

**New York State Department of Health  
Office of Health Insurance Programs  
Division of Quality Improvement and Evaluation**



**Comprehensive Medicaid Case Management (CMCM)  
First-time Mothers/Newborns Program  
Implementation Guidance Manual**

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# **Comprehensive Medicaid Case Management First-time Mothers/Newborns Program**

## **Implementation Guidance Manual**

### **Introduction**

The purpose of this guidance document is to provide information to assist agencies or counties interested in implementing a comprehensive Medicaid case management (CMCM) program targeting first-time mothers and their newborns in New York State. Pursuant to Section 1915(g)(2) of the Social Security Act, case management services, reimbursable through Medicaid, are generally defined as services that assist eligible individuals gain access to needed medical, social, educational and other services. These services can be further targeted to defined populations or geographic areas without regard to the statewide provision of services and are thus referred to as targeted case management (TCM).

This document describes the First-time Mothers/Newborns TCM program in New York State and provides specific guidance in terms of the target population, services provided and required qualifications of provider agencies and case managers. Information on Medicaid reimbursement, determination of rates and provider enrollment are also included.

### **Program Requirements as Approved in the State Plan Amendment**

#### **Target Population**

The First-time Mothers/Newborns (FTM/N) target group consists of low-income, pregnant women who will be first-time mothers and their newborn children up to each child's second birthday. A woman must be enrolled in the targeted case management program during pregnancy, as early as possible, but no later than twenty-eight weeks gestation.

According to State Plan Amendment (SPA) #09-57, the First-time Mothers/Newborns TCM program is only provided in Monroe County and New York City (NYC).

The goals of the program are to improve pregnancy outcomes by providing comprehensive case management services including:

1. Assessment of each woman's need for medical, educational, social and other services;
2. Development of a care plan for the woman or child with goals and activities to help the woman engage in good preventive health practices;
3. Referral, follow-up and assistance in gaining access to needed services including obtaining prenatal care, improving diets, reducing use of cigarettes, alcohol and illegal substances, improving each child's health and development and reducing quickly recurring and untended pregnancies.

## Services Provided

For the First-time Mothers/Newborns program, case management services are furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. This targeted case management program for first-time mothers and their newborns offers a comprehensive set of case management services by trained registered nurses with BSN degrees; and licensed as professional nurses with the New York State Department of Education. Certification by a nationally-recognized organization, with an evidence-based program in nurse home visits and case management for high risk, first-time mothers and their newborn is preferred.

Case management activities include the following:

- Comprehensive assessment and periodic reassessment of the first-time pregnant woman and her newborn to determine need for medical, educational, social or other services. These assessment activities include:
  - Taking the woman's history and assessing her risk for poor birth outcomes;
  - Identifying the needs of the first-time mother and her newborn 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.
- Development (and periodic revision) of a specific care plan. The care plan will be developed based on the comprehensive assessment conducted of the first-time mother. A written care plan must be completed by the case manager within 30 days of the date of the woman's referral to the targeted case management program and be reviewed and updated by the case manager as required by changes in the recipient's condition or circumstances, but not less frequently than every six (6) months subsequent to the initial plan. Each time the plan is reviewed, the goals established in the initial plan will either be maintained or revised, and the new goals and time frames established.

The written care plan must include, but not be limited to, the following activities:

- Identification of the nature, amount, frequency and duration and cost of the case management services required by a particular recipient;
- Selection of the long-term and short-term goals to be achieved through the case management process;
- Specification of the long-term and short-term goals to be achieved through the case management process;
- Collaboration with health care and other formal and informal service providers, including discharge planners and other case managers as appropriate, through case conferences to encourage exchange of clinical information and to assure:
  - a. the integration of clinical care plans throughout the case management process;

- b. the continuity of service;
- c. the avoidance of duplication of services (including case management services) and
- d. the establishment of a comprehensive case management plan that addresses the medical, social, psychosocial, educational and financial needs of the recipient.

The care plan will state:

- goals and actions to address the medical, social, educational, and other services needed by the woman and child;
  - activities to ensure the active participation of the first-time mother (or the woman's authorized health care decision maker) and others to develop the goals;
  - a course of action identified to respond to the assessed needs of the first-time mother and child; and
  - an agreed upon schedule for re-evaluating goals and course of action.
- Referral and related activities (such as assisting the mother in scheduling appointments for herself and her child) to help the first-time mother and newborn obtain needed services. Activities include linking the mother and child with medical, social, educational providers or other programs and services that may be capable of providing needed services to address identified needs, and achieve goals as specified in the care plan.
  - Monitoring and follow-up activities may be with the first-time mother, other family members or providers. Home visits and other contacts that are necessary to ensure that the care plan is implemented and adequately addresses the mother and newborn's needs will be conducted as frequently as necessary, or at least bi-weekly to determine whether the following conditions are met:
    - services are being furnished in accordance with the care plan;
    - services in the care plan are adequate and
    - if there are changes in the needs or status of the woman and/or her child, then necessary adjustments in the care plan and service arrangements with providers are made.

All contacts must be documented in the recipient's case record. If a visit or contact is missed, the case manager should document the reason for the missed visit/contact in the recipient's case record.

Case management includes contacts with service providers and may also include contact with non-eligible individuals (such as the newborn's father, partners and other relatives) for the purpose of helping the first-time mother and her child access services; identify needs and supports to assist the mother and child in obtaining services, providing case managers with useful feedback and alerting case managers to changes in the mother's or child's needs.

Providers will maintain case records that document for all enrollees receiving targeted case management services 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 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) The timeline for obtaining needed services; and (viii) A timeline for reevaluation of the plan.

The enrollee (mother or child) is required to have an individual case record.

## **Qualifications of Providers**

**Provider Agencies** - Providers of case management to first-time mothers and their children in the target locations may be public or private agencies and organizations, whether operated on a profit-making or not-for profit basis.

