

Table of Contents

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part I. Administration

Subpart 1. General Provisions

Chapter 1.	Administrative Procedures	1
§103.	Employee Criminal History Records Checks	1
§105.	Tribal Consultation Process	1
Chapter 3.	Experimental Procedures	2
§303.	Coverage	2
§305.	Routine Care for Beneficiaries in Clinical Trials	2
Chapter 5.	Telemedicine/Telehealth	2
§501.	Introduction	2
§503.	Claim Submissions	2
§505.	Emergency Provisions	2
Chapter 7.	Out-of-State Services	2
§701.	Out-of-State Medical Care	2
Chapter 9.	Advance Directives	3
Subchapter A.	General Provisions	3
§901.	Definitions	3
§903.	Departmental Information Dissemination	3
Subchapter B.	Provider Responsibilities	3
§915.	Provider Information Dissemination	3
§917.	Policies and Procedures	3
§919.	Mentally Incapacitated	4
§921.	Previously Executed Advance Directives	4
Subchapter C.	Penalties	4
§941.	Noncompliance	4
Chapter 11.	Medical Necessity	4
§1101.	Definition and Criteria	4
Chapter 13.	Prohibition of Provider Steering	4
§1301.	General Provisions	4
§1303.	Provider Sanctions	5
§1305.	Provider Appeal Rights	5
§1307.	Health Plan Sanctions	5
Chapter 15.	Provider Screening and Enrollment	5
§1501.	General Provisions	5
§1503.	Temporary Moratoria	7
§1505.	Managed Care Organization Payment Accountability and Provider Credentialing	7
§1507.	Administrative Appeal	8
§1509.	Basis of Administrative Appeal	8
§1511.	Out-of-State Medicaid Provider Enrollment	8
§1513.	Out-of-Network Providers	9
§1515.	Temporary Moratoria	9
§1517.	Managed Care Organization Payment Accountability and Provider Credentialing	9
§1519.	Definitions	9

Subpart 3. Managed Care for Physical and Behavioral Health

Chapter 21.	Dental Benefits Prepaid Ambulatory Health Plan	10
§2101.	General Provisions.....	10
§2103.	Participation Requirements	10
§2105.	Prepaid Ambulatory Health Plan Responsibilities	11
§2107.	Network Access Standards and Guidelines	15
§2109.	Benefits and Services	15
§2111.	Payment Methodology.....	18
§2113.	Prompt Payment of Claims.....	19
§2115.	Grievance and Appeals Processes	20
§2117.	Independent Review Process for Dental Provider Claims	20
Chapter 31.	General Provisions	21
§3101.	Introduction	21
§3103.	Recipient Participation	21
§3105.	Enrollment Process	23
§3107.	Disenrollment and Change of Managed Care Organization.....	25
§3109.	Member Rights and Responsibilities.....	26
§3111.	Independent Review Process for Provider Claims	27
§3113.	Directed Payments.....	29
Chapter 33.	Coordinated Care Network Shared Savings Model	30
§3301.	Participation Requirements	30
§3307.	Reimbursement Methodology	30
Chapter 35.	Managed Care Organization Participation Criteria.....	31
§3501.	Participation Requirements	31
§3503.	Managed Care Organization Responsibilities	32
§3505.	Network Access Standards and Guidelines	34
§3507.	Benefits and Services	35
§3509.	Reimbursement Methodology	38
§3511.	Prompt Pay of Claims.....	39
Chapter 37.	Grievance and Appeal Process.....	40
Subchapter A.	Member Grievances and Appeals	40
§3701.	Introduction	40
§3703.	Definitions	41
§3705.	General Provisions.....	41
§3707.	Handling of Member Grievances and Appeals	42
§3709.	Notice of Adverse Benefit Determination.....	42
§3711.	Resolution and Notification.....	43
§3713.	Expedited Resolution of Appeals	44
§3715.	Continuation of Services during the Pending MCO Appeal or State Fair Hearing [Formerly LAC 50:I.3711]	44
§3717.	Effectuation of Reversed Appeal Resolutions [Formerly LAC 50:I.3713].....	45
Subchapter B.	Provider Grievance and Appeal Process	45
§3721.	General Provisions.....	45
Chapter 39.	Sanctions and Measures to Obtain Compliance.....	45
§3901.	General Provisions.....	45
Chapter 40.	Audit Requirements	46
§4001.	General Provisions.....	46

Subpart 5. Provider Fraud and Recovery

Chapter 41. Surveillance and Utilization Review Subsystem (SURS).....	47
Subchapter A. General Provisions	47
§4101. Foreword.....	47
§4103. Definitions	48
§4105. Material.....	50
§4107. Statistical Sampling.....	51
Subchapter B. Prepayment or Post-Payment Claims Review.....	51
§4115. Departmental and Provider Obligations	51
§4117. Claims Review.....	52
§4119. Claims Review Scope and Extent.....	52
Subchapter C. Investigations	53
§4129. Investigations.....	53
Subchapter D. Conduct	53
§4143. Introduction	53
§4145. Prohibited Conduct.....	53
§4147. Violations	53
§4149. Scope of a Violation	58
Subchapter E. Administrative Sanctions, Procedures and Processes	59
§4161. Sanctions for Prohibited Conduct.....	59
§4163. Scope of Sanctions	60
§4165. Imposition of Sanction(s)	60
§4167. Mandatory Sanctions	61
§4169. Effective Date of a Sanction.....	61
Subchapter F. Withholding.....	62
§4177. Withholding of Payments.....	62
§4179. Effect of Withholding on the Status of a Provider or Provider-in-Fact with the Medical Assistance Program	63
Subchapter G. Suspension of Medicaid Payments Pending Investigation of Credible Allegations of Fraud	63
§4181. General Provisions.....	63
Subchapter H. Arrangements to Repay.....	64
§4187. Arrangement to Repay.....	64
Subchapter I. Corrective Actions	64
§4195. Corrective Actions Plans	64
Subchapter J. Informal Hearing Procedures and Processes.....	65
§4203. Informal Hearing	65
Subchapter K. Administrative Appeals.....	66
§4211. Administrative Appeal.....	66
§4213. Right to Administrative Appeal and Review.....	66
Subchapter L. Rewards for Fraud and Abuse Information.....	67
§4221. Tip Rewards.....	67
Subchapter M. Miscellaneous.....	67
§4229. Mailing	67
§4231. Confidentiality	67
§4233. Severability Clause.....	67
§4235. Effect of Promulgation	68

Subpart 9. Recovery

Chapter 81. Estate Recovery.....	68
§8101. Definitions.....	68
§8103. General Provisions.....	68
§8105. Administrative Review.....	69
Chapter 83. Third Party Liability.....	70
Subchapter A. Claims.....	70
§8301. Pay and Chase.....	70
§8303. Crossover Claims.....	70
Subchapter B. Data Match with Insurance Carriers.....	71
§8311. General Provisions.....	71
Subchapter C. Newborn Notification.....	71
§8325. Definitions.....	71
§8327. Hospital Requirements.....	71
Subchapter D. Provider Billing and Trauma Recovery.....	72
§8341. Definitions.....	72
§8343. Introduction.....	72
§8347. Recipient Responsibilities.....	72
§8349. Noncompliance and Violations.....	72

Subpart 11. Medicaid Expansion under the Affordable Care Act

Chapter 101. Alternative Benefit Plan.....	72
§10101. General Provisions.....	72
§10103. Benefits and Services.....	73
Chapter 103. Supplemental Nutrition Assistance Program Enrollment Option.....	73
§10301. General Provisions.....	73

Subpart 13. Electronic Health Records

Chapter 125. Incentive Payments.....	73
§12501. General Provisions.....	73
§12503. Qualifying Criteria for Professional Practitioners.....	73
§12505. Qualifying Criteria for Hospitals.....	74

Part II. Nursing Facilities

Subpart 1. General Provisions

Chapter 5. Admissions.....	75
§501. Preadmission Screening.....	75
§503. Medical Certification.....	75
§505. Categorical Advance Group Determinations.....	76
§507. Exempted Hospital Discharges.....	77
§509. Changes in Level of Care and Status.....	77
§511. Denials and Appeals Process.....	78

Subpart 3. Standards for Payment

Chapter 101. Standards for Payment for Nursing Facilities	78
Subchapter A. Abbreviations and Definitions	78
§10101. Definitions	78
Subchapter B. General Provisions	81
§10103. Certification	81
§10105. Provider Enrollment	82
§10107. Change in Ownership	82
§10109. Withdrawal from the Medicaid Program	83
Subchapter C. Administration	85
§10111. Introduction	85
§10113. Infection Control	87
§10115. Physical Environment and Sanitation	87
Subchapter D. Resident Care Services	88
§10117. Administrative Services	88
§10119. Physician Services	88
§10121. Nursing Services	89
§10123. Comprehensive Assessment	93
§10125. Comprehensive Care Plan	95
§10127. Pharmacy Services	96
§10129. Dietetic Services	98
§10131. Social Services	99
§10133. Activity Services	100
§10135. Medical Records	100
§10137. Ancillary Services	102
§10139. Hospice Services	103
§10141. Mental Health Rehabilitation Services	104
Subchapter E. Reserved	106
Subchapter F. Vendor Payments	106
§10147. General Provisions	106
§10149. Services and Supplies	107
§10151. Cost Reports	110
§10153. Audits, Inspections, Reviews	113
Subchapter G. Levels of Care	113
§10154. Nursing Facility Level of Care Determinations	113
§10155. Standards for Levels of Care	113
§10156. Level of Care Pathways	123
Subchapter H. Reserved	126
Subchapter I. Resident Rights	126
§10161. General Provisions	126
Subchapter J. Transfer and Discharge Procedures	134
§10163. General Provisions	134
Subchapter K. Complaint Procedures	137
§10165. Purpose and Scope	137
Subchapter L. Sanctions and Appeal Procedures	139
§10167. General Provisions	139

Subpart 5. Reimbursement

Chapter 200. Reimbursement Methodology	152
§20001. General Provisions.....	152
§20003. Cost Reports [Formerly LAC 50:VII.1303]	155
§20005. Rate Determination [Formerly LAC 50:VII.1305]	156
§20006. Reimbursement Adjustment [Formerly LAC 50:VII.1306].....	160
§20007. Case-Mix Index Calculation [Formerly LAC 50:VII.1307].....	160
§20009. Non-State, Government Owned or Operated Facilities and State-Owned or Operated Facilities	161
§20010. Additional Payments and Square Footage Adjustments for Private Room Conversion [Formerly LAC 50:VII.1310]	161
§20011. New Facilities, Changes of Ownership of Existing Facilities and Existing Facilities with Disclaimer or Non-Filer Status [Formerly LAC 50:VII.1311]	162
§20012. Fair Rental Value, Property Tax and Property Insurance Incentive Payments to Buyers of Nursing Facilities [Formerly LAC 50:VII.1312]	162
§20013. Case-Mix Documentation Reviews and Case-Mix Index Reports [Formerly LAC 50:VII.1313]	164
§20015. Appeal Process [Formerly LAC 50:VII.1315]	165
§20017. Reimbursement for Fire Sprinkler Systems and Two-Hour Rated Wall Installations [Formerly LAC 50:VII.1317]	165
§20019. Evacuation and Temporary Sheltering Costs [Formerly LAC 50:VII.1319]	166
§20021. Leave of Absence Days [Formerly LAC 50:VII.1321]	168
§20023. Transition of State-Owned or Operated Nursing Facility to a Private Facility	168
§20024. Transition of Private Nursing Facility to a State-Owned or Operated Nursing Facility through a Change of Ownership	169
§20025. Low Income and Needy Care Collaboration	169
§20026. Geriatric Training Nursing Facility Reimbursement Rate	170
§20027. Specialized Care Reimbursement.....	170
§20029. Supplemental Payments.....	170

Part III. Eligibility

Subpart 1. General Administration

Chapter 1. General Provisions	173
§101. Fair Hearings	173
Chapter 3. Asset Verification Program.....	173
§301. General Provisions.....	173
Chapter 5. Application Processing.....	174
§501. Filing Application.....	174
§503. Application Date.....	174
§505. Federally-Facilitated Marketplace Determinations	174
Chapter 9. Financial Eligibility.....	174
Subchapters A.-C. Reserved.....	174
Subchapter D. Incurred Medical	174
§939. Medically Needy	174
Chapter 11. Express Lane Eligibility	175
§1101. General Provisions.....	175

Table of Contents

§1103. Eligibility Determinations 175
§1105. Automatic Enrollment 175
§1107. Disclosure of Eligibility Data 176

Subpart 3. Eligibility Groups and Factors

Chapter 23. Eligibility Groups and Medicaid Programs 176
§2303. Family Opportunity Act Medicaid Program 176
§2305. Provisional Medicaid Program 177
§2307. Youth Aging Out of Foster Care 177
§2308. Former Foster Care Children Group 178
§2309. Medicaid Purchase Plan [Formerly LAC 50:III.763-765] 178
§2311. Louisiana Health Insurance Premium Payment Program 179
§2313. Medically Needy Program 179
§2315. LaMOMS Program 180
§2317. New Adult Eligibility Group 181
§2325. Medicare Savings Programs 181
§2327. Modified Adjusted Gross Income (MAGI) Groups 182
§2329. Lawfully Resident Children 184
§2330. Twelve-Months Postpartum Medicaid Coverage 184

Subpart 3. Eligibility Groups and Factors

Chapter 23. Eligibility Groups and Medicaid Programs 185
§2331. Act 421 Children’s Medicaid Option (Act 421-CMO/TEFRA) 185
Chapter 25. Eligibility Factors 185
§2523. Citizenship 185
§2525. Twelve-Month Continuous Eligibility 186
§2529. Hospital Presumptive Eligibility 186

Subpart 5. Financial Eligibility

Chapter 103. Income 187
§10305. Income Disregards 187
§10307. Modified Adjusted Gross Income (MAGI) Groups 187
Chapter 107. Resources 188
§10703. General Provisions 188
§10705. Resource Disregards 188
§10717. Types of SSI-Related Resources 188
Chapter 109. Transfers of Assets 190
§10905. Transfers 190

Subpart 9. Long-Term Care Eligibility

Chapter 161. General Provisions 192
§16101. Spousal Impoverishment 192
§16103. Nursing Facility Private-Pay Cost 192

Subpart 11. State Children’s Health Insurance Program

Chapter 201. Louisiana Children's Health Insurance Program (LaCHIP)—Phases 1-3 192
§20101. General Provisions 192
§20103. Eligibility Criteria 192

Table of Contents

Chapter 203. LaCHIP Phase IV—Prenatal Care Services.....	193
§20301. General Provisions.....	193
§20303. Eligibility Criteria.....	193
§20305. Services.....	193
Chapter 205. Louisiana Children’s Health Insurance Program (LaCHIP)—Phase V.....	194
§20501. General Provisions.....	194
§20503. Eligibility Criteria.....	194
§20505. Covered Services.....	195
§20507. Cost Sharing.....	195
§20509. Dental Services Reimbursement Methodology.....	195

Part V. Hospital Services

Subpart 1. Inpatient Hospitals Services

Chapter 1. General Provisions.....	197
§107. Elective Deliveries.....	197
§109. Healthcare-Acquired and Provider Preventable Conditions.....	197
§111. Coverage of Donor Human Breast Milk.....	198
§113. Coverage of Long-Acting Reversible Contraceptives.....	198
§115. Office of Public Health Newborn Screenings.....	198
§117. Laboratory Testing for Coronavirus Disease 2019 (COVID-19).....	198
§119. Coverage of Genetic Testing of Critically Ill Infants.....	198
§121. Distinct Part Psychiatric Units.....	198
§123. Psychiatric Hospitals.....	199
§125. Rehabilitation Hospitals.....	199
§127. Long-Term Hospitals.....	199
Chapter 5. State Hospitals.....	199
Subchapter B. Reimbursement Methodology.....	199
§551. Acute Care Hospitals.....	199
§553. Inpatient Psychiatric Services for State-Owned Hospitals.....	200
Chapter 7. Prospective Reimbursement.....	200
Subchapter A. Appeals Procedure.....	200
§701. Request for Administrative Review.....	200
§703. Administrative Appeal and Judicial Review.....	202
Chapter 9. Non-Rural, Non-State Hospitals.....	202
Subchapter A. General Provisions.....	202
§901. Definitions.....	202
§907. Well Baby Care.....	202
§909. Children’s Specialty Hospitals.....	203
§911. Children's Specialty Hospitals Psychiatric Units.....	203
§915. Distinct Part Psychiatric Units.....	203
Subchapter B. Reimbursement Methodology.....	203
§953. Acute Care Hospitals.....	203
§954. Outlier Payments.....	207
§955. Long-Term Hospitals.....	208
§959. Inpatient Psychiatric Hospital Services.....	209
§961. Inpatient Rehabilitation Hospital Services.....	210
§963. Public Hospitals.....	211

Table of Contents

§965.	Hemophilia Blood Products	211
§967.	Children’s Specialty Hospitals	211
§969.	Transplant Services	213
Chapter 11.	Rural, Non-State Hospitals.....	213
Subchapter A.	General Provisions (Reserved).....	213
Subchapter B.	Reimbursement Methodology.....	213
§1125.	Small Rural Hospitals.....	213
§1127.	Inpatient Psychiatric Hospital Services	214
Chapter 13.	Teaching Hospitals.....	214
Subchapter A.	General Provisions	214
§1301.	Major Teaching Hospitals	214
§1303.	Minor Teaching Hospitals	215
§1305.	Approved Medical Residency Program.....	215
§1309.	Requirements for Reimbursement.....	215
Subchapter B.	Reimbursement Methodology.....	216
§1331.	Acute Care Hospitals.....	216
Chapter 17.	Public-Private Partnerships	216
§1701.	Baton Rouge Area Hospitals	216
§1703.	Reimbursement Methodology	217
Chapter 19.	Urban Metropolitan Statistical Area (MSA) Facility	217
§1901.	Qualifying Criteria.....	217
§1903.	Reimbursement Methodology	217
Chapter 21.	Urban Metropolitan Statistical Area (MSA) Facility–New Orleans Area	217
§2101.	Qualifying Criteria.....	217
§2103.	Reimbursement Methodology	218
Chapter 23.	Medicare Part A Claims for Medicaid Eligible Beneficiaries.....	218
§2301.	Reimbursement Methodology	218
Chapter 24.	Out-of-State Hospitals.....	218
§2401.	General Provisions.....	218
§2403.	Reimbursement Methodology	218

Subpart 3. Disproportionate Share Hospital Payments

Chapter 25.	Disproportionate Share Hospital Payment Methodologies	219
§2501.	General Provisions.....	219
§2503.	Disproportionate Share Hospital Qualifications.....	219
Chapter 27.	Qualifying Hospitals	220
§2701.	Non-Rural Community Hospitals.....	220
§2703.	Federally Mandated Statutory Hospitals	221
§2705.	Small-Rural Hospitals	221
§2707.	Public State-Operated Hospitals.....	222
§2709.	Distinct Part Psychiatric Units.....	223
§2713.	Low Income and Needy Care Collaboration	223
§2715.	Major Medical Centers Located in Central and Northern Areas of the State	225
§2717.	Major Medical Centers with Specialized Burn Care Units Located in the Southwestern Area of the State	226
§2719.	Major Medical Centers Located in the Southeastern Area of the State	226
§2721.	Psychiatric Hospitals Located in the Northern Area of the State	227
Chapter 29.	Public-Private Partnerships	227
§2901.	Qualifying Criteria.....	227
§2903.	Reimbursement Methodology	228

Table of Contents

Chapter 31. Louisiana Low-Income Academic Hospitals 228
 §3101. Qualifying Criteria..... 228
 §3103. Payment Methodology..... 229

Subpart 5. Outpatient Hospital Services

Chapter 51. General Provisions 229
 §5109. Children's Specialty Hospitals..... 229
 §5111. Hospital Provider-Based Outpatient Services 229
 §5113. Never Events 230
 §5117. Service Limits..... 230
Chapter 53. Outpatient Surgery 230
Subchapter A. General Provisions 230
 §5301. Payment for Outpatient Surgery Services 230
Subchapter B. Reimbursement Methodology 230
 §5311. Small Rural Hospitals..... 230
 §5313. Non-Rural, Non-State Hospitals..... 231
 §5315. Non-Rural, Non-State Public Hospitals 232
 §5317. Children's Specialty Hospitals 233
 §5319. State-Owned Hospitals 233
Chapter 55. Clinic Services 234
Subchapter A. General Provision..... 234
 §5501. Payment for Outpatient Hospital Clinic Services..... 234
Subchapter B. Reimbursement Methodology 234
 §5511. Small Rural Hospitals..... 234
 §5513. Non-Rural, Non-State Hospitals..... 234
 §5515. Non-Rural, Non-State Public Hospitals 236
 §5517. Children's Specialty Hospitals 236
 §5519. State-Owned Hospitals 236
Chapter 57. Laboratory Services 237
Subchapter A. General Provisions 237
 §5701. Payment for Outpatient Hospital Laboratory Services..... 237
Subchapter B. Reimbursement Methodology 237
 §5711. Small Rural Hospitals..... 237
 §5713. Non-Rural, Non-State Hospitals..... 237
 §5715. State-Owned Hospitals 238
 §5717. Non-Rural, Non-State Public Hospitals 239
 §5719. Children's Specialty Hospitals 239
Chapter 59. Rehabilitation Services..... 240
Subchapter A. General Provisions 240
 §5901. Payment for Outpatient Hospital Rehabilitation Services..... 240
Subchapter B. Reimbursement Methodology 240
 §5911. Small Rural Hospitals..... 240
 §5913. Non-Rural, Non-State Hospitals..... 241
 §5915. Non-Rural, Non-State Public Hospitals 241
 §5917. Children's Specialty Hospitals 242
 §5919. State-Owned Hospitals 242
 §5921. Rehabilitation Services for Recipients Ages 0 up to Age 3 242
 §5923. Rehabilitation Services for Recipients Ages 3 and Above (Reserved) 243

Table of Contents

Chapter 61. Other Outpatient Hospital Services.....	243
Subchapter A. General Provisions	243
§6101. Payment for Other Outpatient Hospital Services	243
Subchapter B. Reimbursement Methodology.....	243
§6113. Small Rural Hospitals.....	243
§6115. Non-Rural, Non-State Hospitals.....	244
§6117. Non-Rural, Non-State Public Hospitals	245
§6119. Children’s Specialty Hospitals	245
§6127. State-Owned Hospitals	246
Chapter 63. Diabetes Education Services	247
Subchapter A. General Provisions	247
§6301. Introduction	247
§6303. Scope of Services	247
§6305. Provider Participation.....	247
Subchapter B. Reimbursement	247
§6311. Reimbursement Methodology	247
Chapter 67. Public-Private Partnerships.....	247
§6701. Baton Rouge Area Hospitals	247
§6703. Reimbursement Methodology	248
Chapter 69. Out-of-State Hospitals.....	248
Subchapter A. Reserved.....	248
Subchapter B. Reimbursement	248
§6915. Reimbursement Methodology	248
Chapter 71. Medicare Part B Claims for Medicaid Eligible Recipients.....	248
Subchapter A. Reserved.....	248
Subchapter B. Reimbursement	248
§7115. Reimbursement Methodology	248
Chapter 73. Urban Metropolitan Statistical Area (MSA) Facility.....	249
§7301. Qualifying Criteria.....	249
§7303. Reimbursement Methodology	249
Chapter 75. Urban Metropolitan Statistical Area (MSA) Facility–New Orleans Area	249
§7501. Qualifying Criteria.....	249
§7503. Reimbursement Methodology	250

Part VII. Long Term Care

Subpart 3. Intermediate Care Facilities for Persons with Intellectual Disabilities

Chapter 301. General Provisions	251
§30101. Foreword.....	251
§30103. Definitions and Acronyms Specific to Mental Retardation and Other Developmental Disabilities.....	251
Chapter 303. Provider Enrollment	255
§30301. General Provisions.....	255
§30303. General Admission and Funding	256
§30305. Program Enrollment	256
§30307. Ownership.....	257
§30309. Provider Agreement.....	258
Chapter 305. Admission Review	259
§30501. Admission Process.....	259
§30503. Certification Requirements.....	260

Table of Contents

Chapter 307. Records.....	262
Subchapter A. Client Records.....	262
§30701. General Requirements	262
§30703. Admission Records.....	263
§30705. Medical Records.....	264
§30707. Personal Property Records	264
§30709. Financial Records	264
§30711. Cash on Hand	266
§30713. Access to Funds.....	266
§30715. Closing a Discharged Client's Fund Account.....	266
§30717. Disposition of Deceased Client's Personal Funds	267
§30719. Disposition of Deceased Client's Unclaimed Personal Funds.....	267
Subchapter B. Facility Records	267
§30739. General Requirements	267
Chapter 309. Transfers and Discharges	268
§30901. Written Agreements with Outside Resources.....	268
§30903. Facility Responsibilities for Planned or Voluntary Transfer or Discharge Policies	268
§30905. Involuntary Transfer or Discharge	269
§30907. Mass Transfer of Clients	270
Chapter 311. Health Services.....	271
§31101. Client Health and Habilitative Services	271
§31103. Habilitative Treatment Services	271
§31105. Professional Services.....	273
§31107. Pharmaceutical Services.....	273
§31109. Aids and Equipment	273
§31111. Nutritional Services	274
§31113. Clothing.....	274
Chapter 313. Client Behavior Management	274
§31301. Written Policies and Procedures.....	274
§31303. Interventions to Manage Inappropriate Client Behavior	274
Chapter 315. Client Rights.....	276
§31501. Written Policies	276
§31503. Notification of Rights	276
§31505. Statute Authority	276
§31507. Client Rights.....	277
§31509. Violation of Rights	278
Chapter 317. Complaints	278
§31701. Purpose and Scope.....	278
§31703. Applicability	278
§31705. Duty to Report	279
§31707. Where to Submit Complaint.....	279
§31709. Disposition of Complaints.....	279
§31711. Informal Reconsideration	279
§31713. Tracking Incidents	280
Chapter 319. Utilization Review	280
§31901. Utilization Review	280
Chapter 321. Appeals.....	280
§32101. Administrative Appeals	280
§32103. Notice and Appeal Procedure.....	281
§32105. Collection of Fines	281

Table of Contents

Chapter 323. Sanctions	282
§32301. Noncompliance	282
§32303. Authority	282
§32305. Special Staffing	282
§32307. Withholding of Vendor Payments	282
§32309. Civil Fines	283
Chapter 325. Decertification	285
§32501. Termination of Certification	285
Chapter 327. Emergency Awareness	288
§32701. Disaster Preparedness	288
Chapter 329. Reimbursement Methodology	288
Subchapter A. Non-State Facilities	288
§32901. Cost Reports	288
§32903. Rate Determination	289
§32904. Temporary Reimbursement for Private Facilities	292
§32905. ICAP Requirements	293
§32907. ICAP Monitoring	293
§32909. Audits	294
§32911. Exclusions from Database	295
§32913. Leave of Absence Days	295
§32915. Complex Care Reimbursements	295
§32917. Dedicated Program Funding Pool Payments	295
Subchapter C. Public Facilities	296
§32965. State-Owned and Operated Facilities	296
§32967. Quasi-Public Facilities	296
§32969. Transitional Rates for Public Facilities	296
Chapter 331. Vendor Payments	297
§33101. Income Consideration in Determining Payment	297
§33103. Payment Limitations	297
§33105. Evacuation and Temporary Sheltering Costs	300

Part IX. Professional Services Program

Subpart 1. General Provisions

Chapter 6. Outpatient Physician Services	303
§601. General Provisions	303
Chapter 7. Diabetes Education Services	303
§701. General Provisions	303
§703. Scope of Services	303
§705. Provider Participation	303
Chapter 9. Fluoride Varnish Application Services	303
§901. General Provisions	303
§903. Scope of Services	303
§905. Provider Participation	303
Chapter 11. Tobacco Cessation Counseling Services	303
§1101. General Provisions	303
§1103. Scope of Services	304
§1105. Provider Participation	304

Table of Contents

Chapter 13.	Physician Directed Treatment-In-Place Ambulance Services	304
§1301.	General Provisions.....	304
§1303.	Scope of Services	304
§1305.	Reimbursement.....	304

Subpart 3. Licensed Professionals (Reserved)

Subpart 5. Formerly School Based Health Centers (Reserved)

Subpart 7. Immunizations

Chapter 83.	Children’s Immunizations.....	305
§8301.	General Provisions.....	305
§8305.	Reimbursement Methodology	305
Chapter 85.	Adult Immunizations.....	305
§8501.	General Provisions.....	305
§8505.	Reimbursement Methodology	305

Subparts 9. - 13. Reserved.

