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

TARGETED CASE MANAGEMENT SERVICES
High-Risk Pregnant Women

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

Individuals who are enrolled in an Arkansas Medicaid program other than the ARHOME program residing in the community and not while inpatient in a hospital and are either pregnant with a high-risk pregnancy, as evidenced by a high-risk pregnancy diagnosis, OR received high-risk pregnancy TCM services while pregnant and delivered the baby within the previous twelve (12) months.

_____ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to _____ 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)

B. Areas of State in which services will be provided (§1915(g)(1) of the Act):

__X__ Entire State

____ Only in the following geographic areas:

C. 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)).

D. 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 may be delivered through home visits and includes the following assistance:

1. 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;
   - Assessments/Reassessments are required at least annually.

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D. Definitions of Services (continued)

2. 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;
   - Care plans must be updated/renewed at least annually.

3. 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

4. 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.

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D. Definition of Services (continued)

Case managers will continue to monitor and follow-up on the care plan while conducting case management activities, including assessments, referrals and linkages to service providers, during visits. The visits may be as frequent as needed by the client but must be at least every 30 days, which will allow regular assessment of the plan implementation. The case manager will assess the services or community resources received and adequacy of the services. The case manager also will identify the beneficiaries' action steps, determine whether they require additional support or adjustments of services or activities and document relevant activities/changes. At least annually the care plan must be fully reviewed with beneficiaries to ensure the activities are relevant, appropriate and are being followed and update the plan as necessary. Beneficiary interviews may occur through a home visit, face-to face office visit, or other contact method that allows gathering the information needed.

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))

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

Hospital providers licensed as general hospitals with an obstetrics unit with a model recognized by the U.S. Department of Health and Human Services Home Visiting Evidence of Effectiveness (HOMEVEE) program to be effective in improving maternal and child health that have applied and been approved to become Maternal Life360 providers. The hospital may use its own staff or subcontract for case management. Case managers employed by the hospital will have no direct relationship with the inpatient department, and case management services will not be provided by the inpatient or acute unit of the hospital. Case managers will be focused on the person-centered care delivered for the beneficiaries in the community and will not duplicate coordination provided through other hospital-delivered services. Case managers delivering this benefit must be able to provide all components of targeted case management within their scope of practice. Case managers must also meet the following criteria:

- A minimum or a high school diploma or GED and experience with early childhood education, childhood development, or social work, family support, maternity, or case management services, or demonstrated comparable experience or competency through educational or other professional activities to provide the required TCM services for the population.

F. 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:

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G. 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:

1. Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
2. 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
3. Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

H. 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.

I. 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.

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J. Monitoring

Providers must meet established standards that measure services under this program/state plan service to eligible beneficiaries. The State will monitor performance on these standards through monthly expenditure reporting and quarterly progress reporting. Providers will use the MMIS to enroll individuals and enter visits provided in order to monitor individual enrollment and services rendered. The state will also review quality metrics for individual provider- and system-level goals.

The state will ensure that providers meet acceptable performance, including the process and health outcomes and case documentation/program reporting, and will address any identified non-compliance for these services. Audits will ensure case records are maintained as required.

K. 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))

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J. Monitoring

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The state will ensure that providers meet acceptable performance, including the process and health outcomes and case documentation/program reporting, and will address any identified non-compliance for these services. Audits will ensure case records are maintained as required.

K. 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))

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE Revised: ~~November 1, 1997~~ January 1, 2023

~~Reserved~~

19. Case Management Services

E. High-Risk Pregnant Women

Program Rates

Effective January 1, 2023, targeted case management services provided by a qualified enrolled provider described in Supplement 1-Attachment 3.1-A and Supplement 1 Attachment 3.1-B Targeted Case Management Services, High-Risk Pregnant Women shall be reimbursed a per member per month rate (PMPM), in the amount of $300. At least one of the services described in Supplement 1-Attachment 3.1-A or Supplement 1 Attachment 3.1-B Targeted Case Management Services, High-Risk Pregnant Women included in the PMPM must be provided within the service payment unit in order for providers to bill the PMPM rate.

Any provider delivering services through the PMPM will be paid the PMPM rate and cannot bill separately; and, Medicaid providers delivering separate services outside of the PMPM may bill for those separate services in accordance with the state plan.

Payment for 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.

Payments shall be limited to a maximum of 12 months postpartum.

Limitations

Case management does not include expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service.

Case management does not include 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))

Program Rates Development and Adjustments

Existing state program costs reviewed included the State's 2021 Maternal and Infant Early Childhood Home Visiting (MIECHV) program budget request that included staff salaries, other direct program costs to provide the services, and administration. Room and board, and other unallowable facility costs were not considered in the rate development. The state will review data of all enrolled providers at least annually, ensure beneficiaries receive the types, quantity, and intensity of services required to meet their medical needs and to ensure that the rates remain economic and efficient based on the services that are actually provided as part per member per month rate.