Case management services may be provided by agencies, facilities, persons and other groups possessing the capacity to provide services that are approved by the Commissioner of New York State Department of Health (DOH), the single state Medicaid agency, based upon an approved proposal submitted to the New York State DOH. Providers may include:

- facilities licensed or certified under New York State law or regulation as Licensed Home Care Services Agencies (LHCSA) or Certified Home Health Agencies (CHHA);  
or
- a county health department, including the health department of the City of New York.

**Case Managers** - Case managers must have the education, experience, training and/or knowledge in the areas necessary to conduct case management services including: assess the needs and capabilities of the pregnant or parenting woman and her child; develop a care plan based on assessment; assist the first-time mother/child in obtaining access to medical, social, educational and other services; make referrals to medical, social, educational and other providers; and monitor activities to ensure that the care plan is effectively implemented and addresses the assessed needs.

Case managers under this program are required to be registered nurses with BSN degrees; and licensed as professional nurses with the New York State Department of Education. Certification by a nationally-recognized organization, with an evidence-based program in nurse home visits and case management for high risk, first time mothers and their newborn is preferred.

Case managers in this targeted case management program will meet or exceed the standards set by the single State Medicaid Agency. The case manager must have two years experience in a substantial number of the case management activities. Voluntary or part-time experience which can be verified will be accepted on a pro-rata basis.

The two years of experience may be substituted by:

- a) one year of case management experience and a degree in a health or human services field;
- b) one year case management experience and an additional year of experience in other activities with the target population; or
- c) a bachelor's or master's degree which includes a practical encompassing a substantial number of activities with the target population.

## **Determination of Rate - Rate Methodology**

Visit-based rates are calculated for Targeted Case Management services for the First-time Mothers/Newborns Program. The rates allow for costs of nurses, supervisors, fringe benefits and overhead related to providing targeted case management services only. Rates are based on a two and one-half year program cycle. Agency rates were set as of May 1, 2009 and are effective for services on or after that date. All rates are available upon request from the New York State Department of Health, Office of Health Insurance Programs. Except as otherwise noted in the State Plan Amendment (SPA), state developed fee schedule rates are the same for both governmental and private providers.

### **Payment for Services:**

Up to four (4) 15 minute units can be billed per service date when one or more of the CMCM services are provided. Each recipient is allowed a maximum of 260 units (which can be billed over a two and a half year time period). Billable units are for time spent delivering a case management service. That service typically occurs face to face with the recipient but may also consist of telephone contacts, mail or e-mail contacts as necessary to provide referral linkages or conduct follow-up activities. Time spent traveling to a recipient to provide case management services is not billable.

## **Medicaid Provider Enrollment**

Provider agencies must be enrolled in Medicaid to submit claims for First-time Mothers/Newborns CMCM/TCM services. Enrolling in the FTM/N program involves the following steps:

- 1) Contact the Monroe County Department of Health, or in NYC, contact the New York City Department of Health and Mental Hygiene (NYCDOHMH), Nurse Family Partnership Program to submit a proposal to provide case management services under the First-time Mothers/Newborns program;
- 2) If approved, the local Department of Health or NYCDOHMH will inform the NYS DOH that a new agency has been approved;
- 3) A Medicaid provider application will be mailed to the agency for completion. First-time Mothers/Newborns program agencies will be assigned a category of service of 0265 (Home Health). The application requires a National Provider Identifier (NPI) that is a unique identifier for CMCM/TCM services. You can request an NPI electronically at: <https://nppes.cms.hhs.gov/>.
- 4) The NYSDOH will review the Medicaid provider application and if approved, issue a Medicaid Provider ID number and effective date.
- 5) This new Medicaid Provider ID and effective date are submitted by the NYSDOH First-time Mothers/Newborns program administrator to the eMedNY claims database to allow billing under Medicaid rate code of 5260.



6) When the rate code information is established on the eMedNY system, the new Medicaid CMCM/TCM provider can begin submitting claims from the enrollment effective date.

For more information about Medicaid provider enrollment please visit the eMedNY website at: <http://www.emedny.org/info/ProviderEnrollment/index.html>

### **Provider Training**

The eMedNY system provides training for Medicaid providers to assist them in understanding and complying with the New York State Medicaid requirements for billing and submitting claims for eligible recipients. Providers can access training information on the eMedNY web site at: <http://www.emedny.org/training/index.aspx> and self help documents at: <http://www.emedny.org/selfhelp/index.html>

### **Provider Manuals**

The Comprehensive Medicaid Case Management (CMCM) Provider Manuals contain detailed information about providing comprehensive Medicaid case management services in NYS and also identifies policy and billing guidelines that are specific to the First-Time Mothers/Newborns program. Providers can access the CMCM manuals on the eMedNY web site at: <http://www.emedny.org/providermanuals/index.html>

### **Application to Expand Target Service Area**

If a county is interested in submitting a proposal to participate in the First-time Mothers/Newborns Program, they must submit their proposal to the NYS DOH with required information about their program. The requested information includes a narrative justification for their participation; a Time Study; and an Estimated Expenditure Summary Table for the most current, complete calendar year. See following attachments.

- Attachment 1 - Time Study Definitions. This document provides instructions for completing the TCM Time Study.
- Attachment 2 - First-time Mothers/Newborns TCM Time Study Form (Sample)
- Attachment 3 - First-time Mothers/Newborns Estimated Expenditures Summary Table. The results of the time study are used to complete the Estimated Expenditure Summary Table.

## **Frequently Asked Questions**

### **1. What is the First-time Mothers/Newborns program?**

First-time Mothers/Newborns is a comprehensive Medicaid case management (CMCM) program and is also known as Targeted Case Management (TCM). TCM was authorized by Congress under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. According to the Centers for Medicare and Medicaid Services definition, “Case management consists of services which help beneficiaries gain access to needed medical, social, educational, and other services.”

### **2. Who is eligible for this program?**

The First-time Mothers/Newborns target group consists of low-income, pregnant women who will be first-time mothers and their newborn children up to each child’s second birthday. A woman must be enrolled in the targeted case management program during pregnancy, as early as possible, but no later than twenty-eight weeks gestation. The pregnant woman must be a first-time mother who is eligible for Medicaid. While entry into the program begins with the mother, the child could only be the enrollee if the mother loses Medicaid eligibility.

