C. Allocate Direct Service Cost to Medicaid. To determine the amount of cost that may be attributed to Medicaid, total direct service cost (employee and vendor) shall be multiplied by the ratio of Medicaid students in the LEA to all students in the LEA. This results in total cost that may be certified as Medicaid's portion of school-based personal care services cost. The Medicaid enrolled student ratio is calculated one time in each cost report year. This calculation is based on the statewide student count performed in October each year.

D. Reconciliation of LEA Certified Cost and Medicaid Management Information System (MMIS) Paid Claims. Each LEA shall complete the personal care services cost report and submit the cost report(s) no later than five months after the fiscal year period ends (June 30), and reconciliation shall be completed within 12 months from the fiscal year end. All filed personal care services cost reports shall be subject to desk review by the department's audit contractor. The department shall reconcile the total expenditures (both state and federal share) for each LEA's services. The Medicaid certified cost expenditures from the personal care services cost report(s) will be reconciled against the MMIS paid claims data and the department shall issue a notice of final settlement, after all reviews, that denotes the amount due to or from the LEA. This reconciliation is inclusive of all services provided by the LEA.

E. Cost settlement process will be handled in accordance with §9505.G.

F. Delinquent cost report penalty will be handled in accordance with §9505.H.

G. State monitoring will be handled in accordance with §9505.I.

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, LR 45:565 (April 2019), amended LR 47:741 (June 2021), LR 49:1388 (August 2023).

Chapter 97. Office of Public Health Uncompensated Care Payments

§9701. General Provisions

A. 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 child health services including hearing and speech therapy services, maternity services, and children's special health services rendered to Medicaid recipients.

B. 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.

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 and the Office of Public Health, LR 39:93 (January 2013).

§9703. Reimbursement Methodology

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

B. 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.

1. 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.

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 and the Office of Public Health, LR 39:93 (January 2013).

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 shall comply with the policies contained in this Subpart 7. 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 or legal guardian and other persons/professionals deemed appropriate. Services are provided in accordance with a written comprehensive plan of care which includes measurable, person-centered outcomes.

C. Recipient Freedom of Choice. Recipients have the right to select the provider of their case management services from among those available agencies enrolled to

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

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

1. the recipient moves to another LDH region; or

2. there are irreconcilable differences between the agency and the recipient.

E. Recipients who are age 25 and under and require ventilator assisted care may receive their case management services through the Children's Hospital Ventilator Assisted Care Program.

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 12:834 (December 1986), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 19:648 (May 1993), LR 23:732 (June 1997), repealed and promulgated LR 25:1251 (July 1999), repromulgated for inclusion in LAC, LR 30:1036 (May 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 32:1607 (September 2006), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1124 (August 2021), LR 49:2107 (December 2023).

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

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

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

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

4. 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 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 supports are being delivered as planned;

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

c. whether the recipient is satisfied with the 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. A complete review of the CPOC shall be performed on a quarterly basis, at a minimum, to assure that the goals and services are appropriate to the recipient's needs as identified in the assessment/reassessment process. A reassessment is also required when a major change occurs in the status of the recipient and/or his family or legal guardian.

7. 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 shall 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 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, OCDD and the Bureau of Health Services Financing will allow two quarterly visits per year, that are not the initial visit or the annual plan of care visit, to be conducted virtually in lieu of face-to-face visits as long as the case meets the criteria set forth by the department for targeted and waiver case management services. The Children's Choice Waiver requires an in-home visit within six to nine months of the start of a plan of care. Additionally, an in-home visit is required for the annual planning meeting. For Supports Waiver, an in-home visit is required once a year. The remaining quarterly visits may occur at the vocational agency's location. The agency shall ensure that more frequent home visits are performed if indicated in the recipient's CPOC. The purpose of the home visit, if it is determined necessary, is to:

1. 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 agency shall also ensure that the service provider and recipient are given a copy of the recipient's most current CPOC and any subsequent updates.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 12:834 (December 1986) amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 19:648 (May 1993), LR 23:732 (June 1997), repealed and promulgated LR 25:1251 (July 1999), repromulgated LR 30:1036 (May 2004), amended by the Department of Health, Bureau of Health Services Financing, and the Office for Citizens with Developmental Disabilities, LR 47:1125 (August 2021), LR 49:2108 (December 2023).

Chapter 105. Provider Participation

§10501. Participation Requirements

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

1. licensure and certification requirements;

2. provider enrollment;

3. the Case Management Manual; and

4. the specific terms of individual performance agreements.

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

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

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

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

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

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

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

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

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

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

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

8. assure the recipient's right to elect to receive or terminate case management services (except for recipients in any OCDD waiver). Assure that each recipient is offered freedom of choice in the selection of an available case management agency (per agency policy);

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

10. with the recipient’s permission, agree to maintain regular contact, share relevant information and coordinate medical services with the recipient’s qualified licensed physician or other licensed health care practitioner who is acting within the scope of practice of his/her respective licensing board(s) and/or certification(s);

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

12. complete management reports; and

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 12:834 (December 1986) amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 23:732 (June 1997) repealed and promulgated LR 25:1251 (July 1999), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 29:38 (January 2003), repromulgated for inclusion in LAC, LR 30:1037 (May 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office of Citizens with Developmental Disabilities, LR 32:1608 (September 2006), amended LR 34:663 (April 2008), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1126 (August 2021), LR 49:2108 (December 2023).

