NOTICE OF INTENT

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 proposes to amend LAC 50:XV.Chapters 101-113 and 117, and repeal Chapter 115 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities propose to amend the provisions governing the Targeted Case Management Program in order to: 1) repeal the provisions limiting the maximum number of recipients and the percentages of the available recipient population that a case management agency may serve in a region; and 2) update language throughout the administrative Rule to reflect current practices.

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. 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~~shall 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:

1. – 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~~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~~department ~~will~~shall 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~~ 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 ~~DHH~~LDH case management administrator. Good cause is determined to exist under the following circumstances:

1. the recipient moves to another ~~DHH~~LDH region; or

2. ...

E. Recipients who are ~~being transitioned from a developmental center into the New Opportunities Waiver (NOW)~~ age 25 and under and require ventilator assisted care may receive

their case management services through the ~~Office for Citizens with Developmental Disabilities (OCDD)~~Children's Hospital Ventilator Assisted Care Program.

F. ~~Recipients who are under the age~~Monitoring. The Department of ~~21 and require ventilator assisted care may receive~~ Health and the Department of Health and Human Services have the authority to monitor and audit all case management ~~services through the Children's Hospital Ventilator Assisted Care Program~~agencies in order to determine continued compliance with the rules, policies, and procedures governing case management services.

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~~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 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:

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 ~~establish a contract between the case manager and~~ assess support needs of the recipient for the provision of ~~service~~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 ~~purpose of the~~ CPOC

~~is~~attempts to identify the ~~services~~supports required and the resources available to meet these needs.

a. The CPOC ~~must~~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 ~~must~~shall be directly involved and agree to assume specific functions and responsibilities.

b. The CPOC ~~must~~shall be completed and submitted for approval within ~~35~~60 calendar days of the referral for case management services for initial CPOCs.

4. Case Management Linkage. Linkage is assignment of the case management agency (CMA) to an individual. The CMA is responsible for 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~~shall 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~~supports are being delivered as planned;

b. if ~~services~~supports are effective and adequate to meet the recipient’s needs; and

c. whether the recipient is satisfied with the ~~services~~supports.

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~~shall 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 or legal guardian.

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~~shall occur when the recipient:

i. – iv. ...

b. The closure process ~~must~~shall 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 with the exception of individuals participating in either the Children's Choice Waiver or the Supports Waiver. 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, the in-home visit is required once a year. The remaining quarterly visit 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 case management agency shall ~~also be responsible for monitoring~~ monitor service providers quarterly through telephone monitoring, on-site observation of service visits and review of the service providers' records. The agency ~~must~~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:

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~~ shall comply with:

1. ...

2. provider enrollment ~~requirements~~;

3. ...

4. the specific terms of individual ~~contractual~~ performance 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~~ The participation of case management agencies ~~interested in serving certain~~ providing service to targeted and waiver 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~~be limited contingent on the approval of a 1915(b)(4) waiver by the Centers for Medicare and Medicaid Service (CMS) ~~DHH administrative region for which approval has been granted~~.

C. The ~~participation of case management agencies providing service~~ following are enrollment requirements applicable to all case management agencies, regardless of the targeted ~~and~~or waiver ~~populations will be limited contingent on the approval of a 1915(b)(4) waiver by the Centers for Medicare and Medicaid Service (CMS).~~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, 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 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 contracts/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 assurance plan (QAP) for approval within 90 days of enrollment. Six months following approval of the QAP 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.

~~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 New Opportunities Waiver, Elderly and Disabled Adult Waiver and Children's Choice 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~~D. - D.12. 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:

§10503. Provider Responsibilities

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

B. Case management agencies ~~must~~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 ~~must~~shall 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~~shall be full-time employees and ~~must~~shall 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~~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 ~~must~~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 ~~must~~shall be able to reach an actual person in case of an emergency, not a recording.