### **3. What services are provided?**

The First-time Mothers/Newborns TCM program provides 4 key services: 1) comprehensive assessment and periodic reassessment, 2) development (and periodic revision) of a specific care plan, 3) referral and related activities and 4) monitoring and follow-up activities.

### **4. How are services billed?**

Up to four (4) 15 minute units can be billed per service date when one or more of the TCM services are provided. Each recipient is allowed a maximum of 260 units (which can be billed over a two and a half year time period). Billable units are for time spent delivering a case management service only. The number of units should be calculated in accordance with the chart below

1 unit	=	from 5 minutes to 15 minutes
2 units	=	From 16 minutes to 30 minutes
3 units	=	From 31 minutes to 45 minutes
4 units	=	From 46 minutes to 60 minutes

### **5. How can a first-time pregnant woman enroll in this CMCM/TCM program?**

Eligible women can be identified by the local Department of Social Services (LDSS), the county (or city) Department of Health or by the First-time Mothers/Newborns provider agency.

**6. Where in NYS are First-time Mothers/Newborns provider agencies located?**

Currently, provider agencies are located in NYC and Monroe County.

**7. What provider agencies are eligible to participate?**

Providers may include:

- facilities licensed or certified under New York State law or regulation as Licensed Home Care Services Agencies (LHCSA) or Certified Home Health Agencies (CHHA).
- a county health department, including the health department of the City of New York.

In NYC, the New York City Department of Health and Mental Hygiene (NYCDOHMH) is responsible for determining agencies eligible for participation in this program and will contract with them for the provision of all FTM/N TCM services. In Monroe County, the Monroe County Department of Health is responsible for determining agencies eligible for participation in this program.

**8. How are First-time Mothers/Newborns provider agencies paid?**

Provider agencies bill Medicaid for First-time Mothers/Newborns billable services. Up to four (4) 15 minute units can be billed per service date when one or more of the CMCM services are provided. Each recipient is allowed a maximum of 260 units (which can be billed over a two and a half year time period). Billable units are for time spent delivering a case management service.

**9. Typically, first visits and occasional other visits can involve more than 60 minutes of billable activities – is it possible to claim more than four (4) units per service date, or use an aggregate cap of 260 units over the course of 2.5 years without a per visit cap of 4 units (60 minutes)? Nurse experience is that there is often an uneven distribution of time dedicated to TCM activities, since nurses are responding to individual patient needs. Therefore, a nurse may spend 90 minutes on TCM activities on one visit and 15 minutes on the next.**

Based on the CMS-approved State Plan Amendment (SPA) #09-57, it is not possible to extend the maximum number of billable units on the initial or any subsequent visits.

**10. Since clients receiving First-time Mothers/Newborns Targeted Case Management are followed for 2.5 years, are ongoing assessments/reassessments billable over this whole period?**

Yes, assessments/reassessments can be conducted during contacts with the client. These reassessments would be TCM billable activities. Results of reassessment must be documented in the client's record, and the client's care plan amended as appropriate based on the results of reassessment. In accordance with SPA #09-57, the client's written care plan must be

developed within 30 days of the date of the woman's referral to TCM, and reviewed and updated as required, but not less frequently than every six months.

**11. At what point in the woman's pregnancy can she enroll in the First-time Mothers/Newborns TCM program?**

A woman must be enrolled in the targeted case management program during pregnancy, as early as possible, but **no later than twenty-eight weeks gestation**. A recipient can only be enrolled in one targeted case management program at a time.

**12. In describing care plan development, the Policy guidelines refer to "activities to ensure the active participation of the first-time mother..." Can you please provide examples?**

It is important that the recipient of case management services takes part in the development of the care plan and agrees with the goals established. The 'activities' per se may include asking the recipient what goals she would like to achieve or suggesting a goal and asking if she agrees. This is a common procedure for case management. Documentation in the client's file must reflect the active involvement of the mother in the development of the care plan and goals.

**13. How frequently is the client contacted by the nurse case manager?**

Visits must be conducted in accordance with the schedule in the approved State Plan Amendment #09-57, which indicates that home visits and other contacts that are necessary to ensure that the care plan is implemented must be conducted at least bi-weekly. All contacts must be documented in the recipient's case record. If a visit or contact is missed, the case manager should document the reason for the missed visit/contact in the recipient's case record.

**14. Will audit guidelines for this TCM program be provided?**

The Office of the Medicaid Inspector General (OMIG) conducts audits of Medicaid programs and will conduct audits based upon the minimum requirements outlined in SPA #09-57 and relevant regulations, including case management regulations 18 NYCRR 505.16. Audit tools used by the state are not publicly available. Agencies can best prepare for audits by using the CMS-approved State Plan Amendment and eMedNY Policy Guidelines for CMC providers as the basis for all policies and procedures for the FTM/N program, including billing.

**15. SPA #09-57 states that provider agencies may include: a) facilities licensed or certified under New York State law or regulation as Licensed Home Care Service Agencies (LHCSA) or Certified Home Health Agencies (CHHA). Must each CHHA or LHCSA provider submit a proposal to the state in order to enroll as a First-time Mothers/Newborns provider?**

In NYC, the New York City Department of Health and Mental Hygiene (NYCDOHMH) is responsible for determining agencies eligible for participation in this program and will contract with them for the provision of all FTM/N TCM services. In Monroe County, the

Monroe County Department of Health is responsible for determining agencies eligible for participation in this program.

- 16. Are providers operating under a Certified Home Health Agency (CHHA) license required to follow the CHHA regulations for First-time Mothers/Newborns TCM? For example, does the State DOH requirement to have signed physician orders for nursing visits provided under the CHHA apply to TCM nurse visits?**

The rules for TCM nurse visits are dictated by the First-time Mothers/Newborns State Plan Amendment #09 – 57 and NYS regulations for case management 18 NYCRR 505.16. For First-time Mothers/Newborns TCM services, signed physician orders are not required.