Subpart 15. Reimbursement

Chapter 151.	Reimbursement Methodology.....	306
Subchapter A.	General Provisions	306
§15101.	Enhanced Federal Medical Assistance Percentage Rate for Preventive Services	306
§15103.	Diabetes Education Services	306
§15105.	Fluoride Varnish Application Services	306
§15106.	Tobacco Cessation Counseling Services	306
§15107.	Never Events	306
§15109.	Elective Deliveries.....	306
§15110.	State-Owned or Operated Professional Services Practices	306
Subchapter B.	Physician Services.....	307
§15111.	General Provisions.....	307
§15113.	Reimbursement Methodology	307
Subchapter C.	Adjunct Services	309
§15121.	Payment for Adjunct Services	309
Subchapter D.	Anesthesia Services.....	309
§15131.	General Provisions.....	309
§15133.	Formula-Based Reimbursement	309
§15135.	Flat Fee Reimbursement.....	310
Subchapter E.	Family Planning Services.....	310
§15141.	General Provisions.....	310
§15143.	Reimbursement.....	310
Subchapter F.	Supplemental Payments	310
§15151.	State-Owned or Operated Professional Services Practices	310
§15153.	Non-State-Owned or Operated Professional Services Practices	311
§15155.	Qualifying Criteria—Professional Services of Practitioners Affiliated with Tulane School of Medicine.....	311
Subchapter G.	Midwifery Services	312
§15161.	General Provisions.....	312
§15163.	Reimbursement Methodology	312

Part XI. Clinic Services

Subpart 1. Rehabilitation Clinics

Chapter 1.	General Provisions	313
§101.	Definitions	313
§103.	Services.....	313
Chapter 3.	Reimbursement	313
§301.	Rehabilitation (Ages 3 and Over).....	313

Subpart 3. Reserved

Subpart 5. Family Planning

Chapter 35.	Reimbursement	313
§3501.	Reimbursement Methodology	313

Subpart 7. Prenatal Health Care

Chapter 51.	General Provisions	314
§5101.	Covered Services	314

Subpart 9. End Stage Renal Disease Facilities

Chapter 69.	Reimbursement	314
§6901.	General Provisions.....	314
§6903.	Medicare Part B Claims.....	314

Subpart 11. Ambulatory Surgical Centers

Chapter 75.	Reimbursement	314
§7501.	General Provisions.....	314
§7503.	Reimbursement Methodology	315

Subpart 13. Federally-Qualified Health Centers

Chapter 101.	General Provisions	315
§10101.	Purpose	315
Chapter 103.	Services	316
§10301.	Scope of Services [Formerly §10501].....	316
§10303.	Service Limits [Formerly §10503].....	316
Chapter 105.	Provider Participation.....	316
§10501.	Provider Enrollment [Formerly §10301].....	316
§10503.	Standards for Participation [Formerly §10303].....	316
Chapter 107.	Reimbursement Methodology	317
§10701.	Prospective Payment System.....	317
§10703.	Alternate Payment Methodology.....	317

Subpart 15. Rural Health Clinics

Chapter 161.	General Provisions	318
§16101.	Purpose	318
Chapter 163.	Services	318
§16301.	Scope of Services [Formerly §16501].....	318
§16303.	Service Limits [Formerly §16503].....	319

Table of Contents

Chapter 165. Provider Participation [Formerly Chapter 163]	319
§16501. Provider Enrollment [Formerly §16301].....	319
§16503. Standards for Participation [Formerly §16303].....	319
Chapter 167. Reimbursement Methodology.....	319
§16701. Prospective Payment System.....	319
§16703. Alternate Payment Methodology.....	320
§16705. Hospital-Based Rural Health Clinics.....	320

Part XIII. Home Health Program

Subpart 1. Home Health Services

Chapter 1. General Provisions	323
§101. Definitions [Formerly LAC 50:XIX.101]	323
§103. Requirements for Home Health Services [Formerly LAC 50:XIX.103]	323
§105. Home Health Agency Responsibilities [Formerly LAC 50:XIX.105]	324
§121. Cost Reporting Requirements.....	324
Chapter 3. Medical Necessity	324
§301. General Provisions [Formerly LAC 50:XIX.301].....	324
§303. Provisions for Infants and Toddlers [Formerly LAC 50:XIX.303].....	325
§305. Extended Nursing Services for Ages 0-21	325
Chapter 5. Retrospective Review.....	326
§501. Home Health Visits [Formerly LAC 50:XIX.501].....	326
Chapter 7. Reimbursement Methodology.....	326
§701. Nursing and Home Health Aide Services.....	326
Chapter 8. American Rescue Plan Act Funding	326
§801. Nursing Recruitment and Retention Payments.....	326
Chapter 9. Rehabilitation Services.....	327
§901. General Provisions.....	327
§905. Reimbursement Methodology	327

Subpart 3. Medical Equipment, Supplies and Appliances

Chapter 85. Provider Participation.....	327
§8501. Accreditation Requirements	327
§8503. Provider Responsibilities.....	328
Chapter 103. Reimbursement Methodology	328
§10301. General Provisions.....	328

Part XV. Services for Special Populations

Subpart 1. Applied Behavior Analysis-Based Therapy Services

Chapter 1. General Provisions	331
§101. Program Description and Purpose	331
§103. Recipient Criteria.....	331
Chapter 3. Services	331
§301. Covered Services and Limitations.....	331
§303. Treatment Plan.....	332
Chapter 5. Provider Participation.....	332
§501. General Provisions.....	332

Table of Contents

Chapter 7.	Reimbursements	333
§701.	General Provisions.....	333
§703.	Reimbursement Methodology	333

Subpart 3. Hospice

Chapter 31.	General Provisions	333
§3101.	Introduction	333
Chapter 33.	Provider Participation.....	334
§3301.	Conditions for Participation	334
Chapter 35.	Recipient Eligibility	334
§3501.	Election of Hospice Care.....	334
§3503.	Waiver of Payment for Other Services.....	335
§3505.	Revoking the Election of Hospice Care/Discharge	335
§3507.	Change of Designated Hospice	336
Chapter 37.	Provider Requirements.....	336
§3701.	Requirements for Coverage	336
§3703.	Certification of Terminal Illness	336
§3705.	Plan of Care	337
§3707.	Record Keeping.....	337
§3709.	Self Assessment.....	337
Chapter 39.	Covered Services.....	337
§3901.	Medical and Support Services	337
Chapter 41.	Prior Authorization.....	339
§4101.	Prior Authorization of Hospice Services	339
Chapter 43.	Reimbursement	340
§4301.	General	340
§4303.	Levels of Care for Payment.....	340
§4305.	Payment Methodology.....	340
§4307.	Payment for Long Term Care Residents	341
§4309.	Limitation on Payments for Inpatient Care	342
§4311.	Coinsurance for Medicare	342
§4313.	Services Not Related to Terminal Illness	342
§4315.	Life-Prolonging Treatments for Beneficiaries under the Age of 21.....	342

Subpart 5. Early and Periodic Screening, Diagnosis, and Treatment

Chapter 65.	General Provisions	342
§6501.	Screening Services.....	342
§6503.	Service Limit Exemptions	343
§6505.	Provider Restrictions	343
Chapter 69.	Dental Services.....	343
§6901.	General Provisions.....	343
§6903.	Covered Services	343
§6905.	Reimbursement.....	344
Chapter 71.	Health Services.....	346
§7101.	Recipient Criteria.....	346
§7103.	Covered Services	346
§7105.	Professional Staffing Requirements	347
§7107.	EarlySteps Reimbursement	348

Table of Contents

Chapter 73.	Personal Care Services	348
§7301.	Introduction	348
§7303.	Services.....	349
§7305.	Beneficiary Qualifications.....	349
§7307.	Prior Authorization.....	349
§7309.	Place of Service	350
§7311.	Service Limits.....	350
§7313.	Standards for Payment.....	350
§7315.	Provider Qualifications.....	351
§7317.	Provider Responsibilities.....	351
§7319.	EPSDT PCS Provider Responsibilities	351
§7321.	Reimbursement.....	352
§7323.	Nonreimbursable Services.....	352
Chapter 79.	Therapeutic Residential Intervention Services—Residential Treatment Facilities (Reserved)	353
Chapter 85.	Durable Medical Equipment—Eyeglasses.....	353
§8501.	Eye Care	353
Chapter 87.	Durable Medical Equipment—Hearing Devices.....	353
Subchapter A.	Hearing Aids	353
§8701.	Prior Authorization.....	353
§8703.	Reimbursement.....	353
Subchapter B.	Cochlear Device	354
§8717.	Eligibility and Prior Authorization.....	354
§8719.	Recipient Criteria.....	354
§8721.	Cochlear Implant Team	355
§8723.	Expenses Covered/Noncovered.....	355
Chapter 91.	School Based Health Centers	355
Subchapter A.	General Provisions	355
§9101.	Purpose	355
§9103.	Registry of School Based Health Centers	356
Subchapter B.	Provider Participation.....	356
§9111.	Provider Qualifications.....	356
§9113.	Standards of Participation.....	356
Subchapter C.	Services	357
§9121.	Scope of Services	357
Subchapter D.	Staffing Requirements.....	357
§9131.	Minimum Staffing Requirements	357
Subchapter E.	Reimbursement	357
§9141.	Reimbursement Methodology	357
Chapter 93.	Substance Abuse Services.....	357
§9301.	General Provisions.....	357
§9303.	Covered Services	357
§9305.	Provider Qualifications.....	358
§9307.	Reimbursement Methodology	359
Chapter 95.	School-Based Health Services	359
Subchapter A.	School-Based Medicaid Medical Direct Services.....	359
§9501.	General Provisions.....	359
§9503.	Covered Services	360
§9505.	Reimbursement Methodology	361
§9507.	Local Education Agency Responsibilities.....	363

Table of Contents

Subchapter B. School-Based EPSDT Transportation Services	363
§9511. General Provisions.....	363
§9515. Reimbursement Methodology	363
Subchapter C. School-Based Medicaid Personal Care Services.....	365
§9521. General Provisions.....	365
§9523. Covered Services	365
§9525. Reimbursement Methodology	365
Chapter 97. Office of Public Health Uncompensated Care Payments	366
§9701. General Provisions.....	366
§9703. Reimbursement Methodology	366

Subpart 7. Targeted Case Management

Chapter 101. General Provisions	366
§10101. Program Description.....	366
Chapter 103. Core Elements	367
§10301. Services.....	367
Chapter 105. Provider Participation.....	368
§10501. Participation Requirements	368
§10503. Provider Responsibilities.....	369
§10505. Staff Education and Experience	370
§10507. Staff Training.....	371
Chapter 107. Reimbursement	371
§10701. Reimbursement.....	371
§10703. Cost Reports	372
§10704. Targeted Case Management Workforce Retention Bonus Payments.....	372
Chapter 109. Infants and Toddlers.....	372
§10901. Introduction	372
§10905. Staff Training.....	373
Chapter 113. Early, Periodic Screening, Diagnosis and Treatment.....	374
§11301. Introduction	374
§11303. Recipient Qualifications	374
Chapter 117. Individuals with Developmental Disabilities	375
§11701. Introduction	375
§11703. Electronic Visit Verification.....	375

Subpart 9. Personal Care Services

Chapter 129. Long Term Care	375
§12901. General Provisions.....	375
§12903. Covered Services	376
§12905. Eligibility Criteria.....	377
§12907. Recipient Rights and Responsibilities	377
§12909. Standards for Participation	378
§12911. Staffing Requirements	379
§12913. Service Delivery	379
§12915. Service Limitations.....	379
§12917. Reimbursement.....	380
§12919. Cost Reporting Requirements.....	380
§12921. Direct Service Worker Wages, Other Benefits, and Workforce Bonus Payments.....	380

Subpart 13. Pregnant Women Extended Services

Chapter 163. Substance Use Screening and Intervention Services	381
§16301. General Provisions.....	381
§16303. Scope of Services	381
§16305. Reimbursement Methodology	382

Subpart 15. Health Services for American Indians

Chapter 201. General Provisions	382
§20103. Cancellation of Participation	382
Chapter 203. Provider Participation.....	382
§20301. “638” Facilities	382
Chapter 205. Recipient Eligibility	382
§20501. Target Population	382
Chapter 207. Covered Services.....	382
§20701. Outpatient Services.....	382
§20703. Service Limitations.....	383
§20705. Reimbursement Methodology	383

Subpart 17. Family Planning Services

Chapter 251. General Provisions	383
§25101. Purpose	383
Chapter 253. Eligibility Criteria	383
§25301. Recipient Qualifications	383
Chapter 255. Services	384
§25501. Covered Services	384
§25503. Service Delivery	384
Chapter 257. Reimbursement	384
§25701. Reimbursement Methodology	384

Subpart 18. Free-Standing Birthing Centers

Chapter 265. General Provisions	384
§26501. Purpose	384
§26503. Definitions	384
Chapter 267. Services	385
§26701. Scope of Services	385
Chapter 269. Provider Participation.....	385
§26901. General Provisions.....	385
§26903. Staffing Requirements	385
Chapter 271. Reimbursement	385
§27101. Reimbursement Methodology	385

Subpart 19. Pediatric Day Health Care Program

Chapter 275. General Provisions	385
§27501. Program Description and Purpose	385
§27503. Recipient Criteria.....	386
Chapter 277. Services	386
§27701. Service Coverage and Limitations.....	386

Table of Contents

Chapter 279. Provider Participation..... 387
 §27901. General Provisions..... 387
Chapter 281. Reimbursement Methodology..... 387
 §28101. General Provisions..... 387

Part XVII. Prosthetics and Orthotics

Subpart 1. General Provisions

Chapter 1. Prior Authorization..... 389
 §101. Purchase and Repairs..... 389
Chapter 3. Provider Participation..... 389
 §301. Accreditation Requirements 389
 §303. Provider Responsibilities..... 390
Chapter 5. Reimbursement 390
 §501. Reimbursement Methodology 390
 §503. Medicare Part B Claims..... 391

Subpart 3. Prosthetic Devices

Chapter 15. Artificial Eyes, Scleral Shell, and Related Services 391
 §1501. Introduction 391
 §1503. Medical Necessity 391
 §1705. Implanting the Vagus Nerve Stimulator..... 392
 §1707. Programming the Vagus Nerve Stimulator 392

Subpart 5. Orthotic Devices

Chapter 103. Orthopedic Shoes and Corrections..... 392
 §10307. Orthopedic Shoes..... 392
Chapter 105. Osteogenic Bone Growth Stimulators..... 392
 §10501. General Provisions..... 392
 §10503. Medical Necessity 392
 §10505. Reimbursement Methodology 393

Part XIX. Other Services

Subpart 3. Laboratory and Radiology Services

Chapter 39. General Provisions 395
 §3901. Introduction 395
 §3903. Service Limitations..... 395
Chapter 41. Provider Participation..... 395
 §4101. Physicians and Other Licensed Practitioners Office Services..... 395
 §4103. Independent Laboratories 395
Chapter 43. Reimbursement 395
 §4301. Laboratory Services Reimbursement Methodology 395
 §4334. Radiology Services Reimbursement Methodology 396

Part XXI. Home and Community-Based Services Waivers

Subpart 1. General Provisions

Chapter 1.	Freedom of Choice	397
§101.	General Provisions.....	397
Chapter 3.	Eligibility.....	397
§301.	Termination of Coverage for Displaced Recipients	397
§303.	Active Duty Military Families.....	397
§305.	Continued Eligibility	398
Chapter 5.	Support Coordination Standards for Participation for Office of Aging and Adult Services Waiver Programs	398
Subchapter A.	General Provisions	398
§501.	Introduction	398
§503.	Certification Requirements.....	398
§505.	Certification Issuance	398
§507.	Certification Refusal or Revocation and Fair Hearing	399
§509.	Certification Review.....	399
Subchapter B.	Administration and Organization.....	399
§513.	Governing Body	399
§515.	Business Location and Operations	400
§517.	Financial Management	400
§519.	Policy and Procedures	400
§521.	Organizational Communication.....	400
Subchapter C.	Provider Responsibilities	401
§525.	General Provisions.....	401
§527.	Support Coordination Services.....	402
§529.	Transfers and Discharges	402
§531.	Staffing Requirements	403
§533.	Personnel Standards.....	403
§535.	Employment and Recruitment Practices	404
§537.	Orientation and Training	404
§539.	Participant Rights	405
§541.	Grievances	405
§543.	Critical Incident Reporting	405
§545.	Participant Records.....	406
§547.	Emergency Preparedness.....	406
§549.	Continuous Quality Improvement Plan	406
§551.	Support Coordination Monitoring	406
§553.	Workforce Retention Bonus Payments	407
Chapter 7.	Reimbursement Methodology	407
§701.	General Provisions.....	407
§703.	Cost Reporting Requirements.....	407
§705.	Rate Methodology	408
Subchapter B.	Adult Day Health Care Providers	409
§707.	General Provisions.....	409
§709.	Rate Methodology	409
§711.	Cost Reporting.....	409
§713.	Cost Categories Included in the Cost Report	412
§715.	Allowable Costs.....	415

Table of Contents

§717.	Non-allowable Costs	415
§719.	Audits	416
§721.	Exclusions from the Database	417
§723.	Provider Reimbursement	417
Chapter 9.	Provider Requirements	419
Subchapter A.	General Provisions	419
§901.	Settings Requirements for Service Delivery	419
§903.	Electronic Visit Verification.....	420
§904.	Social Security Verification	420
§905.	Critical Incident Reporting.....	421
Chapter 11.	Fiscal Employer Agent Standards for Participation in Home and Community-Based Services Waiver Programs	421
Subchapter A.	General Provisions	421
§1101.	Introduction	421
§1103.	Certification Requirements.....	421
§1105.	Certification Issuance	421
§1107.	Certification Refusal or Revocation and Fair Hearing.....	422
§1109.	Certification Review.....	422
Subchapter B.	Administration and Organization.....	422
§1115.	Governing Body	422
§1117.	Business Location and Operations	422
§1119.	Financial Management	423
§1121.	Policy and Procedures	423
§1123.	Organizational Communication.....	423
Subchapter C.	Provider Responsibilities	423
§1129.	General Provisions.....	423
§1131.	Fiscal Employer Agent Requirements.....	425
§1133.	Transfers and Discharges	425
§1135.	Staffing Requirements	425
§1137.	Employer Rights.....	426
§1139.	Grievances	426
§1141.	Electronic Visit Verification (EVV) Requirements	426
§1143.	Employer Records	426
§1145.	Emergency Preparedness.....	426
§1147.	Fiscal Employer Agent Monitoring.....	427

Subpart 3. Adult Day Health Care

Chapter 21.	General Provisions	427
§2101.	Introduction	427
§2103.	Program Description.....	428
§2105.	Request for Services Registry [Formerly §2107].....	428
§2107.	Programmatic Allocation of Waiver Opportunities	429
Chapter 23.	Services	429
§2301.	Covered Services	429
§2303.	Individualized Service Plan.....	430
§2305.	Plan of Care	431
Chapter 25.	Admission and Discharge Criteria	431
§2501.	Admission Criteria.....	431
§2503.	Admission Denial or Discharge Criteria	431

Table of Contents

Chapter 27. Provider Responsibilities 432
 §2701. General Provisions..... 432
 §2703. Reporting Requirements 432
Chapter 29. Reimbursement 432
 §2901. Reimbursement and Rate Requirements 432
 §2903. Adult Day Health Care (ADHC) Direct Support Worker Wages, Other Benefits, and
 Workforce Retention Bonus Payments [Formerly LAC 50:XXI.2901]..... 433

Subpart 5. Supports Waiver

Chapter 53. General Provisions 434
 §5301. Purpose 434
 §5303. Settings for Home and Community-Based Services 434
Chapter 55. Target Population 435
 §5501. Participant Qualifications and Admissions Criteria 435
 §5503. Denial of Admission or Discharge Criteria 435
 §5505. Needs-Based Assessment 435
Chapter 57. Covered Services..... 436
 §5701. Supported Employment Services 436
 §5703. Day Habilitation 437
 §5705. Prevocational Services..... 437
 §5707. Respite 438
 §5709. Habilitation 438
 §5713. Personal Emergency Response System 438
 §5715. Support Coordination 438
 §5717. Housing Stabilization Transition Services 439
 §5719. Housing Stabilization Services 439
 §5721. Dental Services 440
 §5723. Community Life Engagement Development 440
 §5725. Specialized Medical Equipment and Supplies 441
Chapter 59. Provider Participation..... 441
 §5901. General Provisions..... 441
 §5903. Electronic Visit Verification..... 441
Chapter 61. Reimbursement 442
 §6101. Unit of Reimbursement 442

Subpart 7. Community Choices Waiver

Chapter 81. General Provisions 444
 §8101. Introduction 444
 §8103. Request for Services Registry 444
 §8105. Programmatic Allocation of Waiver Opportunities 444
 §8107. Resource Assessment and Allocation Process 445
Chapter 83. Covered Services..... 446
 §8301. Support Coordination 446
 §8302. Long-Term Personal Care Services 447
 §8303. Transition Intensive Support Coordination 447
 §8305. Environmental Accessibility Adaptations 447
 §8307. Personal Assistance Services..... 447
 §8309. Transition Services 449
 §8311. Adult Day Health Care Services..... 449
 §8313. Caregiver Temporary Support Services 449

Table of Contents

§8315.	Assistive Devices and Medical Supplies	450
§8317.	Home Delivered Meals	450
§8321.	Nursing Services	451
§8323.	Skilled Maintenance Therapy	451
§8325.	Housing Transition or Crisis Intervention Services	452
§8327.	Housing Stabilization Services	453
§8329.	Monitored In-Home Caregiving Services	453
§8331.	Assistive Technology	454
§8335.	Financial Management Services	454
Chapter 85.	Self-Direction Initiative	454
§8501.	Self-Direction Service Option	454
Chapter 86.	Organized Health Care Delivery System	455
§8601.	General Provisions.....	455
Chapter 87.	Plan of Care.....	455
§8701.	Plan of Care	455
Chapter 89.	Admission and Discharge Criteria	455
§8901.	Admission Criteria.....	455
§8903.	Admission Denial or Discharge Criteria	456
Chapter 91.	Waiver Cost Neutrality	456
§9101.	Waiver Costs Limit.....	456
Chapter 93.	Provider Responsibilities	456
§9301.	General Provisions.....	456
§9303.	Reporting Requirements	457
Chapter 95.	Reimbursement	457
§9501.	Reimbursement and Rate Requirements	457
§9503.	Direct Support/Service Worker Wages, Other Benefits, and Workforce Retention Bonus Payments	458

Subpart 9. Children's Choice

Chapter 111.	General Provisions	459
§11101.	Introduction	459
§11103.	Participant Qualifications and Admissions Criteria	459
§11104.	Admission Denial or Discharge Criteria	460
§11105.	Money Follows the Person Rebalancing Demonstration	460
§11107.	Allocation of Waiver Opportunities	460
Chapter 113.	Service.....	461
§11301.	Service Cap.....	461
§11303.	Service Definitions	461
Chapter 115.	Provider Participation Requirements	465
Subchapter A.	Provider Qualifications	465
§11501.	Support Coordination Providers and Service Providers	465
Subchapter B.	Provider Requirements.....	466
§11521.	General Requirements for Medicaid Enrollment	466
§11523.	Enrollment	466
§11525.	Case Management Providers	467
§11527.	Direct Service Providers.....	467
§11529.	Professional Services Providers	468
§11531.	Electronic Visit Verification.....	468

Table of Contents

Chapter 117. Crisis Provisions.....	468
§11701. Participation in Children’s Choice	468
§11703. Crisis Designation Criteria	469
§11705. Crisis Extension Provisions	469
Chapter 119. Noncrisis Provisions.....	469
§11905. Determination Responsibilities and Appeals.....	469
Chapter 121. Reimbursement Methodology.....	469
§12101. Unit of Reimbursement	469
Chapter 123. Self-Direction Initiative	471
§12301. Self-Direction Service Delivery Option	471

Subpart 11. New Opportunities Waiver

Chapter 137. General Provisions	472
§13701. Introduction	472
§13702. Settings for Home and Community-Based Services	473
§13703. Beneficiary Qualifications and Admissions Criteria	473
§13704. Needs-Based Assessment	473
§13705. Denial of Admission or Discharge Criteria	474
§13706. Resource Allocation	474
§13707. Programmatic Allocation of Waiver Opportunities	475
Chapter 139. Covered Services.....	475
§13901. Individual and Family Support Services	475
§13902. Individual and Family Support Supplemental Payments	477
§13903. Center-Based Respite Care.....	478
§13905. Community Life Engagement Development.....	478
§13907. Supported Independent Living	479
§13909. Substitute Family Care	479
§13911. Day Habilitation	480
§13913. Supported Employment	480
§13915. Transportation for Day Habilitation and Supported Employment Models	482
§13917. Prevocational Services.....	482
§13919. Environmental Accessibility Adaptations	483
§13921. Specialized Medical Equipment and Supplies	484
§13923. Personal Emergency Response Systems	484
§13925. Professional Services.....	484
§13927. Skilled Nursing Services	485
§13929. One-Time Transitional Expenses	486
§13931. Adult Companion Care.....	486
§13935. Housing Stabilization Transition Service.....	487
§13937. Housing Stabilization Service	488
§13939. Monitored In-Home Caregiving Services	488
§13941. Dental Services	489
Chapter 141. Self-Direction Initiative	490
§14101. Self-Direction Service Delivery Option	490
Chapter 142. Provider Participation Requirements	491
§14201. Electronic Visit Verification.....	491
§14202. Incident Reporting, Tracking and Follow-Up	491
Chapter 143. Reimbursement	491
§14301. Unit of Reimbursement	491

Subpart 13. Residential Options Waiver

Chapter 161. General Provisions	493
§16101. Introduction	493
§16103. Program Description.....	493
§16104. Settings for Home and Community Based Services.....	494
§16105. Beneficiary Qualifications.....	494
§16106. Money Follows the Person Rebalancing Demonstration	495
§16107. Programmatic Allocation of Waiver Opportunities	495
§16109. Admission Denial or Discharge Criteria	496
Chapter 163. Covered Services.....	496
§16301. Assistive Technology and Specialized Medical Equipment and Supplies	496
§16303. Community Living Supports	497
§16305. Companion Care.....	498
§16307. Day Habilitation Services.....	499
§16309. Dental Services.....	500
§16311. Environmental Accessibility Adaptations	501
§16313. Host Home.....	502
§16317. Nursing Services.....	504
§16319. One Time Transitional Services	505
§16321. Personal Emergency Response System (PERS).....	506
§16323. Prevocational Services.....	506
§16325. Professional Services.....	507
§16327. Respite Care Services—Out of Home.....	508
§16329. Shared Living Services.....	509
§16333. Support Coordination	512
§16335. Supported Employment.....	512
§16337. Transportation-Community Access.....	513
§16339. Housing Stabilization Transition Services	514
§16341. Housing Stabilization Services.....	515
§16343. Adult Day Health Care Services.....	516
§16345. Monitored In-Home Caregiving Services	516
Chapter 165. Self-Direction Initiative	517
§16501. Self-Direction Service Option	517
Chapter 167. Provider Participation.....	519
§16701. General Provisions.....	519
§16703. Staffing Restrictions and Requirements	520
§16705. Electronic Visit Verification.....	520
Chapter 169. Reimbursement	520
§16901. Unit of Reimbursement	520
§16903. Direct Service Worker Wages and Bonus Payments	521
§16905. Support Coordination	522

Part XXII. 1115 Demonstration Waivers

Subparts 1. - 3. Reserved

Subpart 5. Louisiana Hurricane Relief Waiver

Chapter 41. General Provisions	525
§4101. Purpose	525

Table of Contents

Chapter 43.	Eligible Populations	525
§4301.	Definitions	525
§4303.	Eligibility Requirements	525
Chapter 45.	Covered Services	525
§4501.	Medicaid State Plan Services	525
§4503.	Non-Medicaid State Plan Services	525
Chapter 47.	Provider Participation	526
§4701.	Participation Requirements	526
Chapter 49.	Requests for Payment	526
§4901.	Submission Requirements	526
Chapter 51.	Uncompensated Care Pool Reimbursement	526
§5101.	Allowable Payment	526
Chapter 53.	Administrative Appeals	527
§5301.	Fair Hearings and Appeals	527

Subpart 7. Healthy Louisiana Opioid Use Disorder/Substance Use Disorder Waiver

Chapter 61.	General Provisions	527
§6101.	Purpose	527
Chapter 63.	Eligibility	527
§6301.	General Provisions	527
Chapter 65.	Services	527
§6501.	Covered Services	527
§6503.	Service Delivery	527
Chapter 67.	Provider Participation	528
§6701.	General Provisions	528
§6703.	Reporting Requirements	528
Chapter 69.	Reimbursement	528
§6901.	General Provisions	528
§6903.	Reimbursement Methodology	528

Part XXIII. All Inclusive Care for the Elderly

Chapter 1.	General Provisions	529
§101.	Purpose and Scope	529
§103.	Organization Application and Evaluation	529
§105.	Administrative Requirements	529
Chapter 3.	Services	530
§301.	Medicare and Medicaid Coordination	530
§303.	Services Provided	530
§305.	Excluded Services	531
§307.	Conditions of Service	531
§309.	Emergency Services	531
Chapter 5.	Recipient Enrollment	532
§501.	Eligibility	532
§503.	Enrollment	533
§505.	Disenrollment	533
Chapter 7.	Quality Assessment and Performance Improvement	534
§701.	Organization Responsibilities	534
§703.	Quality Assessment and Performance Improvement Plan	534
§705.	Minimum Requirements	534

Table of Contents

§707.	Internal Activities	534
§709.	Additional Activities	535
§711.	Committees with Community Input	535
Chapter 9.	Sanctions	535
§901.	Violations	535
§903.	Imposition of Sanctions by CMS	536
Chapter 11.	Appeals.....	536
§1101.	Participant Rights, Grievances, and Appeals	536
Chapter 13.	Reimbursement	536
§1301.	Payment	536

Part XXV. Adult Dentures

Chapter 1.	General Provisions	539
§101.	Prior Authorization	539
Chapter 3.	Provider Participation and Recipient Criteria	539
§301.	Participation Requirement	539
§303.	Recipient Qualifications	539
Chapter 5.	Covered Services.....	539
§501.	Adult Denture Services.....	539
§503.	Denture Replacement and Denture Reline	539
Chapter 7.	Reimbursement	540
§701.	Fees.....	540

Part XXVII. Medical Transportation Program

Chapter 3.	Emergency Medical Transportation.....	541
Subchapter A.	Reserved.....	541
Subchapter B.	Ground Transportation	541
§325.	Reimbursement.....	541
§327.	Supplemental Payments for Ambulance Providers	542
§331.	Enhanced Reimbursements for Qualifying Emergency Ground Ambulance Service Providers.....	543
Subchapter C.	Aircraft Transportation.....	544
§351.	Standards for Participation	544
§353.	Reimbursement.....	544
§355.	Supplemental Payments for Ambulance Providers	545
Chapter 5.	Non-Emergency Medical Transportation.....	546
Subchapter A.	General Provisions	546
§501.	Introduction	546
§503.	Prior Approval and Scheduling	546
§505.	Requirements for Coverage	546
Subchapter B.	Beneficiary Participation.....	547
§511.	General Provisions.....	547
Subchapter C.	Provider Responsibilities	547
§517.	Provider Enrollment	547
Subchapter D.	Reimbursement	547
§523.	General Provisions.....	547
Subchapter E.	Non-Emergency Medical Transportation American Rescue Plan Act	548
§531.	Non-Emergency Medical Transportation Bonus Payments	548
Chapter 7.	Non-Emergency Ambulance Transportation	548
§701.	Introduction	548

Table of Contents

§703.	Provider Responsibilities.....	548
§705.	Prior Approval and Scheduling	549
§707.	Reimbursement.....	549

Part XXIX. Pharmacy

Chapter 1.	General Provisions	551
§105.	Medicaid Pharmacy Benefits Management System Point of Sale—Prospective Drug Utilization Program	551
§107.	Prior Authorization.....	552
§109.	Medicare Part B.....	552
§111.	Copayment.....	552
§113.	Prescription Limit.....	553
§115.	Drug Coverage Limits	553
§117.	Time Limits	554
§119.	Maximum Quantity	554
§123.	Medication Administration.....	555
Chapter 3.	Lock-In Program	555
§301.	Introduction	555
§303.	Recipient Placement in the Lock-In Mechanism.....	555
§307.	Notification Directives	555
§309.	Restrictions	556
§311.	Appeals	556
§313.	Changing Lock-In Providers	556
§315.	Recipient Profile Review.....	556
Chapter 5.	Narcotics and Controlled Substances.....	557
§501.	Schedule II Narcotic Analgesic Prescriptions	557
Chapter 9.	Methods of Payment	557
Subchapter A.	General Provisions	557
§901.	Definitions	557
§903.	Claims Documentation	557
Subchapter B.	Professional Dispensing Fee	557
§915.	General Provisions.....	557
Subchapter C.	Estimated Acquisition Cost.....	558
§935.	Estimated Acquisition Cost Formula.....	558
Subchapter D.	Maximum Allowable Costs.....	558
§945.	Reimbursement Methodology	558
§947.	Payments to Dispensing Physician.....	558
§949.	Fee for Service Cost Limits	558
Subchapter E.	340B Program	560
§961.	Definitions	560
§963.	Reimbursement.....	560
Subchapter F.	Antihemophilia Drugs	560
§971.	Reimbursement.....	560
Subchapter G.	Reserved.....	560
Subchapter H.	Vaccines	560
§991.	Vaccine Administration Fees	560
§993.	Vaccine Reimbursement.....	561
Chapter 11.	Value-based Agreement Programs.....	561
§1101.	General Provisions.....	561

Part XXXI. Refugee Medical Assistance

Chapter 1.	Refugee Medical Assistance Program	563
§101.	General Provisions.....	563
§103.	Eligibility Requirements.....	563
§105.	Covered Services	563
§107.	Certification Period	563

Part XXXIII. Behavioral Health Services

Subpart 1. Healthy Louisiana and Coordinated System of Care Waiver

Chapter 1.	Managed Care Organizations and the Coordinated System of Care Contractor.....	565
§101.	General Provisions.....	565
§103.	Recipient Participation	565
§105.	Enrollment Process	566
§107.	Enrollee Rights and Responsibilities.....	566
Chapter 3.	Managed Care Organizations and the Coordinated System of Care Contractor Participation	567
§301.	Participation Requirements and Responsibilities	567
§303.	Benefits and Services	567
§305.	Service Delivery	568
Chapter 5.	Reimbursement	568
§501.	General Provisions.....	568
§503.	Directed Payments.....	568
Chapter 7.	Grievance and Appeals Process	569
§701.	General Provisions.....	569
§703.	Provider Grievance and Appeal Process	570
Chapter 9.	Monitoring Activities	570
§901.	General Provisions.....	570

Subpart 2. General Provisions

Chapter 17.	Behavioral Health Services Reimbursements	570
§1701.	Physician Payment Methodology	570

Subpart 3. Children's Mental Health Services

Chapter 21.	General Provisions	570
§2101.	Introduction	570
§2103.	Recipient Qualifications	571
Chapter 23.	Services	571
§2301.	General Provisions.....	571
§2303.	Covered Services	571
Chapter 25.	Provider Participation.....	572
§2501.	Provider Responsibilities.....	572
Chapter 27.	Reimbursement	572
§2701.	General Provisions.....	572
§2703.	Reimbursement Methodology	572

Subpart 5. School-Based Behavioral Health Services

Chapter 41.	General Provisions	572
§4101.	Introduction	572
§4103.	Recipient Qualifications	572
Chapter 43.	Services	573
§4301.	General Provisions.....	573
§4303.	Covered Services	573
§4305.	Service Limitations and Exclusions	573
Chapter 45.	Provider Participation.....	573
§4501.	Local Education Agency Responsibilities.....	573
Chapter 47.	Payments	574
§4701.	Reimbursement Methodology	574

Subpart 7. Adult Mental Health Services

Chapter 61.	General Provisions	575
§6101.	Introduction	575
§6103.	Recipient Qualifications	575
Chapter 63.	Services	576
§6301.	General Provisions.....	576
§6303.	Assessments.....	576
§6305.	Treatment Plan.....	576
§6307.	Covered Services	577
Chapter 65.	Provider Participation.....	577
§6501.	Provider Responsibilities.....	577
Chapter 67.	Reimbursement	577
§6701.	Reimbursement Methodology	577

Subpart 8. Services for Targeted Populations

Chapter 71.	General Provisions	577
§7101.	Introduction	577
§7103.	Recipient Qualifications	578
Chapter 73.	Services	578
§7301.	General Provisions.....	578
§7303.	Covered Services	578
Chapter 75.	Provider Participation.....	579
§7501.	Provider Responsibilities.....	579
Chapter 77.	Reimbursement	579
§7701.	Reimbursement Methodology	579

Subpart 9. Home and Community-Based Services Waiver

Chapter 81.	General Provisions	579
§8101.	Introduction	579
§8103.	Recipient Qualifications	579
Chapter 83.	Services	580
§8301.	General Provisions.....	580
§8303.	Service Plan Development	580
§8305.	Covered Services	581

Table of Contents

Chapter 85. Provider Participation.....	581
§8501. Provider Responsibilities.....	581
Chapter 87. Reimbursement	582
§8701. Reimbursement Methodology	582

Subpart 11. Psychiatric Residential Treatment Facility Services

Chapter 101. General Provisions	582
§10101. Introduction	582
§10103. Recipient Qualifications	582
Chapter 103. Services	582
§10301. General Provisions.....	582
§10303. Covered Services	582
Chapter 105. Provider Participation.....	583
§10501. Provider Responsibilities.....	583
Chapter 107. Reimbursement	583
§10701. General Provisions.....	583
§10703. Reimbursement Methodology (Reserved).....	584
§10705. In-State Psychiatric Residential Treatment Facilities.....	584
§10707. Out-of-State Psychiatric Residential Treatment Facilities	584

Subpart 13. Therapeutic Group Homes

Chapter 121. General Provisions	584
§12101. Introduction	584
§12103. Recipient Qualifications	585
Chapter 123. Services	585
§12301. General Provisions.....	585
§12303. Covered Services	585
Chapter 125. Provider Participation.....	586
§12501. Provider Responsibilities.....	586
Chapter 127. Reimbursement	586
§12701. General Provisions.....	586
§12703. Reimbursement Methodology (Reserved).....	587
§12705. In-State Therapeutic Group Homes.....	587
§12707. Out-of-State Therapeutic Group Homes	587

Subpart 15. Substance Use Disorders Services

Chapter 141. General Provisions	587
§14101. Introduction	587
§14103. Recipient Qualifications	587
Chapter 143. Services	587
§14301. General Provisions.....	587
§14303. Covered Services	588
Chapter 145. Provider Participation.....	588
§14501. Provider Responsibilities.....	588
Chapter 147. Reimbursement	588
§14701. General Provisions.....	588
§14703. Reimbursement Methodology	589

**Subpart 16. Coverage for Treatment for Opioid Use Disorder in 7
Opioid Treatment Programs**

Chapter 151. General Provisions	589
§15101. Introduction	589
§15103. Recipient Qualifications	589
Chapter 153. Services	589
§15301. General Provisions.....	589
§15303. Covered Services	589
Chapter 155. Provider Participation.....	589
§15501. Provider Responsibilities.....	589
Chapter 157. Reimbursement	590
§15701. Reimbursement Methodology	590

Subpart 17. Supplemental Payments

Chapter 161. General Provisions	590
§16101. Qualifying Criteria.....	590
§16103. Payment Methodology.....	590

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part I. Administration

Subpart 1. General Provisions

Chapter 1. Administrative Procedures

§103. Employee Criminal History Records Checks

A. Pursuant to Act 147 of the 2017 Regular Session of the Louisiana Legislature, the Department of Health (the “department”) shall perform criminal history records checks of current and prospective employees, contractors or subcontractors, within the Medicaid eligibility section, that have access to federal tax information (FTI) and/or criminal history record information.

