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 outomes identified in the recipient's comprehensive plan of care. All case management agencies shall be required to incorporate personal outcome measures in the development of comprehensive plans of care and to implement procedures for self-evaluation of the agency. All case management agencies must comply with the policies

contained in this Subpart 7 and the *Medicaid Case Management Services Provider Manual* issued March 1, 1999 and all subsequent changes. Case management is defined as services provided to individuals to assist them in gaining access to the full range of needed services including:

1. medical;
2. social;
3. educational; and
4. other support services.

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

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

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

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

E. Recipients who are being transitioned from a developmental center into the New Opportunities Waiver (NOW) may receive their case management services through the Office for Citizens with Developmental Disabilities (OCDD).

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

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

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Chapter 103. Core Elements

§10301. Services

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

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

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

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

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

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

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

5. Case Management Follow-Up/Monitoring. Follow-up/monitoring is the mechanism used by the case manager to

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

a. if services are being delivered as planned;

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

c. whether the recipient is satisfied with the services.

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

7. Case Management Transition/Closure

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

i. no longer requires services;

ii. desires to terminate services;

iii. becomes ineligible for services; or

iv. chooses to transfer to another case management agency.

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

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

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

2. maximize opportunities; and/or

3. revise support strategies or personal outcomes.

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

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Chapter 105. Provider Participation

§10501. Participation Requirements

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

1. licensure and certification requirements;

2. provider enrollment requirements;

3. the Case Management Manual; and

4. the specific terms of individual contractual agreements.

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

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

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

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

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

b. demonstrating knowledge of the eligibility requirements and application procedures for federal, state,

and local government assistance programs which are applicable to the target population served;

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

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

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

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

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

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

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

8. assure the recipient's right to elect to receive or terminate case management services (except for recipients in the 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.

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§10503. Provider Responsibilities

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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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).

§10505. Staff Education and Experience

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

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

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

2. a licensed registered nurse with one year of paid experience as a registered nurse in public health or a human-service-related field providing direct services or case management services; or

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

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

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

C. Case Management Supervisors. All case management supervisors must meet one of the following education and experience requirements:

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

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

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

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

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

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

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

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

E. Case Manager Trainee

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

a. infants and toddlers;

b. 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.

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§10507. Staff Training

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

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

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

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

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

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

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

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

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Chapter 107. Reimbursement

§10701. Reimbursement

A. Effective for dates of service on or after May 1, 2008, reimbursement for case management services shall be a prospective rate for each approved unit of service provided to the recipient.

1. One quarter hour (15 minutes) is the standard unit of service which covers both service provision and administrative costs.

2. All services must be prior authorized.

B. A technical amendment (Public Law 100-617) in 1988 specifies that the Medicaid Program is not required to pay for case management services furnished to consumers

without charge. This is in keeping with Medicaid's longstanding position as the payer of last resort. With the statutory exceptions of case management services included in the individualized education programs (IEPs) or individualized family service plans (IFSPs) and services furnished through title V public health agencies, reimbursement by Medicaid payment for case management services cannot be made:

1. when another third party payer is liable; nor

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

C. Effective for dates of service on or after February 1, 2005, the reimbursement rate for targeted case management services for infants and toddlers shall be 75 percent of the rate (a 25 percent reduction) in effect on January 31, 2005.

D. Effective for dates of service on or after September 1, 2008, the reimbursement rate for targeted case management services rendered to infants and toddlers shall be increased by 25 percent of the rate in effect on August 31, 2008.

E. Effective for dates of service on or after February 1, 2009, 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:

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.

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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).