- 17. It is our understanding that case management activities conducted outside of a visit (such as calls made in the office) would be billable. Is this correct?**

Billable units are for time spent delivering a case management service. Services are typically provided face to face with the recipient but may also consist of telephone contacts, mail or e-mail contacts as necessary to provide referral linkages or conduct follow-up activities. Time spent traveling to a recipient to provide case management services is not billable. As a reminder, home visits and other contacts that are necessary to ensure that the care plan is implemented must be conducted at least bi-weekly. Please consult the Policy Guidelines on the eMedNY website for a list of all non-billable activities:

[http://www.emedny.org/ProviderManuals/CMCM/PDFS/CMCM\\_Policy.pdf](http://www.emedny.org/ProviderManuals/CMCM/PDFS/CMCM_Policy.pdf)

All billable time spent providing TCM services, whether in person or by phone/mail/e-mail, must be documented in the recipient's case management chart.

- 18. Is billing allowed for TCM activities (assessment/reassessment, plan of care/goal setting, monitoring and follow-up, referral/service linkages) that occur during a home visit only? Or, are we allowed to bill for all TCM activities, regardless of the setting?**

TCM activities conducted during face-to-face visits with the client are billable regardless of the location or setting including but not limited to hospitals and schools. It is expected that the face to face visits in the First-time Mothers/Newborns program would take place in the home, particularly at the outset of service delivery.

- 19. It is our understanding that up to four (4) 15 minute units per service date are allowed, regardless of the number of visits conducted for a particular client that day. Is this correct?**

A maximum of four (4) 15 minute units can be billed per service date per client no matter how many visits were conducted that day.

- 20. How should billing for multiple births be handled?**

In the case of multiples, if the mother is enrolled in FTM/N TCM, all TCM services provided to mother and child (or children) are billed to the mother. If the mother loses Medicaid

eligibility, each child can be enrolled in TCM individually and TCM services for each child may be billed for separately. Separate appointment times (separate sessions) must be documented in order to bill for each child. Documentation must be maintained separately for each child in accordance with the requirements in SPA #09-57, including care plans and goals, and six-month review and update of the care plans. In addition, the case manager cannot bill for more than one recipient for the same period of time.

**21. Can you clarify what is a billable assessment activity and what are non-billable assessment activities (i.e., medical vs. TCM assessments)?**

TCM assessment activities are for the provider to assess a client's need for medical care or educational or social services, but not to provide the actual medical care or other services.

**22. Can you clarify what are billable activities for the mother vs. the child?**

Only one person (mother or child) can be enrolled in FTM/N TCM at a time. The child could only be the enrollee if the mother loses Medicaid eligibility. In the case of multiples, please refer to Question #20 above.

Examples -

- 1) The mother is pregnant, all TCM services are provided to the mother and are billed under the mother; or
- 2) The baby is born, TCM services are provided to both mother and newborn and are billed under the mother, or
- 3) The mother loses eligibility 60 days after the baby is born. The baby is enrolled in TCM and TCM services provided to the baby are billable under the baby. TCM services that are specifically provided to the mother are only billable under the baby when these services are related to the baby and are primarily provided for the benefit of the baby. For example, assessment and referral for breastfeeding consultation would be a reimbursable TCM service.

**23. Can you clarify what is meant by the term “service needs” (For instance, would linking/referring a client to a website be considered a referral/service linkage)?**

Linking or referring a client to a website, for example, referring a client to the NYS Smokers' Quitline, or giving a client a phone number for a self-help group or mom's group or making the phone call to the referral provider are all examples of acceptable linking/referring. As a reminder, between 5 – 15 minutes of service time must be provided in order to bill for one unit. If the TCM client self refers to a service this is not a billable activity

**24. What reporting requirements are there for TCM providers?**

Client-related data will be monitored on a periodic basis with reports created from the eMedNY claims database. The Quarterly Provider Activity Report form (Attachment 8), as specified in the 1989 Comprehensive Medicaid Case Management Administrative Directive 89-29 is not required for the FTM/N TCM program at this time. Other specific fiscal or program reporting requirements for the FTM/N TCM program have not yet been determined.

**25. What are acceptable staff replacements and billing practices, for instance when case managers are on leave or unavailable to help the client?**

If a case manager is taking the place of another case manager when the assigned case manager of record is not available, that person must meet the same qualifications for case manager as set forth in SPA #09-57 in order for the services to be billed as TCM. Staff employed in administration or supervision who do not have the qualifications of a case manager cannot bill for case management services.

**26. Can you clarify what individuals (other than the mother) may be authorized to act as a recipient of case management services on the child's behalf?**

Case management includes contacts with non-eligible individuals (such as the newborn's father) for the purpose of helping the first-time mother and her child access services; identifying needs and supports to assist the mother and child in obtaining services; providing case managers with useful feedback and alerting case managers to changes in the mother or child's needs (42 CFR 440.169(e)).

**27. Can there be family case management charts instead of individual charts?**

The enrollee (mother or child) is required to have an individual case record.

**28. Is there a time limitation on when a care plan must be completed by the case manager?**

SPA #09-57 requirements specify that a written care plan must be completed by the case manager within 30 days of the woman's referral to the targeted case management program. If a care plan cannot be completed within this timeframe, the reasons must be documented in the client's chart.

The definition of case management services are described in the SPA #09-57, Page 1-M2 and in Federal Regulations, 42 CFR 440.169 (Attachment 5).

**29. Is it possible to get a list of TCM programs in NYC, so nurse case managers can have more informed conversations with clients and potential clients about enrolling in TCM and possible transfer from one TCM program to another?**

A Medicaid client can only be enrolled in one targeted case management program. Case managers engaged with women and infants in the First-time Mothers/Newborns Program should access information about additional resources and other case management programs in their geographic area through the local Health Department and/or Department of Social Services.