1. In compliance with the requirements of R.S. 15.587.5, current or prospective employees, contractors or subcontractors within the Medicaid eligibility section shall be required to submit to a criminal history records check to be conducted by the Louisiana Bureau of Criminal Identification and Information.

a. Fingerprints and other identifying information shall be submitted to the Louisiana Bureau of Criminal Identification and Information by the current or prospective employee, contractor or subcontractor.

2. The department shall also request local criminal history records checks for current or prospective employees, contractors or subcontractors within the Medicaid eligibility section with access to FTI and/or criminal history record information.

a. The local criminal history records checks request shall be sent to any jurisdiction where the current or prospective employee, contractor or subcontractor has lived, worked or attended school within the last five years.

3. Fingerprinting and national, state and local criminal history records checks shall be used by the department to determine the suitability of current or prospective employees, contractors or subcontractors within the Medicaid eligibility section to access federal tax information and records.

a. Prospective employees shall be subject to fingerprinting and national, state and local criminal history records checks only after a conditional offer of employment has been made.

b. Current employees, contractors and subcontractors shall be subject to fingerprinting and national, state and local criminal history records checks at a minimum of every 10 years.

4. The costs of providing the criminal history records check for current employees, contractors or subcontractor within the Medicaid eligibility section shall be charged to

the department by the Louisiana Bureau of Criminal Identification and Information for furnishing information contained in its criminal history and identification files, including any additional costs of providing the national and local criminal history records checks, which pertains to the current or prospective employee, contractor or subcontractor.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 254.3 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 44:2006 (November 2018).

§105. Tribal Consultation Process

A. Pursuant to §1902(a)(73) and §2107(e)(I) of the Social Security Act, the Medicaid Program hereby establishes a process to seek advice on a regular, ongoing basis from designees of the state’s federally-recognized Indian tribal organizations and Indian health programs about Medicaid and Children’s Health Insurance Program matters that may have a direct impact on Indian health programs and tribal organizations.

B. The department shall comply with the technical requirements for providing verification of the tribal consultation process to the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) when changes to the Medicaid Program are submitted through:

1. state plan amendments;
2. waivers, including:
 - a. newly proposed submissions;
 - b. amendments;
 - c. extensions;
 - d. renewals; and
 - e. waiver terminations.

C. In accordance with the approved Medicaid State Plan governing the tribal consultation process, the Medicaid Program will periodically provide a summary, which includes the changes being made by the Medicaid Program, to the federally-recognized Louisiana tribal organizations to initiate the tribal consultation process.

1. Tribal organizations will have 30 days to respond with any comments, unless the date for submission of the changes to CMS becomes critical and needs to be expedited. Expedited submissions will have a 7-day comment period. This notification and comment period applies to all State Plan and waiver submissions.

2. If comments are received, they will be forwarded to the state Medicaid director, or his/her designee, for further consideration. If no comments are received within the 30- or 7-day time frame, the Medicaid Program will make the assumption the tribes agree with the provisions in the proposed state plan and waiver documents and proceed accordingly.

D. The tribal comment period must expire prior to the submission of state plan and waiver documents to CMS.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 42:892 (June 2016).

Chapter 3. Experimental Procedures

§303. Coverage

A. Louisiana Medicaid does not cover any Federal Drug Administration (FDA) designated experimental or investigational medical procedures or devices until those procedures or devices have received final FDA approval or when a procedure or device is specifically approved for coverage by the Medicaid director.

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 22:844 (September 1996), amended LR 30:1698 (August 2004).

§305. Routine Care for Beneficiaries in Clinical Trials

A. The Medicaid program shall cover routine patient costs for items and services furnished in connection with participation in a qualifying clinical trial in accordance with section 1905(gg) of the Social Security Act.

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 46:796 (June 2020), amended LR 48:2293 (September 2022).

Chapter 5. Telemedicine/Telehealth

§501. Introduction

A. Telemedicine/telehealth is the use of an interactive audio and video telecommunications system to permit real time communication between a distant site health care practitioner and the beneficiary. There is no restriction on the originating site (i.e., where the beneficiary is located) and it can include, but is not limited to, a healthcare facility, school, or the beneficiary's home.

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 31:2032 (August 2005), amended by the Department of Health, Bureau of Health Services Financing, LR 46:796 (June 2020), LR 48:1825 (July 2022).

§503. Claim Submissions

A. Medicaid covered services provided via telemedicine/telehealth shall be identified on claim submissions by appending the appropriate place of service or modifier to the appropriate procedure code, in line with current policy.

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 31:2032 (August 2005), amended by the Department of Health, Bureau of Health Services Financing, LR 45:436 (March 2019), LR 48:1825 (July 2022).

§505. Emergency Provisions

A. In the event that the federal or state government declares an emergency or disaster, the Medicaid Program may temporarily cover services provided through the use of an interactive audio telecommunications system, without the requirement of video, if such action is deemed necessary to ensure sufficient services are available to meet beneficiaries' needs.

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 48:1825 (July 2022).

Chapter 7. Out-of-State Services

§701. Out-of-State Medical Care

A. Medical claims for out-of-state services are honored when:

1. medical services are needed because of a medical emergency;
2. medical services are needed and the beneficiary's health would be in danger if the beneficiary were required to travel to the beneficiary's state of residence;
3. the state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state; or
4. it is general practice for beneficiaries in a particular locality to use medical resources in another state.

B. Prior authorization is required for out-of-state non-emergency care.

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, LR 5:24 (February 1979), amended LR 6:491 (August 1980), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 2:847 (May 2006), amended by the Department of Health, Bureau of Health Services Financing, LR 46:1393 (October 2020).

Chapter 9. Advance Directives

Subchapter A. General Provisions

§901. Definitions

Advance Directive—a written statement of instruction in a form recognized under state law relating to the provision of medical care in the event of incapacity, including the living will and the durable power of attorney for health care.

Durable Power of Attorney for Health Care—a document made in accordance with *Louisiana Civil Code*, Act 2985 et seq., designating a person to act on the executing person's behalf in making medical treatment decisions.

Health Care Provider—any health maintenance organization, home health agency, hospice, hospital, or nursing facility.

Information Concerning Advance Directive—pamphlets on advance directive in Louisiana and preprinted advance directive forms.

Living Will—a written declaration made in accordance with R.S. 40:1299.58.3, in which a person provides instruction regarding the kinds of life-saving or life-sustaining care and treatment that the person does or does not wish to receive in the event of incapacitation or terminal illness, including the suspension of nutrition and hydration.

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 20:791 (July 1994), LR 32:847 (May 2006).

§903. Departmental Information Dissemination

A. The department shall supply all health care providers with information concerning advance directives.

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 20:791 (July 1994), LR 32:847 (May 2006).

Subchapter B. Provider Responsibilities

§915. Provider Information Dissemination

A. A health care provider shall distribute information concerning advance directives to each person at the time of admission into a facility or upon initiation of services, as follows.

1. A hospital and a nursing facility shall provide the written information at the time the patient/resident is admitted.

2. A hospice program shall provide the written information at the time care commences.

3. A home health agency shall provide the written information before the commencement of home care services.

4. A health maintenance organization or health insuring organization shall provide the written information at the time of enrollment.

B. A health care provider shall have a written policy concerning advance directives which shall be available for inspection.

C. If a health care provider declines to comply with an advance directive or parts thereof, this information shall be included in the written information disseminated by the health care provider under Subsections A and B above. In addition, the health care provider must assist a person whose advance directive would not be honored by that provider to locate another provider who will honor the advance directive. Such assistance may consist of transferring the person to another facility or referring the person to a new provider within the facility who will honor the advance directive.

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 20:791 (July 1994), LR 32:847 (May 2006).

§917. Policies and Procedures

A. Each health care provider shall establish and maintain written policies and procedures regarding advance directives. A health care provider shall maintain these policies and procedures for review by the department during a survey. These policies and procedures must include:

1. a written provision relating to individual rights, under federal and state law/regulation to make decisions concerning medical treatment;

2. the right of a patient to formulate advance directives as defined by the federal and state laws/regulations;

3. provisions providing adequate written notice of individual adult patients (at the time of admission, commencement, or enrollment) concerning patient rights;

4. a copy of existing advance directives in the patient's medical records;

5. documentation of information dissemination as required in §915;

6. documentation in the individual's medical record as to whether the individual has executed an advance directive;

7. a plan for participation in community and staff educational campaigns regarding advance directive by newsletters, articles in local newspapers, local news reports, or commercials; and

8. an assurance of compliance with state law with regard to:

- a. informing relevant personnel and networks of health care providers and services;
- b. providing information about advance directives;
- c. ascertaining existence of advance directives;
- d. making reasonable efforts to obtain copies by written request; and
- e. transferring copies of advance directives brought in by individuals seeking provider services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 20:791 (July 1994), LR 32:847 (May 2006).

§919. Mentally Incapacitated

A. If a person is mentally incapacitated at the time of admission to or initiation of service by a health care provider, the health care provider shall disseminate information regarding advance directives to the family or legal representative of the person. When the person's incapacity has been alleviated, the health care provider shall provide the information to the person.

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 20:791 (July 1994), LR 848 (May 2006).

§921. Previously Executed Advance Directives

A. Except as provided by R.S. 40:1299.58.7(B) and (D), when the health care provider is presented with a copy of a patient's advance directive, the health care provider shall comply with the advance directive.

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 20:791 (July 1994), LR 32:848 (May 2006).

Subchapter C. Penalties

§941. Noncompliance

A. The department may access provider records to verify documentation of date and time of execution of advance directives. Any inquiry shall be directed to the appropriate staff member. Determination of a violation shall result in a notice of noncompliance.

B. Failure to correct a violation listed in a notice of noncompliance may result in sanctions against the provider imposed by the department and may include exclusion from the Medicare and Medicaid programs.

C. Registration of any complaint shall be processed according to the department's complaint procedure.

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 20:791 (July 1994), LR 32:848 (May 2006).

Chapter 11. Medical Necessity

§1101. Definition and Criteria

A. Medically necessary services are defined as those health care services that are in accordance with generally accepted evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care.

B. In order to be considered medically necessary, services must be:

1. deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and

2. those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the recipient.

C. Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time.

D. Although a service may be deemed medically necessary, it doesn't mean the service will be covered under the Medicaid Program. Services that are experimental, non-FDA approved, investigational or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

1. The Medicaid director, in consultation with the Medicaid medical director, may consider authorizing services at his discretion on a case-by-case basis.

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 36:2563 (November 2010), repromulgated LR 37:441 (January 2011).

Chapter 13. Prohibition of Provider Steering

§1301. General Provisions

A. Definitions

Health Plan—any managed care organization (MCO), prepaid inpatient *health plan* (PIHP), prepaid ambulatory *health plan* (PAHP), or primary care case management (PCCM) entity contracted with the Medicaid Program.

Provider—any Medicaid service *provider* contracted with a health plan and/or enrolled in the Medicaid Program.

Provider Steering—unsolicited advice or mass-marketing directed at Medicaid recipients by health plans, including any of the entity’s employees, affiliated providers, agents, or contractors, that is intended to influence or can reasonably be concluded to influence the Medicaid recipient to enroll in, not enroll in, or disenroll from a particular health plan(s).

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 40:2589 (December 2014).

§1303. Provider Sanctions

A. First Offense. If the department determines that a provider has participated in provider steering, the department will notify the provider in writing and, at its sole discretion, may impose any of the following sanctions as applicable.

1. If a provider has steered a Medicaid recipient to enroll in a particular managed care health plan, payments to the provider for services rendered to the Medicaid recipient for the time period the recipient’s care was coordinated by the health plan may be recouped.

2. If a provider has steered a Medicaid recipient to participate in Medicaid fee-for-service, payments to the provider for services rendered to the recipient for the time period the recipient’s care was paid for through Medicaid fee-for-service may be recouped.

3. A provider may be assessed a monetary sanction of up to \$1,000 for each recipient steered to join a particular managed care health plan or to participate in Medicaid fee-for-service. The maximum total penalty per incident shall not exceed \$10,000.

4. A provider may be required to submit a letter to the particular Medicaid recipient notifying him/her of the imposed sanction and his/her right to freely choose another participating managed care health plan or, if eligible, participate in Medicaid fee-for-service.

B. Second Offense

1. If a provider continues to participate in provider steering after having been cited once for provider steering, and receiving one of the above sanctions, that provider may then be subject to disenrollment from the Medicaid program.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:2589 (December 2014).

§1305. Provider Appeal Rights

A. Informal Hearing

1. A provider who has received a notice of sanction shall be provided with an informal hearing if the provider makes a written request for an informal hearing within 15 days of the mailing of the notice of sanction. The request for an informal hearing must be made in writing and sent in

accordance with the instructions contained in the notice of sanction. The time and place for the informal hearing will be provided in the notice scheduling the informal hearing.

2. Following the informal hearing, the department shall inform the provider, by written notice, of the results of the informal hearing. The provider has the right to request an administrative appeal within 30 days of the date on the notice of the informal hearing results that is mailed to the provider.

B. Administrative Appeals

1. The provider may seek an administrative appeal of the department’s decision to impose sanctions.

2. If the provider timely requests an informal hearing, the 30 days for filing an appeal with the DAL will commence on the date the notice of the informal hearing results are mailed or delivered to the provider.

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 40:2589 (December 2014).

§1307. Health Plan Sanctions

A. If the department determines the Health Plan or its subcontractors has participated in provider steering, the department, at its sole discretion, may impose the following sanctions.

1. The member(s) may be dis-enrolled from the health plan at the earliest effective date allowed.

2. Up to 100 percent of the monthly capitation payment or care management fee for the month(s) the member(s) was enrolled in the health plan may be recouped.

3. The health plan may be assessed a monetary penalty of up to \$5,000 per member.

4. The health plan may be required to submit a letter to each member notifying he member of their imposed sanction and of their right to choose another health plan.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:2589 (December 2014).

Chapter 15. Provider Screening and Enrollment

§1501. General Provisions

A. Pursuant to the provisions of the Patient Protection and Affordable Care Act (PPACA), Public Law 111-148, 42 C.F.R. § Part 455, Subpart E, and the 21st Century Cures Act, the Medicaid Program adopts the following provider enrollment and screening requirements. The Centers for Medicare and Medicaid Services (CMS) has established guidelines for provider categorization based on an assessment of potential for fraud, waste, and abuse for each provider type. The Medicaid Program shall determine the

risk level for providers and will adopt these federal requirements in addition to any existing requirements. Providers must comply with all applicable federal regulations and state requirements for their provider type prior to enrollment with the Medicaid Program. Additional enrollment requirements may be adopted in the future.

B. In accordance with PPACA and federal regulations, the Medicaid Program shall screen all initial applications, including applications for a new practice location, and any applications received in response to a re-enrollment or revalidation, utilizing the following guidelines. If a provider could fit within more than one risk level described in this section, the highest level of screening is applicable.

1. Provider types shall be categorized by the following risk levels:

a. high categorical risk—categories of service that pose a significant risk of fraud, waste, and abuse to the Medicaid Program;

b. moderate categorical risk—categories of service that pose a moderate risk of fraud, waste, and abuse to the Medicaid Program;

c. limited categorical risk—categories of service that pose a minor risk of fraud, waste, and abuse to the Medicaid Program.

C. Screening activities for the varying risk levels shall include the following mandates.

1. High risk level screening activities shall include:

a. fingerprinting submission by the provider and any person with a 5 percent or more direct or indirect ownership interest in the provider, within 30 days upon request from CMS or the Department of Health (LDH);

b. criminal background checks for all disclosed individuals;

c. site visits before and after enrollment by LDH and/or CMS, its agents, or designated contractors; and

d. verification of provider-specific requirements including, but not limited to:

i. license verification;

ii. national plan and provider enumeration system (NPPES) national provider identifier (NPI) registry check;

iii. Office of Inspector General (OIG) exclusion check;

iv. disclosure of ownership/controlling interest information;

v. the Social Security Administration's death master file (SSA DMF) check;

vi. Medicaid and Children's Health Insurance Program (CHIP) state information sharing system (MCSIS) check;

vii. systems for award management (SAM) check;

viii. LA adverse actions check; and

ix. provider enrollment, chain, and ownership system (PECOS) check.

2. Moderate risk level screening activities shall include:

a. site visits before and after enrollment by LDH and/or CMS, its agents, or designated contractors; and

b. verification of provider-specific requirements including, but not limited to:

i. license verification;

ii. NPPES NPI check;

iii. OIG exclusion check;

iv. disclosure of ownership/controlling interest information;

v. SSA DMF check;

vi. MCSIS check;

vii. SAM check;

viii. LA adverse actions check; and

ix. PECOS check.

3. Limited risk level screening activities shall include, but are not limited to:

a. verification of provider-specific requirements including:

i. license verification;

ii. NPPES NPI check;

iii. OIG exclusion check;

iv. disclosure of ownership/controlling interest information verification;

v. SSA DMF check;

vi. MCSIS check;

vii. SAM check;

viii. LA adverse actions check; and

ix. PECOS check.

D. The Medicaid Program may rely on, but is not limited to, the results of provider screenings performed by:

1. Medicare contractors;

2. other Medicaid agencies; or

3. CHIP of other states.

E. Updated Medicaid enrollment forms may require additional information for all disclosed individuals.

F. Providers shall be required to revalidate their enrollments with the Medicaid Program at a minimum of five year intervals. A more frequent revalidation requirement, a minimum of three year intervals, shall apply

to durable medical equipment (DME) providers and pharmacy providers with DME or home medical equipment (HME) specialty enrollments. All providers shall be required to revalidate their enrollment under PPACA and Medicaid criteria.

G. Provider Screening Application Fee

1. In compliance with the requirements of the PPACA and 42 C.F.R. § 455.460, the department shall collect an application fee for provider screening prior to executing provider agreements from prospective or re-enrolling providers other than:

- a. individual physicians or non-physician practitioners; or
- b. providers who:
 - i. are enrolled in title XVIII of the Social Security Act;
 - ii. are enrolled in another state's title XIX or XXI plan; or
 - iii. have paid the applicable application fee to a Medicare contractor or another state.

2. The department shall return the portion of all fees collected which exceed the cost of the screening to CMS.

H. After deactivation of a provider enrollment number for any reason, before the provider's enrollment may be reactivated, the department must re-screen the provider and require payment of associated provider application fees.

I. Any enrolled provider is subject to CMS, its agents, its designated contractors, or the department conducting unannounced on-site inspections of any and all provider locations.

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 39:1051 (April 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 44:920 (May 2018), LR 50:978 (July 2024).

§1503. Temporary Moratoria

A. The department will deny or terminate a provider's enrollment in the Medical Assistance Program in accordance with 42 C.F.R. § 455.416.

B. The department may deny or terminate a provider's enrollment in the Medical Assistance Program for any of the grounds listed in R.S. 46:437.14.

C. The department may deny a provider's application for enrollment in the Medical Assistance Program if, based on the grounds listed in R.S. 46:437.14, the secretary determines that the denial is in the best interest of the Medical Assistance Program and the department specifies the reasons for denial, as permitted by R.S. 46:437.13(C)(2).

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 39:1052 (April 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 50:979 (July 2024).

§1505. Managed Care Organization Payment Accountability and Provider Credentialing

A. A provider, or their agent, who seeks to appeal a notice of action issued by the department may first request an informal hearing with the department.

B. A provider, or their agent, who has received a notice of action shall be provided with an informal hearing if the provider, or their agent, makes a written request to the department for an informal hearing within 15 days of the date of the notice of action.

C. The notice of action is presumed to be received by the provider if the notice is mailed to the provider's mailing address listed with the Medicaid Program or if the notice is electronically mailed to the provider's e-mail address listed with the Medicaid Program.

D. The request for an informal hearing must be made in writing and sent in accordance with the instructions in the notice of action.

E. The time and place for the informal hearing will be set out in the notice of setting of the informal hearing.

F. The informal hearing is designed to provide the opportunity:

1. for the provider or agent of the provider to informally review the situation and action proposed by the department;

2. for the department to offer alternatives based on information presented by the provider or agent of the provider, if any; and

3. for the provider or agent of the provider or other person to evaluate the necessity for seeking an administrative appeal. During the informal hearing, the provider or agent of the provider may be afforded the opportunity to talk with the department's personnel involved in the situation, to review pertinent documents on which the alleged violations are based, to ask questions, to seek clarification, to provide additional information and be represented by counsel or other person. Upon agreement of all parties, an informal discussion may be recorded or transcribed.

G. At any time prior to the issuance of the written results of the informal hearing, the notice of action may be modified by the department.

1. If a finding or reason is removed from the notice of action by the department, no additional time will be granted to the provider, or their agent, to prepare for the informal hearing.

2. If additional reasons or actions are added to the notice of action prior to, during, or after the informal hearing, the provider, or their agent, shall be granted an additional 10 working days to prepare responses to the new

reasons or actions proposed by the department, unless the 10-day period is waived by the provider, or their agent.

H. Notice of the Results of the Informal Hearing. Following the informal hearing, the department shall inform the provider, or their agent, in writing of the results of the informal hearing, which could range from modifying or upholding the termination, denial, or other actions contained in the notice. The notice of the results of the informal hearing must be signed by the director of the Bureau of Health Services Financing (BHSF) or their designee and the section chief of Medicaid Program Operations and Compliance or their designee

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 45:273 (February 2019), amended LR 50:980 (July 2024).

§1507. Administrative Appeal

A. The provider, or their agent, has the right to request an administrative appeal within 30 days of the date of the notice of action or within 30 days of the date of the notice of the results of the informal hearing.

B. The appeal request must be adequate as to form and timely lodged with the Division of Administrative Law.

C. The notice of action and the notice of the results of the informal hearing are presumed to be received by the provider if the notice is mailed to the provider's mailing address listed with the Medicaid Program or if the notice is electronically mailed to the provider's e-mail address listed with the Medicaid Program.

D. The department shall not terminate an existing Medicaid provider agreement unless the provider, or their agent, has exhausted their appeal rights, the timeframe for an appeal has expired, or the termination is permitted due to the imposition of sanction(s) by the department and the director of Program Integrity pursuant to LAC 50:I.4101 et seq.

E. The provider's termination or denial in the Medicaid Program will become final if the provider, or their agent, does not timely request an appeal in accordance with the appeal deadlines described in this Subpart or once the provider's appeal rights are otherwise exhausted.

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 50:980 (July 2024).

§1509. Basis of Administrative Appeal

A. A provider, or their agent, may only appeal to the Division of Administrative Law a notice of action or a notice of the results of the informal hearing issued by the department that terminates or denies the provider's enrollment in Medicaid. Other actions by the department related to Medicaid provider enrollment and screening are not appealable.

1. If the provider, or their agent, timely requests an administrative appeal, then the provider, or their agent, has the right to challenge the basis for the termination or denial imposed by the department related to the provider's Medicaid enrollment, provider enrollment application, and/or the revalidation application.

2. The provider, or their agent, must specifically state the basis for the appeal and the actions challenged on appeal.

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 50:980 (July 2024).

§1511. Out-of-State Medicaid Provider Enrollment

A. An out-of-state provider is a provider located in a state other than Louisiana whose services are rendered in that state, excluding Louisiana Medicaid trade areas.

B. An out-of-state provider who wishes to participate in the Louisiana Medicaid Program must enroll with the Louisiana Medicaid Program and be assigned an identification number.

C. To enroll, the provider must submit a provider enrollment application to Louisiana Medicaid.

D. A retroactive provider enrollment date of no more than 365 days may be considered for approval by the department under the following circumstances:

1. A provider requests that the enrollment be retroactive to a specific date.

2. The provider submits proof of service rendered to a Louisiana Medicaid beneficiary within 365 days prior to the application received date, via submission of the claim.

3. All risk screening activities support that the provider was eligible as of the requested date of enrollment.

E. Out-of-state providers must accept Louisiana Medicaid reimbursement as payment in full for the covered services authorized. The department reserves the right to set rates for services.

F. Out-of-state providers who furnish services to Medicaid beneficiaries are not required to be enrolled if they meet the following criteria as detailed in the CMS Medicaid Provider Enrollment Compendium:

1. the item or service is furnished by an institutional provider, individual practitioner, or pharmacy at an out-of-state practice location;

2. the furnishing provider's NPI is on the claim;

3. the furnishing provider is enrolled and in an approved status in Medicare or in another state's Medicaid plan;

4. the claim represents services furnished; and

5. the claim represents either:

- a. a single instance of care furnished over a 180-day period; or
- b. multiple instances of care furnished to a single beneficiary over a 180-day period.

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 50:981 (July 2024).

§1513. Out-of-Network Providers

A. Out-of-network providers under single case agreements are not considered network providers and therefore are not subject to the requirements at 42 C.F.R. § 438.602(b). Out-of-network providers do not have to be screened and/or enrolled in the department's fee-for-service program. Additionally, emergency room physicians are only subject to 42 C.F.R. § 438.602(b) to the extent they meet the definition of a network provider in 42 C.F.R. § 438.2.

B. The department may adopt limits or thresholds that require out-of-network providers to convert to an in-network status upon reaching a specific threshold of services provided to a network beneficiary or beneficiaries. A provider's conversion to an in-network status triggers the requirement for the provider to be screened and enrolled pursuant to 42 C.F.R. § 438.602(b)(1).

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 50:981 (July 2024).

§1515. Temporary Moratoria

A. The department will comply with 42 C.F.R. § 455.470, which pertains to the imposition of temporary moratoria on the enrollment of new providers or provider types as implemented by the secretary of the U.S. Department of Health and Human Services (HSS).

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 50:981 (July 2024).

§1517. Managed Care Organization Payment Accountability and Provider Credentialing

A. All managed care organizations (MCOs) participating in the Medical Assistance Program must comply with all requirements described in R.S. 46:460.72 and R.S. 46:460.73, which pertain to provider notices and payment accountability.

B. A provider who receives a notification of deficiency from a Medicaid MCO as described in R.S. 46:460.73(A)(1) may seek review of the matter to the department if the conditions of R.S. 46:460.73(A)(2) apply. The provider must notify the department of their intent to appeal the notification within 10 calendar days of the date of the MCO's notification and provide a detailed request for

departmental review with supporting documents within 15 calendar days of the date of the MCO's notification.

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 50:981 (July 2024).

§1519. Definitions

A. As used in this Subpart the following terms shall have the following meanings:

1. *Agent*—a person who is employed by or has a contractual relationship with a provider or who acts on behalf of the provider.

2. *Beneficiary*—an individual who is enrolled to receive health care through the Medical Assistance Program.

3. *Claim*—any request or demand, including any and all documents or information required by federal or state law or by rule made against Medical Assistance Program funds for payment. A claim may be based on costs or projected costs and includes any entry or omission in a cost report or similar document, book of account, or any other document which supports, or attempts to support, the claim. Each claim may be treated as a separate claim, or several claims may be combined to form one claim.

4. *Department*—the Louisiana Department of Health (LDH).

5. *Disclosed Individuals*—persons required to be disclosed to the department, as the Medicaid agency, by the provider, such as, but not limited to:

a. *Agents or Managing Employees*—Pursuant to 42 C.F.R. § 455.106(a), a provider must disclose to the Medicaid agency the identity of each person who is an agent or managing employee of the provider and has been convicted of certain crimes. An agent or managing employee is any individual who exercises operational or managerial control, conducts day-to-day operations of the provider agency, or any person with authority to obligate or act on behalf of the disclosing entity, such as, but not limited to, a general manager, business manager, administrator, board member, chief operating officer, trustee, or partner.

b. *Persons with Ownership or Control Interest*—Pursuant to 42 C.F.R. §455.104(b), a provider must disclose the identity of all persons that have an ownership or control interest (either separately or in combination) of 5 percent or more in the provider.

6. *Division of Administrative Law*—the Louisiana Division of Administrative Law, which operates as Louisiana's centralized administrative hearings panel for disputes between government agencies and regulated individuals and entities.

7. *Federal Regulations*—the provisions contained in the Code of Federal Regulations (C.F.R.) or the Federal Register (FR).

8. *General Terms*—Definitions contained in applicable federal laws and regulations shall also apply to this Subpart and all department regulations. In the case of a conflict between federal definitions and departmental definitions, the department's definition shall apply unless the federal definition, as a matter of law, supersedes a departmental definition. Definitions contained in applicable state laws shall also apply to this and all departmental definitions. In the case of a conflict between a state statutory definition and a departmental definition, the departmental definition shall apply unless the state statutory definition, as a matter of state law, supersedes the departmental definition.

9. *Informal Hearing*—an informal conference between the provider, or other persons and the section chief of Medicaid Program Operations and Compliance or his/her designee and the Medicaid director or his/her designee.

10. *Medical Assistance Program or Medicaid*—the Medical Assistance Program (Title XIX) of the Social Security Act administered by the Department of Health, commonly referred to as Medicaid, the Medicaid Program, or Bureau of Health Services Financing (BHSF).

11. *Notice of Action*—a written notification of an action taken or to be taken by the department or BHSF, including a notice of termination of enrollment in the Medicaid Program or a notice of denial of enrollment in the Medicaid Program.

12. *Person*—any natural person, company, corporation, partnership, firm, association, group, or other legal entity or as provided by law.

