RULE

Department of Health
Bureau of Health Services Financing

Pharmacy Benefit Management Program
Over-the-Counter Coverage
(LAC 50:XXIX.107)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XXIX.107 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 50
PUBLIC HEALTH-MEDICAL ASSISTANCE
Part XXIX. Pharmacy

Chapter 1. General Provisions

§107. Prior Authorization

A. – C.3. ...

D. Drugs Excluded from Coverage. As provided by §1927(d)(2) of the Social Security Act, the following drugs are excluded from program coverage:

1. – 3. ...

4. select prescription vitamins and mineral products, except:

a. – n. ...

o. urinary PH modifiers (phosphorus, specifically K Phos Neutral and Phospha Neutral);and

5. select over-the-counter covered outpatient drugs as determined by the department.

E. – E.2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S, 36:254, Title XIX of the Social Security Act, and the 1995-96 General Appropriations Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:1053 (June 2006), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1180 (June 2017), LR 43:1553 (August 2017), LR 45:665 (May 2019), LR 46:33 (January 2020), LR 48:1582 (June 2022), LR 49:

Stephen R. Russo, JD

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Professional Services Program

The Department of Health, Bureau of Health Services Financing has repealed the following uncodified Rules in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act:

Register Date	Title	Register Volume, Number	Page Number
December 20, 1978	Submission of physician claims	Volume 4, No. 12	511
January 20, 1982	Definition of "Physician services"	Volume 8, No. 1	9
April 20, 1982	Podiatry service implementation	Volume 8, No. 4	190
June 20, 1983	Cease payment for specimen collection	Volume 9, No. 6	412
August 20, 1983	Change in limits for outpatient hospital services	Volume 9, No. 8	551
December 20, 1985	MAP Delete prior authorization for surgical procedures	Volume 11, No. 12	1147
March 20, 1996	Chiropractic Care	Volume 22, No. 3	216-217
August 20, 1996	Reduction Mammoplasty	Volume 22, No. 8	713
February 20, 1997	Reimbursement for Medicare Part B Claims	Volume 23, No. 2	203
October 20, 1997	Professional Services Program - Chiropractic Care Services	Volume 23, No. 10	1320
December 20, 2000	Chiropractic Service—Termination of Services	Volume 26, No. 12	2792

This Rule is promulgated in accordance with the provisions of the Administrative Procedures Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Stephen R. Russo, JD

Secretary

RULE

Department of Health
Bureau of Health Services Financing
and
Office for Citizens with Developmental Disabilities

Targeted Case Management
(LAC 50:XV.Chapters 101-117)

The Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities have amended LAC 50:XV.Chapters 101-117 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 50

PUBLIC HEALTH-MEDICAL ASSISTANCE
Part XV. Services for Special Populations
Subpart 7. Targeted Case Management

Chapter 101. General Provisions

§10101. Program Description

A. – A.4. ...

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 or legal guardian 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. If the recipient fails to respond, the department shall automatically assign them to an available provider. Recipients who are auto-assigned may change once to an available provider if they are more than 30 days but fewer than 45 days from auto assignment.

D. Recipients shall 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 LDH case management administrator. Good cause is determined to exist only under the following circumstances:

D.1. – F. ...

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 Human Resources, Office of Family Security, LR 12:834 (December 1986), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services

Financing, LR 19:648 (May 1993), LR 23:732 (June 1997), repealed and promulgated LR 25:1251 (July 1999), repromulgated for inclusion in LAC, LR 30:1036 (May 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 32:1607 (September 2006), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1124 (August 2021), LR 49:

Chapter 103. Core Elements

§10301. Services

A. – A.1. ...

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 assess the support needs of the recipient for the provision of supports. The assessment shall be performed in the recipient’s home or another location that the recipient’s family or legal guardian chooses.

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 CPOC attempts to identify the supports required and the resources available to meet these needs.

a. The CPOC shall be developed through a collaborative process involving the recipient, family or legal guardian, 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 or legal guardian, case manager, support system, and appropriate professional personnel shall be directly involved and agree to assume specific functions and responsibilities.

b. For initial CPOCs for the Office for Citizens with Developmental Disabilities (OCDD), the CPOC shall be completed and submitted for approval within 60 calendar days of the referral for case management services, and initial CPOCs for early and periodic screening, diagnosis and treatment (EPSDT), the CPOC shall be completed and submitted within 35 days.