**30. How far back may a provider back-bill for TCM activities provided to a particular client?**

The agency can bill for TCM services provided to an enrollee back to the date that their eligibility for TCM was effective in the Welfare Management System with a restriction/exception code 35 provided there is case record documentation to support it. Medicaid providers have up to two years from the date of service to submit claims.

**31. Can someone from the Office of the Medicaid Inspector General (OMIG) review documentation submitted by agencies providing First-time Mothers/Newborns TCM to see if they are on the “right track” for billing under Targeted Case Management?**

No, this is not an OMIG activity. Please refer to Q&A # 14 for additional information.

**32. Would it be possible to get clinical documentation guidance from the NYSDOH for First-time Mothers/Newborns TCM?**

While TCM services do not include the provision of ‘clinical’ services, the documentation requirements for services furnished under the First-time Mothers/Newborns TCM Program are specified in SPA #09-57.

**33. Is there a provision to grandfather in RNs without BSN degrees as case managers who can bill Medicaid for First-time Mothers/Newborns TCM?**

No. State Plan Amendment (SPA) #09-57 requires that case managers under this program must be registered nurses with BSN degrees and licensed as professional nurses with the New York State Education Department. The SPA goes on to state a preferred qualification and indicates that case managers in this program will meet or exceed the standards set by the single State Medicaid Agency.

## **References**

### **Helpful Links**

NYS Case management regulations, Social Services Law - 18 NYCRR 505.16

<http://w3.health.state.ny.us/dbspace/NYCRR18.nsf/56cf2e25d626f9f785256538006c3ed7/0bf103d6dc0a7ced85256722007690e1?OpenDocument&Highlight=0,505.16>

eMedNY Comprehensive Medicaid Case Management Policy Manual

[http://www.emedny.org/ProviderManuals/CMCM/PDFS/CMCM\\_Policy.pdf](http://www.emedny.org/ProviderManuals/CMCM/PDFS/CMCM_Policy.pdf)

eMedNY Comprehensive Medicaid Case Management Billing Manual

[http://www.emedny.org/ProviderManuals/CMCM/PDFS/CMCM\\_Billing\\_Guidelines\\_UB04.pdf](http://www.emedny.org/ProviderManuals/CMCM/PDFS/CMCM_Billing_Guidelines_UB04.pdf)

### **Attachments**

Attachment 1 - Time Study Definitions

Attachment 2 - First-time Mothers/Newborns TCM\_Time Study

Attachment 3 - First-time Mothers/Newborns Program\_Estimated Expenditures Summary Table

Attachment 4 - Legislative Authority - NYS Public Health Law § 33-a



Attachment 5 - Federal Case Management Regulations – CMS, HHS 42 CFR §440.169  
Attachment 6 - State Plan Amendment #09-57

## **Attachment 1 – Time Study Definitions**

### **First-time Mothers/Newborns Target Case Management Activity Code Descriptions**

#### **A. Assessment**

- Obtaining and documenting client medical, educational, social and other history.
  - Identify issues and concerns:
    - Assess mother and infant’s medical, social educational and other service needs.
    - Assess home environment for health/safety risks including exposure to lead, asbestos, violence and other factors that affect the infants health.
- Obtain information from other family members, medical providers, social workers, and educators to assist in developing a complete assessment of the eligible individual.
- Talking with the mother about her personal health, nutrition and exercise; her ability to manage all other responsibilities while caring for the baby; the baby’s exposure to second-hand smoke or other substances used by others, and her social support as they directly impact the plan of care and services to the infant.
- Discussions with mother on parenting skills.

#### **B. Plan of Care/Goal Setting & Agreement for Next Visit – Initial and On-going**

- Work with client/mother/decision-maker in developing/documenting goals for a specific plan of care:
  - Specific short and long term goals
  - Course of action to respond to the medical, social, educational and other service needs.
- Determining what must be tracked for infant/mother:
  - Track infant’s illness, injury, visits to primary care, ER, or other providers; changes in infant’s eating/sleeping behaviors; exposure to health/safety risks including lead, asbestos, violence, and other hazards that affect the infant’s health.
  - Track mother’s health, educational and social needs/goals as they directly impact the plan of care and services to the infant.
- Includes time in the office or in the field preparing the plan of care and consulting with the mother on development of the appropriate plan to address the medical, educational, social, and other service needs.
- Continued discussions with mother on how to improve parenting skills.

#### **C. Referrals**

- Referrals and related activities for mental health/counseling, WIC, Food Stamps, homeless/housing services, etc. (Excludes Medicaid).
- Referrals that qualify must address medical, educational, social, or other service need of the infant or mother that directly impacts the plan of care and services to the mother/infant.
- Does not include a referral for a Medicaid eligibility determination. (This activity should be coded as “G” - all other.)

#### **D. Monitoring and Follow-up/Review and Report of Progress –**

- Monitoring and follow-up to make sure:
  - Services are being furnished in accordance with the plan of care.
  - Services in the plan of care are adequate.
  - Determine if changes are needed based on the changing needs of the client.
  - Determine if necessary adjustments in the plan of care and service arrangements with providers have been made.
- Obtaining information from the client, family members, providers or other entities to assess/monitor and follow-up with above activities.

#### **E. Direct Services –**

These are activities that generally fall outside the case management function described in activities A-D or are “medical treatment” and would be billable under another Medicaid billable code. Examples:

- Well baby exams
- Administering emergency first aid
- “Hands on” demonstrations

#### **F. General Administration-**

- Staff meetings or training received related directly to NFP
- Paid time off
- Breaks/lunch/dinner

#### **G All Other Activities –**

- All other activities not listed in A-F above.
- Training – (non NFP)

**Attachment 2**

**First-time Mothers/Newborns Targeted Case Management  
Time Study**

Name: \_\_\_\_\_ Date Training was Completed: \_\_\_\_\_

Caseload #: \_\_\_\_\_ Agency Name: \_\_\_\_\_

**Activity Codes:**

**A – Assessment** Obtaining information from the individual, family members and others to evaluate appropriate services and to develop/document goals.