13. *Provider*—a health care provider as defined in R.S. 46:437.3(A)(9).

14. *Provider Agreement*—the document(s), including electronic documents, signed by or on behalf of the provider in accordance with R.S. 46:437.11-437.14, which enrolls the provider in the Medical Assistance Program and grants to the provider a provider number and the privilege to participate in the Medical Assistance Program. This definition shall not be construed to conflict with the definition of provider agreement included in R.S. 437.3(A)(21).

15. *Provider Enrollment*—the process through which a person or provider becomes enrolled in the Medical Assistance Program through the department for the purpose of providing goods, services, or supplies to one or more Medicaid beneficiaries.

16. *Provider Number*—a provider's billing or claim reimbursement number issued by the department through BHSF under the Medical Assistance Program.

17. *Rule or Regulation*—any rule or regulation promulgated by the department in accordance with the Administrative Procedure Act and any federal rule or regulation promulgated by the federal government in accordance with federal law.

18. *Secretary*—the Secretary of the Department of Health.

19. *Termination*—the termination or revocation of the provider agreement with the department to participate in the Medical Assistance Program. In a termination action, the state Medicaid agency has taken an action to revoke the provider's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired. The requirement for termination applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include, but is not limited to:

- a. fraud;
- b. integrity; or
- c. quality.

20. *Trade Areas*—Arkansas, Mississippi, and Texas counties directly touching Louisiana parish borders. Trade areas are treated with the same criteria as in-state providers.

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 50:981 (July 2024).

Subpart 3. Managed Care for Physical and Behavioral Health

Chapter 21. Dental Benefits Prepaid Ambulatory Health Plan

§2101. General Provisions

A. Effective May 1, 2014, the Department of Health, Bureau of Health Services Financing shall adopt provisions to establish a comprehensive system of delivery for dental services covered under the Medicaid Program. The dental benefits plan shall be administered under the authority of a 1915(b) waiver by implementing a prepaid ambulatory health plan (PAHP) which shall be responsible for the necessary operational and administrative functions to ensure adequate service coordination and delivery.

B. All Medicaid beneficiaries will receive dental services administered by a dental benefit plan manager (DBPM).

1. The number of DBPMs shall be no more than required to meet the Medicaid enrollee capacity requirements and ensure choice for Medicaid beneficiaries.

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 40:784 (April 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 46:1227 (September 2020), LR 49:682 (April 2023).

§2103. Participation Requirements

A. In order to participate in the Medicaid Program, a DBPM must be a successful bidder, be awarded a contract with the department, and complete the readiness review.

B. A DBPM must:

1. meet the federal definition of a PAHP as defined in 42 CFR §438.2;

2. have a license or certificate of authority issued by the Louisiana Department of Insurance to operate as a Medicaid risk bearing “prepaid entity” pursuant to R.S. 22:1016 and submit with the proposal response;

3. have a certificate from the Louisiana Secretary of State, to conduct business in the state;

4. meet solvency standards as specified in federal regulations and title 22 of the *Louisiana Revised Statutes*;

5. have a network capacity to enroll a minimum of 1,288,625 Medicaid members into the network;

6. be without an actual or perceived conflict of interest that would interfere or give the appearance of impropriety or of interfering with the contractual duties and obligations under this contract or any other contract with LDH, and any and all applicable LDH written policies. Conflict of interest shall include, but is not limited to, the contractor serving, as the Medicaid fiscal intermediary contractor for LDH;

7. be awarded a contract with LDH, and successfully completed the readiness review prior to the start date of operations; and

8. have the ability to provide core dental benefits and services to all assigned members on the day the Dental Benefits Program is implemented.

C. A DBPM shall ensure the provision of core dental benefits and services to all eligible enrollees when the Dental Benefit Program is implemented.

D. Upon request by the Centers for Medicare and Medicaid Services, the Office of Inspector General, the Government Accounting Office, the department or its designee, a DBPM shall make all of its records pertaining to its contract (services provided thereunder and payment for services) with the department available for review, evaluation and audit. The records shall include, but are not limited to the following:

1. pertinent books and documents;
2. financial records;
3. dental records and documents; and
4. provider records and documents involving financial transactions related to the contract.

E. A DBPM shall maintain an automated management information system that collects, analyzes, integrates, and reports data that complies with department and federal reporting requirements.

F. A DBPM shall obtain insurance coverage(s) as specified in the terms of the contract. Subcontractors, if any, shall be covered under these policies or have insurance comparable to the DBPM’s required coverage.

G. A DBPM shall provide all financial reporting as specified in the terms of the contract.

H. In the event of noncompliance with the contract and the department’s guidelines, a DBPM shall be subject to the sanctions specified in the terms of the contract including, but not limited to:

1. corrective action plans;
2. monetary penalties; or
3. suspension and/or termination of the DBPM’s contract.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:784 (April 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 46:1228 (September 2020), LR 49:1066 (June 2023).

§2105. Prepaid Ambulatory Health Plan Responsibilities

A. The DBPM shall be responsible for the administration and management of its requirements and responsibilities under the contract with the department and any and all department issued guidance. This includes all subcontracts, employees, agents and anyone acting for or on behalf of the DBPM.

1. No subcontract or delegation of responsibility shall terminate the legal obligation of the DBPM to the department to ensure that all requirements are carried out.

2. A DBPM shall possess the expertise and resources to ensure the delivery of dental benefits and services to members and to assist in the coordination of covered dental services, as specified in the terms of the contract.

3. A DBPM shall have written policies and procedures governing its operation as specified in the contract and department issued guidance.

4. A DBPM shall not discriminate against enrollees on the basis of race, gender, color, national origin, age, health status or need for dental services, and shall not use any policy or practice that has the effect of discriminating on any such basis.

5. The DBPM shall abide by all enrollment and disenrollment policy and procedures as outlined in the contract developed by the department.

B. The department will contract with an enrollment broker who will be responsible for the enrollment and disenrollment process for DBPM participants. The enrollment broker shall be:

1. the primary contact for beneficiaries regarding the DBPM enrollment and disenrollment process, and shall assist the beneficiary to enroll in a DBPM;

2. the only authorized entity, other than the department, to assist a beneficiary in the selection of a DBPM; and

3. responsible for notifying all DBPM members of their enrollment and disenrollment rights and responsibilities within the timeframe specified in the contract.

C. Enrollment Period. The annual enrollment of a DBPM member shall be for a period of up to 12 months from the date of enrollment, contingent upon his/her continued Medicaid eligibility. A member shall remain enrolled in the DBPM until:

1. LDH or its enrollment broker approves the member's written, electronic or oral request to disenroll or transfer to another DBPM for cause; or
2. the annual open enrollment period or after the lock-in period; or
3. the member becomes ineligible for Medicaid and/or the DBPM program.

D. Automatic Assignment Process

1. LDH shall establish an auto-assignment process for potential enrollees who do not request enrollment in a specified DBPM, or who cannot be enrolled into the requested DBPM for reasons including, but not limited to, the DBPM having reached its enrollment capacity limit or as a result of LDH-initiated sanctions.

2. DBPM automatic assignments shall take into consideration factors including, but not limited to:

- a. assigning members of family units to the same DBPM. If multiple DBPM linkages exist within the household, the enrollee shall be enrolled to the DBPM of the youngest household enrollee;
- b. existing provider-enrollee relationships; or
- c. previous DBPM-enrollee relationship.

3. Auto-assignments on any basis other than household enrollment in DBPM will not be made to a DBPM whose enrollee share is at or above 60 percent of the total statewide membership.

E. Voluntary Selection of DBPM for New Enrollees

1. Potential enrollees shall be given an opportunity to choose a DBPM at the time of application. Once the potential enrollee is determined eligible, their choice of DBPM shall be transmitted to the enrollment broker.

2. During the 90 days following the date of the enrollee's initial enrollment into a DBPM, the enrollee shall be allowed to request disenrollment without cause by submitting an oral or written request to the enrollment broker.

3. All eligible enrollees shall be provided an annual open enrollment period at least once every 12 months thereafter.

4. All enrollees shall be given the opportunity to choose a DBPM at the start of a new DBPM contract either through the regularly scheduled open enrollment period or special enrollment period.

F. Annual Open Enrollment

1. The department will provide an opportunity for all DBPM members to retain or select a new DBPM during an annual open enrollment period. The enrollment broker will mail a re-enrollment offer prior to each annual enrollment period to the DBPM member. Each DBPM member shall receive information and the offer of assistance with making informed choices about the participating DBPMs and the availability of choice counseling.

2. The enrollment broker shall provide the individual with information on each DBPM from which they may select.

3. During the open enrollment period, each Medicaid enrollee shall be given 60 calendar days to either remain in their existing DBPM or select a new DBPM.

G. Selection or Automatic Assignment of a Primary Dental Provider for Mandatory Populations for All Covered Services

1. The DBPM is responsible to develop a primary dental provider (PDP) automatic assignment methodology in accordance with the department's requirements for the assignment of a PDP to an enrollee who:

- a. does not make a PDP selection within 30 calendar days of enrollment to the DBPM;
- c. selects a PDP within the DBPM that has reached their maximum physician/patient ratio; or
- d. selects a PDP within the DBPM that has restrictions/limitations (e.g., pediatric only practice).

2. Assignment shall be made to a PDP with whom the enrollee has a provider-beneficiary relationship. If there is no provider-beneficiary relationship, the enrollee may be auto-assigned to a provider who is the assigned PDP for a household family member enrolled in the DBPM. If other household family members do not have an assigned PDP, auto-assignment shall be made to a provider with whom a family member has a provider-beneficiary relationship.

3. If there is no enrollee or household family provider-beneficiary relationship, enrollees shall be auto-assigned to a PDP, based on criteria such as age, geographic proximity, and spoken languages.

4. An enrollee shall be allowed to request at any time, verbally or in writing, to change his or her PDP and the DBPM must agree to grant the request.

H. Disenrollment and Change of Dental Benefit Plan Manager

1. An enrollee may request disenrollment from the DBPM as follows:

- a. for cause, at any time. The following circumstances are cause for disenrollment:
 - i. the DBPM does not, because of moral or religious objections, cover the service the enrollee seeks;

ii. the enrollee needs related services to be performed at the same time; not all related services are available within the DBPM and the enrollee's PDP or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk;

iii. the contract between the DBPM and LDH is terminated;

iv. poor quality of care rendered by the DBPM as determined by LDH;

v. lack of access to DBPM covered services as determined by LDH; or

vi. any other reason deemed to be valid by LDH and/or its agent; or

b. without cause for the following reasons:

i. During the ninety 90 days following the date of the beneficiary's initial enrollment into the DBPM or during the 90 days following the date the enrollment broker sends the beneficiary notice of that enrollment, whichever is later;

ii. upon automatic re-enrollment under 42 CFR §438.56(g), if a temporary loss of Medicaid eligibility has caused the beneficiary to miss the annual open enrollment opportunity;

iii. when LDH imposes the intermediate sanction provisions specified in 42 CFR §438.702(a)(3); or

iv. after LDH notifies the DBPM that it intends to terminate the contract as provided by 42 CFR §438.722.

I. Involuntary Disenrollment

1. The DBPM may request involuntary disenrollment of an enrollee if the enrollee's utilization of services constitutes fraud, waste, and/or abuse such as misusing or loaning the enrollee's ID card to another person to obtain services. In such case the DBPM shall report the event to LDH and the Medicaid Fraud Control Unit (MFCU).

2. The DBPM shall submit disenrollment requests to the enrollment broker, in a format and manner to be determined by LDH.

3. The DBPM shall ensure that involuntary disenrollment documents are maintained in an identifiable enrollee record.

4. The DBPM shall not request disenrollment because of an adverse change in physical or mental health status or because of the enrollee's health diagnosis, utilization of medical services, diminished mental capacity, preexisting medical condition, refusal of medical care or diagnostic testing, attempt to exercise his/her rights under the DBPM's grievance system, or attempt to exercise his/her right to change, for cause, the primary care provider that he/she has chosen or been assigned. Further, in accordance with 42 CFR §438.56, the DBPM shall not request disenrollment because of an enrollee's uncooperative or disruptive behavior resulting from his or her special needs, except when his or her continued enrollment seriously impairs the DBPM's

ability to furnish services to either this particular enrollee or other enrollees.

5. The DBPM shall not request disenrollment for reasons other than those stated in the contract with LDH. In accordance with 42 CFR §438.56(b)(3), LDH shall ensure that the DBPM is not requesting disenrollment for other reasons by reviewing and rendering decisions on all disenrollment request forms submitted to the enrollment broker.

6. All disenrollment requests shall be reviewed on a case-by-case basis and the final decision is at the sole discretion of LDH or its designee. All decisions are final and not subject to the dispute resolution process by the DBPM.

7. When the DBPM's request for involuntary disenrollment is approved by LDH, the DBPM shall notify the enrollee in writing of the requested disenrollment. The notice shall include:

a. the reason for the disenrollment;

b. the effective date;

c. an instruction that the enrollee choose a new DBPM; and

d. a statement that if the enrollee disagrees with the decision to disenroll, the enrollee has a right to submit a request for a state fair hearing.

8. Until the enrollee is disenrolled by the enrollment broker, the DBPM shall continue to be responsible for the provision of all DBPM covered services to the enrollee.

J. A DBPM shall be required to provide service authorization, referrals, coordination, and/or assistance in scheduling the covered dental services as specified in the terms of the contract.

K. The DBPM shall establish and implement a quality assessment and performance improvement program as specified in the terms of the contract and department issued guidance.

L. A DBPM shall develop and maintain a utilization management program including policies and procedures with defined structures and processes as specified in the terms of the contract and department issued guides.

M. The DBPM must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse. The DBPM shall comply with all state and federal laws and regulations relating to fraud, abuse, and waste in the Medicaid programs as well all requirements set forth in the contract and department issued guidance.

N. A DBPM shall collect data on enrollees and provider characteristics and on services furnished to members through an encounter data system as specified in the contract and all department issued guidance.

O. A DBPM shall be responsible for conducting routine provider monitoring to ensure:

PUBLIC HEALTH—MEDICAL ASSISTANCE

1. continued access to dental care for eligible Medicaid beneficiaries; and

2. compliance with departmental and contract requirements.

P. A DBPM shall not engage the services of a provider who is in non-payment status with the department or is excluded from participation in federal health care programs (i.e., Medicare, Medicaid, CHIP, etc.).

Q. Dental records shall be maintained in accordance with the terms and conditions of the contract. These records shall be safeguarded in such a manner as to protect confidentiality and avoid inappropriate disclosure according to federal and state law.

R. The DBPM shall provide both member and provider services in accordance with the terms of the contract and department issued guides.

1. The DBPM shall submit provider manuals and provider directory to the department for approval prior to distribution, annually and subsequent to any revisions.

a. The DBPM must provide a minimum of 60 days' notice to the department of any proposed material changes to the member handbooks and/or provider manuals.

b. After approval has been received from the department, the DBPM must provide a minimum of 30 days' notice to the members and/or providers of any proposed material changes to the required member education materials and/or provider manuals.

S. Member education materials shall include, but not be limited to:

1. a welcome packet including, but not limited to:

a. a welcome letter highlighting major program features and contact information for the DBPM; and

b. a provider directory when specifically requested by the member (also must be available in searchable format on-line);

2. member rights and protections as specified in 42 CFR §438.100 and the DBPM's contract with the department including, but not limited to:

a. a member's right to change providers within the DBPM;

b. any restrictions on the member's freedom of choice among DBPM providers; and

c. a member's right to refuse to undergo any dental service, diagnoses, or treatment or to accept any service provided by the DBPM if the member objects (or in the case of a child, if the parent or guardian objects) on religious grounds;

3. member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the DBPM or the department including, but not limited to reporting to the department's Medicaid Customer Service Unit if the member has or obtains another health

insurance policy, including employer sponsored insurance; and

4. the amount, duration, and scope of benefits available under the DBPM's contract with the department in sufficient detail to ensure that members understand the benefits to which they are entitled, including, but not limited to:

a. information about oral health education and promotion programs;

b. the procedures for obtaining benefits, including prior authorization requirements and benefit limits;

c. how members may obtain benefits, including emergency services, from out-of-network providers;

d. the policy on referrals for specialty care; and

e. the extent to which, and how, after-hour services are provided;

5. information to call the Medicaid Customer Service Unit toll-free telephone number or visit a local Medicaid eligibility office to report changes in parish of residence, mailing address or family size changes;

6. a description of the DBPM's member services and the toll-free telephone number, fax telephone number, e-mail address and mailing address to contact DBPM's member services department;

7. instructions on how to request multi-lingual interpretation and translation services when needed at no cost to the member. This information shall be included in all versions of the handbook in English, Spanish and Vietnamese; and

8. grievance, appeal and state fair hearing procedures and time frames as described in 42 CFR §438.400 through §438.424 and in the DBPM's contract with the department.

T. The provider manual shall include but not be limited to:

1. description of the DBPM;

2. core dental benefits and services the DBPM must provide;

3. emergency dental service responsibilities;

4. policies and procedures that cover the provider complaint system. This information shall include, but not be limited to:

a. specific instructions regarding how to contact the DBPM to file a provider complaint; and

b. which individual(s) has the authority to review a provider complaint;

5. information about the DBPM's grievance system, that the provider may file a grievance or appeal on behalf of the member with the member's written consent, the time frames and requirements, the availability of assistance in filing, the toll-free telephone numbers and the member's

right to request continuation of services while utilizing the grievance system;

6. medical necessity standards as defined by LDH and practice guidelines;

7. practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions;

8. primary care dentist responsibilities;

9. other provider responsibilities under the subcontract with the DBPM;

10. prior authorization and referral procedures;

11. dental records standards;

12. claims submission protocols and standards, including instructions and all information necessary for a clean and complete claim and samples of clean and complete claims;

13. DBPM prompt pay requirements;

14. notice that provider complaints regarding claims payment shall be sent to the DBPM;

15. quality performance requirements; and

16. provider rights and responsibilities.

U. The provider directory for members shall be developed in two formats:

1. a hard copy directory for members and, upon request, potential members; and

2. a web-based online directory for members and the public.

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 40:784 (April 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 46:1228 (September 2020), LR 49:682 (April 2023).

§2107. Network Access Standards and Guidelines

A. The DBPM must maintain and monitor a provider network that is supported by written agreements and is sufficient to provide adequate access to enrollees as required by federal law and the terms as set forth in the contract. The DBPM shall adhere to the federal regulations governing access standards, as well as the specific requirements of the contract and all department-issued guides.

B. The DBPM shall cover all necessary services to treat an emergency dental condition.

1. *Emergency Dental Condition*—a dental or oral condition that requires immediate services for relief of symptoms and stabilization of the condition. Such conditions include:

- a. severe pain;
- b. hemorrhage;

- c. acute infection;
- d. traumatic injury to the teeth and surrounding tissue; or
- e. unusual swelling of the face or gums.

2. Emergency dental services are those services necessary for the treatment of any condition requiring immediate attention for the relief of pain, hemorrhage, acute infection, or traumatic injury to the teeth, supporting structures (periodontal membrane, gingival, alveolar bone), jaws, and tissue of the oral cavity.

C. The DBPM must maintain a provider network and in-area referral providers in sufficient numbers, as determined by the department, to ensure that all of the required core dental benefits and services are available and accessible in a timely manner in accordance with the terms and conditions in the contract and department issued guide.

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 40:786 (April 2014).

§2109. Benefits and Services

A. Core benefits and services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to enrollees under the Louisiana Medicaid state plan.

1. *Core benefits and services* shall be defined as those oral health care services and benefits required to be provided to Medicaid eligible individuals as specified under the terms of the contract and department-issued guides.

B. The following is a summary listing of the core dental benefits and services that a DBPM is required to provide:

- 1. diagnostic services which include oral examinations, radiographs and oral/facial images, diagnostic casts and accession of tissue—gross and microscopic examinations;
- 2. preventive services which include:
 - a. prophylaxis;
 - b. topical fluoride treatments;
 - c. sealants;
 - d. fixed space maintainers; and
 - e. re-cementation of space maintainers;
- 3. restorative services which include:
 - a. amalgam restorations;
 - b. composite restorations;
 - c. stainless steel and polycarbonate crowns;
 - d. stainless steel crowns with resin window;
 - e. pins, core build-ups, pre-fabricated posts and cores;

PUBLIC HEALTH—MEDICAL ASSISTANCE

- f. resin-based composite restorations;
 - g. appliance removal;
 - h. unspecified restorative procedures; and
 - i. ancillary medical services;
4. endodontic services which include:
- a. pulp capping;
 - b. pulpotomy;
 - c. endodontic therapy on primary and permanent teeth (including treatment plan, clinical procedures, and follow-up care);
 - d. apexification/recalcification;
 - e. apicoectomy/periradicular services;
 - f. unspecified endodontic procedures; and
 - g. organ transplant-related services;
5. periodontal services which include:
- a. gingivectomy;
 - b. periodontal scaling and root planning;
 - c. full mouth debridement; and
 - d. unspecified periodontal procedures;
6. removable prosthodontics services which include:
- a. complete dentures;
 - b. partial dentures;
 - c. denture repairs;
 - d. denture relines; and
 - e. unspecified prosthodontics procedures;
7. maxillofacial prosthetics services which include fluoride gel carrier;
8. fixed prosthodontics services which include:
- a. fixed partial denture pontic;
 - b. fixed partial denture retainer; and
 - c. other unspecified fixed partial denture services;
9. oral and maxillofacial surgery services which include:
- a. non-surgical extractions;
 - b. surgical extractions;
 - c. coronal remnants extractions;
 - d. other surgical procedures;
 - e. alveoloplasty;
 - f. surgical incision;
 - g. temporomandibular joint (TMJ) procedure;
 - h. other unspecified repair procedures;

- i. durable medical equipment and certain supplies;
10. orthodontic services which include:
- a. interceptive and comprehensive orthodontic treatments;
 - b. minor treatment to control harmful habits; and
 - c. other orthodontic services; and
11. adjunctive general services which include:
- a. palliative (emergency) treatment;
 - b. anesthesia;
 - c. professional visits;
 - d. miscellaneous services; and
 - e. unspecified adjunctive procedures.

NOTE: This overview is not all inclusive. The contract, policy transmittals, approved Medicaid State Plan, regulations, provider bulletins, provider manuals, published fee schedules, and guides issued by the department are the final authority regarding services.

C. The core benefits and services provided to the members shall include, but are not limited to, those services specified in the contract policy transmittals, approved Medicaid state plan, regulations, provider bulletins, provider manuals, and fee schedules, issued by the department are the final authority regarding services.

D. Excluded Services. The DBPM is not obligated to provide for services that are experimental, non-FDA approved, investigational, or cosmetic and are specifically excluded from Medicaid coverage and will be deemed “not medically necessary.” The Medicaid director, in consultation with the Medicaid dental director, may consider authorizing services at his/her discretion on a case-by-case basis.

E. Utilization Management

1. The DBPM shall develop and maintain policies and procedures with defined structures and processes for a utilization management (UM) program that incorporates utilization review and service authorization, which include, at minimum, procedures to evaluate medical necessity and the process used to review and approve the provision of dental services. The DBPM shall submit an electronic copy of the UM policies and procedures to LDH for written approval within thirty calendar days from the date the contract is signed by the DBPM, but no later than prior to the readiness review, annually thereafter, and prior to any revisions.

2. The UM Program policies and procedures shall meet all Utilization Review Accreditation Commission (URAC) standards or equivalent and include medical management criteria and practice guidelines that:

- a. are adopted in consultation with a contracting dental care professionals;
- b. are objective and based on valid and reliable clinical evidence or a consensus of dental care professionals in the particular field;

- c. are considering the needs of the members; and
- d. are reviewed annually and updated periodically as appropriate.

3. The policies and procedures shall include, but not be limited to:

- a. the methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of dental care services;
- b. the data sources and clinical review criteria used in decision making;
- c. the appropriateness of clinical review shall be fully documented;
- d. the process for conducting informal reconsiderations for adverse determinations;
- e. mechanisms to ensure consistent application of review criteria and compatible decisions;
- f. data collection processes and analytical methods used in assessing utilization of dental care services; and
- g. provisions for assuring confidentiality of clinical and proprietary information.

4. The DBPM shall disseminate the practice guidelines to all affected providers and, upon request, to members. The DBPM shall take steps to encourage adoption of the guidelines.

5. The DBPM must identify the source of the dental management criteria used for the review of service authorization requests, including but not limited to:

- a. the vendor must be identified if the criteria were purchased;
- b. the association or society must be identified if the criteria are developed/recommended or endorsed by a national or state dental care provider association or society;
- c. the guideline source must be identified if the criteria are based on national best practice guidelines; and
- d. the individuals who will make medical necessity determinations must be identified if the criteria are based on the dental/medical training, qualifications, and experience of the DBPM dental director or other qualified and trained professionals.

6. UM Program dental management criteria and practice guidelines shall be disseminated to all affected providers and members upon request. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines.

7. The DBPM shall have written procedures listing the information required from a member or dental care provider in order to make medical necessity determinations. Such procedures shall be given verbally to the covered person or healthcare provider when requested. The procedures shall outline the process to be followed in the event the DBPM

determines the need for additional information not initially requested.

8. The DBPM shall have written procedures to address the failure or inability of a provider or member to provide all the necessary information for review. In cases where the provider or member will not release necessary information, the DBPM may deny authorization of the requested service(s).

9. The DBPM shall have sufficient staff with clinical expertise and training to apply service authorization medical management criteria and practice guidelines.

10. The DBPM shall use the department's definition of medical necessity for medical necessity determinations. The DBPM shall make medical necessity determinations that are consistent with the department's definition.

11. The DBPM shall submit written policies and processes for LDH approval, within thirty calendar days, but no later than prior to the readiness review, of the contract signed by the DBPM, on how the core dental benefits and services the DBPM provides ensure:

- a. the prevention, diagnosis, and treatment of health impairments;
- b. the ability to achieve age-appropriate growth and development; and
- c. the ability to attain, maintain, or regain functional capacity.

12. The DBPM must identify the qualification of staff who will determine medical necessity. Determinations of medical necessity must be made by qualified and trained practitioners in accordance with state and federal regulations.

13. The DBPM shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease shall determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested.

14. The individual(s) making these determinations shall have no history of disciplinary action or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional or moral character.

15. The individual making these determinations is required to attest that no adverse determination will be made regarding any dental procedure or service outside of the scope of such individual's expertise.

16. The DBPM shall provide a mechanism to reduce inappropriate and duplicative use of healthcare services. Services shall be sufficient in an amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished and that are no less than the amount, duration or scope for the same services furnished to eligibles under the Medicaid State Plan. The DBPM shall not

arbitrarily deny or reduce the amount, duration or scope of required services solely because of diagnosis, type of illness or condition of the member. The DBPM may place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization control (with the exception of EPSDT services), provided the services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR 438.210.

17. The DBPM shall ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member.

18. The DBPM shall report fraud and abuse information identified through the UM program to LDH's Program Integrity Unit.

19. In accordance with 42 CFR §456.111 and 456.211, the DBPM utilization review plan must provide that each enrollee's record includes information needed for the UR committee to perform UR required under this Section. This information must include, at least, the following:

- a. identification of the enrollee;
- b. the name of the enrollee's dentist;
- c. date of admission and dates of application for, and authorization of, Medicaid benefits if application is made after admission;
- d. the plan of care required under 42 CFR 456.80 and 456.180;
- e. initial and subsequent continued stay review dates described under 42 CFR 456.128, 456.133; 456.233 and 456.234;
- f. date of operating room reservation, if applicable; and
- g. justification of emergency admission, if applicable.

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 40:786 (April 2014), amended by the Department of Health, Bureau of Health Services Financing, LR46:1231 (September 2020).

§2111. Payment Methodology

A. Payments to the Dental Benefit Plan. The department, or its fiscal intermediary, shall make monthly capitation payments to the dental benefit plan based on a per member, per month (PMPM) rate.

1. The department reserves the right to re-negotiate the PMPM rates:

- a. if the rate floor is removed;
- b. as a result of federal or state budget reductions or increases;

c. due to the inclusion or removal of a Medicaid covered dental service(s) not incorporated into the monthly capitation rates; or

d. in order to comply with federal requirements.

2. The rates may also be adjusted based on legislative appropriations and budgetary constraints. Any adjusted rates must continue to be actuarially sound as determined by the department's actuarial contractor and will require an amendment to the contract that is mutually agreed upon by both parties.

3. The department or its fiscal intermediary, may reimburse a DBPM's monthly capitation payments in the aggregate on a lump sum basis when administratively necessary.

B. The DBPM must agree to accept the PMPM rate as payment-in-full from the department and agree not to seek additional payment from a member for any unpaid cost.

C. A DBPM shall assume 100 percent liability for any expenditure above the prepaid premium.

D. A DBPM shall meet all financial reporting requirements specified in the terms of the contract.

E. Any cost sharing imposed on Medicaid members must be in accordance with the federal regulations governing cost sharing and cannot exceed the amounts reflected in the Medicaid state plan, but the amounts can be less than the cost sharing levels in the state plan.

F. The DBPM shall not assign its rights to receive the PMPM payment, or its obligation to pay, to any other entity.

G. In the event that an incorrect payment is made to the DBPM, all parties agree that reconciliation will occur. If an error or overcharge is discovered by the department, it will be handled in accordance with the terms and conditions of the DBPM's contract.

H. Network Provider Reimbursement

1. The DBPM shall provide reimbursement for defined core dental benefits and services provided by an in-network provider pursuant to the terms of its contract with the department.

2. The network provider may enter into alternative reimbursement arrangements with the DBPM if the network provider initiates the request and it is approved in advance by the department.

I. Emergency or Out-of-Network Provider Reimbursement. The DBPM shall make prompt payment for covered emergency dental services that are furnished by providers that have no arrangements with the DBPM for the provision of such services. Reimbursement by the DBPM to out-of-network providers for the provision of emergency dental services shall be no more than what would be paid under Medicaid FFS.

J. A DBPM shall have a medical loss ratio (MLR) for each MLR reporting year, which shall align with the capitation rating period, except in circumstances in which

the MLR reporting period must be revised to align to a CMS-approved capitation rating period.

1. Following the end of the MLR reporting year, a DBPM shall provide an annual MLR report, in accordance with the financial reporting guide issued by the department.

2. The annual MLR report shall be limited to the DBPM's MLR for services provided to Medicaid enrollees and payment received under the contract with the department, separate from any other products the DBPM may offer in the state of Louisiana.

3. An MLR shall be reported in the aggregate, including all services provided under the contract, unless the department requires separate reporting and a separate MLR calculation for specific populations.

a. The MLR shall not be less than 85 percent using definitions for health care services, quality initiatives and administrative cost as specified in 42 CFR 438.8. If the MLR is less than 85 percent, the DBPM will be subject to refund the difference, within the timeframe specified, to the department. The portion of any refund due the department that has not been paid, within the timeframe specified, will be subject to interest at the current Federal Reserve Board lending rate or in the amount of 10 percent per annum, whichever is higher.

4. The department shall provide for an audit of the DBPM's annual MLR report and make public the results within 60 calendar days of finalization of the audit.

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 40:788 (April 2014), amended LR 46:953 (July 2020), LR 47:369 (March 2021), LR 49:1725 (October 2023).

§2113. Prompt Payment of Claims

A. Network Providers. All subcontracts executed by the DBPM shall comply with the terms in the contract. Requirements shall include at a minimum:

1. the name and address of the official payee to whom payment shall be made;

2. the full disclosure of the method and amount of compensation or other consideration to be received from the DBPM; and

3. the standards for the receipt and processing of claims as specified by the department in the DBPM's contract with the department and department-issued guides.

B. Network and Out-of-Network Providers

1. The DBPM shall make payments to its network providers, and out-of-network providers, subject to conditions outlined in the contract and department-issued guides.

a. The DBPM shall pay 90 percent of all clean claims, as defined by the department, received from each provider type within 15 business days of the date of receipt.

b. The DBPM shall pay 99 percent of all clean claims within 30 calendar days of the date of receipt.

2. The provider must submit all claims for payment no later than 12 months from the date of service.

3. The DBPM and all providers shall retain any and all supporting financial information and documents that are adequate to ensure that payment is made in accordance with applicable federal and state laws.

a. Any such documents shall be retained for a period of at least six years or until the final resolution of all litigation, claims, financial management reviews, or audits pertaining to the contract.

4. There shall not be any restrictions on the right of the state and federal government to conduct inspections and/or audits as deemed necessary to assure quality, appropriateness or timeliness of services and reasonableness of costs.

