute and relative factors, which put pregnancies at risk for preterm birth or poor pregnancy outcome. One absolute factor or two relative factors determine(s) the pregnancy to be "at risk". An initial assessment consists of at least 2 encounters: one that must be a visit in the recipient's home and must be performed by the care coordinator; the other may be performed by either the care coordinator or the Community Health Worker (CHW).
2. Development of the plan of care - Together with the client, the Care Coordinator will develop a plan of care based on the client's unique individual health and social needs. A CHW may assist the Care Coordinator in the development of this plan.
3. Implementation - If the risk assessment shows the pregnancy to be at risk for poor pregnancy outcome or preterm birth, to implement the plan of care developed with the client, the Care Coordinator, or CHW working in consultation with the Care Coordinator, will contact potential providers, make appointments for services, arrange for transportation to services, follow up to assure appointments have been kept or rescheduled, make appropriate referrals, and otherwise link client to needed community resources.
4. Monitoring - The Care Coordinator, or CHW working in consultation with the Care Coordinator, will monitor the execution of the plan of care throughout the pregnancy to assure client receives the necessary components of care.
5. Reassessment - In each trimester the Care Coordinator, or CHW working in consultation with the care coordinator, will reassess the client's risk factors and update the plan of care accordingly.
6. Postpartum Assessment - Following confinement, the Care Coordinator will complete a postpartum and newborn assessment as well as an outcome report to evaluate the effectiveness of the plan of care. CHW's may not perform this assessment.

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E. Qualifications of Providers:

MINIMUM CARE COORDINATION QUALIFICATIONS

1. Physicians licensed by the state of Indiana.
2. Registered Nurses licensed by the state of Indiana.
3. Dietitians registered with the Commission on Dietetic Registration of the American Dietetic Association.
4. Social Workers with baccalaureate or master's degrees from schools accredited by the Council on Social Work Education, or social workers certified by the state of Indiana.
5. Community Health Workers (CHW), working under the supervision of one of the professionals listed in 1 - 4 above. Community Health Workers must have a high school diploma or its equivalent and certification by the Indiana State Department of Health.

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

1. Eligible recipients will have free choice of providers of care coordination services for pregnancy.
2. Eligible recipients will have free choice of providers of other medical care under the Plan.

G. Payment for care coordination services for pregnant women under the Plan does not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
CASE MANAGEMENT SERVICES

Target Group:

The target group consists of categorically needy persons with HIV (Human Immune Deficiency Virus) infection, whether symptomatic or asymptomatic, regardless of county of residence.

Areas of state in which services will be provided:

X Entire state.

   Only in the following geographic areas.

C. Comparability of Services

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

X Services are not comparable in amount, duration and Scope. Authority of section 1915(g)(1) of the Act is Invoked to provide services without regard to the Requirements of section 1902(a)(10)(B) of the Act.

Definition of Services

HIV care coordination is a specialized form of case management for persons with HIV infection. Care coordination consists of goal-oriented activities which locate or create, facilitate access to, coordinate and monitor the full range of HIV-related health and human services to encourage the cost effective use of medical and community resources and to promote the well being of the individual while ensuring the person's freedom of choice.

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Under the authority of section 1915(g) of the Social Security Act, care coordination services are those that will assist eligible persons who have contracted HIV or AIDS to gain access to needed medical, psychological, social, educational, spiritual and other services.

Activities to be undertaken by a care coordinator are as follows:

Assessment - The care coordinator will verify HIV positive status and gather information on clients in the targeted group who seek care coordination services.

Service Plan Development - Based upon the information gathered in the assessment, the care coordinator and the client will develop a comprehensive service plan.

Implementation - To implement the service plan developed with the client or his/her representative, the care coordinator will procure agreements with service providers, coordinate delivery of services and maintain the client's record.

Monitoring - The care coordinator will assure implementation of the services identified in the service plan by monitoring planned interventions in a timely fashion and obtaining confirmation of scheduled interventions by the client, the service provider, or both.

Evaluation - The care coordinator will periodically engage in activities designed to measure the appropriateness and effectiveness of the service plan.