4. – 5.c. ...

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. A complete review of the CPOC shall be performed on a

quarterly basis, at a minimum, 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 or legal guardian.

7. – 7.b. ...

B. In addition to the provision of the core elements, OCDD and the Bureau of Health Services Financing will allow two quarterly visits per year, that are not the initial visit or the annual plan of care visit, to be conducted virtually in lieu of face-to-face visits as long as the case meets the criteria set forth by the department for targeted and waiver case management services. The Children’s Choice Waiver requires an in-home visit within six to nine months of the start of a plan of care. Additionally, an in-home visit is required for the annual planning meeting. For Supports Waiver, an in-home visit is required once a year. The remaining quarterly visits may occur at the vocational agency’s location. 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. – 3. ...

C. The agency shall 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 Human Resources, Office of Family Security, LR 12:834 (December 1986) amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 19:648 (May 1993), LR 23:732 (June 1997), repealed and promulgated LR 25:1251 (July 1999), repromulgated LR 30:1036 (May 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1125 (August 2021), LR 49:

Chapter 105. Provider Participation

§10501. Participation Requirements

A. – A.4. ...

B. 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; and

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

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

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

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 Medicaid performance agreements 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 shall attend all training mandated by the department. Each case manager and supervisor shall satisfactorily complete case management related training annually to meet the minimum training requirements;

6. submit to the local governing entity (LGE) an agency quality improvement plan (QIP) for approval within 90 days of enrollment. Six months following approval of the QIP and annually thereafter, the agency shall submit an agency self-evaluation in accordance with departmental guidelines;

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 any OCDD waiver). Assure that each recipient is offered freedom of choice in the selection of an available case management agency (per agency policy);

9. assure that the agency and case managers shall 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 qualified licensed physician or other licensed health care practitioner who is acting within the scope of practice of his/her respective licensing board(s) and/or certification(s);

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

12. complete management reports; and

13. assure that all current and potential employees, contractors and other agents and affiliates have not been excluded from participation in any federal health care program by checking the Department of Health and Human Services’ Office of Inspector General website and the LDH Adverse Actions website upon hire and monthly thereafter. Potential employees must also have a satisfactory response to a criminal background check as required by the EarlySteps program.

C. – C.13. Repealed.

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 Human Resources, Office of Family Security, LR 12:834 (December 1986) amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 23:732 (June 1997) repealed and promulgated LR 25:1251 (July 1999), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 29:38 (January 2003), repromulgated for inclusion in LAC, LR 30:1037 (May 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office of Citizens with Developmental Disabilities, LR 32:1608 (September 2006), amended LR 34:663 (April 2008), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1126 (August 2021), LR 49:

§10503. Provider Responsibilities

A. ...

B. Case management agencies shall 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. Agencies have the option to submit a

written request to OCDD if they would like to exceed the 35 recipient maximum caseload per case manager on a time-limited basis. All exceptions to the maximum caseload size or full-time employment of staff requirements shall be prior authorized by the OCDD State Office Waiver Director/designee. All case managers shall be employed by the agency at least 40 hours per five business days and work at least 50 percent of the time during normal business hours. Case management supervisors shall be full-time employees and shall be continuously available to case managers. The agency shall 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 shall 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 shall be able to reach an actual person in case of an emergency via answering service and not a recording.

D. ...

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

2. ...

3. The nurse consultant shall be available to the case management agency at least four hours per week, whether on-site or remotely.

E. – E.3. ...

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 Human Resources, Office of Family Security, LR 12:834 (December 1986) amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 23:732 (June 1997) repealed and promulgated LR 25:1251 (July 1999), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 29:38 (January 2003), repromulgated for inclusion in LAC, LR 30:1038 (May 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1127 (August 2021), LR 49:

§10505. Staff Education and Experience

A. ...

B. Case managers hired or promoted on or after the effective date of this rule revision shall meet the following criteria for education and experience qualifications:

1. – 3. ...