C. Claims Management

1. The DBPM shall process a provider's claims for covered services provided to members in compliance with all applicable state and federal laws, rules, and regulations as well as all applicable DBPM policies and procedures including, but not limited to:

a. claims format requirements;

b. claims processing methodology requirements;

c. explanation of benefits and related function requirements;

d. processing of payment errors;

e. notification to providers requirements; and

f. timely filing.

D. Provider Claims Dispute

1. The DBPM shall:

a. have an internal claims dispute procedure that is in compliance with the contract and must be approved by the department;

b. contract with independent reviewers to review disputed claims;

c. systematically capture the status and resolution of all claim disputes as well as all associate documentation; and

d. report the status of all disputes and their resolution to the department on a monthly basis as specified in the contract.

E. Claims Payment Accuracy Report

1. The DBPM shall submit an audited claims payment accuracy percentage report to the department on a monthly basis as specified in the contract and department-issued DBPM guides.

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 40:789 (April 2014).

§2115. Grievance and Appeals Processes

A. The DBPM shall adhere to the provisions governing the grievance and appeals processes for coordinated care network prepaid models outlined in LAC 50:I.Chapter 37, Subparts B and C.

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 40:790 (April 2014).

§2117. Independent Review Process for Dental Provider Claims

A. Right of Dentist Providers to Independent Review of Claims

1. Pursuant to Act 284 of the 2018 Regular Session of the Louisiana Legislature, for adverse determinations related to dental claims filed on or after November 20, 2018, a dentist/dental provider shall have a right to an independent review of the adverse action of the DBPM.

2. For purposes of these provisions, adverse determinations shall refer to dental claims submitted by healthcare providers for payment for dental services rendered to Medicaid enrollees and denied by the DBPM, in whole or in part, or more than 60 days have elapsed since the claim was submitted and the dentist has received no remittance advice or other written or electronic notice from the DBPM either partially or totally denying the claim.

B. Request for Reconsideration

1. Prior to submitting a request for independent review, a provider shall submit a written request for reconsideration to the DBPM, as provided for by the DBPM and in accordance with this Section. The request shall identify the claim(s) in dispute, the reasons for the dispute, and any documentation supporting the provider's position or request by the DBPM.

2. The DBPM shall acknowledge in writing its receipt of a reconsideration request submitted in accordance with §2117.B.1, within five calendar days after receipt, and render a final decision by providing a response to the provider within 45 calendar days from the date of receipt of the request for reconsideration, unless another time frame is agreed upon in writing by the dentist/dental provider and the DBPM.

3. If the DBPM reverses the adverse determination pursuant to a request for reconsideration, payment of the claim(s) in dispute shall be made no later than 20 days from the date of the DBPM's decision.

C. Independent Review of Dental Claims Requirements

1. If the DBPM upholds the adverse determination, or does not respond to the reconsideration request within the time frames allowed, the provider may file a written notice

with the department requesting the adverse determination be submitted to an independent reviewer. The department must receive the written request from the provider for an independent review within 60 days from the date the provider receives the DBPM's notice of the decision of the reconsideration request, or if the DBPM does not respond to the reconsideration request within the time frames allowed, within 10 days of the last date of the time period allowed for the DBPM to respond.

2. The dentist/dental provider shall include a copy of the written request for reconsideration with the request for an independent review. The appropriate address to be used by the provider for submission of the request shall be Medicaid Dental Benefits Independent Review, P.O. Box 91283, Bin 32, Baton Rouge, LA 70821-9283.

3. Upon receipt of a notice of request for independent review and supporting information and documentation, the department shall refer the adverse determination to the dental claims review panel.

4. Subject to approval by the independent reviewer, a dentist/dental provider may aggregate multiple adverse determinations involving the same DBPM when the specific reason for nonpayment of the claims aggregated involve a dispute regarding a common substantive question of fact or law.

5. Within 14 calendar days of receipt of the request for independent review, the independent reviewer shall request to be provided all information and documentation submitted for reconsideration regarding the disputed claim or claims within 30 calendar days.

6. If the independent reviewer determines that guidance on an administrative issue from the department is required to make a decision, the reviewer shall refer this specific issue to the department for review and concise response to the request within 30 calendar days after receipt.

7. The independent reviewer shall examine all materials submitted and render a decision on the dispute within 60 calendar days. The independent reviewer may request in writing an extension of time from the dental claims review panel to resolve the dispute. If an extension of time is granted by the panel, the independent reviewer shall provide notice of the extension to the dental provider and the DBPM.

8. If the independent reviewer renders a decision requiring the DBPM to pay any claims or portion of the claims, within 20 calendar days, the DBPM shall send the provider payment in full along with interest calculated back to the date the claim was originally denied or recouped.

D. Independent Review Costs

1. The DBPM shall pay the fee for an independent review to the Louisiana State University School of Dentistry. The dentist/dental provider shall, within 10 days of the date of the decision of the independent reviewer, reimburse the DBPM for the fee associated with conducting an independent review when the decision of the DBPM is

upheld. If the provider fails to submit payment for the independent review within 10 days from the date of the decision, the DBPM may withhold future payments to the provider in an amount equal to the cost of the independent review, and the department may prohibit that provider from future participation in the independent review process.

2. If the DBPM fails to pay the bill for the independent reviewer's services, the reviewer may request payment directly from the department from any funds held by the state that are payable to the DBPM.

3. The fee for an independent review of a dental claim shall be paid in an amount established in a memorandum of understanding between the department and the Louisiana State University School of Dentistry, not to exceed \$2,000 per review.

E. Dental Claims Review Panel

1. The dental claims review panel shall select and identify an appropriate number of independent reviewers to comprise a reviewer pool and continually review the number and outcome of requests for reconsideration and independent reviews on an aggregated basis.

2. The panel shall consist of the secretary or his/her duly designated representative, one representative from each DBPM, a number of dentist representatives equal to the number of representatives from DBPMs and the dean of the Louisiana State University School of Dentistry or his/her designee.

3. The reviewer pool selected by the dental claims review panel shall be comprised of dentists who are on the faculty of the Louisiana State University School of Dentistry and have agreed to applicable terms for compensation, confidentiality, and related provisions established by the department. The reviewer pool shall include:

a. For each of the following specialties, at least one dentist who has completed a residency approved by the Commission on Dental Accreditation in that specialty:

- i. periodontics;
- ii. endodontics;
- iii. prosthodontics; and
- iv. oral and maxillofacial surgery.

b. At least two dentists who have completed a residency approved by the Commission on Dental Accreditation in pediatric dentistry.

4. The reviewer pool shall not include any dentist who is currently performing compensated services for the DBPM, whether the compensation is paid directly or through a contract with the Louisiana State University School of Dentistry or other state entity, or has received any such compensation at any time in the prior 12 months.

5. The reviewer pool shall not include any dentist who has received reimbursement for dental services rendered to Medicaid patients in a private practice setting in the past 60 days.

a. Louisiana State University School of Dentistry clinics, including Louisiana State University School of Dentistry faculty practice, shall not be considered a private practice setting for the purposes of determining eligibility to participate in the reviewer pool.

6. No dentist shall be eligible to submit denied Medicaid claims for independent review while participating in the reviewer pool.

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 44:2004 (November 2018).

Chapter 31. General Provisions

§3101. Introduction

A. It is the department's goal to operate a managed health care delivery system that:

1. improves access to care and care coordination;
2. improves the quality of services;
3. promotes healthier outcomes for Medicaid recipients through the establishment of a medical home system of care;
4. provides budget stability; and
5. results in savings as compared to an unmanaged fee-for-service system.

B. Effective for dates of service on or after December 1, 2015, the department will operate a managed care delivery system for an expanded array of services to include comprehensive, integrated physical and behavioral health (basic and specialized) services, named the Bayou Health program, utilizing one model, a risk bearing managed care organization (MCO), hereafter referred to as an "MCO".

C. It is the department's intent to procure the provisions of healthcare services statewide to Medicaid enrollees participating in the Bayou Health program from risk bearing MCOs through the competitive bid process.

1. The number of MCOs shall be no more than required to meet the Medicaid enrollee capacity requirements and ensure choice for Medicaid recipients as required by federal statute.

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 37:1573 (June 2011), amended LR 41:928 (May 2015), LR 41:2362 (November 2015).

§3103. Recipient Participation

A. The following Medicaid recipients shall be mandatory participants in managed care:

1. mandatory enrollees:

a. children up to 19 years of age who are eligible under §1902 and §1931 of the Social Security Act (hereafter referred to as the Act) as poverty-level related groups and optional groups of older children;

b. parents and caretaker relatives who are eligible under §1902 and §1931 of the Act;

c. Children's Health Insurance Program (CHIP) (title XXI) children enrolled in Medicaid expansion program (LaCHIP Phase I, II, III);

d. CHIP (title XXI) prenatal care option (LaCHIP Phase IV) and children enrolled in the separate, stand-alone CHIP program (LaCHIP Phase V);

e. pregnant women whose basis for eligibility is pregnancy, who are only eligible for pregnancy-related services, and whose eligibility extends until 60 days after the pregnancy ends;

f. non-dually eligible aged, blind, and disabled adults over the age of 19;

g. uninsured women under the age of 65 who have been screened through the Centers for Disease Control National Breast and Cervical Cancer Early Detection Program and identified as being in need of treatment for breast and/or cervical cancer, including pre-cancerous conditions and early stage cancer, and are not otherwise eligible for Medicaid;

h. individuals eligible through the Tuberculosis Infected Individual Program;

i. former foster care children eligible under §1902(a)(10)(A)(i)(IX) and (XVII) of the Act;

j. individuals and families who have more income than is allowed for Medicaid eligibility, but who meet the standards for the Regular Medically Needy Program;

k. individuals from age 19 to 65 years old at or below 133 percent of the federal poverty level with a 5 percent income disregard as provided in 42 CFR 435.119, hereafter referred to as the new adult group; or

l. individuals eligible through the Act 421 Children's Medicaid Option (421-CMO) program.

B. Mandatory, Voluntary Opt-In Participants

1. Participation in a managed care organization (MCO) for the following participants is mandatory for specialized behavioral health, applied behavior analysis (ABA)-based therapy and non-emergency medical transportation (NEMT) services (ambulance and non-ambulance) only, and is voluntary for physical health services:

a. individuals who receive services under the authority of the following 1915(c) home and community-based services waivers; and

i. Adult Day Health Care (ADHC) waiver;

ii. Community Choices Waiver (CCW);

iii. New Opportunities Waiver (NOW);

iv. Children's Choice (CC) waiver;

v. Residential Options Waiver (ROW); and

vi. Supports Waiver (SW);

b. individuals under the age of 21 who are otherwise eligible for Medicaid, and who are listed on the DHH Office for Citizens with Developmental Disabilities' request for services registry and not enrolled in the 421-CMO. These children are identified as Chisholm class members:

i. For purposes of these provisions, *Chisholm* class members shall be defined as those children identified in the *Melanie Chisholm, et al vs. Kathy Kliebert* (or her successor) class action litigation.

C. Mandatory, voluntary opt-in populations may initially elect to receive physical health services through Bayou Health at any time.

D. Mandatory, voluntary opt-in populations who elected to receive physical health services through Bayou Health, but returned to legacy Medicaid for physical health services, may return to Bayou Health for physical health services only during the annual open enrollment period.

E. Mandatory MCO Populations—Specialized Behavioral Health Services and Non-Emergency Ambulance Services Only

1. The following populations are mandatory enrollees in Bayou Health for specialized behavioral health services and non-emergency ambulance services only:

a. individuals residing in nursing facilities; and

b. individuals under the age of 21 residing in intermediate care facilities for persons with intellectual disabilities (ICF/ID).

F. Mandatory MCO Populations—Specialized Behavioral Health and NEMT Services (Ambulance and Non-Ambulance) Only

1. Individuals who receive both Medicare and Medicaid (e.g. Medicaid dual eligibles) are mandatory enrollees in Bayou Health for specialized behavioral health and non-emergency medical transportation services only.

G. The enrollment broker will ensure that all participants are notified at the time of enrollment that they may request dis-enrollment from the MCO at any time for cause.

H. Participation Exclusion

1. The following Medicaid and/or CHIP recipients are excluded from participation in an MCO and cannot voluntarily enroll in an MCO. Individuals who:

a. reside in an ICF/ID (adults);

b. are partial dual eligibles;

c. receive services through the Program for All-Inclusive Care for the Elderly (PACE);

d. have a limited period of eligibility and participate in either the Spend-Down Medically Needy Program or the Emergency Services Only program;

e. receive services through the Take Charge Plus program; or

f. are enrolled in the Louisiana Health Insurance Premium Payment (LaHIPP) Program.

EXCEPTION: This exclusion does not apply to LaHIPP enrollees eligible to receive behavioral health services only through the managed care organizations.

I. The department reserves the right to institute a medical exemption process for certain medically high risk recipients that may warrant the direct care and supervision of a non-primary care specialist on a case by case basis.

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 37:1573 (June 2011), amended LR 40:310 (February 2014), LR 40:1096 (June 2014), LR 40:2258 (November 2014), LR 41:929 (May 2015), LR 41:2363 (November 2015), LR 42:754 (May 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1522 (September 2016), LR 43:663 (April 2017), LR 43:1553 (August 2017), LR 44:1253 (July 2018), LR 47:1871 (December 2021).

§3105. Enrollment Process

A. The MCO shall abide by all enrollment and disenrollment policy and procedures as outlined in the contract developed by the department.

B. The department will contract with an enrollment broker who will be responsible for the enrollment and disenrollment process for MCO participants. The enrollment broker shall be:

1. the primary contact for Medicaid recipients regarding the MCO enrollment and disenrollment process, and shall assist the recipient to enroll in an MCO;

2. the only authorized entity, other than the department, to assist a Medicaid recipient in the selection of an MCO; and

3. responsible for notifying all MCO members of their enrollment and disenrollment rights and responsibilities within the timeframe specified in the contract.

C. Enrollment Period. The annual enrollment of an MCO member shall be for a period of up to 12 months from the date of enrollment, contingent upon his/her continued Medicaid and MCO eligibility. A member shall remain enrolled in the MCO until:

1. DHH or its enrollment broker approves the member's written, electronic or oral request to disenroll or transfer to another MCO for cause; or

2. the annual open enrollment period or after the lock-in period; or

3. the member becomes ineligible for Medicaid and/or the MCO program.

D. Special Open Enrollment Period for Specialized Behavioral Health Integration

1. The department, through its enrollment broker, will provide an opportunity for all populations to be mandatorily enrolled into Bayou Health for specialized behavioral health services. These populations will be given a 60-day choice period to proactively choose an MCO.

2. Each potential MCO member shall receive information and the offer of assistance with making informed choices about the participating MCOs and the availability of choice counseling.

3. During the special enrollment period, current members who do not proactively request reassignment will remain with their existing MCO.

4. These new members will be encouraged to make a choice among the participating MCOs. When no choice is made, auto-assignment will be used as outlined in §3105.G.2.a.

E. Special Enrollment Provisions for Mandatory, Opt-In Population Only

1. Mandatory, opt-in populations may request participation in Bayou Health for physical health services at any time. The effective date of enrollment shall be no later than the first day of the second month following the calendar month the request for enrollment is received. Retroactive begin dates are not allowed.

2. The enrollment broker will ensure that all mandatory, opt-in populations are notified at the time of enrollment of their ability to disenroll for physical health at any time. The effective date will be the first day of a month, and no later than the first day of the second month following the calendar month the request for disenrollment is received.

3. Following an opt-in for physical health and selection of an MCO and subsequent 90-day choice period, these members will be locked into the MCO for 12 months from the effective date of enrollment or until the next annual enrollment period unless they elect to disenroll from physical health.

F. Enrollment of Newborns. Newborns of Medicaid eligible mothers, who are enrolled at the time of the newborn's birth, will be automatically enrolled with the mother's MCO, retroactive to the month of the newborn's birth.

1. If there is an administrative delay in enrolling the newborn and costs are incurred during that period, the member shall be held harmless for those costs and the MCO shall pay for these services.

2. The MCO and its providers shall be required to:

a. report the birth of a newborn within 48 hours by requesting a Medicaid identification (ID) number through the department's online system for requesting Medicaid ID numbers; and

b. complete and submit any other Medicaid enrollment form required by the department.

G. Selection of an MCO

1. As part of the eligibility determination process, Medicaid and LaCHIP applicants, for whom the department determines eligibility, shall receive information and assistance with making informed choices about participating MCOs from the enrollment broker. These individuals will be afforded the opportunity to indicate the plan of their choice on their Medicaid financial application form or in a subsequent contract with the department prior to determination of Medicaid eligibility.

2. All new recipients who have made a proactive selection of an MCO shall have that MCO choice transmitted to the enrollment broker immediately upon determination of Medicaid or LaCHIP eligibility. The member will be assigned to the MCO of their choosing unless the plan is otherwise restricted by the department.

a. Recipients who fail to choose an MCO shall be automatically assigned to an MCO by the enrollment broker, and the MCO shall be responsible to assign the member to a primary care provider (PCP) if a PCP is not selected at the time of enrollment into the MCO.

b. For mandatory populations for all covered services as well as mandatory, specialized behavioral health populations, the auto-assignment will automatically enroll members using a hierarchy that takes into account family/household member enrollment, or a round robin method that maximizes preservation of existing specialized behavioral health provider-recipient relationships.

3. All new recipients shall be immediately, automatically assigned to an MCO by the enrollment broker if they did not select an MCO during the financial eligibility determination process.

a. Special Provisions for Medicaid Expansion. Individuals enrolled in the Take Charge Plus and/or the Greater New Orleans Community Health Connection (GNOCHC) Waiver program upon implementation of the new adult group will be auto assigned to an MCO by the enrollment broker as provided for in the automatic assignment process defined in §3105.H-H.3.

4. All new recipients will be given 90 days to change plans if they so choose.

a. Special Provisions for Medicaid Expansion. Individuals transferred from Take Charge Plus and/or GNOCHC will be given 90 days to change plans without cause following auto assignment to an MCO upon implementation of the new adult group.

5. The following provisions will be applicable for recipients who are mandatory participants.

a. If there are two or more MCOs in a department designated service area in which the recipient resides, they shall select one.

b. Recipients may request to transfer out of the MCO for cause and the effective date of enrollment into the new plan shall be no later than the first day of the second month following the calendar month that the request for disenrollment is filed.

H. Automatic Assignment Process

1. The following participants shall be automatically assigned to an MCO by the enrollment broker in accordance with the department's algorithm/formula and the provisions of §3105.E:

a. mandatory MCO participants, with the exceptions noted in §3105.G.2.a.i;

b. pregnant women with Medicaid eligibility limited to prenatal care, delivery and post-partum services; and

c. other recipients as determined by the department.

2. MCO automatic assignments shall take into consideration factors including, but not limited to:

a. assigning members of family units to the same MCO;

b. existing provider-enrollee relationships;

c. previous MCO-enrollee relationship;

d. MCO capacity; and

e. MCO performance outcome indicators.

3. MCO assignment methodology shall be available to recipients upon request to the enrollment broker.

I. Selection or Automatic Assignment of a Primary Care Provider for Mandatory Populations for All Covered Services

1. The MCO is responsible to develop a PCP automatic assignment methodology in accordance with the department's requirements for the assignment of a PCP to an enrollee who:

a. does not make a PCP selection after being offered a reasonable opportunity by the MCO to select a PCP;

b. selects a PCP within the MCO that has reached their maximum physician/patient ratio; or

c. selects a PCP within the MCO that has restrictions/limitations (e.g. pediatric only practice).

2. The PCP automatically assigned to the member shall be located within geographic access standards, as specified in the contract, of the member's home and/or who best meets the needs of the member. Members for whom an MCO is the secondary payor will not be assigned to a PCP by the MCO, unless the member requests that the MCO do so.

3. If the enrollee does not select an MCO and is automatically assigned to a PCP by the MCO, the MCO shall allow the enrollee to change PCP, at least once, during the first 90 days from the date of assignment to the PCP.

Effective the ninety-first day, a member may be locked into the PCP assignment for a period of up to nine months beginning from the original date that he/she was assigned to the MCO.

4. If a member requests to change his/her PCP for cause at any time during the enrollment period, the MCO must agree to grant the request.

J. Lock-In Period

1. Members have 90 days from the initial date of enrollment into an MCO in which they may change the MCO for any reason. Medicaid enrollees may only change MCOs without cause within the initial 90 days of enrollment in an MCO. After the initial 90-day period, Medicaid enrollees/members shall be locked into an MCO until the annual open enrollment period, unless disenrolled under one of the conditions described in this Section, with the exception of the mandatory, opt-in populations, who may disenroll from Bayou Health for physical health and return to legacy Medicaid at any time.

K. Annual Open Enrollment

1. The department will provide an opportunity for all MCO members to retain or select a new MCO during an annual open enrollment period. Notification will be sent to each MCO member and voluntary members who have opted out of participation in Bayou Health at least 60 days prior to the effective date of the annual open enrollment. Each MCO member shall receive information and the offer of assistance with making informed choices about MCOs in their area and the availability of choice counseling.

2. Members shall have the opportunity to talk with an enrollment broker representative who shall provide additional information to assist in choosing the appropriate MCO. The enrollment broker shall provide the individual with information on each MCO from which they may select.

3. During the open enrollment period, each Medicaid enrollee shall be given the option to either remain in their existing MCO or select a new MCO.

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 37:1574 (June 2011), amended LR 40:310 (February 2014), LR 40:1097 (June 2014), LR 41:929 (May 2015), LR 41:2364 (November 2015), LR 42:755 (May 2016).

§3107. Disenrollment and Change of Managed Care Organization

A. A member may request disenrollment from an MCO for cause at any time, effective no later than the first day of the second month following the month in which the member files the request.

B. A member may request disenrollment from an MCO without cause at the following times:

1. during the 90 days following the date of the member's initial enrollment with the MCO or the date the

department sends the member notice of the enrollment, whichever is later;

2. at least once a year during the member's annual open enrollment period thereafter;

3. upon automatic re-enrollment if a temporary loss of Medicaid eligibility has caused the member to miss the annual open enrollment opportunity; or

4. if the department imposes the intermediate sanction against the MCO which grants enrollees the right to terminate enrollment without cause and notifies the affected enrollees of their right to disenroll.

C. All member-initiated disenrollment requests must be made to the enrollment broker.

1. Oral requests to disenroll shall be confirmed by the enrollment broker by return call with written documentation, or in writing to the requestor.

2. A member's oral or written request to disenroll must be acted on no later than the first day of the second month following the month in which the member filed the request. If not, the request shall be considered approved.

3. If the disenrollment request is denied, the member may access the state's fair hearing process as outlined in the contract.

4. The effective date of disenrollment shall be no later than the first day of the second month following the calendar month the request for disenrollment is filed.

D. Disenrollment for Cause

1. A member may initiate disenrollment or transfer from their assigned MCO after the first 90 days of enrollment for cause at any time. The following circumstances are cause for disenrollment:

a. the MCO does not, because of moral or religious objections, cover the service that the member seeks;

b. the member needs related services to be performed at the same time, not all related services are available within the MCO and the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk;

c. the contract between the MCO and the department is terminated;

d. to implement the decision of a hearing officer in an appeal proceeding by the member against the MCO or as ordered by a court of law; and

e. other reasons including, but not limited to:

i. poor quality of care;

ii. lack of access to services covered under the contract; or

iii. the member's active specialized behavioral health provider ceases to contract with the MCO; or

iv. documented lack of access to providers experienced in dealing with the enrollee's health care needs.

E. Involuntary Disenrollment

1. The MCO may submit an involuntary disenrollment request to the enrollment broker, with proper documentation for fraudulent use of the MCO identification card. In such cases, the MCO shall report the incident to the Bureau of Health Services Financing.

2. The MCO shall promptly submit such disenrollment requests to the enrollment broker. The effective date of an involuntary disenrollment shall not be earlier than 45 calendar days after the occurrence of the event that prompted the request for involuntary disenrollment. The MCO shall ensure that involuntary disenrollment documents are maintained in an identifiable member record.

3. All requests will be reviewed on a case-by-case basis and subject to the sole discretion of the department. All decisions are final and are not subject to MCO dispute or appeal.

4. The MCO may not request disenrollment because of a member's:

- a. health diagnosis;
- b. adverse change in health status;
- c. utilization of medical services;
- d. diminished mental capacity;
- e. pre-existing medical condition;
- f. refusal of medical care or diagnostic testing;
- g. uncooperative or disruptive behavior resulting from his or her special needs;
- h. attempt to exercise his/her rights under the MCO's grievance system; or
- i. attempt to exercise his/her right to change, for cause, the primary care provider that he/she has chosen or been assigned.

F. Department Initiated Disenrollment

1. The department will notify the MCO of the member's disenrollment or change in eligibility status due to the following reasons:

- a. loss of Medicaid eligibility or loss of MCO enrollment eligibility;
- b. death of a member;
- c. member's intentional submission of fraudulent information;
- d. member becomes an inmate of a public institution;
- e. member moves out of state;
- f. member becomes Medicare eligible;

g. member is placed in a nursing facility or intermediate care facility for persons with intellectual disabilities;

h. loss of MCO's participation.

G. If the MCO ceases participation in the Medicaid Program, the MCO shall notify the department in accordance with the termination procedures described in the contract.

1. The enrollment broker will notify MCO members of the choices of remaining MCOs.

2. The exiting MCO shall assist the department in transitioning the MCO members to another MCO.

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 37:1575 (June 2011), amended LR 40:311 (February 2014), LR 41:931 (May 2015), LR 41:2365 (November 2015).

§3109. Member Rights and Responsibilities

A. The MCO member's rights shall include, but are not limited to the right to:

1. receive information in accordance with federal regulations and as described in the contract and department issued guides;
2. receive courteous, considerate and respectful treatment provided with due consideration for the member's dignity and privacy;
3. receive information on available treatment options and alternatives in a manner appropriate to the member's condition and ability to understand;
4. participate in treatment decisions, including the right to:
 - a. refuse treatment;
 - b. complete information about their specific condition and treatment options including, but not limited to the right to receive services in a home or community setting or in an institutional setting if desired;
 - c. seek second opinions;
 - d. information about available experimental treatments and clinical trials and how such research can be accessed; and
 - e. assistance with care coordination from the PCP's office;
5. be free from any form of restraint or seclusion as a means of coercion, discipline, retaliation or convenience;
6. express a concern about their MCO or the care it provides, or appeal an MCO decision, and receive a response in a reasonable period of time;
7. receive a copy of their medical records, including, if the HIPAA privacy rule applies, the right to request that the records be amended or corrected as allowed in federal regulations;

8. be furnished health care services in accordance with federal regulations governing access standards;

9. implement an advance directive as required in federal regulations:

a. the MCO must provide adult enrollees with written information on advanced directive policies and include a description of applicable state law. The written information must reflect changes in state law as soon as possible, but no later than 90 days after the effective date of change;

b. members have the right to file a grievance concerning noncompliance with the advance directive requirements to the department or other appropriate licensing or certification agency as allowed in federal regulations;

10. choose his/her health professional to the extent possible and appropriate in accordance with federal regulations; and

11. be furnished health care services in accordance with all other applicable federal regulations.

B. Members shall have the freedom to exercise the rights described herein without any adverse effect on the member's treatment by the department or the MCO, or its contractors or providers.

C. The MCO member's responsibilities shall include, but are not limited to:

1. informing the MCO of the loss or theft of their MCO identification card;

2. presenting their identification card when using health care services;

3. being familiar with the MCO's policies and procedures to the best of his/her abilities;

4. contacting the MCO, by telephone or in writing (formal letter or electronically, including email), to obtain information and have questions clarified;

5. providing participating network providers with accurate and complete medical information;

6. following the prescribed treatment of care recommended by the provider or letting the provider know the reasons the treatment cannot be followed, as soon as possible;

7. making every effort to keep any agreed upon appointments and follow-up appointments and contacting the provider in advance if they are unable to do so; and

8. accessing preventive care services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1576 (June 2011), amended LR 40:311 (February 2014), LR 41:931 (May 2015), LR 41:2365 (November 2015).

§3111. Independent Review Process for Provider Claims

A. Definitions

Abuse—provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

Fraud—an intentional deception or misrepresentation made by a person or a provider with the knowledge that the deception could result in some unauthorized benefit to him/her or some other person or entity. It includes any act that constitutes fraud under applicable federal or state law.

Mental Health Rehabilitation Provider—an outpatient healthcare program provider of any psychosocial rehabilitation (PRS), crisis intervention (CI) and/or community psychiatric support and treatment (CPST) services that promotes the restoration of community function and well-being of an individual diagnosed with a mental health or mental or emotional disorder.

Waste—over-utilization of services, or practices that result in unnecessary cost to the Medicaid program. Waste is generally not considered to be caused by criminally negligent actions but rather by misuse of resources. Any overpayment which is not considered either fraud or abuse, is considered waste.

B. Right of Providers to Independent Review

1. Pursuant to Act 349 of the 2017 Regular Session of the Louisiana Legislature, for adverse determination related to claims filed on or after January 1, 2018, a healthcare provider shall have a right to an independent review of the adverse action of the managed care organization (MCO).

2. Pursuant to Act 204 of the 2021 Regular Session of the Louisiana Legislature, mental health rehabilitation service providers shall have a right to an independent review of an adverse determination taken by an MCO that results in a recoupment of the payment of a claim based upon a finding of waste or abuse.

3. For purposes of these provisions, adverse determinations shall refer to claims submitted by healthcare providers for payment for services rendered to Medicaid enrollees and denied by an MCO, in whole or in part, or a claim that results in recoupment of a payment from the healthcare provider.

C. Request for Reconsideration

1. A provider shall submit a written request for reconsideration to the MCO. The request shall identify the claim(s) in dispute, the reasons for the dispute, and any documentation supporting the provider's position or request by the MCO within 180 days from one of the following dates:

a. the date on which the MCO transmits remittance advice or other notice electronically;

b. 60 days from the date the claim was submitted to the MCO if the provider receives no notice from an MCO, either partially or totally, denying the claim; or

c. the date on which the MCO recoups monies remitted for a previous claim payment.

2. The MCO shall acknowledge in writing its receipt of a reconsideration request submitted in accordance with §3111.C.1, within five calendar days after receipt of the request and, render a final decision by providing a response to the provider within 45 calendar days from the date of receipt of the request for reconsideration, unless another time frame is agreed upon in writing by the provider and the MCO.

D. Independent Review Requirements

1. If the MCO upholds the adverse determination, or does not respond to the reconsideration request within the time frames allowed, the provider may file a written notice with the department requesting the adverse determination be submitted to an independent reviewer. The department must receive the written request from the provider for an independent review within 60 days from the date the provider receives the MCO's notice of the decision of the reconsideration request, or if the MCO does not respond to the reconsideration request within the time frames allowed, the last date of the time period allowed for the MCO to respond.

2. The provider shall include a copy of the written request for reconsideration with the request for an independent review. The address to be used by the provider for submission of the request shall be LDH/Health Plan Management, P.O. Box, 91030, Bin 24, Baton Rouge, LA 70821-9283, Attn: Independent Review.

3. If the MCO reverses the adverse determination pursuant to a request for reconsideration, payment of the claim(s) in dispute shall be made no later than 20 days from the date of the MCO's decision.

4. Subject to approval by the department, a provider may aggregate multiple adverse determinations involving the same MCO when the specific reason for nonpayment of the claims aggregated involve a dispute regarding a common substantive question of fact or law.

5. Within 14 calendar days of receipt of the request for independent review, the independent reviewer shall request to be provided all information and documentation submitted for reconsideration regarding the disputed claim or claims within 30 calendar days.

6. If the independent reviewer determines that guidance on a medical issue from the department is required to make a decision, the reviewer shall refer this specific issue to the department for review and concise response to the request within 90 calendar days after receipt.

7. The independent reviewer shall examine all materials submitted and render a decision on the dispute within 60 calendar days. The independent reviewer may request in writing an extension of time from the department

to resolve the dispute. If an extension of time is granted by the department, the independent reviewer shall provide notice of the extension to the provider and the MCO.

8. If the independent reviewer renders a decision requiring a MCO to pay any claims or portion of the claims, within 20 calendar days, the MCO shall send the provider payment in full along with 12 percent interest calculated back to the date the claim was originally denied or recouped.

9. Within 60 calendar days of an independent reviewer's decision, either party to the dispute may file suit in any court having jurisdiction to review the independent reviewer's decision to recover any funds awarded by the independent reviewer to the other party.

