RULE

Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing

Targeted Case Management
(LAC 50:XV.Chapters 101-119)

Editor's Note: The following Subpart has recently been compiled and is being promulgated for codification purposes.

The table below shows the compiled Rules used to create each Section.

Section Number	Rules
10101	LR 12:834 (December 1986), LR 19:648 (May 1993), LR 23:732 (June 1997), and LR 25:1251 (July 1999).
10301	LR 12:834 (December 1986), LR 19:648 (May 1993), LR 23:732 (June 1997), and LR 25:1251 (July 1999).
10501	LR 12:834 (December 1986), LR 23:732 (June 1997), LR 25:1251 (July 1999), and LR 29:38 (January 2003).
10503	LR 12:834 (December 1986), LR 23:732 (June 1997), LR 25:1251 (July 1999), and LR 29:38 (January 2003).
10505	LR 12:834 (December 1986), LR 23:732 (June 1997), LR 25:1251 (July 1999), and LR 29:38 (January 2003).
10507	LR 12:834 (December 1986), LR 23:732 (June 1997), (LR 25:1251 (July 1999), LR 26:2796 (December 2000), LR 26:2797 (December 2000), and LR 29:39 (January 2003).
10701	LR 12:834 (December 1986), LR 18:964 (September 1992), LR 23:732 (June 1997), and LR 25:1251 (July 1999).
10901	LR 18:849 (August 1992), and LR 20:18 (January 1994).
10903	LR 18:849 (August 1992), and LR 20:18 (January 1994).
10905	LR 18:849 (August 1992), LR 19:648 (May 1993), and LR 20:18 (January 1994).
11101	LR 26:2796 (December 2000)
11103	LR 26:2796 (December 2000), and LR 29:1481 (August 2003)
11105	LR 26:2796 (December 2000)
11301	LR 26:2797 (December 2000)
11303	LR 26:2797 (December 2000)
11501	LR 15:480 (June 1989), LR 23:732 (June 1997), and LR 25:1251 (July 1999).
11503	LR 15:480 (June 1989), LR 23:732 (June 1997), and LR 25:1251 (July 1999).
11505	LR 12:834 (December 1986), LR 19:645 (May 1993), LR 19:648 (May 1993), LR 23:732 (June 1997), and LR 25:1251 (July 1999).
11701	LR 16:312 (April 1990), LR 23:732 (June 1997), and LR 25:1251 (July 1999).
11901	LR 15:479 (June 1989), LR 23:732 (June 1997), and LR 25:1251 (July 1999).
11903	LR 15:479 (June 1989)
11905	LR 15:479 (June 1989), LR 19:645 (May 1993), LR 23:732 (June 1997), and LR 25:1251 (July 1999).

Title 50
PUBLIC HEALTHC MEDICAL ASSISTANCE
Part XV. Services for Special Populations
Subpart 7. Targeted Case Management

Chapter 101. General Provisions

§10101. Program Description

A. This Subpart 7 governs the provision of case management services to targeted population groups and certain home and community based services waiver groups. The primary objective of case management is the attainment of the personal outcomes identified in the recipient=s comprehensive plan of care. All case management agencies shall be required to incorporate personal outcome measures in the development of comprehensive plans of care and to implement procedures for self-evaluation of the agency. All case management agencies must comply with the policies contained in this Subpart 7 and the *Medicaid Case Management Services Provider Manual* issued March 1, 1999 and all subsequent changes. Case management is defined as services provided to individuals to assist them in gaining access to the full range of needed services including:

a. medical;
b. social;
c. educational; and
d. other support services.

B. The department utilizes a broker model of case management in which recipients are referred to other agencies for the specific services they need. These services are determined by individualized planning with the recipient=s family, and other persons/professionals deemed appropriate. Services are provided in accordance with a written comprehensive plan of care which includes measurable person-centered outcomes.

C. Recipient Freedom of Choice. Recipients have the right to select the provider of their case management services from among those available agencies enrolled to participate in the program. Recipients are requested to indicate a first and second choice of a provider from among those available providers in the region. If the recipient fails to respond or fails to indicate a second choice of provider and their first choice is full, the department will automatically assign them to an available provider. Recipients who are auto-assigned may change once, after 30 days but before 45 days of auto assignment, to an available provider.