**B – Plan of Care/Goal Setting and Agreement for Next Visit** Development of a plan of care and course of action to address medical, social, educational and other service needs.

**C – Referrals** Referrals that address medical, educational, social, or other service need. This does not include a referral for a Medicaid eligibility determination, which is coded G.

**D – Monitoring and Follow Up** Monitor to ensure services in plan of care are adequate and delivered.

**E – Direct Services** Billable Medicaid Services such as giving first aid; or well baby exams.

**F – General Administration** Paid time off, meal or other breaks, staff meetings/training that relate to TCM.

**G - All Other Activities** Meetings/training not relating to TCM; any other activity that does not fall into A-F.

- For each 15 minute time interval enter the activity code that best describes your activity.
- Circle **O**, **V**, or **T** if activity was in **Office**, at a **Visit**, or **Traveling**.
- Circle **P**, **I**, or **T** as appropriate if your activity related to **Prenatal**, **Infant** or **Toddler** stage. (This is not needed for codes F and G.)

	Hour 1	Hour 2	Hour 3	Hour 4	Hour 5	Hour 6	Hour 7	Hour 8
0 - 15	O V T P I T	O V T P I T	O V T P I T	O V T P I T	O V T P I T	O V T P I T	O V T P I T	O V T P I T

16 - 30	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT
31 - 45	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT
46 - 60	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT
	Hour 9	Hour 10	Hour 11	Hour 12	Hour 13	Hour 14	Hour 15	Hour 16
0 - 15	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT
16 - 30	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT
31 - 45	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT
46 - 60	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT
	Hour 17	Hour 18	Hour 19	Hour 20	Hour 21	Hour 22	Hour 23	Hour 24
0 - 15	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT
16 - 30	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT
31 - 45	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT

46 - 60	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT
	Hour 25	Hour 26	Hour 27	Hour 28	Hour 29	Hour 30	Hour 31	Hour 32
0 - 15	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT
16 - 30	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT
31 - 45	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT
46 - 60	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT
	Hour 33	Hour 34	Hour 35	Hour 36	Hour 37	Hour 38	Hour 39	Hour 40
0 - 15	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT
16 - 30	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT
31 - 45	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT
46 - 60	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT	OVT PIT

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Attachment 3**

**FIRST-TIME MOTHERS/NEWBORNS PROGRAM  
ESTIMATED EXPENDITURES SUMMARY  
Year \_\_\_\_\_**

	Agency/County		Contractors <sup>^</sup>		Total	
	FTE	Costs	FTE	Costs	FTE	Costs
<b>Personal Services</b>						
Nurses		\$ -			0	\$ -
Supervisors				\$ -	0	\$ -
Other Field Staff		\$ -		\$ -	0	\$ -
Administrative Staff		\$ -		\$ -	0	\$ -
<b>Non-Personal Services</b>						
Other Non-Personal Services		\$		\$		\$
<b>Other Direct Costs</b>						
Fringe Benefits		\$		\$		\$
Agency Overhead		\$		\$		\$
<b>Total Expenditures</b>		\$ -		\$	0	\$ -
Clients served		\$		\$		
Total # of nurse hours in one year <sup>1</sup>						
% of time in TCM activities <sup>2</sup>						
% of clients enrolled in Medicaid						
Estimated hours billed to Medicaid						
Hourly Rate	\$		\$			
Expected Medicaid Reimbursement						

<sup>^</sup>Contractors' costs include in-kind contributions

<sup>1</sup> assumes # Nurses x Total Days Worked x # Hrs/day

<sup>2</sup> % of time in TCM activities (Visit only) based on results from Time Study

Attachment 4

Legislative Authority NYS Public Health Law § 33-a

50 § 33-a. The public health law is amended by adding a new section 2530  
51 to read as follows:

52 § 2530. Nurse-family partnership. 1. The commissioner is authorized to  
53 establish, subject to federal financial participation and within amounts  
54 appropriated therefor, the nurse-family partnership program, a Medicaid  
55 program subject to title eleven of article five of the social services  
56 law, aimed at improving the health of eligible participants.

S. 6808--C

114

A. 9808--C

1 2. As used in this section, the following terms shall have the follow-  
2 ing meanings:

3 (a) "Eligible participant" means a person enrolled in medical assist-  
4 ance under title eleven of article five of the social services law who  
5 is a pregnant woman who will be a first-time mother; and her newborn,  
6 either or both of whom is at risk for poor outcomes. "Participant" means  
7 an eligible participant who is participating in the nurse-family part-  
8 nership program.

9 (b) "Nurse-family partnership program" or "program" means the nurse-  
10 family partnership program established under this section.

11 (c) "Nurse-family partnership provider" or "provider" means a county  
12 health department, including the health department of the city of New  
13 York, or an entity in contract with such a health department to provide  
14 services under the program or an entity that contracts directly with the  
15 commissioner to provide services under this program.

16 (d) "Case management services" means services that assist a partic-  
17 ipant in gaining access to needed medical, social, educational, and  
18 other services, including: an assessment to determine service needs;  
19 development of a care plan based on the assessment; referral to medical,  
20 social, educational and other providers; and monitoring and other  
21 follow-up activities to ensure that the care plan is effectively imple-  
22 mented and addresses the assessed needs.

23 3. The nurse-family partnership program is a nurse home-visiting  
24 program in which a nurse-family partnership provider provides case  
25 management and nursing services (primarily nurse home visits to partic-  
26 ipants) to eligible participants up to the child's second birthday.  
27 Participation in the program shall be voluntary for eligible partic-  
28 ipants.

29 4. A nurse-family partnership provider shall be approved by a nation-  
30 ally-recognized organization involved with nurse-family partnership  
31 programs, designated by the commissioner, and shall meet such other  
32 criteria as established by the commissioner.

33 5. The commissioner may establish the nurse-family partnership program  
34 in one or more social services districts and may establish program  
35 enrollment limits based on analysis of need and available appropri-  
36 ations.