E. Independent Review Costs

1. The fee for conducting an independent review shall be paid to the independent reviewer by the MCO within 30 calendar days of receipt of a bill for services. A provider shall, within 10 days of the date of the decision of the independent reviewer, reimburse a MCO for the fee associated with conducting an independent review when the decision of the MCO is upheld. If the provider fails to submit payment for the independent review within 10 days from the date of the decision, the MCO may withhold future payments to the provider in an amount equal to the cost of the independent review, and the department may prohibit that provider from future participation in the independent review process.

2. If the MCO representatives fails to pay the bill for the independent reviewer's services, the reviewer may request payment directly from the department from any funds held by the state that are payable to the MCO.

F. Independent Reviewer Selection Panel

1. The independent reviewer selection panel shall select and identify an appropriate number of independent reviewers and determine a uniform rate of compensation be paid to each reviewer, not to exceed \$2,000 per review.

2. The panel shall consist of the secretary or his/her duly designated representative, two provider representatives and two MCO representatives.

3. Each MCO shall utilize only independent reviewers who are selected in accordance with Act 349 of the 2017 Regular Session of the Louisiana Legislature, and shall comply with the provisions of this Section in the resolution of disputed adverse determinations.

G. Penalties

1. An MCO in violation of any provision governing the independent review process herein may be subject to a penalty of up to \$25,000 per violation.

2. An MCO may be subject to an additional penalty of up to \$25,000 if subject to more than 100 independent reviews annually and the percentage of adverse determinations overturned in favor of the provider as a result of an independent review is greater than 25 percent.

H. Independent Review Applicability

1. Independent review shall not apply to any adverse determination:

a. associated with a claim filed with an MCO prior to January 1, 2018, regardless of whether the claim is re-filed after that date;

b. associated with an adverse determination involved in litigation or arbitration;

c. not associated with a Medicaid enrollee.

2. Independent review does not otherwise prohibit or limit any alternative legal or contractual remedy available to a provider to contest the partial or total denial of a claim for payment for healthcare services. Any contractual provision executed between a provider and a MCO which seeks to limit or otherwise impede the appeal process as set forth in this Section shall be null, void, and deemed to be contrary to the public policy of this state.

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 44:283 (February 2018), amended LR 47:1876 (December 2021).

§3113. Directed Payments

A. Hospital Directed Payments

1. Subject to written approval by the Centers for Medicare and Medicaid Services (CMS), the Department of Health (hereafter referred to as “the department” and/or “LDH”) shall provide directed payments to qualifying hospitals that participate in the Healthy Louisiana Medicaid managed care program, in accordance with the applicable section 438.6(c) preprint(s) approved by CMS, federal regulations, and departmental requirements. Each CMS approved directed payment arrangement is effective for one Healthy Louisiana Medicaid managed care contract rating period.

2. *Qualifying Hospital*—either of the following:

a. an in-state provider of inpatient and outpatient hospital services (excluding freestanding psychiatric hospitals, freestanding rehabilitation hospitals, and long-term acute care hospitals) that meets the criteria specified in the applicable section 438.6(c) preprint approved by CMS and departmental requirements; or

b. an in-state hospital provider of long-term acute care, psychiatric services, and rehabilitation services for both inpatient and outpatient hospital services that meet the criteria specified in the applicable section 438.6(c) preprint approved by CMS and departmental requirements.

3. The department shall assign qualifying hospitals to provider classes based upon criteria specified in the applicable section 438.6(c) preprint(s) approved by CMS, in accordance with departmental requirements.

a. Qualifying hospitals shall have no right to an administrative appeal regarding any issue related to provider

classification, including, but not limited to, provider class assignment, the effective date of provider class assignment, or qualifying determinations.

4. The department shall utilize an interim payment process, whereby interim directed payments will be calculated based on provider class assignment utilizing the data and methodology specified in the applicable section 438.6(c) preprint(s) approved by CMS, in accordance with departmental requirements.

a. Qualifying hospitals shall have no right to an administrative appeal regarding calculation of interim directed payments.

b. The department reserves the right to discontinue the interim directed payments to any hospital whose projected recoupment due to shifts in utilization is greater than 50 percent of their estimated interim directed payments or any hospital who discontinues operations during or prior to the directed payment contract period.

5. The department shall cause interim directed payments to be paid on a quarterly basis to the Healthy Louisiana Medicaid managed care organizations (MCOs), in accordance with departmental requirements.

a. The MCOs shall pay interim directed payments to qualified hospitals within 10 business days of receipt of quarterly interim directed payment information from LDH. If a barrier exists that will not allow the MCO to pay the interim directed payments within 10 business days of receipt, the MCO shall immediately notify LDH. LDH at its sole discretion will determine if penalties for late payment may be waived.

b. The qualifying hospital may request that the MCOs deposit their interim directed payments into a separate bank account owned/held by the qualifying hospital. Interim directed payments shall not be deposited into a bank account that is owned/held by more than one qualifying hospital.

6. In accordance with the applicable section 438.6(c) preprint(s) approved by CMS, federal regulations, and departmental requirements, directed payments must be based on actual utilization and delivery of services during the applicable contract period.

a. Within 12 months of the end of each state fiscal year (SFY), LDH shall perform a reconciliation as specified in the applicable section 438.6(c) preprint approved by CMS and departmental requirements.

i. Qualifying hospitals shall have no right to an administrative appeal regarding any issue related to reconciliation, including, but not limited to, the timing and process.

b. Qualified hospitals are strongly encouraged to submit claims as quickly as possible after SFY end.

7. If a qualifying hospital that is subject to a reconciliation will not be participating in a directed payment arrangement in the future, the qualified hospital shall pay all

amounts owed to LDH, if any, within 30 calendar days' notice of the amount owed, in accordance with departmental requirements.

a. In addition to all other available remedies, LDH has the authority to offset all amounts owed by a qualifying hospital due to a reconciliation against any payment owed to the qualifying hospital, including, but not limited to, any payment owed by the MCOs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:245 and Title XIX of the Social Security Act

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 49:264 (February 2023), amended LR 49:1566 (September 2023).

Chapter 33. Coordinated Care Network Shared Savings Model

§3301. Participation Requirements

A. In order to participate in the Bayou Health Program after January 31, 2015, a coordinated care network shared savings model (CCN-S) must be an entity that operated as a CCN-S contracted with the department during the period of February 1, 2012 through January 31, 2015.

B. Participation in the Bayou Health program shared savings model after January 31, 2015 is for the exclusive purpose of fully executing provisions of the CCN-S contract relative to the determinations of savings realized or refunds due to the department for CCN-S operations during the period of February 1, 2012 through January 31, 2015.

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 37:1577 (June 2011), amended LR 41:932 (May 2015), LR 42:755 (May 2016).

§3307. Reimbursement Methodology

A. The department or its fiscal intermediary shall make lump sum savings payments to the CCN-S, if eligible, as described in the CCN-S contract.

B. The department will determine savings realized or refunds due to the department on a periodic basis.

1. The department may make an interim determination and will make a final determination of savings achieved or refunds due for each CCN-S for each contract year.

a. Interim determinations may be made for less than 12 months of service during the contract year. For dates of service with less than 12 months of elapsed time after the end of the contract period an adjustment for incurred but not reported (IBNR) claims will be made.

b. Final determinations will not be made for less than 12 months of service during the contract year. Final determinations will be made when all dates of service during the contract year have 12 months of elapsed time from the last date of service. Final determinations will use data updated since the interim determination.

2. The determination will calculate the difference between the actual aggregate cost of authorized services and the aggregate per capita prepaid benchmark (PCPB).

3. The PCPB will be set on the basis of health status-based risk adjustment.

a. The health risk of the Medicaid enrollees enrolled in the CCN-S will be measured using a nationally recognized risk-assessment model.

b. Utilizing this information, the PCPBs will be adjusted to account for the health risk for the enrollees in each CCN-S relative to the overall population being measured.

c. The health risk of the enrollees and associated CCN-S risk scores and the PCPBs will be updated periodically to reflect changes in risk over time.

4. Costs of the following services will not be included in the determination of the PCPB. These services include, but are not limited to:

- a. nursing facility;
- b. dental services;
- c. personal care services (children and adults);
- d. hospice;
- e. school-based individualized education plan services provided by a school district and billed through the intermediate school district;
- f. specified Early Steps Program services;
- g. specialized behavioral health services (e.g. provided by a psychiatrist, psychologist, social worker, psychiatric advanced nurse practitioner;
- h. targeted case management;
- i. non-emergency medical transportation;
- j. intermediate care facilities for persons with intellectual disabilities;
- k. home and community-based waiver services;
- l. durable medical equipment and supplies; and
- m. orthotics and prosthetics.

5. Individual member total cost for the determination year in excess of an amount specified in the contract will not be included in the determination of the PCPB, nor will it be included in actual cost at the point of determination so that outlier cost of certain individuals and/or services will not jeopardize the overall savings achieved by the CCN-S.

6. The CCN-S will be eligible to receive up to 60 percent of savings if the actual aggregate costs of authorized services, including enhanced primary care case management fees advanced, are determined to be less than the aggregate PCPB (for the entire CCN-S enrollment).

a. Shared savings will be limited to five percent of the actual aggregate costs, including the enhanced primary

care case management fees paid. Such amounts shall be determined in the aggregate and not for separate enrollment types.

b. The department may make an interim payment to the CCN for savings achieved based on the interim determination. Interim payments shall not exceed 75 percent of the eligible amount.

c. The department will make a final payment to the CCN for savings achieved based on the final determination. The final payment amount will be up to the difference between the amount of the interim payment (if any) and the final amount eligible for distribution.

d. For determination periods during the CCN-S first two years of operation, any distribution of CCN-S savings will be contingent upon the CCN meeting the established “early warning system” administrative performance measures and compliance under the contract. After the second year of operation, distribution of savings will be contingent upon the CCN-S meeting department established clinical quality performance measure benchmarks and compliance with the contract.

7. In the event the CCN-S exceeds the PCPB in the aggregate (for the entire CCN-S enrollment) as calculated in the final determination, the CCN-S will be required to refund up to 50 percent of the total amount of the enhanced primary care case management fees paid to the CCN-S during the period being determined.

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 37:1581 (June 2011), amended LR 40:311 (February 2014), LR 41:932 (May 2015).

Chapter 35. Managed Care Organization Participation Criteria

§3501. Participation Requirements

A. In order to participate in the Bayou Health Program, a managed care organization must be a successful bidder, be awarded a contract with the department, and complete the readiness review.

B. An MCO must:

1. meet the federal definition of an managed care organization as defined in federal regulations;
2. meet the requirements of R.S. 22:2016 and be licensed or have a certificate of authority from the Louisiana Department of Insurance (DOI) pursuant to title 22 of the *Louisiana Revised Statutes* at the time a proposal is submitted;
3. be certified by the Louisiana Secretary of State to conduct business in the state;
4. meet solvency standards as specified in federal regulations and Title 22 of the Louisiana Revised Statutes;

5. meet NCQA health plan accreditation or agree to submit an application for accreditation at the earliest possible date as allowed by NCQA and once achieved, maintains accreditation through the life of this agreement;

6. have a network capacity to enroll a minimum of 250,000 Medicaid and LaCHIP eligibles; and

7. not have an actual or perceived conflict of interest that, in the discretion of the department, would interfere or give the appearance of possibly interfering with its duties and obligations under this Rule, the contract and any and all appropriate guides. Conflict of interest shall include, but is not limited to, being the fiscal intermediary contractor for the department; and

8. establish and maintain a performance bond in the amount specified by the department and in accordance with the terms of the contract.

9. Except for licensure and financial solvency requirements, no other provisions of title 22 of the *Revised Statutes* shall apply to an MCO participating in the Louisiana Medicaid Program.

C. An MCO shall ensure the provision of core benefits and services to Medicaid enrollees as specified in the terms of the contract.

D. Upon request by the Centers for Medicare and Medicaid Services, the Office of Inspector General, the Government Accounting Office, the department or its designee, an MCO shall make all of its records pertaining to its contract (services provided there under and payment for services) with the department available for review, evaluation and audit. The records shall include, but are not limited to the following:

1. pertinent books and documents;
2. financial records;
3. medical records and documents; and
4. provider records and documents involving financial transactions related to the contract.

E. An MCO shall maintain an automated management information system that collects, analyzes, integrates and reports data that complies with department and federal reporting requirements.

1. The MCO shall submit to the department for approval the MCO’s emergency/contingency plan if the MCO is unable to provide the data reporting specified in the contract and department issued guides.

F. An MCO shall obtain insurance coverage(s) including, but not limited to, workman’s compensation, commercial liability, errors and omissions, and reinsurance as specified in the terms of the contract. Subcontractors, if any, shall be covered under these policies or have insurance comparable to the MCO’s required coverage.

G. An MCO shall provide all financial reporting as specified in the terms of the contract.

H. An MCO shall secure and maintain a performance and fidelity bond as specified in the terms of the contract during the life of the contract.

I. In the event of noncompliance with the contract and the department's guidelines, an MCO shall be subject to the sanctions specified in the terms of the contract including, but not limited to:

1. corrective action plans;
2. monetary penalties;
3. temporary management; or
4. suspension and/or termination of the MCO's contract.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1583 (June 2011), amended LR 41:933 (May 2015), LR 41:2366 (November 2015).

§3503. Managed Care Organization Responsibilities

A. The MCO shall be responsible for the administration and management of its requirements and responsibilities under the contract with the department and any and all department issued guides. This includes all subcontracts, employees, agents and anyone acting for or on behalf of the MCO.

1. No subcontract or delegation of responsibility shall terminate the legal obligation of the MCO to the department to assure that all requirements are carried out.

B. An MCO shall possess the expertise and resources to ensure the delivery of core benefits and services to members and to assist in the coordination of covered services, as specified in the terms of the contract.

1. An MCO shall have written policies and procedures governing its operation as specified in the contract and department issued guides.

C. An MCO shall accept enrollees in the order in which they apply without restriction, up to the enrollment capacity limits set under the contract.

1. An MCO shall not discriminate against enrollees on the basis of race, gender, color, national origin, age, health status, sexual orientation, or need for health care services, and shall not use any policy or practice that has the effect of discriminating on any such basis.

D. An MCO shall be required to provide service authorization, referrals, coordination, and/or assistance in scheduling the covered services consistent with standards as defined in the Louisiana Medicaid State Plan and as specified in the terms of the contract.

E. An MCO shall provide a chronic care management program as specified in the contract.

F. The MCO shall establish and implement a quality assessment and performance improvement program as

specified in the terms of the contract and department issued guides.

G. An MCO shall develop and maintain a utilization management program including policies and procedures with defined structures and processes as specified in the terms of the contract and department issued guides.

H. An MCO shall develop and maintain effective continuity of care activities which ensure a continuum of care approach to providing health care services to members.

I. The MCO must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse.

1. The MCO shall comply with all state and federal laws and regulations relating to fraud, abuse, and waste in the Medicaid and CHIP program as well all requirements set forth in the contract and department issued guides.

J. An MCO shall maintain a health information system that collects, analyzes, integrates and reports data as specified in the terms of the contract and all department issued guides.

1. An MCO shall collect data on enrollees and provider characteristics and on services furnished to members through an encounter data system as specified in the contract and all department issued guides.

K. An MCO shall be responsible for conducting routine provider monitoring to ensure:

1. continued access to care for Medicaid recipients; and
2. compliance with departmental and contract requirements.

L. An MCO shall ensure that payments are not made to a provider who is in non-payment status with the department or is excluded from participation in federal health care programs (i.e., Medicare, Medicaid, CHIP, etc.).

M. Medical records shall be maintained in accordance with the terms and conditions of the contract. These records shall be safeguarded in such a manner as to protect confidentiality and avoid inappropriate disclosure according to federal and state law.

N. An MCO shall participate on the department's Medicaid Quality Committee to provide recommendations for the Bayou Health Program.

O. An MCO shall participate on the department's established committees for administrative simplification and quality improvement, which will include physicians, hospitals, pharmacists, other healthcare providers as appropriate, and at least one member of the Senate and House Health and Welfare Committees or their designees.

P. The MCO shall provide both member and provider services in accordance with the terms of the contract and department issued guides.

1. The MCO shall submit member handbooks, provider handbooks, and templates for the provider directory to the department for approval prior to distribution and subsequent to any material revisions.

a. The MCO must submit all proposed changes to the member handbooks and/or provider handbooks to the department for review and approval in accordance with the terms of the contract and the department issued guides.

b. After approval has been received from the department, the MCO must provide notice to the members and/or providers at least 30 days prior to the effective date of any proposed material changes to the plan through updates to the member handbooks and/or provider handbooks.

Q. The member handbook shall include, but not be limited to:

1. a table of contents;
2. a general description regarding:
 - a. how the MCO operates;
 - b. member rights and responsibilities;
 - c. appropriate utilization of services including emergency room visits for non-emergent conditions;
 - d. the PCP selection process; and
 - e. the PCP's role as coordinator of services;
3. member rights and protections as specified in 42 CFR §438.100 and the MCO's contract with the department including, but not limited to:
 - a. a member's right to disenroll from the MCO, including disenrollment for cause;
 - b. a member's right to change providers within the MCO;
 - c. any restrictions on the member's freedom of choice among MCO providers; and
 - d. a member's right to refuse to undergo any medical service, diagnoses, or treatment, or to accept any health service provided by the MCO if the member objects (or in the case of a child, if the parent or guardian objects) on religious grounds;
4. member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the MCO or the department, including but not limited to:
 - a. immediately notifying the MCO if he or she has a Worker's Compensation claim, a pending personal injury or medical malpractice law suit, or has been involved in an auto accident;
 - b. reporting to the department if the member has or obtains another health insurance policy, including employer sponsored insurance; and
 - c. a statement that the member is responsible for protecting his/her identification card and that misuse of the

card, including loaning, selling or giving it to others could result in loss of the member's Medicaid eligibility and/or legal action;

5. the amount, duration, and scope of benefits available under the MCO's contract with the department in sufficient detail to ensure that members have information needed to aid in understanding the benefits to which they are entitled including, but not limited to:

- a. specialized behavioral health;
 - b. information about health education and promotion programs, including chronic care management;
 - c. the procedures for obtaining benefits, including prior authorization requirements and benefit limits;
 - d. how members may obtain benefits, including family planning services, from out-of-network providers;
 - e. how and where to access any benefits that are available under the Louisiana Medicaid state plan, but are not covered under the MCO's contract with the department;
 - f. information about early and periodic screening, diagnosis and treatment (EPSDT) services;
 - g. how transportation is provided, including how to obtain emergency and non-emergency medical transportation;
 - h. the post-stabilization care services rules set forth in 42 CFR 422.113(c);
 - i. the policy on referrals for specialty care, including specialized behavioral health services and other benefits not furnished by the member's primary care provider;
 - j. for counseling or referral services that the MCO does not cover because of moral or religious objections, the MCO is required to furnish information on how or where to obtain the service;
 - k. how to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show";
 - l. the extent to which and how after-hour crisis and emergency services are provided; and
 - m. information about the MCO's formulary and/or preferred drug list (PDL), including where the member can access the most current information regarding pharmacy benefits;
6. instructions to the member to call the Medicaid Customer Service Unit toll free telephone number or access the Medicaid member website to report changes in parish of residence, mailing address or family size changes;
7. a description of the MCO's member services and the toll-free telephone number, fax number, e-mail address and mailing address to contact the MCO's Member Services Unit;

8. instructions on how to request multi-lingual interpretation and translation services when needed at no cost to the member. This information shall be included in all versions of the handbook in English and Spanish;

9. grievance, appeal, and state fair hearing procedures and time frames as described in 42 CFR §438.400 through §438.424 and the MCO's contract with the department; and

10. information regarding specialized behavioral health services, including but not limited to:

a. a description of covered behavioral health services;

b. where and how to access behavioral health services and behavioral health providers, including emergency or crisis services;

c. general information on the treatment of behavioral health conditions and the principles of:

i. adult, family, child, youth and young adult engagement;

ii. resilience;

iii. strength-based and evidence-based practices; and

iv. best/proven practices;

d. description of the family/caregiver or legal guardian role in the assessment, treatment, and support for individuals with an emphasis on promoting engagement, resilience, and the strengths of individuals and families; and

e. any limitations involving the provision of information for adult persons who do not want information shared with family members, including age(s) of consent for behavioral health treatment, as per 42 CFR part 2.

R. The provider handbook shall include, but not be limited to:

1. billing guidelines;

2. medical management/utilization review guidelines;

3. case management guidelines;

4. claims processing guidelines and edits;

5. grievance and appeals procedures and process;

6. other policies, procedures, guidelines, or manuals containing pertinent information related to operations and pre-processing claims;

7. description of the MCO;

8. core benefits and services the MCO must provide, including a description of all behavioral health services;

9. information on how to report fraud, waste and abuse; and

10. information on obtaining transportation for members.

S. The provider directory for members shall be developed in four formats:

1. a hard copy directory to be made available to members and potential members upon request;

2. an accurate electronic file refreshed weekly of the directory in a format to be specified by the department and used to populate a web-based online directory for members and the public;

3. an accurate electronic file refreshed weekly of the directory for use by the enrollment broker; and

4. a hard copy abbreviated version, upon request by the enrollment broker.

T. The department shall require all MCOs to utilize the standard form designated by the department for the prior authorization of prescription drugs, in addition to any other currently accepted facsimile and electronic prior authorization forms.

1. An MCO may submit the prior authorization form electronically if it has the capabilities to submit the form in this manner.

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 37:1583 (June 2011), amended LR 39:92 (January 2013), LR 40:66 (January 2014), LR 41:933 (May 2015), LR 41:2366 (November 2015).

§3505 Network Access Standards and Guidelines

A. The MCO must maintain and monitor a provider network that is supported by written agreements and is sufficient to provide adequate access of healthcare to enrollees as required by federal law and the terms as set forth in the contract. The MCO shall adhere to the federal regulations governing access standards as well as the specific requirements of the contract and all department issued guides.

B. The MCO must provide for service delivery out-of-network for any core benefit or service not available in network for which the MCO does not have an executed contract for the provision of such medically necessary services. Further, the MCO must arrange for payment so that the Medicaid enrollee is not billed for this service.

C. The MCO shall cover all medically necessary services to treat an emergency medical condition in the same amount, duration, and scope as stipulated in the Medicaid State Plan.

1. Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

a. placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

- b. serious impairment to bodily functions; or
- c. serious dysfunction of any bodily organ or part.

2. Emergency services means covered inpatient and outpatient services that are as follows:

a. furnished by a provider that is qualified to furnish these services under this Section; and

b. needed to evaluate or stabilize an emergency medical condition.

3. Post-stabilization care services means covered services, related to an emergency medical condition, that are provided after an member is stabilized in order to maintain the stabilized condition or, under the circumstances described in 42 CFR §438.114, to improve or resolve the member's condition.

D. The MCO must maintain a provider network and in-area referral providers in sufficient numbers, as determined by the department, to ensure that all of the required core benefits and services are available and accessible in a timely manner in accordance with the terms and conditions in the contract and department issued guide.

E. Any pharmacy or pharmacist participating in the Medicaid Program may participate as a network provider if licensed and in good standing with the Louisiana State Board of Pharmacy and accepts the terms and conditions of the contract offered to them by the MCO.

1. The MCO shall not require its members to use mail service pharmacy.

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 37:1585 (June 2011), amended LR 39:92 (January 2013), LR 41:935 (May 2015).

§3507. Benefits and Services

A. Core benefits and services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to enrollees under Louisiana Medicaid state plan.

1. Core benefits and services shall be defined as those health care services and benefits required to be provided to Medicaid MCO members enrolled in the MCO as specified under the terms of the contract and department issued guides.

2. Covered services shall be defined as those health care services and benefits to which a Medicaid and LaCHIP eligible individual is entitled to under the Louisiana Medicaid state plan.

B. The MCO:

1. shall ensure that medically necessary services, defined in LAC 50:I.1101, are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are being furnished;

2. may not arbitrarily deny or reduce the amount, duration, or scope of a required service because of diagnosis, type of illness, or condition of the member;

3. may place appropriate limits on a service:

a. on the basis of certain criteria, such as medical necessity; or

b. for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose;

4. shall provide core benefits and services as outlined and defined in the contract and shall provide medically necessary and appropriate care to Medicaid MCO Program members;

5. shall provide all of the core benefits and services consistent with, and in accordance with, the standards as defined in the Title XIX Louisiana Medicaid state plan:

a. the MCO may exceed the limits as specified in the minimum service requirements outlined in the contract;

b. no medical service limitation can be more restrictive than those that currently exist under the Title XIX Louisiana Medicaid State Plan;

6. shall provide pregnancy-related services that are necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of being pregnant and includes, but is not limited to prenatal care, delivery, postpartum care, and family planning/interconception care services for pregnant women in accordance with federal regulations; and

7. shall establish a pharmaceutical and therapeutics (P and T) committee or similar committee for the development of its formulary and the PDL.

C. If the MCO elects not to provide, reimburse for, or provide coverage of a counseling or referral service because of an objection on moral or religious grounds, the MCO must furnish information about the services it does not cover in accordance with §1932(b)(3)(B)(ii) of the Social Security Act and federal regulations by notifying:

1. the department in its response to the department's request for proposals (RFP) or whenever it adopts the policy during the term of the contract;

2. the potential enrollees before and during enrollment in the MCO;

3. enrollees within 90 days after adopting the policy with respect to any particular service; and

4. members through the inclusion of the information in the member handbook.

D. The following is a summary listing of the core benefits and services that an MCO is required to provide:

- 1. inpatient hospital services;
- 2. outpatient hospital services;
- 3. ancillary medical services;

PUBLIC HEALTH—MEDICAL ASSISTANCE

4. organ transplant-related services;
5. family planning services as specified in 42 CFR §431.51(b)(2) (not applicable to an MCO operating under a moral and religious objection as specified in the contract);
6. EPSDT/well child visits, excluding dental services;
7. emergency medical services;
8. communicable disease services;
9. durable medical equipment and certain supplies;
10. prosthetics and orthotics;
11. emergency and non-emergency medical transportation;
12. home health services;
13. basic and specialized behavioral health services, including applied behavior analysis (ABA) -based therapy services, excluding Coordinated System of Care services;
14. school-based health clinic services provided by the Office of Public Health certified school-based health clinics;
15. physician services;
16. maternity services;
17. chiropractic services;
18. rehabilitation therapy services (physical, occupational, and speech therapies);
19. pharmacy services (outpatient prescription medicines dispensed, with the exception of those who are enrolled in Bayou Health for behavioral health services only, or the contractual responsibility of another Medicaid managed care entity):
 - a. specialized behavioral health only members will receive pharmacy services through legacy Medicaid;
20. hospice services;
21. personal care services (age 0-20);
22. pediatric day healthcare services;
23. audiology services;
24. ambulatory surgical services;
25. laboratory and radiology services;
26. emergency and surgical dental services;
27. clinic services;
28. pregnancy-related services;
29. pediatric and family nurse practitioner services;
30. licensed mental health professional services, including advanced practice registered nurse (APRN) services;
31. federally qualified health center (FQHC)/rural health clinic (RHC) services;
32. early stage renal disease (ESRD) services;

33. optometry services;
34. podiatry services;
35. rehabilitative services, including crisis stabilization;
36. respiratory services; and
37. other services as required which incorporate the benefits and services covered under the Medicaid State Plan, including the essential health benefits provided in 42 CFR 440.347.

NOTE: This overview is not all inclusive. The contract, policy transmittals, state plan amendments, regulations, provider bulletins, provider manuals, published fee schedules, and guides issued by the department are the final authority regarding services.

E. Transition Provisions

1. In the event a member transitions from an MCO included status to an MCO excluded status or MCO specialized behavioral health only status before being discharged from a hospital and/or rehabilitation facility, the cost of the entire admission will be the responsibility of the MCO. This is only one example and does not represent all situations in which the MCO is responsible for cost of services during a transition.

2. In the event a member is transitioning from one MCO to another and is hospitalized at 12:01 a.m. on the effective date of the transfer, the relinquishing MCO shall be responsible for both the inpatient hospital charges and the charges for professional services provided through the date of discharge. Services other than inpatient hospital will be the financial responsibility of the receiving MCO.

F. The core benefits and services provided to the members shall include, but are not limited to, those services specified in the contract.

1. Policy transmittals, State Plan amendments, regulations, provider bulletins, provider manuals, and fee schedules, issued by the department are the final authority regarding services.

G. Excluded Services

1. The following services will continue to be reimbursed by the Medicaid Program on a fee-for-service basis, with the exception of dental services which will be reimbursed through a dental benefits prepaid ambulatory health plan under the authority of a 1915(b) waiver. The MCO shall provide any appropriate referral that is medically necessary. The department shall have the right to incorporate these services at a later date if the member capitation rates have been adjusted to incorporate the cost of such service. Excluded services include:

- a. services provided through the Early-Steps Program (IDEA Part C Program services);
- b. intermediate care facility services for persons with intellectual disabilities;
- c. personal care services (age 21 and over);
- d. nursing facility services;

EXCEPTION: Skilled nursing facility services may be utilized for members who transition from acute care hospital services as a step-down continuum of care.

e. individualized education plan services provided by a school district and billed through the intermediate school district, or school-based services funded with certified public expenditures;

f. targeted case management services; and

g. all OAAS/OCDD home and community-based §1915(c) waiver services.

H. Utilization Management

1. The MCO shall develop and maintain policies and procedures with defined structures and processes for a utilization management (UM) program that incorporates utilization review. The program shall include service authorization and medical necessity review and comply with the requirements set forth in this Section, the contract and department issued guides.

a. The MCO shall submit UM policies and procedures to the department for written approval annually and subsequent to any revisions.

2. The UM Program policies and procedures shall, at a minimum, include the following requirements:

a. the individual(s) who is responsible for determining medical necessity, appropriateness of care, level of care needed, and denying a service authorization request or authorizing a service in amount, duration or scope that is less than requested, must meet the following requirements. The individual shall:

i. be a licensed clinical professional with appropriate clinical expertise in the treatment of a member's condition or disease;

ii. have no history of disciplinary action or sanctions, including loss of staff privileges or participation restrictions that have been taken or are pending such action by any hospital, governmental agency or unit, or regulatory body, that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional competence or moral character; and

iii. attest that no adverse determination will be made regarding any medical procedure or service outside of the scope of such individual's expertise;

b. the methodology utilized to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services;

c. the data sources and clinical review criteria used in decision making;

d. the appropriateness of clinical review shall be fully documented;

e. the process for conducting informal reconsiderations for adverse determinations;

f. mechanisms to ensure consistent application of review criteria and compatible decisions;

g. data collection processes and analytical methods used in assessing utilization of healthcare services; and

h. provisions for assuring confidentiality of clinical and proprietary information.

3. The UM Program's medical management and medical necessity review criteria and practice guidelines shall be reviewed annually and updated periodically as appropriate. The MCO shall use the medical necessity definition as set forth in LAC 50:I.1101 for medical necessity determinations.

a. Medical management and medical necessity review criteria and practice guidelines shall:

i. be objective and based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

ii. consider the needs of the members;

iii. be adopted in consultation with contracting health care professionals; and

iv. be disseminated to all affected providers, members, and potential members upon request.

b. The MCO must identify the source of the medical management criteria used for the review of medical necessity and for service authorization requests.

i. The vendor must be identified if the criteria are purchased.

ii. The association or society must be identified if the criteria are developed/recommended or endorsed by a national or state health care provider association or society.

iii. The guideline source must be identified if the criteria are based on national best practice guidelines.

iv. The individuals who will make medical necessity determinations must be identified if the criteria are based on the medical training, qualifications, and experience of the MCO medical director or other qualified and trained professionals.

4. The MCO shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease shall determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested.

5. The MCO shall ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member in accordance with 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR §422.210.

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

NOTE: HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing,

LR 37:1585 (June 2011), amended LR 39:92 (January 2013), repromulgated LR 39:318 (February 2013), LR 41:936 (May 2015), LR 41:2367 (November 2015), LR 42:755 (May 2016), amended the Department of Health, Bureau of Health Services Financing, LR 44:61 (January 2018), LR 44:1253 (July 2018), LR 44:1902 (October 2018).

§3509. Reimbursement Methodology

A. Payments to an MCO. The department, or its fiscal intermediary, shall make monthly capitation payments to the MCO based on a per member, per month (PMPM) rate.

1. The department will establish monthly capitation rates within an actuarially sound rate range certified by its actuaries. Consistent with all applicable federal rules and regulations, the rate range will initially be developed using fee-for-service claims data, Bayou Health shared savings claims data, Bayou Health managed care organization encounter data, Louisiana Behavioral Health Partnership (LBHP) encounter data, financial data reported by Bayou Health managed care organizations and the LBHP statewide management organization, supplemental ad hoc data, and actuarial analyses with appropriate adjustments.