D. Recipients must be linked to a case management agency for a six-month period before they can transfer to another agency unless there is good cause for the transfer. Approval of good cause shall be made by the DHH case management administrator. Good cause is determined to exist under the following circumstances:

1. the recipient moves to another DHH region; or
2. there are irreconcilable differences between the agency and the recipient.

E. Recipients who are being transitioned from a developmental center into the MD/DD Waiver Program shall receive their case management services through the Office for Citizens with Developmental Disabilities (OCDD).

F. Recipients who are under the age of 21 and require ventilator assisted care may receive case management services through the Children=s Hospital Ventilator Assisted Care Program.

G. Monitoring. The Department of Health and Hospitals and the Department of Health and Human Services have the authority to monitor and audit all case management agencies in order to determine continued compliance with the rules, policies, and procedures governing case management services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing LR 30:1036 (May 2004).

Chapter 103. Core Elements

§10301. Services

A. All Medicaid-enrolled case management agencies are required to perform the following core elements of case management services.

1. Case Management Intake. The purpose of intake is to serve as an entry point for case management services and to gather baseline information to determine the recipient's need, appropriateness, eligibility and desire for case management.

2. Case Management Assessment. Assessment is the process of gathering and integrating formal and informal information regarding a recipient's goals, strengths, and needs to assist in the development of a person centered comprehensive plan of care. The purpose of the assessment is to establish a contract between the case manager and recipient for the provision of service. The assessment shall be performed in the recipient=s home.

3. Comprehensive Plan of Care Development. The comprehensive plan of care (CPOC) is a written plan based upon assessment data (which may be multidisciplinary), observations and other sources of information which reflect the recipient's needs, capacities and priorities. The purpose of the CPOC is to identify the services required and the resources available to meet these needs.

a. The CPOC must be developed through a collaborative process involving the recipient, family, case manager, other support systems, appropriate professionals and service providers. It shall be developed in the presence of the recipient; therefore, it cannot be completed prior to a meeting with the recipient. The recipient, family, case manager, support system and appropriate professional personnel must be directly involved and agree to assume specific functions and responsibilities.

b. The CPOC must be completed and submitted for approval within 35 calendar days of the referral for case management services.

4. Case Management Linkage. Linkage is the arranging of services agreed upon with the recipient and identified in the CPOC. Upon the request of the recipient or responsible party, attempts must be made to meet service needs with informal resources as much as possible.

5. Case Management Follow-Up/Monitoring. Follow-up/monitoring is the mechanism used by the case manager to assure the appropriateness of the CPOC. Through follow-up/monitoring activity, the case manager not only determines the effectiveness of the CPOC in meeting the recipient's needs, but identifies when changes in the recipient's status necessitate a revision in the CPOC. The purpose of follow-up/monitoring contacts is to determine:

a. if services are being delivered as planned;

b. if services are effective and adequate to meet the recipient=s needs; and

c. whether the recipient is satisfied with the services.

6. Case Management Reassessment. Reassessment is the process by which the baseline assessment is reviewed and information is gathered for evaluating and revising the overall CPOC. At least every quarter, a complete review of the CPOC must be performed to assure that the goals and services are appropriate to the recipient's needs as identified in the assessment/reassessment process. A reassessment is also required when a major change occurs in the status of the recipient and/or his family.

7. Case Management Transition/Closure

a. Provided that the recipient has satisfied the requirements of linkage under §10301.A.4, discharge from a case management agency must occur when the recipient:

i. no longer requires services;

ii. desires to terminate services;

iii. becomes ineligible for services; or

iv. chooses to transfer to another case management agency.

b. The closure process must ease the transition to other services or care systems. The agency shall not retaliate in any way against the recipient for terminating services or transferring to another agency for case management services.

B. In addition to the provision of the core elements, a minimum of one home visit per quarter is required for all recipients of optional targeted and waiver case management services. The agency shall ensure that more frequent home visits are performed if indicated in the recipient=s CPOC. The purpose of the home visit, if it is determined necessary, is to:

1. assess the effectiveness of support strategies and to assist the individual to address problems;

2. maximize opportunities; and/or

3. revise support strategies or personal outcomes.

C. The case management agency shall also be responsible for monitoring service providers quarterly through telephone monitoring, on-site observation of service visits and review of the service providers' records. The agency must also ensure that the service provider and recipient are given a copy of the recipient=s most current CPOC and any subsequent updates.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing LR 30:1036 (May 2004).