37 6. Nurse-family partnership program services provided by a provider to  
38 an eligible participant under this section shall be deemed to be medical  
39 assistance services under title eleven of article five of the social  
40 services law. The commissioner may establish, subject to the approval of  
41 the director of the division of the budget, rates of payment to nurse-  
42 family partnership providers for providing nurse-family partnership  
43 program services.



44 7. The commissioner shall submit all appropriate amendments to the  
45 state plan for medical assistance and shall submit applications for  
46 waivers of the federal social security act as shall be necessary to  
47 obtain federal financial participation in the costs of services provided  
48 pursuant to this section.

## Attachment 5

### Centers for Medicare & Medicaid Services, HHS 42 CFR § 440.169

#### § 440.169 Case management services.

(a) *Case management services* means services furnished to assist individuals, eligible under the State plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services, in accordance with § 441.18 of this chapter.

(b) *Targeted case management services* means case management services furnished without regard to the requirements of § 431.50(b) of this chapter (related to statewide provision of services) and § 440.240 (related to comparability).

Targeted case management services may be offered to individuals in any defined location of the State or to individuals within targeted groups specified in the State plan.

(c) [Reserved]

(d) The assistance that case managers provide in assisting eligible individuals obtain services includes—

(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 the following:

(i) Taking client history.

(ii) Identifying the needs of the individual, and completing related documentation.

(iii) 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.

(2) Development (and periodic revision) of a specific care plan based on the information collected through the assessment, that includes the following:

(i) Specifies the goals and actions to address the medical, social, educational, and other services needed by

the eligible individual.

(ii) 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.

(iii) Identifies a course of action to respond to the assessed needs of the eligible individual.

(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, and 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.

(4) Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual 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 help determine whether the following conditions are met:

(i) Services are being furnished in accordance with the individual's care plan.

(ii) Services in the care plan are adequate.

(iii) There are changes in the needs or status of the eligible individual.

Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers. .

**Attachment 6**

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New York – First-time Mothers/Newborns

Supplement I to Attachment 3.1 A

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: New York State

TARGETED CASE MANAGEMENT SERVICES

For First-time Mothers and Newborns

Target Group: **M – First-time Mothers and their Newborns**

The primary target group consists of low-income, pregnant women who will be first-time mothers and their newborn children up to each child's second birthday. A woman must be enrolled in the targeted case management program during pregnancy, as early as possible, but no later than twenty-eight weeks gestation.

The goals of this program are to improve pregnancy outcomes by providing comprehensive case management services including: 1) assessment of each woman's need for medical, education, social and other services; 2) development of a care plan for each woman with goals and activities to help the woman engage in good preventive health practices; and 3) referral, follow-up and assistance in gaining access to needed services including obtaining prenatal care, improving diets, reducing use of cigarettes, alcohol and illegal substances, improving each child's health and development and reducing quickly recurring and unintended pregnancies.

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

\_\_\_\_\_ Entire State

X Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide):

New York City and Monroe County

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**Comparability of Services (Sections 1902(a)(10)(B) and 1915(g)(1))**

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

X  Services are not comparable in amount, duration, and scope. (Section 1915(g)(1)). By enrolling in this targeted case management program, first-time mothers and their newborns will be receiving comprehensive case management services that are not comparable to the amount, duration and scope of services provided to all Medicaid eligible pregnant women.

**Definition of Services (42 CFR 440.169):**

Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. This targeted case management program for first-time mothers and their newborns offers a comprehensive set of case management services through home visits by trained registered nurses. Case management services provided include the following:

1. Comprehensive assessment and periodic reassessment of the first-time pregnant woman and her newborn to determine the need for medical, educational, social or other services. These assessment activities include:
  - a) taking the woman's history and assessing her risk for poor birth outcomes;
  - b) identifying the needs of the first-time mother and her newborn 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.
2. Development (and periodic revision) of a specific care plan. A care plan will be developed based on the comprehensive assessment conducted of the first-time mother. A written care plan must be completed by the case manager within 30 days of the date of the woman's referral to the targeted case management program and must include, but not be limited to, the following activities:
  - i. Identification of the nature, amount, frequency and duration and cost of the case management services required by a particular recipient;
  - ii. Selection of the long-term and short-term goals to be achieved through the case management process;

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- iii. Specification of the long-term and short-term goals to be achieved through the case management process;
- iv. Collaboration with health care and other formal and informal service providers, including discharge planners and other case managers as appropriate, through case conferences to encourage exchange of clinical information and to assure:
  - a. the integration of clinical care plans throughout the case management process;
  - b. the continuity of service;
  - c. the avoidance of duplication of services (including case management services) and
  - d. the establishment of a comprehensive case management plan that addresses the medical, social, psychosocial, educational and financial needs of the recipient.

The care plan will state:

- a) goals and actions to address the medical, social, educational, and other services needed by the woman and child;
- b) activities to ensure the active participation of the first-time mother (or the woman's authorized health care decision maker) and others to develop the goals;
- c) a course of action identified to respond to the assessed needs of the first-time mother and child; and
- d) an agreed upon schedule for re-evaluating goals and course of action.

The plan will be reviewed and updated by the case manager as required by changes in the recipient's condition or circumstances, but not less frequently than every six (6) months subsequent to the initial plan. Each time the care plan is reviewed, the goals established in the initial plan will either be maintained or revised, and new goals and time frames established.

3. Referral and related activities (such as scheduling appointments for the mother and child) to help the first-time mother and newborn obtain needed services including:

- a) activities that help link the mother and child with medical, social, educational providers or other program and services in the community that are capable of providing needed services to address identified needs, and achieve goals as specified in the care plan.

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4. Monitoring and follow-up activities

Monitoring and follow-up activities may be with the first-time mother, other family members or providers. Home visits and other contacts that are necessary to ensure that the care plan is implemented and adequately addresses the mother and newborn’s needs will be conducted as frequently as necessary, or at least bi-weekly to determine whether the following conditions are met:

- services are being furnished in accordance with the care plan;
- services in the care plan are adequate and
- if there are changes in the needs or status of the woman and/or her child, then, necessary adjustments in the care plan and service arrangements with providers are made.