D. ...

1. Each case management agency ~~must~~shall have a written job description and consultation plan that describes how the nurse consultant ~~will~~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 ~~on-site at~~to 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~~Records. All agency records shall be maintained in an accessible, standardized order and format at the LDH enrolled office site. The agency shall have sufficient space, facilities, and supplies to ensure effective record keeping.

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

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

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

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

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

~~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~~F. – F.3. 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 30:1038 (May 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:

§10505. Staff Education and Experience

A. Each Medicaid-enrolled agency ~~must~~shall 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~~ hired or promoted on or after the effective date of this rule revision shall meet the following criteria for 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 master's degree in social work from a program accredited by the Council on Social Work Education; or

2. a currently 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~~(RN); or

3. a bachelor's or master's degree in ~~social work from~~ a human service related field which includes psychology education, counseling, social ~~work program accredited by the Council on Social Work Education.~~services, sociology, philosophy, family and consumer sciences, criminal justice, rehabilitation services, child development, substance abuse, gerontology, and vocational rehabilitation; or

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~~Repealed.

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

C. Case ~~Management Supervisors. All case~~ management supervisors ~~must meet one of the following~~hired or promoted on or after the effective date of this rule revision, shall meet the following criteria for education and experience ~~requirements~~:

1. a bachelor's or 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~~a program accredited ~~college or university~~ by the Council on Social Work Education 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~~support coordination 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~~ currently licensed registered nurse with at least two years of paid nursing 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 bachelor's or master's degree 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~~which includes psychology, education, counseling, social services, sociology, philosophy, family and consumer sciences, criminal justice,

rehabilitation services, child development, substance abuse, gerontology, and vocational rehabilitation and two years of paid post degree experience in providing support coordination services; 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~~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.

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~~Repealed.

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

1. – 2. ...

~~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. new opportunities waiver;~~

~~c. elderly and disabled adult waiver;~~

~~d. targeted EPSDT; and~~

~~e. children's choice waiver.~~

~~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~~E. - E.2.e. 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 30:1038 (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:

§10507. Staff Training

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

B. Training for New Staff. A minimum of 16 hours of orientation ~~must~~shall be provided to all staff, volunteers, and students within one week of employment. A minimum of eight hours of the orientation training ~~must~~shall 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~~shall 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~~shall satisfactorily complete a minimum of ~~40~~20 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~~20 hours.

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

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 LR 26:2796 (December 2000), LR

26:2797 (December 2000), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 29:39 (January 2003), repromulgated LR 30:1039 (May 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:

Chapter 107. Reimbursement

§10701. Reimbursement

A. ~~Effective for dates of service on or after May 1, 2008, reimbursement~~Reimbursement for case management services ~~shall be a prospective rate for each approved unit of service provided to the recipient.~~for the Infant and Toddler Program (EarlySteps):

1. ...

2. All services ~~must~~shall be prior authorized.

B. – B.2. ...

C. Effective for dates of service on or after ~~February~~ July 1, ~~2005~~2012, the reimbursement rate for ~~targeted~~ case management services ~~for infants and toddlers shall be 75~~ provided to the following targeted populations shall be reduced by 1.5 percent of the ~~rate~~ rates ~~(a 25 percent reduction) in effect~~ on ~~January 31, 2005.~~file as of June 30, 2012:

1. participants in the Early and Periodic Screening, Diagnosis, and Treatment Program; and

2. individuals with developmental disabilities who participate in the New Opportunities Waiver.

D. Effective for dates of service on or after ~~September~~ July 1, ~~2008~~2014, ~~the reimbursement rate for targeted~~ case management services ~~rendered~~provided to ~~infants and toddlers shall be increased by 25 percent of the rate in effect on August 31, 2008~~participants in the New Opportunities Waiver shall be reimbursed at a flat rate for each approved unit of service.

1. The standard unit of service is equivalent to one month and covers both service provision and administrative (overhead) costs.

a. Service provision includes the core elements in:

i. §10301 of this Chapter;

ii. the case management manual; and

iii. performance agreements.