Chapter 105. Provider Participation

§10501. Participation Requirements

A. In order to participate as a case management services provider in the Medicaid Program, an agency must comply with:

1. licensure and certification requirements;

2. provider enrollment requirements;

3. the Case Management Manual; and

4. the specific terms of individual contractual agreements.

B. Providers interested in enrolling to provide Medicaid case management services must submit a written request to the Bureau of Community Supports and Services (BCSS) identifying the case management population and the region they wish to serve. A new provider must attend a provider enrollment orientation prior to obtaining a provider enrollment packet. The bureau will offer orientation sessions at least twice per year. Enrollment packets will only be accepted for service delivery in those DHH regions that currently have open enrollment for case management agencies interested in serving certain targeted populations. A separate PE-50 and Disclosure of Ownership form is required for each targeted or waiver population and DHH designated region that the agency plans to serve, as well as for each office site it plans to operate. The agency shall provide services only in the parishes of the DHH administrative region for which approval has been granted.

C. The participation of case management agencies providing service to targeted and waiver populations will be limited contingent on the approval of a 1915(b)(4) waiver by the Centers for Medicare and Medicaid Service (CMS).

D. The following are enrollment requirements applicable to all case management agencies, regardless of the targeted or waiver group served. Failure to comply with these requirements may result in sanctions and/or recoupment and disenrollment. The agency shall:

1. demonstrate direct experience in successfully serving the target population and shall have demonstrated knowledge of available community services and methods for accessing them including:

a. the maintenance of a current file containing community resources available to the target population and established linkages with those resources;

b. demonstrating knowledge of the eligibility requirements and application procedures for federal, state, and local government assistance programs which are applicable to the target population served;

c. the employ of sufficient number of case manager and supervisory staff to comply with the staff coverage, staffing qualifications and maximum caseload size requirements described in §§10503 and 10701.

2. demonstrate administrative capacity and financial resources to provide all core elements of case management services and ensure effective service delivery in accordance with DHH licensing and programmatic requirements;

3. submit a yearly audit of case management costs only and have no outstanding or unresolved audit disclaimer(s) with DHH;

4. assure that all agency staff is employed in accordance with Internal Revenue Service (IRS) and Department of Labor regulations. The subcontracting of individual case managers and/or supervisors is prohibited. However, those agencies who have been awarded Medicaid contracts for case management services may subcontract with another licensed case management agency for case manager and/or supervisory staff if prior approval has been obtained from the Department;

5. assure that all new staff satisfactorily completes an orientation and training program in the first 90 days of employment. All case managers must attend all training mandated by the department. Each case manager and supervisor must satisfactorily complete case management related training annually to meet the minimum training requirements;

6. submit to the Bureau of Community Supports and Services an agency quality improvement plan (QAP) for approval within 90 days of enrollment. Six months following approval of the QAP and annually thereafter, the agency must submit an agency self-evaluation using the requirements contained in the Medicaid case management services provider manual.

7. document and maintain recipient records in accordance with federal and state regulations governing confidentiality and licensing requirements;

8. assure the recipient=s right to elect to receive or terminate case management services (except for recipients in the MR/DD or Elderly and Disabled Adult Waiver Programs). Assure that each recipient has freedom of choice in the selection of an available case management agency (every six months), a qualified case manager, or other service providers and the right to change providers or case managers;

9. assure that the agency and case managers will not provide case management and Medicaid reimbursed direct services to the same recipient(s) unless by an affiliate agency with a separate board of directors;

10. with the recipient=s permission, agree to maintain regular contact, share relevant information and coordinate medical services with the recipient=s attending physician;

11. demonstrate the capacity to participate in the department=s electronic data gathering system(s). All requirements for data submittal must be followed and participation is required for all enrolled case management agencies. The software is the property of the department;

12. complete management reports as described in the provider manual.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing LR 30:1037 (May 2004).

§10503. Provider Responsibilities

A. In order to be reimbursed by the Medicaid Program, an enrolled provider of targeted or waiver case management service must comply with all of the requirements listed in this §10503.

B. Case management agencies must maintain sufficient staff to serve recipients within the mandated caseload size of 35 with a supervisor to staff ratio of no more than eight case managers per supervisor. All case managers must be employed by the agency at least 40 hours per week and work at least 50 percent of the time during normal business hours (8 a.m. to 5 p.m., Monday through Friday). Case management supervisors must be full-time employees and must be continuously available to case managers by telephone or beeper at all other times when not on site when case management services are being provided. All exceptions to the maximum caseload size or full-time employment of staff requirements must be prior authorized by the bureau. The agency must have a written policy to ensure service coverage for all recipients during the normal absences of case managers and supervisors or prior to the filling of vacated staff positions.