X Case management includes contacts with non-eligible individuals (such as the newborn’s father) who are directly related to identifying the needs and care, for the purposes of helping the first-time mother and her child access services; identifying needs and supports to assist the mother and child in obtaining services; providing case managers with useful feedback and altering case managers to changes in the mother or child’s needs (42 CFR 440.169(e)).

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

**1. Provider Agencies**

Providers of targeted case management to first-time mothers and their children in the target groups may be public or private agencies and organizations, whether operated on a profit-making or not-for profit basis.

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Case management services may be provided by agencies, facilities, persons and other groups possessing the capability to provide services that are approved by the Commissioner of New York State Department of Health (DOH), the single state Medicaid agency, based upon an approved proposal submitted to the New York State DOH. Providers may include:

- a) facilities licensed or certified under New York State law or regulation as Licensed Home Care Services Agencies (LHCSA) or Certified Home Health Agencies (CHHA);
- b) a county health department, including the health department of the City of New York.

**2. Case Managers**

Case managers must have the education, experience, training and/or knowledge in the areas necessary to conduct case management services including: assess the needs and capabilities of the pregnant or parenting woman and her child; develop a care plan based on the assessment; assist the first-time mother/child in obtaining access to medical, social, education and other services; make referrals to medical, social, educational and other providers; and monitor activities to ensure that the care plan is effectively implemented and addresses the assessed needs. Case managers under this program are required to be registered nurses with BSN degrees; and be licensed as professional nurses with the New York State Department of Education. Certification by a nationally-recognized organization, with an evidence-based program in nurse home visits and case management for high risk, first-time mothers and their newborn is preferred.

Case managers in this targeted case management program will meet or exceed the standards set by the single State Medicaid Agency. The case manager must have two years experience in a substantial number of case management activities. Voluntary or part-time experience which can be verified will be accepted on a pro-rata basis.

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New York – First-time Mothers/Newborns

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The two years of experience may be substituted by:

- a) one year of case management experience and a degree in a health or human services field;
- b) one year case management experience and an additional year of experience in other activities with the target population; or
- c) a bachelor's or master's degree which includes a practical encompassing a substantial number of activities with the target population.

As a single state Medicaid agency, criteria for case managers is stated in Administrative Directive 89 ADM-29 for case management provider entities and case management staff under section D entitled Provider Qualifications and Participation Standards.

**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 recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.
- 2. Eligible recipients will have free choice of the providers of other medical care under the plan.

**Freedom of Choice Exception (Section 1915(g)(1) and 42 CFR 441.18(b)):**

\_\_\_ Target group consists of eligible individuals with development disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness 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;

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-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 services under the plan does not duplicate payment made to public agencies or private entities under other program authorities for this same purpose.

Case management providers are paid on a unit-of-service basis that does not exceed 15 minutes. A detailed description of the reimbursement methodology identifying the data used to develop the rate is included in Attachment 4.19B.

**Case Records (42 CFR.18(a)(7)):**

Providers maintain case records that document for all recipients receiving targeted case management services 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 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) The timeline for obtaining needed services; and (viii) A timeline for reevaluation of the plan.

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**Limitations**

Case Management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in Section 441.169 when the case management activities are an integral and inseparable component of another 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 Section 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)). First-time mothers who are in foster care or under the jurisdiction of the juvenile justice system or the criminal justice system will not be eligible for targeted case management services under this program.

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 Section 1903(c) of the Act. (Sections 1902(a)(25) and 1905(c)).

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11(g)

Attachment 4.19-B  
(10/09)

**Case Management Target Group M Method of Reimbursement:**

**Rate Methodology for Targeted Case Management Services for First-time Mothers/Newborns**

Visit-based rates have been calculated for Targeted Case Management services for the First-Time Mothers/Newborn Program. The rates will allow for costs of nurses, supervisors, fringe benefits and overhead related to providing targeted case management services only. Rates are based on a two and one-half year program cycle. The maximum length of a visit is sixty ~~ten~~ minutes and is billed in fifteen-minute increments with a maximum of two-hundred and sixty increments.

Allowable nursing and nursing supervisor salaries are determined based on a time study and an analysis of registered nurses' salaries in the counties in the state that will be providing targeted case management services. The allowable number of supervisors for reimbursement purposes is based on a time study and is to not exceed one supervisor per seven nurses. The allowable number of nurses for reimbursement purposes is based on a time study and is to not exceed one nurse per 24 clients. Fringe benefits are capped at thirty percent (30%) of salaries of agency nurses and supervisors, and agency overhead is capped at twenty-five (25%) of agency nurse and supervisor salaries and fringe benefits.

The total percentage of fringe costs is calculated by dividing the fringe benefit amount by the total amount of agency nurse and supervisor salaries and is capped at 30% of the salaries of agency nurses and supervisors. The total percentage of agency overhead costs is calculated by adding the totals of all other agency administrative and overhead costs (agency costs exclusive of nurse salaries, supervisor salaries and fringe benefits), and then dividing this amount by the total of agency nurses and supervisors salaries and allowable fringe benefit expenditures and is capped at 25% of the allowable salaries and fringe benefits of agency nurses and supervisors.

Hourly rates are calculated by dividing total allowable agency expenditures by the total number of nurse-hours in one year. This amount is divided by four (4) to determine the 15-minute incremental unit-of-service in which the visit will be billed.

The agency's rates were set as of May 1, 2009 and are effective for services on or after that date. All rates are published in the various program manuals and are also available upon request from the State agencies involved. Except as otherwise noted in the plan, state developed fee schedules rates are the same for both governmental and private providers.

*\* The approved version contained a typographical error which has been corrected by pen and ink. Correct period of visit is 60 minutes. B.P. Waugh  
Resident  
CMS 10.28.10*

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