2. As the Bayou Health managed care program matures and fee-for-service, shared savings and LBHP data are no longer available, there will be increasing reliance on Bayou Health managed care organization encounter data and/or financial data to set future rates, subject to comparable adjustments.

3. Capitation rates will be set for all MCOs at the beginning of each contract period and will be periodically reviewed and adjusted as deemed necessary by the department.

4. Capitation rates will be risk-adjusted for the health of Medicaid enrollees enrolled in the MCO as appropriate.

a. The health risk of the Medicaid enrollees enrolled in the MCO will be measured using a national-recognized risk-assessment model.

b. Utilizing this information, the capitation rates will be adjusted to account for the health risk of the enrollees in each MCO relative to the overall population being measured.

c. The health risk of the members and associated MCO risk scores will be updated periodically to reflect changes in risk over time.

d. The department will provide the MCO with advance notice of any major revision to the risk-adjustment methodology.

5. Kick Payments. MCOs may be reimbursed a one-time supplemental lump sum payment, hereafter referred to as a “kick payment”, for the provision of certain services that meet specific conditions, in an amount determined by the department’s actuaries.

a. The kick payment is intended to cover the cost of a specific care event or treatment. Payment will be made to the MCO upon submission of satisfactory evidence of the event or treatment.

b. Only one kick payment will be made per event or treatment.

6. Capitation rates related to pharmacy services will be adjusted to account for pharmacy rebates.

7. The department, or its fiscal intermediary, may reimburse an MCO’s monthly capitation payments or kick payments in the aggregate on a lump sum basis when administratively necessary.

B. As Medicaid is the payor of last resort, an MCO must agree to accept the PMPM rate as payment-in-full from the department and agree not to seek additional payment from a member for any unpaid cost.

C. The MCO rate does not include graduate medical education payments or disproportionate share hospital payments. These supplemental payments will be made to applicable providers outside the PMPM rate by the department according to methodology consistent with existing Rules.

D. An MCO shall assume 100 percent liability for any expenditure above the PMPM rate.

E. The MCO shall meet all financial reporting requirements specified in the terms of the contract.

F. An MCO shall have a medical loss ratio (MLR) for each MLR reporting year, which shall align with the capitation rating period, except in circumstances in which the MLR reporting period must be revised to align to a CMS-approved capitation rating period.

1. Following the end of the MLR reporting year, an MCO shall provide an annual MLR report, in accordance with the financial reporting guide issued by the department.

2. The annual MLR report shall be limited to the MCO’s medical loss ratio for services provided to Medicaid enrollees and payment received under the contract with the department, separate from any other products the MCO may offer in the state of Louisiana.

3. An MLR shall be reported in the aggregate, including all services provided under the contract, unless the department requires separate reporting and a separate MLR calculation for specific populations.

a. The aggregate MLR shall not be less than 85 percent using definitions for health care services, quality initiatives and administrative cost as specified in 45 CFR Part 158. If the aggregate MLR is less than 85 percent, the MCO will be subject to refund the difference, within the timeframe specified, to the department. The portion of any refund due the department that has not been paid, within the timeframe specified, will be subject to interest at the current Federal Reserve Board lending rate or in the amount of 10 percent per annum, whichever is higher.

b. The department may request MLR reporting that distinguishes physical and basic behavioral health from specialized behavioral health. Neither the 85 percent minimum nor the refund applicable to the aggregate shall apply to distinct MLRs reported.

4. The department shall provide for an audit of the MCO's annual MLR report and make public the results within 60 calendar days of finalization of the audit.

G. Any cost sharing imposed on Medicaid members must be in accordance with the federal regulations governing cost sharing and cannot exceed the amounts reflected in the Louisiana Medicaid State Plan, but the amounts can be less than the cost sharing levels in the State Plan.

H. The department may adjust the PMPM rate, during the term of the contract, based on:

1. changes to core benefits and services included in the capitation rate;
2. changes to Medicaid population groups eligible to enroll in an MCO;
3. changes in federal requirements; and/or
4. legislative appropriations and budgetary constraints.

I. Any adjusted rates must continue to be actuarially sound and will require an amendment to the contract.

J. The MCO shall not assign its rights to receive the PMPM payment, or its obligation to pay, to any other entity.

1. At its option, the department may, at the request of the MCO, make payment to a third party administrator.

K. In the event that an incorrect payment is made to the MCO, all parties agree that reconciliation will occur.

1. If an error or overcharge is discovered by the department, it will be handled in accordance with the terms and conditions of the contract.

L. Network Provider Reimbursement

1. Reimbursement for covered services shall be equal to or greater than the published Medicaid fee-for-service rate in effect on the date of service, unless mutually agreed by both the plan and the provider in the provider contract to pay otherwise.

a. The MCO shall pay a pharmacy dispensing fee, as defined in the contract, at a rate no less than the minimum rate specified in the terms of the contract.

2. The MCO's subcontract with the network provider shall specify that the provider shall accept payment made by the MCO as payment-in-full for core benefits and services provided and shall not solicit or accept any surety or guarantee of payment from the department or the member.

a. The term "member" shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the member being served.

3. The MCO shall pay federally qualified health centers (FQHCs) and rural health clinics (RHCs) at least the amount LDH would pay for such services through fee-for-service or defined by the prospective payment system (PPS) rate or the alternative payment methodology rate in effect on the date of service for each encounter.

M. Out-of-Network Provider Reimbursement

1. The MCO is not required to reimburse more than 90 percent of the published Medicaid fee-for-service rate in effect on the date of service to out-of-network providers to whom they have made at least three documented attempts to include the provider in their network as per the terms of the contract.

2. If three attempts to contract with the provider prior to the delivery of the medically necessary service have not been documented, the MCO shall reimburse the provider the published Medicaid fee-for-service rate in effect on the date of service.

3. The MCO is not required to reimburse pharmacy services delivered by out-of-network providers. The MCO shall maintain a system that denies the claim at the point-of-sale for providers not contracted in the network.

N. Reimbursement for Emergency Services for In-Network or Out-of-Network Providers

1. The MCO is financially responsible for ambulance services, emergency and urgently needed services and maintenance, and post-stabilization care services in accordance with the provisions set forth in 42 CFR §422.113.

2. The reimbursement rate for medically necessary emergency services shall be no less than the published Medicaid fee-for-service rate in effect on the date of service, regardless of whether the provider that furnished the services has a contract with the MCO.

a. The MCO may not concurrently or retrospectively reduce a provider's reimbursement rate for these emergency services, including ancillary and diagnostic services, provided during an episode of care.

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 37:1587 (June 2011), amended LR 39:92 (January 2013), LR 41:937 (May 2015), LR 41:2367 (November 2015), LR 42:755 (May 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 45:1771 (December 2019), LR 49:1725 (October 2023), LR 49:1727 (October 2023).

§3511 Prompt Pay of Claims

A. Network Providers. All subcontracts executed by the MCO shall comply with the terms in the contract. Requirements shall include at a minimum:

1. the name and address of the official payee to whom payment shall be made;

2. the full disclosure of the method and amount of compensation or other consideration to be received from the MCO; and

3. the standards for the receipt and processing of claims are as specified by the department in the MCO's contract with the department and department issued guides.

B. Network and Out-of-Network Providers

1. The MCO shall make payments to its network providers, and out-of-network providers, subject to the conditions outlined in the contract and department issued guides.

a. The MCO shall pay 90 percent of all clean claims, as defined by the department, received from each provider type within 15 business days of the date of receipt.

b. The MCO shall pay 99 percent of all clean claims within 30 calendar days of the date of receipt.

c. The MCO shall pay annual interest to the provider, at a rate specified by the department, on all clean claims paid in excess of 30 days of the date of receipt. This interest payment shall be paid at the time the claim is fully adjudicated for payment.

2. Medicaid claims must be filed within 365 days of the date of service.

a. The provider may not submit an original claim for payment more than 365 days from the date of service, unless the claim meets one of the following exceptions:

i. the claim is for a member with retroactive Medicaid eligibility and must be filed within 180 days from linkage into an MCO;

ii. the claim is the Medicare claim and shall be submitted within 180 days of Medicare adjudication; and

iii. the claim is in compliance with a court order to carry out hearing decisions or agency corrective actions taken to resolve a dispute, or to extend the benefits of a hearing decision or corrective action.

3. The MCO and all providers shall retain any and all supporting financial information and documents that are adequate to ensure that payment is made in accordance with applicable federal and state laws.

a. Any such documents shall be retained for a period of at least six years or until the final resolution of all litigation, claims, financial management reviews, or audits pertaining to the contract.

4. There shall not be any restrictions on the right of the state and federal government to conduct inspections and/or audits as deemed necessary to assure quality, appropriateness or timeliness of services and reasonableness of costs.

C. Claims Management

1. The MCO shall process a provider's claims for covered services provided to members in compliance with all applicable state and federal laws, rules and regulations as well as all applicable MCO policies and procedures including, but not limited to:

a. claims format requirements;

b. claims processing methodology requirements;

c. explanation of benefits and related function requirements;

d. processing of payment errors;

e. notification to providers requirements; and

f. timely filing.

D. Provider Claims Dispute

1. The MCO shall:

a. have an internal claims dispute procedure that is in compliance with the contract and department issued guide and approved by the department;

b. contract with independent reviewers to review disputed claims;

c. systematically capture the status and resolution of all claim disputes as well as all associate documentation; and

d. Report the status of all disputes and their resolution to the department on a monthly basis as specified in the contract and department issued guides.

E. Claims Payment Accuracy Report

1. The MCO shall submit an audited claims payment accuracy percentage report to the department on a monthly basis as specified in the contract and department issued MCO guides.

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 37:1589 (June 2011), amended LR 41:938 (May 2015), LR 42:276 (February 2016).

Chapter 37. Grievance and Appeal Process

Subchapter A. Member Grievances and Appeals

§3701. Introduction

A. An MCO must have a grievance system for Medicaid enrollees that complies with federal regulations. The MCO shall establish and maintain a procedure for the receipt and prompt internal resolution of all grievances and appeals in accordance with all applicable state and federal laws and as specified in the contract and all department issued guides.

B. The MCO's grievance and appeals procedures, and any changes thereto, must be approved in writing by the department prior to their implementation and must include, at a minimum, the requirements set forth herein.

1. The MCO shall refer all members who are dissatisfied, in any respect, with the MCO or its subcontractor to the MCO's designee who is authorized to review and respond to grievances and to require corrective action.

2. The member must exhaust the MCO's internal grievance/appeal process prior to accessing the state fair hearing process.

C. The MCO shall not create barriers to timely due process. If the number of appeals reversed by the state fair hearing process exceeds 10 percent of appeals received within a 12 month period, the MCO may be subject to sanctions.

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 37:1589 (June 2011), amended LR 41:938 (May 2015).

§3703. Definitions

Adverse Benefit Determination—any of the following:

1. the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
2. the reduction, suspension, or termination of a previously authorized service;
3. the denial, in whole or in part, of payment for a service;
4. the failure to provide services in a timely manner, as defined by the state;
5. the failure of an MCO to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals;
6. the denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductible, coinsurance, and other member financial liabilities.

Appeal—a request for review of an adverse benefit determination as defined in this Section.

Grievance—an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to:

1. the quality of care or services provided;
2. aspects of interpersonal relationships, such as rudeness of a provider or employee;
3. failure to respect the member's rights regardless of whether remedial action is requested; or
4. the member's rights to dispute an extension of time proposed by the MCO to make an authorization decision.

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 37:1589 (June 2011), amended LR 41:939 (May 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:285 (February 2018).

§3705. General Provisions

A. The MCO must have a system in place for members that includes a grievance process, an appeal process, and

access to the state fair hearing process once the MCO's appeal process has been exhausted.

B. Filing Requirements

1. **Authority to File.** A member, or a representative of his/her choice, including a provider acting on behalf of the member and with the member's written consent, may file a grievance and an MCO level appeal. Once the MCO's appeals process has been exhausted, a member or his/her representative, with the member's written consent, may request a state fair hearing.

a. An MCO's provider, acting on behalf of the member and with his/her written consent, may file a grievance, appeal, or request a state fair hearing on behalf of a member.

2. **Filing Timeframes.** The member, or a representative or provider acting on the member's behalf and with his/her written consent, may file an appeal within 60 calendar days from the date on the MCO's notice of adverse benefit determination.

3. Filing Procedures

a. The member may file a grievance either orally or in writing with the MCO.

b. The member, or a representative or provider acting on the member's behalf and with the member's written consent, may file an appeal either orally or in writing. Oral appeals must be followed by a signed, written appeal unless the member requested an expedited appeal.

C. Grievance Notice and Appeal Procedures

1. The MCO shall ensure that all members are informed of the state fair hearing process and of the MCO's grievance and appeal procedures.

a. The MCO shall provide a member handbook to each member that shall include descriptions of the MCO's grievance and appeal procedures.

b. Forms to file grievances, appeals, concerns, or recommendations to the MCO shall be available through the MCO, and must be provided to the member upon request. The MCO shall make all forms easily available on its website.

D. Grievance and Appeal Records

1. The MCO must maintain records of grievances and appeals. A copy of the grievance logs and records of the disposition of appeals shall be retained for 10 years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the 10-year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular 10-year period, whichever is later.

E. All state fair hearing requests shall be sent directly to the state designated entity.

F. The MCO will be responsible for promptly forwarding any adverse decisions to the department for further review and/or action upon request by the department or the MCO member.

G. The department may submit recommendations to the MCO regarding the merits or suggested resolution of any grievance or appeal.

H. Information to Providers and Subcontractors. The MCO must provide the information about the grievance system as specified in federal regulations to all providers and subcontractors at the time they enter into a contract.

I. Recordkeeping and Reporting Requirements. Reports of grievances and resolutions shall be submitted to the department as specified in the contract. The MCO shall not modify the grievance system without the prior written approval of the department.

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 37:1590 (June 2011), amended LR 41:939 (May 2015), LR 41:2368 (November 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:285 (February 2018).

§3707. Handling of Member Grievances and Appeals

A. In handling grievances and appeals, the MCO must meet the following requirements:

1. give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free telephone numbers that have adequate TTY/TTD and interpreter capability;

2. acknowledge receipt of each grievance and appeal;

3. ensure that the individuals who make decisions on grievances and appeals are individuals who:

a. were not involved in any previous level of review or decision-making, nor a subordinate of any such individual; and

b. if deciding on any of the following issues, are individuals who have the appropriate clinical expertise, as determined by the department, in treating the member's condition or disease:

i. an appeal of a denial that is based on lack of medical necessity;

ii. a grievance regarding denial of expedited resolution of an appeal; or

iii. a grievance or appeal that involves clinical issues.

B. Special Requirements for Appeals

1. The process for appeals must:

a. provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing,

unless the member or the provider requests expedited resolution;

b. provide the member a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. The MCO must inform the member of the limited time available for this in the case of expedited resolution;

c. provide the member and his/her representative an opportunity, before and during the appeals process, to examine the member's case file, including medical records, any other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO during the appeals process. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals; and

d. include, as parties to the appeal:

i. the member and his/her representative; or

ii. the legal representative of a deceased member's estate.

2. The MCO's staff shall be educated concerning the importance of the grievance and appeal procedures and the rights of the member and providers.

3. The appropriate individual or body within the MCO having decision making authority as part of the grievance and appeal procedures shall be identified.

4. Failure to Make a Timely Decision

a. Appeals shall be resolved no later than the stated time frames and all parties shall be informed of the MCO's decision.

b. If a determination is not made by the contractual time frames, the member's request will be deemed to have been exhausted and the member may initiate a state fair hearing.

5. The MCO shall inform the member that he/she may seek a state fair hearing if the member is not satisfied with the MCO's decision in response to an appeal.

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 37:1590 (June 2011), amended LR 41:940 (May 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:286 (February 2018).

§3709. Notice of Adverse Benefit Determination

A. Language and Format Requirements. The notice must be in writing and must meet the language and format requirements of federal regulations in order to ensure ease of understanding. Notices must also comply with the standards set by the department relative to language, content, and format.

B. Content of Notice. The notice must explain the following:

1. the adverse benefit determination the MCO or its subcontractor has taken or intends to take;

2. the reasons for the adverse benefit determination, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination;

3. the member's right to file an appeal with the MCO;

4. the member's right to request a state fair hearing after the MCO's one-level appeal process has been exhausted;

5. the procedures for exercising the rights specified in this Section;

6. the circumstances under which expedited resolution is available and the procedure to request it; and

7. the member's right to have previously authorized services continue pending resolution of the appeal, the procedure to make such a request, and the circumstances under which the member may be required to pay the costs of these services.

C. Notice Timeframes. The MCO must mail the notice within the following timeframes:

1. for termination, suspension, or reduction of previously authorized Medicaid-covered services, at least 10 days before the date of action, except as permitted under federal regulations;

2. for denial of payment, at the time of any action taken that affects the claim; or

3. for standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires and within 14 calendar days following receipt of the request for service. A possible extension of up to 14 additional calendar days may be granted under the following circumstances:

a. the member, or his/her representative or a provider acting on the member's behalf, requests an extension; or

b. the MCO justifies (to the department upon request) that there is a need for additional information and that the extension is in the member's interest.

D. If the MCO extends the timeframe in accordance with this Section, it must:

1. give the member written notice of the reason for the decision to extend the timeframe;

2. inform the member of the right to file a grievance if he/she disagrees with that decision; and

3. issue and carry out its determination as expeditiously as the member's health condition requires, but no later than the date that the extension expires.

E. For service authorization decisions not reached within the timeframes specified in this Section, this constitutes a

denial and is thus an adverse action on the date that the timeframes expire.

1. For expedited service authorization decisions where a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, but no later than 72 hours after receipt of the request for service.

2. The MCO may extend the 72-hour time period by up to 14 calendar days if the member or provider acting on behalf of the member requests an extension, or if the MCO justifies (to the department upon request) that there is a need for additional information and that the extension is in the member's interest.

F. The department shall conduct random reviews to ensure that members are receiving such notices in a timely manner.

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 37:1591 (June 2011), amended LR 41:940 (May 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:286 (February 2018).

§3711. Resolution and Notification

A. The MCO must resolve each grievance and appeal, and provide notice as expeditiously as the member's health condition requires, within the timeframes established in this Section. The MCO must provide written notice to all members who filed a grievance whether the grievance was filed with the MCO or the department.

B. Specific Timeframes

1. For standard disposition of a grievance and notice to the affected parties, the timeframe is established as 30 days, or the timeframe established by the department, not to exceed 90 days, from the day the MCO receives the grievance.

2. For standard resolution of an appeal and notice to the affected parties, the timeframe is established as 30 calendar days from the day the MCO receives the appeal.

3. For expedited resolution of an appeal and notice to affected parties, the timeframe is established as 72 hours or as expeditiously as the member's health requires after the MCO receives the appeal.

C. Extension of Timeframes

1. The MCO may extend the timeframes by up to 14 calendar days under the following circumstances:

a. the member requests the extension; or

b. the MCO shows to the satisfaction of the department, upon its request, that there is need for additional information and that the delay is in the member's interest.

D. If the MCO extends the timeframes for any extension not requested by the member, it must give the member written notice of the reason for the delay.

E. Format of Notice

1. The MCO shall follow the method specified by the department to notify a member of the disposition of a grievance.

2. For all appeals, the MCO must provide written notice of the resolution.

3. For notice of an expedited resolution, the MCO must provide written notice of the resolution and also make reasonable efforts to provide oral notice.

F. Content of Notice of Appeal Resolution. The written notice of the resolution must include, at a minimum, the following information:

1. the results of the resolution process and the date it was completed;

2. for appeals not resolved wholly in favor of the members:

a. the right to request a state fair hearing and the procedure to make the request;

b. the right to request to receive previously authorized services during the hearing process and the procedure to make such a request; and

c. that the member may be held liable for the cost of those services if the hearing decision upholds the MCO's action.

G. Requirements for State Fair Hearings

1. The department shall comply with the federal regulations governing fair hearings. The MCO shall comply with all of the requirements as outlined in the contract and department issued guides.

2. If the member has exhausted the MCO's one-level appeal procedures, the member may initiate a state fair hearing within 120 days from the date of the MCO's notice of appeal resolution.

3. The parties to the state fair hearing include the MCO as well as the member and his/her representative or the representative of a deceased member's estate.

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 41:941 (May 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:286 (February 2018).

§3713. Expedited Resolution of Appeals

A. The MCO must establish and maintain an expedited review process for appeals when the MCO determines (either from a member's request or indication from the provider making the request on the member's behalf or in support of the member's request) that taking the time for a standard resolution could seriously jeopardize the member's

life or health or ability to attain, maintain, or regain maximum function.

B. If the MCO denies a request for expedited resolution of an appeal, it must:

1. transfer the appeal to the timeframe for standard resolution; and

2. make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two calendar days with a written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he/she disagrees with the decision.

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 41:941 (May 2015), amended by the Department of Health, Bureau of Health Services Financing LR 44:287 (February 2018).

§3715. Continuation of Services during the Pending MCO Appeal or State Fair Hearing [Formerly LAC 50:I.3711]

A. *Timely Filing*—filing on or before the later of the following:

1. within 10 calendar days of the MCO's mailing of the notice of adverse benefit determination; or

2. the intended effective date of the MCO's proposed adverse benefit determination.

B. Continuation of Benefits. The MCO must continue the member's benefits if the:

1. member or the provider, with the member's written consent, files the appeal timely;

2. appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

3. services were ordered by an authorized provider;

4. original period covered by the original authorization has not expired; and

5. member timely files for continuation of benefits.

C. Duration of Continued or Reinstated Benefits

1. If, at the member's request, the MCO continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of following occurs:

a. the member withdraws the appeal or request for state fair hearing;

b. 10 calendar days pass after the MCO mails the notice providing the resolution of the appeal against the member, unless the member has requested a state fair hearing with continuation of benefits, within the 10-day timeframe, until a state fair hearing decision is reached; or

c. a state fair hearing entity issues a hearing decision adverse to the member.

D. Member Liability for Services. If the final resolution of the appeal is adverse to the member, the MCO may recover from the member the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this Section, and in accordance with federal regulations.

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 37:1591 (June 2011), amended LR 41:942 (May 2015), amended by the Department of Health, Bureau of Health Services Financing LR 44:287 (February 2018).

§3717. Effectuation of Reversed Appeal Resolutions [Formerly LAC 50:I.3713]

A. Provision of Services during the Appeal Process

1. If the MCO or the state fair hearing entity reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires, but no later than 72 hours from the date it receives notice reversing the decision.

B. If the MCO or the state fair hearing entity reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCO must pay for those services in accordance with the contract.

C. At the discretion of the secretary, the department may overrule a decision made by the Division of Administration, Division of Administrative Law (the state fair hearing entity).

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 37:1592 (June 2011), amended LR 41:942 (May 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:287 (February 2018).

Subchapter B. Provider Grievance and Appeal Process

§3721. General Provisions

A. If the provider is filing a grievance or appeal on behalf of the member, the provider shall adhere to the provisions outlined in Subchapter A of this Chapter.

B. The MCO must have a grievance and appeals process for claims, medical necessity, and contract disputes for providers in accordance with the contract and department issued guides.

1. The MCO shall establish and maintain a procedure for the receipt and prompt internal resolution of all provider initiated grievances and appeals as specified in the contract and all department issued guides.

2. The MCO's grievance and appeals procedures, and any changes thereto, must be approved in writing by the department prior to their implementation.

3. Notwithstanding any MCO or department grievance and appeal process, nothing contained in any document, including, but not limited to Rule or contract, shall preclude an MCO provider's right to pursue relief through a court of appropriate jurisdiction.

4. The MCO shall report on a monthly basis all grievance and appeals filed and resolutions in accordance with the terms of the contract and department issued guide.

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 37:1592 (June 2011), amended LR 41:942 (May 2015).

Chapter 39. Sanctions and Measures to Obtain Compliance

§3901. General Provisions

A. The MCO agrees to be subject to intermediate sanctions and other measures to obtain compliance with the terms and conditions of the contract.

1. The specific grounds for intermediate sanctions and other measures to obtain compliance shall be set forth within the contract.

2. The determination of noncompliance is at the sole discretion of the department.

3. It shall be at the department's sole discretion as to the proper recourse to obtain compliance.

B. Intermediate Sanctions

1. The department may impose intermediate sanctions on the MCO if the department finds that the MCO acts or fails to act as specified in 42 CFR §438.700 et seq., or if the department finds any other actions/occurrences of misconduct subject to intermediate sanctions as specified in the contract.

2. The types of intermediate sanctions that the department may impose shall be in accordance with §1932 of the Social Security Act (42 U.S.C. §1396u-2) and 42 CFR §438.700 et seq.

3. The department will provide the MCO with due process in accordance with 42 CFR 438.700 et seq., including timely written notice of sanction and pre-termination hearing.

4. The department will give the CMS Regional Office written notice whenever it imposes or lifts a sanction for one of the violations listed in 42 CFR §438.700 et seq., specifying the affected MCO, the kind of sanction, and the reason for the department's decision to lift a sanction.

C. Other Measures. In addition to intermediate sanctions, the department may impose other measures to obtain MCO compliance with the terms and conditions of the contract,

including but not limited to administrative actions, corrective action plans, and/or monetary penalties as specified in the contract.

1. Administrative actions exclude monetary penalties, corrective action plans, intermediate sanctions, and termination, and include but are not limited to a warning through written notice or consultation and education regarding program policies and procedures.

2. The MCO may be required to submit a corrective action plan (CAP) to the department within the timeframe specified by the department. The CAP, which is subject to approval or disapproval by the department, shall include:

- a. steps to be taken by the MCO to obtain compliance with the terms of the contract;
- b. a timeframe for anticipated compliance; and
- c. a date for the correction of the occurrence identified by the department.

3. The department, as specified in the contract, has the right to enforce monetary penalties against the MCO for certain conduct, including but not limited to failure to meet the terms of a CAP.

4. Monetary penalties will continue until satisfactory correction of an occurrence of noncompliance has been made as determined by the department.

D. Any and all monies collected as a result of monetary penalties or intermediate sanctions against a MCO or any of its subcontractors, or any recoupment(s)/repayment(s) received from the MCO or any of its subcontractors, shall be placed into the Louisiana Medical Assistance Trust Fund established by R.S. 46:2623.

E. Termination for Cause

1. Issuance of Notice Termination

a. The department may terminate the contract with an MCO when it determines the MCO has failed to perform, or violates, substantive terms of the contract or fails to meet applicable requirements in §§1903(m), 1905(t) or 1932 of the Social Security Act in accordance with the provisions of the contract.

b. The department will provide the MCO with a timely written Notice of Intent to Terminate notice. In accordance with federal regulations, the notice will state:

- i. the nature and basis of the sanction;
 - ii. pre-termination hearing and dispute resolution conference rights, if applicable; and
 - iii. the time and place of the hearing.
- c. The termination will be effective no less than 30 calendar days from the date of the notice.

d. The MCO may, at the discretion of the department, be allowed to correct the deficiencies within 30 calendar days of the date that the notice was issued, unless

other provisions in this Section demand otherwise, prior to the issue of a notice of termination.

F. Termination due to Serious Threat to Health of Members

1. The department may terminate the contract immediately if it is determined that actions by the MCO or its subcontractor(s) pose a serious threat to the health of members enrolled in the MCO.

2. The MCO members will be enrolled in another MCO.

G. Termination for Insolvency, Bankruptcy, Instability of Funds. The MCO's insolvency or the filing of a bankruptcy petition by or against the MCO shall constitute grounds for termination for cause.

H. Termination for Ownership Violations

1. The MCO is subject to termination unless the MCO can demonstrate changes of ownership or control when a person with a direct or indirect ownership interest in the MCO (as defined in the contract and PE-50) has:

- a. been convicted of a criminal offense as cited in §1128(a), (b)(1) or (b)(3) of the Social Security Act, in accordance with federal regulations;
- b. had civil monetary penalties or assessment imposed under §1128(A) of the Social Security Act; or
- c. been excluded from participation in Medicare or any state health care program.

I. MCO Requirements Prior to Termination for Cause. The MCO shall comply with all of the terms and conditions stipulated in the contract and department issued guides during the period prior to the effective date of termination. The MCO is required to meet the requirements as specified in the contract if terminated for cause.

J. Termination for Failure to Accept Revised Monthly Capitation Rate. Should the MCO refuse to accept a revised monthly capitation rate as provided in the contract, the MCO may provide written notice to the department requesting that the contract be terminated effective at least 60 calendar days from the date the department receives the written request. The department shall have sole discretion to approve or deny the request for termination, and to impose such conditions on the granting of an approval as it may deem appropriate, but it shall not unreasonably withhold its approval.

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 37:1596 (June 2011), amended LR 41:943 (May 2015).

Chapter 40. Audit Requirements

§4001. General Provisions

A. The MCO and its subcontractors shall comply with all audit requirements specified in the contract and department issued guides.

B. The MCO and its subcontractors shall maintain supporting financial information and documents that are adequate to ensure that payment is made in accordance with applicable federal and state requirements, and are sufficient to ensure the accuracy and validity of claims.

1. Such documents, including all original claim forms, shall be maintained and retained by the MCO and or its subcontractors for a period of six years after the contract expiration date or until the resolution of all litigation, claim, financial management review, or audit pertaining to the contract, whichever is longer.

2. The MCO or its subcontractors shall provide any assistance that such auditors and inspectors reasonably may require to complete with such audits or inspections.

C. There shall be no restrictions on the right of the state and federal government to conduct inspections and audits as deemed necessary to assure quality, appropriateness or timeliness of services and reasonableness of their costs.

D. Upon reasonable notice, the MCO and its subcontractors shall provide the officials and entities identified in the contract and department issued guides with prompt, reasonable, and adequate access to any records, books, documents, and papers that are related to the performance of the contract.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1597 (June 2011), amended LR 41:944 (May 2015).

Subpart 5. Provider Fraud and Recovery

Chapter 41. Surveillance and Utilization Review Subsystem (SURS)

Subchapter A. General Provisions

§4101. Foreword

A. The Medical Assistance Program is a four-party arrangement: the taxpayer; the government; the beneficiaries; and the providers. The secretary of the Department of Health and Hospitals (DHH), through this Chapter 41, recognizes:

1. the obligation to the taxpayers to assure the fiscal and programmatic integrity of the Medical Assistance Program. The secretary has zero tolerance for fraudulent, willful, abusive or other ill practices perpetrated upon the Medical Assistance Program by providers, providers-in-fact and others, including beneficiaries. Such practices will be vigorously pursued to the fullest extent allowed under the applicable laws and regulations; and

2. the responsibility to assure that actions brought in pursuit of providers, providers-in-fact and others, including beneficiaries, under this regulation are not frivolous, vexatious or brought primarily for the purpose of

harassment. Providers, providers-in-fact and others, including beneficiaries, must recognize that they have an obligation to obey and follow all applicable laws, regulations, policies, criteria, and procedures.

B. The Department of Health and Hospitals, Bureau of Health Services Financing (BHSF) has adopted this Chapter 41 in order to:

1. establish procedures for conducting surveillance and utilization review of providers and others;

2. define conduct in which providers and others cannot be engaged;

3. establish grounds for sanctioning providers and others who engage in prohibited conduct; and

4. establish the procedures to be used when sanctioning or otherwise restricting a provider and others under the Medicaid Program.

C. The purpose of this regulation is to assure the quality, quantity, and need for such goods, services, and supplies and to provide for the sanctioning of those who do not provide adequate goods, services, or supplies or request payment or reimbursement for goods, services, or supplies which do not comply with the requirements of federal laws, federal regulations, state laws, state regulations, or the rules, procedures, criteria or policies governing providers and others under the Medicaid Program.

D. A further purpose of this regulation is to assure the integrity of the Medicaid Program by providing methods and procedures to:

1. prevent, detect, investigate, review, hear, refer, and report fraudulent or abusive practices, errors, over-utilization, or under-utilization by providers and others;

2. impose any and all administrative sanctions and remedial measures authorized by law or regulation, which are appropriate under the circumstances;

3. pursue recoupment or recovery arising out of prohibited conduct or overpayments;

4. allow for informal resolution of disputes between the Louisiana Medicaid Program and providers and others;

5. establish rules, policies, criteria and procedures; and

6. other functions as may be deemed appropriate.

E. Nothing in this Chapter 41 is intended, nor shall it be construed, to grant any person any right to participate in the Medicaid Program which is not specifically granted by federal law or the laws of this state or to confer upon any person's rights or privileges which are not contained within this regulation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1630 (September 1999), repromulgated

LR 29:584 (April 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:2774 (November 2012).