C. The agency must maintain a toll-free telephone number to ensure that recipients have access to case management services 24 hours a day, seven days a week. Recipients must be able to reach an actual person in case of an emergency, not a recording.

D. Each enrolled case management agency shall employ or contract with a licensed registered nurse to serve as a consultant.

a. Each case management agency must have a written job description and consultation plan that describes how the nurse consultant will participate in the comprehensive plan of care (CPOC) development for medically complex individuals and others as indicated by the high risk indicators.

b. The nurse consultant shall provide consultation to the case management agency staff on health-related issues as well as education and training for case managers and case manager supervisors.

c. The nurse consultant shall be available on-site at the case management agency location at least four hours per week.

E. Agency Caseload Limitations. Under the terms of the contractual agreement, case management agencies have a restriction on the total number of recipients it may serve. In a region where there are two agencies providing services, the maximum number of recipients that any one agency may serve is 60 percent of the available recipient population. In a region where there are three agencies providing services, the maximum number of recipients that any one agency may serve is 40 percent of the available recipient population.

F. Records. All agency records must be maintained in an accessible, standardized order and format at the DHH enrolled office site. The agency must have sufficient space, facilities and supplies to ensure effective record keeping.

1. Administrative and recipient records must be maintained in a manner to ensure confidentiality and security against loss, tampering, destruction or unauthorized use.

2. The case management agency must retain its records for the longer of the following time frames:

a. five years from the date of the last payment; or

b. until the records are audited and all audit questions are answered.

3. Agency records must be available for review by the appropriate state and federal personnel at all reasonable times.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing LR 30:1038 (May 2004).

§10505. Staff Education and Experience

A. Each Medicaid-enrolled agency must ensure that all staff providing case management services meet the qualifications required in this §10701 prior to assuming any full caseload responsibilities.

B. Case Managers. All case managers must meet one of the following minimum education and experience qualifications:

1. a bachelor=s degree in a human service-related field such as psychology, education, rehabilitation counseling, or counseling from an accredited college or university and one year of paid experience in a human-service-related field providing direct services or case management services; or

2. a licensed registered nurse with one year of paid experience as a registered nurse in public health or a human-

service-related field providing direct services or case management services; or

3. a bachelor's or master's degree in social work from a social work program accredited by the Council on Social Work Education.

a. The above-referenced minimum qualifications for case managers are applicable for all targeted and waiver groups. Thirty hours of graduate level course credit in a human-service-related field may be substituted for the one year of required paid experience.

b. In addition, case managers serving High-Risk Pregnant Women must demonstrate knowledge about perinatal care and meet either one of the qualifications cited above or the following qualification;

4. a registered dietician with one year of paid experience in providing nutrition services to pregnant women.

C. Case Management Supervisors. All case management supervisors must meet one of the following education and experience requirements. Supervisors of case managers for High-Risk Pregnant Women must demonstrate knowledge about perinatal care in addition to meeting one of these qualifications:

1. a master's degree in social work, psychology, nursing, counseling, rehabilitation counseling, education (with special education certification), occupational therapy, speech therapy or physical therapy from an accredited college or university and two years of paid post-master's degree experience in a human-service related field providing direct services or case management services. One year of this experience must be in providing direct services to the target population served; or

2. a bachelor's degree in social work from a social work program accredited by the Council on Social Work Education and three years of paid post-bachelor's degree experience in a human-service related field providing direct services or case management services. One year of this experience must be in providing direct services to the target population served; or

3. a licensed registered nurse with three years of paid post-licensure experience as a registered nurse in public health or a human service-related field providing direct services or case management services. Two years of this experience must be in providing direct services to the target population served; or

4. a bachelor's degree in a human-service-related field such as psychology, education, rehabilitation counseling, or counseling from an accredited college or university and four years of paid post-bachelor's degree experience in a human service related field providing direct services or case management services. Two years of this experience must be in providing direct services to the target population served.

a. The above minimum qualifications for case management supervisors are applicable for all targeted and waiver groups. Thirty hours of graduate level course credit in a human-service-related field may be substituted for one year of the required paid experience.