2. All services shall be prior authorized.

E. Effective for dates of service on or after ~~February~~April 1, ~~2009~~2018, ~~the reimbursement for~~ case management services provided to ~~the following targeted populations shall be reduced by 3.5 percent of the rates on file as of January 31, 2009:~~participants in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program shall be reimbursed at a flat rate

for each approved unit of service. The standard of service is equivalent to one month.

~~1. participants in the Nurse Family Partnership Program;~~

~~2. individuals with developmental disabilities who are participants in the new opportunities waiver; and~~

~~3. individuals with disabilities resulting from HIV.~~

~~F. Effective for dates of service on or after July 1, 2009, the reimbursement for case management services provided to participants in the Nurse Family Partnership Program shall be reduced to $115.93 per visit.~~

~~1. Medicaid reimbursement shall be limited to prenatal and postnatal services only. Case management services provided to infants and toddlers shall be excluded from reimbursement under the Nurse Family Partnership Program.~~

~~G. Effective for dates of service on or after July 1, 2012, the reimbursement for case management services provided to the following targeted populations shall be reduced by 1.5 percent of the rates on file as of June 30, 2012:~~

~~1. participants in the Early and Periodic Screening, Diagnosis, and Treatment Program; and~~

~~2. individuals with developmental disabilities who participate in the new opportunities waiver.~~

~~H. Office of Public Health Uncompensated Care Payments~~

~~1. Effective for dates of service on or after July 1, 2012, the department shall provide the Office of Public Health (OPH) with Medicaid payment of their uncompensated care costs for services rendered to Medicaid recipients in the Nurse Family Partnership Program. The Office of Public Health shall certify public expenditures to the Medicaid Program in order to secure federal funding for services provided at the cost of OPH.~~

~~2. The OPH will submit an estimate of cost for services provided under this Chapter.~~

~~a. The estimated cost will be calculated based on the previous fiscal year's expenditures and reduced by the estimate of payments made for services to OPH under this Chapter, which will be referred to as the net uncompensated care cost. The uncompensated care cost will be reported on a quarterly basis.~~

~~3. Upon completion of the fiscal year, the Office of Public Health will submit a cost report which will be used as a settlement of cost within one year of the end of the fiscal year.~~

~~a. Any adjustments to the net uncompensated care cost for a fiscal year will be reported on the CMS Form 64 as a prior period adjustment in the quarter of settlement.~~

~~I. Effective for dates of service on or after February 1, 2013, reimbursement shall not be made for case management services rendered to HIV disabled individuals.~~

~~J. Effective for dates of service on or after February 1, 2013, the department shall terminate Medicaid reimbursement of targeted case management services provided to first-time mothers in the Nurse Family Partnership Program.~~

~~K. Effective for dates of service on or after July 1, 2014, case management services provided to participants in the New Opportunities Waiver shall be reimbursed at a flat rate for each approved unit of service.~~

~~1. The standard unit of service is equivalent to one month and covers both service provision and administrative (overhead) costs.~~

~~a. Service provision includes the core elements in:~~

~~i. §10301 of this Chapter;~~

~~ii. the case management manual; and~~

~~iii. contracted performance agreements.~~

~~2. All services must be prior authorized.~~

~~L. Effective for dates of service on or after April 1, 2018, case management services provided to participants in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program shall be reimbursed at a flat rate for each approved~~

~~unit of service. The standard unit of service is equivalent to one month~~E.1. – L. 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 Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:1040 (May 2004), amended LR 31:2032 (August 2005), LR 35:73 (January 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1903 (September 2009), LR 36:1783 (August 2010), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Public Health, LR 39:97 (January 2013), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3302 (December 2013), LR 40:1700, 1701 (September 2014), LR 41:1490 (August 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:63 (January 2018), LR 47:

§10703. Cost Reports

A. Case management agencies shall provide annual cost reports based on the state fiscal year, ~~starting with the period beginning July 1, 2008 and ending June 30, 2009~~July 1 through June 30. Completed reports are due within 90 calendar days after the end of each state fiscal year or by September 28 of each calendar year.