Reassessment - The care coordinator will make scheduled reassessments to the service plan in view of continuing or changing needs of the client based on the periodic evaluation and make changes as needed.

Termination - Based upon the reassessment of the service plan, the care coordinator will determine whether services should continue.

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Qualification of Providers

MINIMUM CARE COORDINATION QUALIFICATIONS

- R.N. licensed in Indiana with a minimum of one year case management experience and documented case management training.
- 2. M.S.W./M.S.S. with a minimum of one year case management experience and documented case management training.
- 3. B.S.W. or equivalent degree with a minimum of one year case management experience and documented case management training.
- 4. M.S.N. or equivalent Master's nursing degree with a minimum of one year case management experience and documented case management training.
- 5. B.S.N. or equivalent nursing degree with a minimum of one year case management experience and documented case management training.

Documented case management training includes college credit and/or workshop certificate (formal in or out service training). Applicants without documented case management training but possessing other qualifications may apply to state staff for a waiver, in which case they will be required to enroll in an HIV-specific care coordination training program (such as that offered by the Midwest AIDS Training and Education Center), within three months after employment. An additional year of documented case management experience may be substituted for formal case management training via the waiver.

- F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
  - 1. Eligible recipients will have free choice of the providers of case management services.
  - 2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
CASE MANAGEMENT SERVICES

Target Group: Medicaid enrolled individuals identified as seriously mentally ill or seriously emotionally disturbed.

Areas of State in which services will be provided:

- Entire state
- Only in the following geographic areas

Comparability of Services

- Services are provided in accordance with section 1902(a)(10)(B) of the Act.
- Services are not comparable in amount, duration and Scope. Authority of section 1915(g)(1) of the Act is Invoked to provide services without regard to the Requirements of section 1902(a)(10)(B) of the Act.

Definition of Services: Case management services are goal-oriented activities that locate or create, facilitate access to, and coordinate and monitor the full range of basic human needs, treatment and service resources. Components of the service include:

assessment of the impairment, treatment planning, crisis assistance, access to and training for the use of basic community resources, assistance in daily living and obtaining services necessary for meeting basic human needs and monitoring of the overall service delivery; provision of services in a setting accessible and appropriate to the recipient.

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Allowable activities include the following:

**Identification and outreach**, which will serve to integrate services and activities that ensure the individual of the targeted group is linked with appropriate and coordinated services and supports through the outreach to engage them into the service system; outreach activities will serve to assist current Medicaid recipients identified to reach out to gain access to needed medical, social and other services;

**Individual Assessment** will include a comprehensive assessment of basic needs (i.e., food, shelter, clothing, entitlements), specialized needs such as treatment services (i.e., individual psychotherapy, medical consultation, rehabilitation and other social services) and integrate service needs to determine the appropriate level of service intervention to meet such identified needs;

**Service Planning** activities are to ensure that the individual's service needs are translated from what is identified in assessment to a plan of action for the person. An Individual Services/Treatment Plan will identify the skills and support needed by the person to successfully participate in medical treatment and rehabilitative services;

**Implementation** will encompass accessing, coordinating and obtaining commitments for multiple services (I.e., basic supports, medical/health, social, community psychosocial, recreational, crisis and other services) to ensure the success of the individual services/treatment plan;

**Monitoring of Service Delivery and Utilization** shall maintain ongoing contact with individuals and service providers to assure that the appropriate services identified in the individual's services/treatment plan are being delivered and therefore utilized in the manner specified in the plan; activities will ensure that the person follows through on referrals and agencies/providers follow through on the plans and commitments to ensure that the individual is not denied access to services; it allows the recipient an opportunity to evaluate the plan of care and progress toward meeting the objectives, to modify the plan to ensure adjustments are made to the plan that will all serve to ensure client success as well as appropriate and efficient use of services;

**Reassessment** case manager shall make scheduled reevaluations of the individual's situation and modifications to the service plan in view of the person's continuing or changing needs; whether continuation, alteration or termination of the service plan.

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