D. Nurse Consultant. The nurse consultant must meet the following educational qualifications:

1. be a licensed registered nurse with a bachelor's degree in nursing. No substitutions for the bachelor's degree in nursing is allowed; and

2. have one year of paid experience as a registered nurse in a public health or human service field providing direct recipient services or case management.

E. Case Manager Trainee

1. The case management agency must obtain prior approval from the bureau before a case management trainee can be hired. The maximum allowable caseload for a case manager trainee is 20 recipients. The case management trainee position may be utilized to provide services to the following target populations:

a. Infants and Toddlers;
b. HIV;
c. MR/DD Waiver;
d. Elderly and Disabled Adult Waiver; and
e. Targeted EPSDT.

2. The case management trainee must meet the following educational qualifications. A bachelor's degree in:

a. social work;
b. psychology;
c. education;
d. rehabilitation counseling; or
e. a human-service-related field from an accredited college or university.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing LR 30:1038 (May 2004).

§10507. Staff Training

A. Training for case managers and supervisors must be provided or arranged for by the case management agency at its own expense. Agencies must send the appropriate staff to all training mandated by DHH.

B. Training for New Staff. A minimum of 16 hours of orientation must be provided to all staff, volunteers, and students within one week of employment. A minimum of eight hours of the orientation training must address the target population including, but not limited to, specific service needs, available resources and other topics. In addition to the required 16 hours of orientation, all new employees who have no documentation of previous training must receive a minimum of 16 hours of training during the first 90 calendar days of employment related to the target population and the skills and techniques needed to provide case management to that population.

C. Annual Training. Case managers and supervisors must satisfactorily complete a minimum of 40 hours of case management-related training annually which may include updates on subjects covered in orientation and initial training. The 16 hours of orientation training required for new employees are not included in the annual training requirement of at least 40 hours.

D. Documentation. All training required in Subsections B and C above must be evidenced by written documentation and provided to the department upon request.

E. Supervisory Responsibilities. Each case management supervisor shall be responsible for assessing staff performance, reviewing individual cases, providing feedback, and assisting staff to develop problem solving skills using two or more of the following methods:

1. individual, face-to-face sessions with staff;

2. group face-to-face sessions with all case management staff; or

3. sessions in which the supervisor accompanies a case manager to meet with recipients.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing LR 30:1039 (May 2004).

Chapter 107. Reimbursement

§10701. Reimbursement

A. The reimbursement methodology for optional targeted and waiver case management services is a fixed monthly rate for the provision of the core elements of case management services as described in §10301 or in acceptance with the terms of contract by the department.

B. A technical amendment (Public Law 100-617) in 1988 specifies that the Medicaid Program is not required to pay for case management services furnished to consumers without charge. This is in keeping with Medicaid's longstanding position as the payer of last resort. With the statutory exceptions of case management services included in the Individualized Education Programs (IEPs) or Individualized Family Service Plans (IFSPs) and services furnished through Title V public health agencies, reimbursement by Medicaid payment for case management services cannot be made:

1. when another third party payer is liable; nor

2. for services for which no payment liability is incurred.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing LR 30:1040 (May 2004).

Chapter 109. Infants and Toddlers

§10901. Introduction

A. This Chapter authorizes federal financial participation in the funding of Optional Targeted Case Management service for Title XIX eligible infants and toddlers who are ages birth through 2 inclusive (0 - 36 months) who have established medical conditions as defined in Part H of the Individuals with Disabilities Education Act. These criteria are further defined in Chapter 34 of the *Code of Federal Regulations*, Section 303.300.

B. Purpose. To assist eligible recipients in development skills and knowledge to enable them to effectively access and utilize:

1. medical care;
2. social services;
3. educational services; and
4. other service delivery systems.

C. Definitions

Family Service Coordination—case management services which assist with individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.

Individualized Family Service Plan (IFSP)—a written plan that is developed jointly by the family and service providers which identifies the necessary services to enhance the development of the child as well as the family's capacity to meet the needs of their child. The *IFSP* must be based on the multidisciplinary evaluation and assessment of the child and the family's identification of their strengths and needs. The initial *IFSP* must be developed within 45 days following the referral to the child search coordinator with periodic reviews conducted at least every six months and an annual evaluation to review and revise the *IFSP* as appropriate.