§10503. Provider Responsibilities

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

B. Case management agencies shall maintain sufficient staff to serve recipients within the mandated caseload size of 35 with a supervisor to staff ratio of no more than eight case managers per supervisor. Agencies have the option to submit a written request to OCDD if they would like to exceed the 35 recipient maximum caseload per case manager on a time-limited basis. All exceptions to the maximum caseload size or full-time employment of staff requirements shall be prior authorized by the OCDD State Office Waiver Director/designee. All case managers shall be employed by the agency at least 40 hours per five business days and work at least 50 percent of the time during normal business hours. Case management supervisors shall be full-time employees and shall be continuously available to case managers. The agency shall have a written policy to ensure service coverage for all recipients during the normal absences of case managers and supervisors or prior to the filling of vacated staff positions.

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

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

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

2. 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 to the case management agency at least four hours per week, whether on-site or remotely.

E. 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.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 12:834 (December 1986) amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 23:732 (June 1997) repealed and promulgated LR 25:1251 (July 1999), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 29:38 (January 2003), repromulgated .for inclusion in LAC, LR 30:1038 (May 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1127 (August 2021), LR 49:2109 (December 2023).

§10505. Staff Education and Experience

A. Each Medicaid-enrolled agency 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 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 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 (RN); or

3. a bachelor's or master's degree in a human service related field 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; or

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

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

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

1. a bachelor's or master's degree in social work from a program accredited by the Council on Social Work Education and two years of paid post degree experience in providing support coordination services; or

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

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

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

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

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

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

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

Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1127 (August 2021), LR 49:2110 (December 2023).

§10507. Staff Training

A. Training for case managers and supervisors shall be provided or arranged for by the case management agency. Agencies shall send the appropriate staff to all training mandated by LDH.

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

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

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 47:1128 (August 2021).

Chapter 107. Reimbursement

§10701. Reimbursement

A. Reimbursement for case management services for the Infant and Toddler Program (EarlySteps):

1. Effective for dates of service on or after July 1, 2022, case management services provided to participants in the EarlySteps Program shall be reimbursed at a flat rate for each approved unit of service.

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

b. Service provision includes the core elements in:

i. Section 10301 of this Subpart;

ii. the case management manual; and

iii. EarlySteps practices.

2. All services shall 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 July 1, 2012, the reimbursement rate 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.

D. 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. performance agreements.

2. All services shall be prior authorized.

E. 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 of service is equivalent to one month.

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 47:1128 (August 2021), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:2976 (December 2022).

§10703. Cost Reports

A. Case management agencies shall provide annual cost reports based on the state fiscal year, 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 47:1128 (August 2021).

§10704. Targeted Case Management Workforce Retention Bonus Payments

A. Establishment of Targeted Case Management Workforce Retention Bonus Payments

1. Case management agencies for the early and periodic screening, diagnosis, and treatment (EPSDT) targeted population and for participants in the New Opportunities Waiver (NOW) who provided services from April 1, 2021 to October 31, 2022 shall receive bonus payments of $300 per month for the case manager that worked with participants for those months.

2. The case manager who provided services to participants from April 1, 2021 to October 31, 2022 must receive at least $250 of this $300 bonus payment paid to the agency. This bonus payment is effective for all affected case managers of any working status, whether full-time or part-time.

B. Audit Procedures for Targeted Case Management Workforce Bonus Payments

1. The bonus payments reimbursed to case management agencies shall be subject to audit by LDH.

2. Case management agencies shall provide to LDH or its representative all requested documentation to verify that they are in compliance with the targeted case management bonus payments.

3. This documentation may include, but is not limited to, payroll records, wage and salary sheets, check stubs, etc.

4. Case management agencies shall produce the requested documentation upon request and within the time frame provided by LDH.

5. Non-compliance or failure to demonstrate that the bonus payments were paid directly to case managers may result in the following:

a. sanctions; or

b. disenrollment from the Medicaid Program.

C. Sanctions for Targeted Case Management Workforce Bonus Payments

1. The case management agency will be subject to sanctions or penalties for failure to comply with this Rule. The severity of such action will depend upon the following:

a. failure to pay case managers the $250 monthly bonus payments;

b. the number of employees identified as having been paid less than the $250 monthly bonus payments;

c. the persistent failure to pay the $250 monthly bonus payments; or

d. failure to provide LDH with any requested documentation or information related to or for the purpose of verifying compliance with this Rule.

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, LR 49:698 (April 2023).

Chapter 109. Infants and Toddlers

§10901. Introduction

A. This Chapter authorizes federal financial participation in the funding of optional targeted case management service for title XIX eligible infants and toddlers who are ages birth through 2 inclusive (0-35 months) who have a developmental delay or established medical condition associated with developmental delay according to the definition contained in part C of the Individuals with Disabilities Education Act, Sec.635(a)(1) [20 USC 1435 (a)(1)] and as further defined in Title 34 of the Code of Federal Regulations, Part 303, Section 21 (infant or toddler with a disability).

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

1. medical care;

2. social services;

3. educational services; and

4. other service delivery systems.

C. Definitions

Family Service Coordination—case management services which assist with individuals eligible under the plan