4. a bachelor’s degree in liberal arts or general studies with a concentration of at least 16 hours in one of the fields listed in accordance with §10505.B.3; or

5. a bachelor's or master's degree in a field other than listed above, if approved by OCDD and the Bureau of Health Services Financing (BHSF).

C. Case management supervisors hired or promoted on or after the effective date of this rule revision, shall meet the following criteria for education and experience:

1. ...

2. a currently licensed registered nurse (RN) with at least two years of paid nursing experience; or

3. ...

4. a bachelor’s degree in liberal arts or general studies with a concentration of at least 16 hours in one of the fields listed in §10505.C.3 and two years of paid post degree experience in providing support coordination services; or

5. a bachelor's or master's degree in a field other than listed above, if approved by OCDD and BHSF.

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

1. ...

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

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 Human Resources, Office of Family Security, LR 12:834 (December 1986) amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 23:732 (June 1997) repealed and promulgated LR 25:1251 (July 1999), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 29:38 (January 2003), repromulgated for inclusion in LAC, LR 30:1038 (May 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 32:1608 (September 2006), amended LR 34:663 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1700, 1701 (September 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1127 (August 2021), LR 49:

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 (0-35 months) who have a developmental delay or established medical condition associated with developmental delay according to the definition contained in part C of the Individuals with Disabilities Education Act, Sec.635(a)(1) [20 USC 1435 (a)(1)] and as further defined in Title 34 of the Code of Federal Regulations, Part 303, Section 21 (infant or toddler with a disability).

B. – B.4. ...

C. Definitions

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Parent—the term parent/legal guardian when used throughout this Subpart specifically in reference to parents or legal guardians of infants and toddlers aged birth through 2 inclusive (0-35 months) and having a developmental delay or an established medical condition associated with developmental delay refers to the definition of parent according to the Individuals with Disabilities Education Act, Part C and its accompanying regulations for Early Intervention Programs for Infants and Toddlers with Disabilities and therefore means the following:

a. – e. ...

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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, Office of the Secretary, Bureau of Health Services Financing, LR 18:849 (August 1992), amended LR 20:18 (January 1994), repromulgated for inclusion in LAC, LR 30:1040 (May 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1129 (August 2021), LR 49:

§10905. Staff Training

A. The provider shall 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 support 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:

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

a. ...

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

c. – j. ...

B. In-service training specific to EarlySteps is to be arranged and coordinated by the regional 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 shall ensure that each family support coordinator has completed the required orientation and advanced training during the first 90 days of employment and at least 20 hours of approved in-service education in family service coordination and related areas annually.

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

1. satisfactorily completion of at least the 20 hours of family support coordination and related orientation required of family support coordinators during the first 90 days

of employment before assuming supervision of any family service coordination;

2. supervisors shall also complete 20 hours of in-service training each year on such subjects as:

a. family support coordination;

D.2.b. – E. ...

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, Office of the Secretary, Bureau of Health Services Financing, LR 18:849 (August 1992), amended LR 19:648 (May 1993), LR 20:18 (January 1994), repromulgated for inclusion in LAC, LR 30:1040 (May 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1129 (August 2021), LR 49:

Chapter 113. Early and Periodic Screening, Diagnosis and Treatment

§11303. Recipient Qualifications

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

1.- 2.a. ...

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. – d. ...

e. a determination of developmental delay based upon:

i. – iii. ...

iv. an appropriate screening tool; or

v. ...

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, Office of the Secretary, Bureau of Health Services Financing, LR 26:2797 (December 2000) repromulgated for inclusion in LAC, LR 30:1042 (May 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1130 (August 2021), amended LR 49:

Chapter 117. Individuals with Developmental Disabilities

§11703. Electronic Visit Verification

A. – A.1. ...

2. Reimbursement for services may be withheld or denied if a provider:

a. ...

b. uses the system in a manner that is not in compliance with Medicaid's policies and procedures for EVV.

3. ...

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, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1131 (August 2021), amended LR 49:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Stephen R. Russo, JD

Secretary