Multidisciplinary Evaluation (MDE)—the involvement of two or more disciplines or professions in the provision of integrated and coordinated diagnostic procedures to determine a child's eligibility for early intervention services. The evaluation must include all major developmental areas including cognitive development, physical development including:

a. vision;
b. hearing and communicative development;
c. emotional development;
d. self help skills;
e. the assessment of the child's unique needs; and
f. the family's identification of their strengths and needs as related to enhancing the development of the child.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing LR 30:1040 (May 2004).

§10903. Staff Qualifications

A. The provider must ensure that Medicaid-funded family service coordination services for eligible beneficiaries are provided by qualified individuals who meet the following licensure, education, and experience requirements:

1. bachelor's/master's degree in health or human services or related field; and

2. two years post bachelor's/master's degree experience in a health or human services field, (master's degree in social work, or special education with certification in noncategorical preschool handicapped or other certified areas with emphasis on infants, toddlers and families may be substituted for the required two years of experience); or

3. nurse registered and licensed in the state; and

4. two years experience in pediatric, public health or community nursing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing LR 30:1040 (May 2004).

§10905. Staff Training

A. The provider must ensure that Medicaid-funded family service coordination services for eligible beneficiaries are provided by qualified individuals who meet the following training requirements:

1. satisfactory completion of at least 16 hours of orientation prior to performing any family service coordination tasks and an additional 24 hours of related training during the first 90 days of employment. The 16 hours of orientation cover the following subjects:

Agency Specific Training—Eight Hours	
1 hour	Child identification abuse reporting law, emergency and safety procedures
3 hours	Facility personnel policy
4 hours	Orientation to agency policy, including billing and documentation
Childnet Specific Training—Eight Hours	
1 hour	Components of the ChildNet system
1 1/2 hours	Orientation to family needs and participation

2 hours	Interagency agreement/focus and team building
1 hour	Early intervention services (definition and resources)
1 hour	Child search and family service coordinator roles and responsibilities
1 1/2 hours	Multidisciplinary evaluation (MDE) and individualized Family service plan (IFSP) overview.

2. The 24 hours of training to be completed within the first 90 days shall cover the following advanced subjects:

a. state structure for ChildNet, Child search and early intervention service programs;

b. child search and family service coordinator roles and responsibilities in depth;

c. multidisciplinary evaluation (MDE) in depth;

d. procedural safeguards and complaint procedures;

e. family perspective, including the grieving process;

f. cultural diversity;

g. communication with parents and professionals;

h. family empowerment and advocacy;

i. resources, including adaptation of resources to the child's needs; and

j. arranging access for families to support systems, including informal systems.

B. In-service training specific to ChildNet is to be arranged and coordinated by the regional infant and toddler coordinator and specific training content shall be approved by a subcommittee of the state Interagency Coordinating Council, including members from at least the Medicaid agency and the Department of Education. Advanced training in specific subjects (i.e., multidisciplinary evaluations and individualized family service plans) shall be completed by the new family service coordinator prior to assuming those duties.

C. The provider must ensure that each family service coordinator has completed the required orientation and advanced training during the first 90 days of employment and at least 40 hours of approved in-service education in family service coordination and related areas annually.

D. The provider must ensure that family service coordinators are supervised by qualified individuals who meet the following licensure, education, experience, training, and other requirements:

1. satisfactorily completion of at least the 40 hours of family service coordination and related orientation required of family service coordinators during the first 90 days of employment before assuming supervision of any family service coordination;

2. supervisors must also complete 40 hours of in-service training each year on such subjects as:

a. family service coordination;

b. supervision; or

c. administration.

E. The provider must sign a notarized letter of assurance that the requirements of Louisiana Medicaid are met.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing LR 30:1040 (May 2004).

Chapter 111. Nurse Family Partnership Program

§11101. Introduction

A. Providers of nurse home visits for first-time mothers case management services must provide home visit services for eligible recipients in all the following parishes of the Department of Health and Hospitals (DHH) administrative regions:

1. Baton Rouge (2);
2. Thibodaux (3);
3. Lafayette (4);
4. Lake Charles (5);
5. Alexandria (6);
6. Shreveport (7); and
7. Monroe (8).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing LR 30:1041 (May 2004).