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 35:73 (January 2009), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:

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 a developmental delay or established medical ~~conditions as defined~~condition associated with developmental delay according to the definition contained in part ~~H~~C of the Individuals with Disabilities Education Act~~. These criteria are~~, Sec.635(a)(1) [20 USC 1435 (a)(1)] and as further defined in ~~Chapter~~Title 34 of the *Code of Federal Regulations*, ~~section~~Part 303~~.300~~, Section 21 (infant or toddler with a disability).

B. – B.4. ...

C. Definitions

***

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*~~ IFSP shall 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*~~IFSP shall be developed within 45 days following the referral to the ~~child search coordinator~~regional system point of entry office 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~~shall include all major developmental areas including cognitive development, physical development including:

a. ...

b. hearing and ~~communicative~~communication development;

c. social-emotional development;

d. – f. ...

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 (0-36 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 Act, Part C and its accompanying regulations for Early Intervention Programs for Infants and Toddlers with Disabilities and therefore means the following:

a. a biological or adoptive parent of a child;

b. a foster parent, unless State law, regulations, or contractual obligations with a State or local entity prohibit a foster parent from acting as a parent;

c. a guardian generally authorized to act as the child's parent or authorized to make early intervention, educational, health, or developmental decisions for the child (but not the State if the child is a ward of the State);

d. an individual acting in the place of a biological or adoptive parent (including grandparent, stepparent, or other relative) with whom the child lives, or an individual who is legally responsible for the child's welfare; or

e. a surrogate parent who has been appointed in accordance with 34 CFR 303.422 or with the Individuals with Disabilities Education Act, Sec. 639(a)(5) [20 USC 1439(a)(5)].

NOTE: When more than one party is qualified under the definition contained in this Subsection to act as the parent, the biological or adoptive parent must be presumed to be the parent for purposes of Part C of the Individuals with Disabilities Education Act, when attempting to act as the parent under this definition, unless the biological or adoptive does not have legal authority to make educational or early intervention services decisions for the child. If a judicial decree or order identifies a specific person or persons under this subsection to act as the parent of a child to make educational or early intervention service decisions on behalf of the child, then the person or persons must be determined to be the parent for purposes of Part C of the Individuals with Disabilities Education Act, except that if an early intervention services (EIS) provider or a public agency provides any services to a child or any family member of that child, that EIS provider or public agency may not act as a parent for that 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, 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:

§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 non-categorical 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~~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 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), repealed by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:

§10905. Staff Training

A. The provider ~~must~~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 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~~EarlySteps Specific Training—Eight Hours	
1 hour	Components of the ~~ChildNet~~EarlySteps 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~~EarlySteps, child search and early intervention service programs;

b. - j. ...

B. In-service training specific to ~~ChildNet~~EarlySteps 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~~shall 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~~20 hours of approved in-service education in family service coordination and related areas annually.

D. The provider ~~must~~shall 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~~20 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~~shall also complete ~~40~~20 hours of in-service training each year on such subjects as:

a. – c. ...

E. The provider ~~must~~shall 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, 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:

Chapter 113. Early~~,~~ and Periodic Screening, Diagnosis and Treatment

§11301. Introduction

A. This Early~~,~~ and 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~~state Medicaid data contractor for EPSDT case management services. However, for those recipients under 3 years of age, case management services ~~will~~shall 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~~EarlySteps, for eligible children.