§11103. Recipient Qualifications

A. Medicaid recipient must not be beyond the twenty-eighth week of pregnancy and must attest that she meets one of the following definitions of a first-time mother in order to receive nurse home visits case management services. The recipient:

1. is expecting her first live birth, has never parented a child, and plans on parenting this child; or

2. is expecting her first live birth, has never parented a child and is contemplating placing the child for adoption; or

3. has previously been pregnant, but has not delivered a child because of an abortion or miscarriage; or

4. is expecting her first live birth, but has parented stepchildren or younger siblings; or

5. had previously delivered a child, but her parental rights were legally terminated within the first six months of that child=s life; or

6. has delivered a child, but the child died within the first six months of life.

B. The following will be required as verification of first-time mother status:

1. a physician=s statement;
2. medical records;
3. legal documents, or birth and death certificates.

C. After the birth of the child, the focus of nurse home visit for first-time mothers case management is transferred from the mother to the child and services may continue until the child=s second birthday. However, recipients may not receive more than one type of Medicaid funded case management at a time. To incorporate the child's needs into the plan of care, a complete reassessment and an update of the comprehensive plan of care must be completed within six weeks of the delivery and 30 days prior to the child=s first birthday. If during the reassessment it is determined that the child qualifies for CHILDNET and Infants and Toddler=s case management, the nurse home visit case manager shall transfer the child to the Infants and Toddlers Program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing LR 30:1041 (May 2004).

§11105. Staff Qualifications

A. Case managers and supervisors providing services to this targeted population must meet the following educational qualifications:

1. possession of a license or temporary permit to practice professional nursing in the state of Louisiana; and

2. certification of training in the David Olds Prenatal and Early Childhood Nurses Home Visit Model.

B. In addition, a supervisor must have one year of professional nursing experience. A masters degree in nursing or public health may be substituted for the required one year of professional nursing experience for the supervisor.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing LR 30:1042 (May 2004).

Chapter 113. Early, Periodic Screening, Diagnosis and Treatment

§11301. Introduction

A. This Early, Periodic Screening, Diagnosis and Treatment (EPSDT) targeted population shall consist of recipients who are between the ages of 0 and 21 years old, on the Request for Services Registry, and meet the specified eligibility criteria. The point of entry for targeted EPSDT case management services shall be the Office of Citizens with Developmental Disabilities (OCDD) regional offices. However, for those recipients under 3 years of age, case management services will continue to be provided through Childnet. This new targeted population shall be served by agencies who have accepted the department's amendment to their existing contract.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing LR 30:1042 (May 2004).

§11303. Recipient Qualifications

A. In order to be eligible to receive case management services, the EPSDT recipient must be between the age of 0 and 21 and meet one of the following criteria.

1. placement on the Request for Services Registry on or after October 20, 1997, and have passed the OCDD Diagnosis and Evaluation (D&E) process by the later of October 20, 1997, or the date they were placed on the Request for Services Registry; or

2. placement on the Request for Services Registry on or after October 20, 1997, but did not have a D&E by the later of October 20, 1997, or the date they were placed on the Request for Services Registry. Those recipients in this group who subsequently pass or passed the D&E process are eligible for these targeted case management services. For those who do not pass the D&E process, or who are not undergoing a D&E may still receive case management services if they meet the definition of a person with special needs.

*Special Needs*Ca documented, established medical condition, as determined by a licensed physician, that has a high probability of resulting in a developmental delay or that gives rise to a need for multiple medical, social, educational and other services. In the case of a hearing impairment, the determination of special needs must be made by a licensed audiologist or physician.

3. Documentation that substantiates that the EPSDT recipient meets the definition of special needs for case management services includes, but is not limited to:

a. receipt of special education services through the state or local education agency; or

b. receipt of regular services from one or more physicians; or

c. receipt of or application for financial assistance such as SSI because of a medical condition, or the unemployment of the parent due to the need to provide specialized care for the child; or

d. a report by the recipient's physician of multiple health or family issues that impact the recipient's ongoing care; or

e. a determination of developmental delay based upon:

i. the Parents' Evaluation of Pediatric Status;

ii. the Brignance Screens;

iii. the Child Development Inventories;

iv. Denver Developmental Assessment; or

v. any other nationally-recognized diagnostic tool.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing LR 30:1042 (May 2004).

Chapter 115. High Risk Pregnant Women

§11501. Introduction

A. Case management services are provided to pregnant women in need of extra perinatal care, subject to Title XIX limitations. Provision of such services enable recipients to receive multiple health/social/informal services (on an inpatient or an outpatient basis) which the recipient is unable to arrange without assistance. These services shall be limited to certain geographical areas in accordance with the Title XIX State Plan agreement with the Centers for Medicare and Medicaid Service. A recipient will not be forced under this provision to receive case management services for which she may be eligible.

B. Case management services under this provision will not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

C. Maximum units of service covered by this provision per individual per calendar year shall be limited in accordance with the Title XIX State Plan agreement with the Centers for Medicare and Medicaid Service (CMS).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing LR 30:1042 (May 2004).

§11503. Recipient Qualifications

A. A recipient of services must:

1. have been determined medically eligible by the Medicaid agency for extra perinatal care;

2. require services from multiple health /social/informal services providers;

3. be unable to arrange the necessary services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing LR 30:1042 (May 2004).

§11505. Provider Participation

A. In addition to the requirements listed in §10501, case management agencies serving high risk pregnant women must meet the following additional participation requirements:

1. have been certified by the Office of Public Health as having adequate programming and administration to provide the service effectively and efficiently.

2. insure that all case management services are provided by individuals who are licensed to practice in Louisiana or individuals under the supervision of licensed professional staff.

3. demonstrate successful experience with the coordination and/or delivery of services for pregnant women;

4. have a working relationship with a local obstetrical provider and acute care hospital that provides deliveries for 24-hour medical consultation; and

5. have a multidisciplinary team which meet the licensure and perinatal experience requirements applicable for services to high-risk pregnant women. This team shall consist at a minimum, of the following professionals:

a. physician;

b. primary nurse associate or certified nurse manager;

c. registered nurse;

d. social worker; and

e. nutritionist.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing LR 30:1043 (May 2004).

Chapter 117. Mentally Retarded/Developmentally Disabled

§11701. Introduction

A. Case management services are provided to mentally retarded/developmentally disabled (MR/DD) individuals, subject to Title XIX limitations. Provisions of such services enable recipients to receive multiple health/social/informal services (on an inpatient or an outpatient basis) which the recipient is unable to arrange without assistance. The maximum number of units of service covered by this provision per individual per calendar year shall be limited in accordance with the Title XIX State Plan agreement with the Centers for Medicare and Medicaid Service (CMS).

B. The recipient will not be forced to receive case management services for which he or she may be eligible. Case management services will not be used to restrict the access of the recipient to other services available under the State Plan.

C. Payment for case management services will not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Providers of case management services will not be reimbursed for specific services provided to individuals in institutional settings when those services are included in the per diem rate for the institution.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing LR 30:1043 (May 2004).

Chapter 119. HIV Disabled

§11901. Introduction

A. Case Management Services are provided to maximize the health of HIV disabled individuals. The recipient must acquire services from multiple health/social/informal services providers. Case management services under this provision will not be used to restrict the access of the recipient to other services available under the State Plan.

B. In accordance with the Title XIX State Plan agreement with the Centers for Medicare and Medicaid Service (CMS).

1. the maximum number of units of service covered by this provision per individual per calendar year shall be limited; and

2. services shall be limited to certain geographical areas.

C. The recipient may receive services on an inpatient or an outpatient basis and will not be forced under this provision to receive case management services for which he or she may be eligible. Providers of case management services under this provision will not be reimbursed for specific services provided to individuals in institutional settings when those services are included in the per diem rate for the institution.

D. Payment for case management services under this provision will not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing LR 30:1043 (May 2004).

§11903. Recipient Requirements

A. Service will be reimbursed when provided to HIV disabled individuals subject to the provisions below.

1. The recipient must have reached, as documented by a physician, a level 70 on the Karnofsky scale at some time during the course of HIV infection.

2. The recipient must be unable to arrange the necessary services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing LR 30:1043 (May 2004).

§11905. Provider Requirements

A. In addition to the requirements listed in §10501, the provider of case management services must:

1. have one or more documented years providing case management services to HIV disabled individuals;

2. sign a notarized letter of assurance that the requirements of Louisiana Medicaid will be met.

B. In order to be reimbursed by the state, the provider of case management must satisfactorily complete a one-day training approved by the department's HIV program office if serving HIV-infected individuals.

C. The individual assigned as the case manager shall maintain contact with the recipient or his/her legal

representative and these contacts shall be documented in progress notes and address the efficacy of the care plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing LR 30:1043 (May 2004).

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