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:

§11303. Recipient Qualifications

A. In order to be eligible to receive case management services, the EPSDT recipient ~~must~~shall 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~~determined to be eligible for OCDD services through the statement of approval process; 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~~ for those who do not ~~pass the D&E process~~meet eligibility, or who are not undergoing ~~a D&E~~eligibility determination, may still receive case management services if they meet the definition of a person with special needs.

a. *Special Needs*—a documented, established medical condition, as determined by a licensed physician or other qualified licensed health care practitioner in accordance with §10501.C.10, 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 or other qualified licensed health care practitioner in accordance with §10501.C.10.

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. ...

b. receipt of regular services from one or more physicians or other qualified licensed health care practitioner in accordance with §10501.C.10; or

c. ...

d. a report by the recipient's physician or other qualified licensed health care practitioner in accordance with §10501.C.10 of multiple health or family issues that impact the recipient's ongoing care; or

e. a determination of developmental delay based upon:

i. ...

ii. the ~~Brignance~~ Brigance Screens;

iii. – 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:

Chapter 115. Foster Care and Family Support Worker Services

§11501. Introduction

~~A. Effective for dates of service on or after July 1, 2015, the department shall reimburse the Department of Children and Family Services (DCFS) for case management and case management supervision services, provided by DCFS foster care and family support workers, which qualify for Medicaid reimbursement under the Targeted Case Management Program~~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 Hospitals, Bureau of Health Services Financing, LR 41:1723 (September 2015), repealed by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:

§11503. Covered Services

~~A. The Medicaid Program shall provide reimbursement to DCFS for the following case management services:~~

~~1. comprehensive assessment of individual needs;~~

~~2. periodic reassessment of individual needs;~~

~~3. development and periodic revision of a specific care plan;~~

~~4. referral and related activities; and~~

~~5. monitoring and follow-up activities.~~

~~B. Covered services and activities may be rendered to the child, the foster family, or biological family.~~

~~C. Case management functions provided by DCFS family support workers include, but are not limited to:~~

~~1. completing a safety and risk assessment of the child;~~

~~2. completing assessment of family functioning-initial and on-going to include trauma screening as well as screenings for mental health, domestic violence and substance abuse issues;~~

~~3. developing a written care plan, jointly with the family, within the first 30 days;~~

~~4. providing on-going service planning;~~

~~5. providing on-going monitoring of the care plan through home visits, phone calls, etc.; and~~

~~6. providing a link to community resources for parents and children including:~~

~~a. referrals to substance abuse;~~

~~b. mental health services;~~

~~c. domestic violence;~~

~~d. daycare services;~~

~~e. the EarlySteps program;~~

~~f. medical services;~~

~~g. family resource center services;~~

~~h. parenting services;~~

~~i. visit coaching; and~~

~~j. skills building.~~

~~D. Case management functions provided by DCFS foster care workers include, but are not limited to:~~

~~1. completing a social history and assessment;~~

~~2. arranging an initial medical, dental and communicable disease screening upon entry into foster care;~~

~~3. obtaining the medical history of child upon entering foster care, as well as immunization records;~~

~~4. completing a behavioral health screening within 15 days of child entering foster care;~~

~~5. exploring all federal benefits for the child (SSI, death benefits, etc.);~~

~~6. developing case plans and objectives with the family;~~

~~7. preparing cases for presentation to the multi-disciplinary team for consultation;~~

~~8. coordinating with other professionals regarding the needs of the child, family, and/or parent;~~

~~9. continuously assessing the safety of the child and service needs of the child(ren) and families through interviews, observations and other information sources; and~~

~~10. providing supportive services for clients and arranges for the provision of services from community resources based on the case plan.~~

~~E. The following DCFS services shall not be covered:~~

~~1. research gathering and completion of documentation for foster care program;~~

~~2. assessing adoption placement;~~

~~3. recruiting/interviewing foster parents;~~

~~4. serving legal papers;~~

~~5. home investigations;~~

~~6. transportation;~~

~~7. administering foster care subsidies; and~~

~~8. making placement arrangements~~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 Hospitals, Bureau of Health Services Financing, LR 41:1723 (September 2015), repealedby the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:

§11505. Reimbursement

~~A. The department shall utilize a random moment sampling (RMS) procedure as the cost allocation process to determine the reimbursement for services rendered by DCFS staff.~~

~~B. RMS will statistically validate the method for determining the percentage of effort expended by DCFS foster care and family support workers for case management services rendered to Medicaid eligible children.~~

~~C. DCFS foster care and family support workers who render case management services will be randomly selected at a date, time, and frequency designated by the department to participate in a survey, or other process, to determine the amount of time and efforts expended on the targeted population for Medicaid covered services. The RMS responses will be compiled and tabulated using a methodology determined by the department. The results will be used to determine the cost associated with administering the Medicaid covered TCM services, and the final reimbursement to DCFS for the services rendered.~~

~~D. As part of its oversight responsibilities, the department reserves the right to develop and implement any audit and reviewing procedures that it deems are necessary to ensure that payments to DCFS for case management services are accurate and are reimbursement for only Medicaid allowable costs~~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 Hospitals, Bureau of Health Services Financing, LR 41:1724 (September 2015), repealed by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:

Chapter 117. Individuals with ~~Developmental~~Intellectual Disabilities

§11701. Introduction

A. The targeted population for case management services shall consist of individuals with ~~developmental~~intellectual disabilities who are participants in the New Opportunities Waiver.

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 16:312 (April 1990), amended LR 23:732 (June 1997), repealed and promulgated LR 25:1251 (July 1999), repromulgated for inclusion in LAC, LR 30:1043 (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 34:664 (April 2008). consist of individuals with intellectual disabilities who are participants in the New Opportunities Waiver, amended by the

Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:

§11703. Electronic Visit Verification

A. An electronic visit verification (EVV) system shall be used for verifying in-home or face-to-face visit requirements for case management services.

1. Case management providers identified by the department shall use the (EVV) system designated by the department;

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

a. fails to use the EVV system; or

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

3. Requirements for proper use of the EVV system are outlined in the respective program's guidelines.

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:

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.

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have no impact on family functioning, stability or autonomy as described in R.S. 49:972.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

Small Business Analysis

In compliance with Act 820 of the 2008 Regular Session of the Louisiana Legislature, the economic impact of this proposed Rule on small businesses has been considered. It is anticipated that this proposed Rule will have no impact on small businesses, as described in R.S. 49:965.2 et seq.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170

of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct or indirect cost to the provider to provide the same level of service, and will have no impact on the provider's ability to provide the same level of service as described in HCR 170.

Public Comments

Interested persons may submit written comments to Tara A. LeBlanc, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821—9030. Ms. LeBlanc is responsible for responding to inquiries regarding this proposed Rule. The deadline for submitting written comments is at 4:30 p.m. on June 29, 2021.

Public Hearing

Interested persons may submit a written request to conduct a public hearing by U.S. mail to the Office of the Secretary ATTN: LDH Rulemaking Coordinator, Post Office Box 629, Baton Rouge, LA 70821-0629; however, such request must be received no later than 4:30 p.m. on June 9, 2021. If the criteria set forth in R.S.49:953(A)(2)(a) are satisfied, LDH will conduct a public hearing at 9:30 a.m. on June 24, 2021 in Room 118 of the Bienville Building, which is located at 628 North Fourth Street,

Baton Rouge, LA. To confirm whether or not a public hearing will be held, interested persons should first call Allen Enger at (225)342-1342 after June 9, 2021. If a public hearing is to be held, all interested persons are invited to attend and present data, views, comments, or arguments, orally or in writing. In the event of a hearing, parking is available to the public in the Galvez Parking Garage which is located between North Sixth and North Fifth/North and Main Streets (cater-corner from the Bienville Building). Validated parking for the Galvez Garage may be available to public hearing attendees when the parking ticket is presented to LDH staff at the hearing.

Dr. Courtney N. Phillips

Secretary