§4103. Definitions

A. The following specific terms shall apply to all those participating in the Medicaid Program, either directly or indirectly, and shall be applied when making any and all determinations related to this and other departmental regulations, rules, policies, criteria, and procedures applicable to the Medicaid program and its programs.

Affiliate—any person who has a direct or indirect relationship or association with a provider such that the provider is directly or indirectly influenced or controlled by the *affiliate* or has the power to do so. Any person with a direct or indirect ownership interest in a provider is presumed to be an *affiliate* of that provider. Any person who shares in the proceeds or has the right to share in the proceeds of a provider is presumed to be an *affiliate* of that provider unless that person is a spouse or a minor child of the provider and has no other affiliation with the provider other than that of being a family member of the provider.

Agent—a person who is employed by or has a contractual relationship with a provider or who acts on behalf of the provider.

Agreement to Repay—a formal written and enforceable arrangement to repay an identified overpayment, interest, monetary penalties or costs and expenses.

Billing Agent—any agent who performs any or all of the provider's billing functions. Billing agents are presumed to be an agent of the provider.

Billing or Bill—submitting, or attempting to submit, a claim for goods, supplies, or services.

Claim—any request or demand, including any and all documents or information required by federal or state law or by rule made against Medical Assistance Program funds for payment. A claim may be based on costs or projected costs and includes any entry or omission in a cost report or similar document, book of account, or any other document which supports, or attempts to support, the claim. Each claim may be treated as a separate claim, or several claims may be combined to form one claim.

Claims or Payment Review—the process of reviewing documents or other information or sources required or related to the payment or reimbursement to a provider by the department, the department's contractor(s), BHSF, SURS, or the fiscal intermediary in order to determine if the bill or claim should be or should have been paid or reimbursed. Payment and claim reviews are the same process.

Contractor—any person with whom the provider has a contract to perform a service or function on behalf of the provider. A *contractor* is presumed to be an agent of the provider.

Corrective Action Plan—a written plan, short of an administrative sanction, agreed to by a provider, provider-in-

fact or other person with the department, BHSF, or Program Integrity designed to remedy any inefficient, aberrant or prohibited practices by a provider, provider-in-fact or other person. A *corrective action* plan is not a sanction.

Credible Allegation of Fraud—

a. an allegation which has been verified by BHSF or Program Integrity, from any source, including, but not limited to the following:

- i. fraud hotline complaints;
- ii. claims data mining;
- iii. patterns identified through provider audits, civil false claims case; and
- iv. law enforcement investigations;

b. allegations are considered to be credible when they have indicia of reliability and BHSF or Program Integrity has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

Department—the Louisiana Department of Health and Hospitals.

Deputy Secretary—the deputy secretary of the department or authorized designee.

Director of Bureau of Health Services Financing—the director of BHSF or authorized designee.

Director of Program Integrity or Assistant Director of Program Integrity—the individual whom the secretary has designated as the director, program manager or section chief of the Program Integrity Division or the designated assistant to the director of Program Integrity Division respectively or their authorized designee.

Exclusion from Participation—a sanction that terminates a provider, provider-in-fact or other person from participation in the Medicaid Program, and cancels the provider's provider agreement.

a. A provider who is excluded may, at the end of the period of exclusion, reapply for enrollment.

b. A provider, provider-in-fact, or any other person who is excluded may not be a provider or provider-in-fact, agent of a provider, or affiliate of a provider or have a direct or indirect ownership in any provider during their period of exclusion.

False or Fraudulent Claim—a claim which the provider or his billing agent submits knowing the claim to be false, fictitious, untrue, or misleading in regard to any material information. *False or fraudulent claim* shall include a claim which is part of a pattern of incorrect submissions in regard to material information or which is otherwise part of a pattern in violation of applicable federal or state law, rule, or policy.

Federal Regulations—the provisions contained in the *Code of Federal Regulations* (CFR) or the *Federal Register* (FR).

Finalized Sanction or Final Administrative Adjudication or *Order*—a final order imposed pursuant to an administrative adjudication that has been signed by the secretary or the secretary's authorized designee.

Fiscal Agent or Fiscal Intermediary—an organization or legal entity with whom the department contracts to provide for the processing, review of or payment of provider bills and claims.

Good, Service, or Supply—any good, item, device, supply, or service for which a claim is made, or is attempted to be made, in whole or in part.

Health Care Provider—any person furnishing or claiming to furnish a good, service, or supply under the Medical Assistance Programs as defined in R.S. 46:437.3 and any other person defined as a *health care provider* by federal or state law or by rule. For the purpose of this Chapter, *health care provider* and *provider* are interchangeable terms.

Identified Overpayment—the amount of overpayment made to or requested by a provider that has been identified in a final administrative adjudication or order.

Indirect Ownership—the owner has an ownership interest in the provider through some other entity, whether said ownership interest, at any level, is in whole or in part.

Ineligible Recipient—an individual who is not eligible to receive health care through the medical assistance programs.

Informal Hearing—an informal conference between the provider, provider-in-fact, or other persons and the director of Program Integrity or his/her designee related to a notice of corrective action, notice of withholding of payments or notice of sanction.

Investigator or Analyst—any person authorized to conduct investigations on behalf of the department, BHSF, Program Integrity, SURS, or the fiscal intermediary, either through employment or contract for the purposes of payment or programmatic review.

Investigatory Process—the examination of the provider, provider-in-fact, agent-of-the-provider, or affiliate, and any other person or entity, and any and all records held by or pertaining to them pursuant to a written request from BHSF. No adjudication is made during this process.

Knew or Should Have Known—the person knew or should have known that the activity engaged in or not engaged in was prohibited conduct under this regulation or federal or state laws and regulations. The standard to be used in determining *knew or should have known* is that of a reasonable person engaged in the activity or practice related to the Medical Assistance Program at issue.

Knowing or Knowingly—the person has actual knowledge of the information, or acts in deliberate ignorance or reckless disregard of the truth or falsity of the information. The standard to be used in determining *knowing*

or *knowingly* is that of a reasonable person engaged in the activity or practice related to the Medical Assistance Program at issue.

Law—any written constitution, statutory laws, rules, collection of rules, or code prescribed under the authority of the governments of the state of Louisiana or the United States.

Louisiana Administrative Code (LAC)—the *Louisiana Administrative Code*.

Managing Employee—a person who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operations of a provider. *Managing employee* shall include, but is not limited to, a chief executive officer, president, general manager, business manager, administrator, or director.

Medical Assistance Program or Medicaid—the *Medical Assistance Program* (Title XIX of the Social Security Act), commonly referred to as *Medicaid*, and other programs operated by and funded in the department, which provide payment to providers.

Misrepresentation—the knowing failure to truthfully or fully disclose any and all information required, or the concealment of any and all information required on a claim or a provider agreement or the making of a false or misleading statement to the department relative to the Medical Assistance Program.

Notice—actual or constructive *notice*.

Notice of an Action—a written notification of an action taken or to be taken by the department, BHSF or SURS. A notice must be signed by or on behalf of the secretary, director of BHSF, or director of Program Integrity.

Ownership Interest—the possession, directly or indirectly, of equity in the capital or the stock, or right to share in the profits of a provider.

Payment or Reimbursement—the payment or reimbursement to a provider from Medical Assistance Programs' funds pursuant to a claim, or the attempt to seek payment for a claim.

Person—any natural person, company, corporation, partnership, firm, association, group, or other legal entity or as otherwise provided for by law.

Policies, Criteria or Procedure—those things established or provided for through departmental manuals, provider updates, remittance advice, memorandums, or bulletins issued by the Medical Assistance Program or the department.

Program—any program authorized under the Medical Assistance Program.

Program Integrity Division (PID)—the Program Integrity Unit under BHSF within the department, its predecessor and successor.

Provider Agreement—the document(s) signed by or on behalf of the provider and those things established or provided for in R.S. 46:437.11-437.14 or by rule, which enrolls the provider in the Medical Assistance Program or one or more of its programs and grants to the provider a provider number and the privilege to participate in the Medicaid Program or one or more of its programs.

Provider Enrollment—the process through which a person becomes enrolled in the Medical Assistance Program or one of its programs for the purpose of providing goods, services, or supplies to one or more Medicaid recipients.

Provider-in-Fact—person who directly or indirectly participates in management decisions, has an ownership interest in the provider, or other persons defined as a *provider-in-fact* by federal or state law or by rule. A person is presumed to be a *provider-in-fact* if the person is:

- a. a partner;
- b. a board of directors member;
- c. an office holder; or
- d. a person who performs a significant management or administrative function for the provider, including any person or entity who has a contract with the provider to perform one or more significant management or administrative functions on behalf of the provider;
- e. a person who signs the provider enrollment paper work on behalf of the provider;
- f. a managing employee;
- g. an agent of the provider or a billing agent.

Provider Number—a provider's billing or claim reimbursement number issued by the department through BHSF under the Medical Assistance Program.

Recipient—an individual who is eligible to receive health care through the medical assistance programs.

Recoupment—recovery through the reduction, in whole or in part, of payments or reimbursements to a provider.

Recovery—the recovery of overpayments, damages, fines, penalties, costs, expenses, restitution, attorney fees, or interest or settlement amounts.

Referring Provider—any provider, provider-in-fact or anyone operating on the provider's behalf who refers a recipient to another person for the purpose of providing goods, services, or supplies.

Rule or Regulation—any *rule* or *regulation* promulgated by the department in accordance with the Administrative Procedure Act and any federal rule or regulation promulgated by the federal government in accordance with federal law.

Secretary—the secretary of the Department of Health and Hospitals, or his authorized designee.

Statistical Sample—a statistical formula and sampling technique used to produce a statistical extrapolation of the amount of overpayment made to a provider.

SURS Manager—the individual designated by the secretary as the manager of SURS or authorized designee.

Surveillance and Utilization Review Subsystem (SURS)—the section within the department assigned to identify providers for review, conduct payment reviews, and sanction providers resulting from payments to and claims from providers, and any other functions or duties assigned by the secretary.

Undersecretary—the undersecretary of the department or authorized designee.

Violations—any practice or activity by a provider, provider-in-fact, agent-of-the-provider, affiliate, or other persons which is prohibited by law or this Chapter.

Withhold Payment—to reduce or adjust the amount, in whole or in part, to be paid to a provider for pending or future claims during the time of a criminal, civil, or departmental investigation, departmental proceeding, or claims review of the provider.

Working Days—Monday through Friday, except for legal holidays and other situations when the department is closed.

B. General Terms. Definitions contained in applicable federal laws and regulations shall also apply to this and all department regulations. In the case of a conflict between federal definitions and departmental definitions, the department's definition shall apply unless the federal definition, as a matter of law, supersedes a departmental definition. Definitions contained in applicable state laws shall also apply to this and all departmental definitions. In the case of a conflict between a state statutory definition and a departmental definition, the departmental definition shall apply unless the state statutory definition, as a matter of state law, supersedes the departmental definition.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1631 (September 1999), repromulgated LR 29:584 (April 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:2775 (November 2012).

§4105. Material

A. The secretary of the Department of Health and Hospitals establishes the following definitions of material.

1. For the purpose of R.S. 46:438.8 as required under R.S. 46:438.8(D), in determining whether a pattern of incorrect submissions exists in regards to an alleged false or fraudulent claim the incorrect submissions must be 5 percent or more of the total claims submitted, or to be submitted, by the provider during the period covered in the civil action filed or to be filed. The total amount of claims for the

purpose of this provision is the total number of claims submitted, or to be submitted, by the provider during the period of time and type or kind of claim which is the subject of the civil action under R.S. 46:438.8.

2. Statistically valid sampling techniques may be used by either party to prove or disprove whether the pattern was material.

B. This provision is enacted under the authority provided in R.S. 46:438.8(D).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1633 (September 1999), repromulgated LR 29:587 (April 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:2776 (November 2012).

§4107. Statistical Sampling

A. Statistical sampling techniques may be used by any party to the proceedings.

B. A valid sampling technique may be used to produce an extrapolation of the amount of overpayment made to a provider or to show the number of violations committed by a provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1634 (September 1999), repromulgated LR 29:587 (April 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:2776 (November 2012).

Subchapter B. Prepayment or Post-Payment Claims Review

§4115. Departmental and Provider Obligations

A. The department, through the secretary, has an obligation, imposed by federal and state laws and regulations, to:

1. review bills and claims submitted by providers before payment is made or after.

a. Payments made by the Medicaid Program are subject to review by DHH, Program Integrity Division, a contractor to DHH, or the fiscal intermediary at anytime to ensure the quality, quantity, and need for goods, services, or supplies provided to or for a recipient by a provider;

b. it is the function of the Program Integrity Division (PID) and the Surveillance and Utilization Review Subsystem (SURS) to provide for and administer the utilization review process within the department;

2. assure that claims review brought under this regulation are not frivolous, vexatious or brought primarily for the purpose of harassment;

3. recognize the need to obtain advice from applicable professions and individuals concerning the standards to be applied under this Chapter;

4. recognize the right of each individual to exercise all rights and privileges afforded to that individual under the law including, but not limited to, the right to counsel as provided under the applicable laws.

B. Providers have no right to receive payment for bills or claims submitted to BHSF or its fiscal intermediary. Providers only have a right to receive payment for valid claims. Payment of a bill or claim does not constitute acceptance by the department or its fiscal intermediary that the bill or claim is a valid claim. The provider is responsible for maintaining all records necessary to demonstrate that a bill or claim is in fact a valid claim. It is the provider's obligation to demonstrate that the bill or claim submitted was for goods, services, or supplies:

1. provided to a recipient who was entitled to receive the goods, services, or supplies;

2. were medically necessary;

3. were provided by, or authorized by, an individual with the necessary qualifications to make that determination; and

4. were actually provided to the appropriate recipient in the appropriate quality and quantity by an individual qualified to provide the good, service or supply; or

5. in the case of a claim based on a cost report, that each entry is complete, accurate and supported by the necessary documentation.

C. The provider must maintain and make available for inspection all documents required to demonstrate that a bill or claim is a valid claim. Failure on the part of the provider to adequately document means that the goods, services, or supplies will not be paid for or reimbursed by the Medicaid program.

D. A person has no property interest in any payments or reimbursements from Medicaid which are determined to be an overpayment or are subject to payment review.

E. Providers, providers-in-fact and others, including recipients, must recognize that they have an obligation to obey and follow all applicable laws, regulations, policies, criteria, and procedures. In the case of an action brought for incorrect submissions, providers and providers-in-fact recognize the department may impose judicial interest on any outstanding recovery or recoupment, or reasonable cost and expenses incurred as the direct result of the investigation or review, including, but not limited to, the time and expenses incurred by departmental employees or agents and the fiscal intermediary's employees or agents.

F. In determining the amount to be paid or reimbursed to a provider any and all overpayments, recoupment or recovery must be taken into consideration prior to determining the actual amount owed to the provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1634 (September 1999), repromulgated LR 29:587 (April 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:2777 (November 2012).

§4117. Claims Review

A. BHSF establishes the following procedures for review of bills and claims submitted to it or its fiscal intermediary.

1. Prepayment Review

a. Upon concurrence of the director of BHSF and the director of Program Integrity, bills or claims submitted by a provider may be reviewed by BHSF, its contractor(s), or its fiscal intermediary prior to the issuing of or denial of payment or reimbursement.

b. If, during the prepayment review process, it is determined that the provider may be overpaid, BHSF, its contractor(s), or its fiscal intermediary must conduct an investigation to determine the reasons for and estimates of the amount of the potential overpayments.

i. If it is determined that evidence exists which would lead the director of BHSF and the director of Program Integrity to believe that the provider, provider-in-fact, agent of the provider, or affiliate of the provider has engaged in fraudulent, false, or fictitious billing practices or willful misrepresentation, current and future payments shall be withheld, suspended, or zero paid.

ii. If it is determined that evidence exists which would lead the director of BHSF and the director of Program Integrity to believe that overpayments may have occurred through reasons other than fraudulent, false or fictitious billing or willful misrepresentation, current and future payments may be withheld, suspended, or zero paid.

c. Prepayment review is not a sanction and cannot be appealed nor is it subject to an informal hearing. In the case of an ongoing criminal or outside governmental investigation, information related to the investigation shall not be disclosed to the provider, provider-in-fact or other person unless release of such information is otherwise authorized or required under law. Denials or refusals to pay individual bills or claims that are the result of the edit and audit system are not withholdings of payments.

d. Prepayment review is conducted at the absolute discretion of the director of BHSF and the director of Program Integrity.

2. Post-payment Review

a. Providers have a right to receive payment only for those bills that are valid claims. A person has no property interest in any payments or reimbursements from Medicaid, which are determined to be an overpayment or are subject to payment review. After payment to a provider, BHSF, its contractor(s), or its fiscal intermediary may review any or all

payments made to a provider for the purpose of determining if the amounts paid were for valid claims.

b. If, during the post-payment review process, it is determined that the provider may have been overpaid, BHSF, its contractor(s), or its fiscal intermediary must conduct an investigation to determine the reasons for and estimated amounts of the alleged overpayments.

i. If it is determined that evidence exists that would lead the director of BHSF and the director of Program Integrity to believe that the provider, provider-in-fact, agent of the provider, or affiliate of the provider may have engaged in fraudulent, false, or fictitious billing practices or willful misrepresentation, current and future payments shall be withheld, suspended and/or zero paid.

ii. If it is determined that evidence exists that overpayments may have occurred through reasons other than fraud or willful misrepresentation, current and future payments may be withheld, suspended and/or zero paid.

c. Post-payment review resulting in a sanction(s) is appealable and subject to an informal hearing. In the case of an ongoing criminal or outside government investigation, information related to the investigation shall not be disclosed to the provider, provider-in-fact or other person. Denials or refusals to pay individual bills that are the result of the edit and audit system are not withholdings of payments.

d. Post-payment review is conducted is at the absolute discretion of the director of BHSF and director of Program Integrity.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1634 (September 1999), repromulgated LR 29:588 (April 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:2777 (November 2012).

§4119. Claims Review Scope and Extent

A. Prepayment and post-payment review may be limited to specific items or procedures or include all billings or claims by a provider.

B. The length of time a provider is on prepayment or post-payment review shall be at the sole discretion of the director of BHSF and the director of Program Integrity.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1635 (September 1999), repromulgated LR 29:589 (April 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:2778 (November 2012).

Subchapter C. Investigations

§4129. Investigations

A. An investigation may be initiated without cause and requires no justification. The provider and provider-in-fact of the provider have an affirmative duty to cooperate fully with the investigation. The provider and provider-in-fact shall:

1. make all records requested as part of the investigation available for review or copying including, but not limited to, any financial or other business records of the provider or any or all records related to the recipients;

2. make available all agents and affiliates of the provider for the purpose of being interviewed during the course of the investigation at the provider's ordinary place of business or any other mutually agreeable location; and

3. allow the department to take statements from the provider, provider-in-fact, agents of the provider, and any affiliates of the provider, as well as any recipients who have received goods, services, or supplies from the provider or whom the provider has claimed to have provided goods, services, or supplies.

B. The provider and provider-in-fact of the provider have an affirmative duty to cooperate fully with the department and the department's agents, including full and truthful disclosure of all information requested and questions asked.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:153 and 46:442.1, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1635 (September 1999), repromulgated LR 29:589 (April 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:2778 (November 2012).

Subchapter D. Conduct

§4143. Introduction

A. This Subchapter D pertains to:

1. the kinds of conduct which are violations;
2. the scope of a violation;
3. types of violations; and
4. elements of violations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1636 (September 1999), repromulgated LR 29:590 (April 2003).

§4145. Prohibited Conduct

A. Violations are kinds of conduct that are prohibited and constitute a violation under this regulation. No provider, provider-in-fact, agent of the provider, billing agent, affiliate

of a provider or other person may engage in any conduct prohibited by this Chapter. If they do, the provider or provider-in-fact, agent of the provider, billing agent, affiliate of the provider or other person may be subject to:

1. corrective action;
2. withholding of payment;
3. recoupment;
4. recovery;
5. suspension;
6. exclusion;
7. posting bond or other security;
8. monetary penalties; or
9. any other sanction listed in this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1636 (September 1999), repromulgated LR 29:590 (April 2003).

§4147. Violations

A. The following is a list of violations.

1. Failure to comply with any or all federal or state laws, regulations, policy, or rules applicable to the Medical Assistance Program or a program of the Medical Assistance Program in which the provider, provider-in-fact, agent of the provider, billing agent, affiliate or other person is participating.

a. Neither the secretary, director of BHSF, or any other person can waive or alter a requirement or condition established by statute.

b. Requirements or conditions imposed by a statute can only be waived, modified or changed through legislation.

c. Requirements or conditions imposed by a regulation can only be waived, modified, or changed through formal promulgation of a new or amended regulation, unless authority to do so is specifically provided for in the regulation.

d. Providers, providers-in-fact are required and have an affirmative duty to fully inform all their agents and affiliates, who are performing any function connected to the provider's activities related to the Medicaid Program, of the applicable laws, regulations, or rules.

e. Providers, providers-in-fact, agents of providers, billing agents, and affiliates of providers are presumed to know the law, regulations, or rules. Ignorance of the applicable laws, regulations, or rules is not a defense to any administrative action.

2. Failure to comply with any or all policies, criteria, or procedures of the Medical Assistance Program or the

applicable program of the Medical Assistance Program in which the provider, provider-in-fact, agent of the provider, billing agent, or affiliate of the provider is participating.

a. Policies, criteria, and procedures are contained in program manuals, training manuals, remittance advice, provider updates or bulletins issued by or on behalf of the secretary or director of BHSF.

b. Policies, criteria, and procedures can be waived, amended, clarified, repealed, or otherwise changed, either generally or in specific cases, only by the secretary, undersecretary, deputy secretary, or director of BHSF.

c. Such waivers, amendments, clarifications, repeals, or other changes must be in writing and state that it is a waiver, amendment, clarification, or change in order to be effective.

d. Notice of the policies, criteria, and procedures of the Medical Assistance Program and its programs are provided to providers upon enrollment and receipt of a provider number. It is the duty of the provider to obtain the policies, criteria, and procedures which are in effect while they are enrolled in the Medical Assistance Program.

e. Waivers, amendments, clarifications, repeals, or other changes may be mailed to the provider at the address given to BHSF or the fiscal intermediary by the provider for the express purpose of receiving such notifications. Waivers, amendments, clarifications, repeals, or other changes may also be posted on a BHSF or the fiscal intermediary's website for the express purpose of the provider receiving such notifications.

i. It is the duty of the provider to provide the above address and make arrangements to receive these mailings through that address. This includes the duty to inform BHSF or the fiscal intermediary of any changes in the above address prior to actual change of address. It is also the duty of the provider to check the BHSF or the fiscal intermediary's website to obtain policies, criteria, or procedures.

ii. Mailing to the provider's last known address or the posting to a BHSF or the fiscal intermediary's website of a manual, new manual pages, provider updates, bulletins, memorandums, or remittance advice creates a reputable presumption that the provider received it. The burden of proving lack of notice of policy, criteria, or procedure or waivers, amendments, clarifications, repeals, or other changes in same is on the party asserting it.

iii. Providers and providers-in-fact are presumed to know the applicable policies, criteria, and procedures and any or all waivers, amendments, clarifications, repeals, or other changes to the applicable rules, policies, criteria, and procedures which have been mailed to the address provided by the provider or posted to a BHSF or the fiscal intermediary's website for the purpose of receiving notice of same.

iv. Ignorance of an applicable policy, criteria, or procedure or any and all waivers, amendments,

clarifications, repeals, or other changes to applicable policies, criteria, and procedures is not a defense to an administrative action brought against a provider or provider-in-fact.

f. Providers and providers-in-fact are required and have an affirmative duty to fully inform all of their agents and affiliates, who are performing any function connected to the provider's activities related to the Medicaid Program, of the applicable policies, criteria, and procedures and any waivers, amendments, clarifications, repeals, or other changes in applicable policies, criteria, or procedures.

3. Failure to comply with one or more of the terms or conditions contained in the provider's provider agreement or any and all forms signed by or on behalf of the provider setting forth the terms and conditions applicable to participation in the Medical Assistance Program or one or more of its programs.

a. The terms or conditions of a provider agreement or those contained in the signed forms, unless specifically provided for by law or regulation or rule, can only be waived, changed, or amended through mutual written agreement between the provider and the secretary, undersecretary, deputy secretary or the director of BHSF. Those conditions or terms that are established by law or regulation or rule may not be waived, altered, amended, or otherwise changed except through legislation or rulemaking.

b. A waiver, change, or amendment to a term or condition of a provider agreement and any signed forms must be reduced to writing and be signed by the provider and the secretary, undersecretary, deputy secretary or the director of BHSF in order to be effective.

c. Such mutual agreements cannot waive, change, or amend the law, regulations, rules, policies, criteria, or procedures.

d. The provider and provider-in-fact are presumed to know the terms and conditions in their provider agreement and any signed forms related thereto, and any changes to their provider agreement or the signed forms related thereto.

e. The provider and provider-in-fact are required and have an affirmative duty to fully inform all their agents or affiliates, who are performing any function connected to the provider's activities related to the Medicaid Program, of the terms and conditions contained in the provider agreement and the signed forms related thereto and any change made to them. Ignorance of the terms and conditions in the provider agreement or signed forms or any changes to them is not a defense.

i. The department, BHSF, or the fiscal intermediary may, from time to time, provide training sessions and consultation on the law, regulations, rules, policies, criteria, and procedures applicable to the Medical Assistance Program and its programs. These training sessions and consultations are intended to assist the provider, provider-in-fact, agents of providers, billing agents, and affiliates. Information presented during these training sessions and consultations do not necessarily constitute the

official stands of the department and BHSF in regard to the law, regulations, and rules, policies, or procedures unless reduced to writing in compliance with this Subpart.

4. Making a false, fictitious, untrue, misleading statement or concealment of information during the application process or not fully disclosing all information required or requested on the application forms for the Medical Assistance Program, provider number, enrollment paperwork, or any other forms required by the department, BHSF, or its fiscal intermediary that is related to enrollment in the Medical Assistance Program or one of its programs, or failing to disclose any other information which is required under this regulation, or other departmental regulations, rules, policies, criteria, or procedures. This includes the information required under R.S.46:437.11-437.14. Failure to pay any fees or post security related to enrollment is also a violation of this Section.

a. The provider and provider-in-fact have an affirmative duty to inform BHSF in writing through provider enrollment of any and all changes in ownership, control, or managing employee of a provider and fully and completely disclose any and all administrative sanctions, withholding of payments, criminal charges, or convictions, guilty pleas, or no contest pleas, civil judgments, civil fines, or penalties imposed on the provider, provider-in-fact, agent of the provider, billing agent, or affiliates of the provider in this or any other state or territory of the United States.

i. Failure to do so within 10 working days of when the provider or provider-in-fact knew or should have known of such a change or information is a violation of this provision.

ii. If it is determined that a failure to disclose was willful or fraudulent, the provider's enrollment can be voided back to the date of the willful misrepresentation or concealment or fraudulent disclosure.

5. Not being properly licensed, certified, or otherwise qualified to provide for the particular goods, services, or supplies provided or billed for or such license, certificate, or other qualification required or necessary in order to provide a good, service, or supply has not been renewed or has been revoked, suspended, or otherwise terminated is a violation of this provision. This includes, but is not limited to, professional licenses, business licenses, paraprofessional certificates, and licenses or other similar licenses or certificates required by federal, state, or local governmental agencies, as well as, professional or paraprofessional organizations or governing bodies which are required by the Medical Assistance Program. Failure to pay required fees related to licensure or certification is also a violation of this provision.

6. Having engaged in conduct or performing an act in violation of official sanction which has been applied by a licensing authority, professional peer group, or peer review board or organization, or continuing such conduct following notification by the licensing or reviewing body that said conduct should cease.

7. Having been excluded or suspended from participation in Medicare. It is also a violation of this provision for a provider to employ, contract with, or otherwise affiliate with any person who has been excluded or suspended from Medicare during the period of exclusion or suspension.

a. The provider and provider-in-fact after they knew, or should have known of same, have an affirmative duty to:

i. inform BHSF in writing of any such exclusions or suspensions on the part of the provider, provider-in-fact, their agents or their affiliates;

ii. not hire, contract with, or affiliate with any person or entity who has been excluded or suspended from Medicare; and

iii. terminate any and all ownership, employment and contractual relationships with any person or entity that has been excluded or suspended from Medicare.

b. Failure to do so on the part of the provider or provider-in-fact within 10 working days of when the provider or provider-in-fact knew or should have known of any violation of this provision by the provider, provider-in-fact, their agents, or affiliates is a violation of §4147.A.4.

8. Having been excluded, suspended, or otherwise terminated from participation in Medicaid or other publicly funded health care or insurance programs of this state or any other state or territory of the United States. It is also a violation of this Section for a provider to employ, contract with, or otherwise affiliate with any person who has been excluded, suspended, or otherwise terminated from participation in Medicaid or other publicly funded health care or health insurance programs of this state or another state or territory of the United States. It is also a violation of this provision for a provider to employ, contract with, or otherwise affiliate with any person who has been excluded from Medicaid or other publicly funded health care or health insurance programs of this state or any other state or territory of the United States during the period of exclusion or suspension.

a. The provider and provider-in-fact after they knew or should have known of same have an affirmative duty to:

i. inform BHSF in writing of any such exclusions or suspensions on the part of the provider, provider-in-fact, their agents or their affiliates;

ii. not hire, contract with, or affiliate with any person or entity who has been excluded or suspended from any Medicaid or other publicly funded health care or health insurance programs; and

iii. terminate any and all ownership, employment and contractual relationships with any person or entity that has been excluded or suspended from any Medicaid or other publicly funded health care or health insurance programs.

b. Failure to do so on the part of the provider or provider-in-fact within 10 working days of when the

provider or provider-in-fact knew or should have known of any violation of this provision by the provider, provider-in-fact, their agents, or affiliates is a violation of §4147.A.4.

9. Having been convicted of, pled guilty, or pled no contest to a crime, including attempts or conspiracy to commit a crime, in federal court, any state court, or court in any United States territory related to providing goods, services, or supplies or billing for goods, services, or supplies under Medicare, Medicaid, or any other program involving the expenditure of public funds. It is also a violation for a provider to employ, contract with, or otherwise affiliate with any person who has been convicted of, pled guilty, or pled no contest to a crime, including attempts to or conspiracy to commit a crime, in federal court, any state court, or court in any United States territory related to providing goods, services, or supplies or billing for goods, services, or supplies under Medicare, Medicaid, or any other program involving the expenditure of public funds.

a. The provider and provider-in-fact after they knew or should have known of same have an affirmative duty to:

i. inform BHSF in writing of any such convictions, guilty pleas, or no contest plea to the above felony criminal conduct on the part of the provider, provider-in-fact, their agents or their affiliates;

ii. not hire, contract with, or affiliate with any person or entity who has been convicted, pled guilty to, or pled no contest to the above felony criminal conduct; and

iii. terminate any and all ownership, employment and contractual relationships with any person or entity that has been convicted, pled guilty to, or pled no contest to the above felony criminal conduct.

b. Failure to do so on the part of the provider or provider-in-fact within 10 working days of when the provider or provider-in-fact knew or should have known of any violation of this provision by the provider, provider-in-fact, their agents or affiliates is a violation of §4147.A.4.

c. If five years have passed since the completion of the sentence and no other criminal misconduct by that person has occurred during that five year period, this provision is not violated. Criminal conduct which has been pardoned does not violate this provision.

10. Having been convicted of, pled guilty, or pled no contest in federal court, any state court, or court in any United States territory to criminal conduct involving the negligent practice of medicine or any other activity or skill related to an activity or skill performed by or billed by that person or entity under the Medical Assistance Program or one of its programs or which caused death or serious bodily, emotional, or mental injury to an individual under their care. It is also a violation of this provision for a provider to employ, contract with, or otherwise affiliate with any person who has been convicted of, pled guilty, or pled no contest in federal court, any state court, or court in any United States territory to criminal conduct involving the negligent practice of medicine or any other activity or skill related to an activity or skill performed by or billed by that person or

entity under the Medical Assistance Program or one of its programs or which caused death or serious bodily, emotional, or mental injury to an individual under their care.

a. The provider and provider-in-fact after they knew or should have known of same have an affirmative duty to:

i. inform BHSF in writing of any such convictions, guilty plea, or no contest plea to the above criminal conduct on the part of the provider, provider-in-fact, their agents or affiliates;

ii. not hire, contract with, or affiliate with any person or entity who has been convicted, pled guilty to, or pled no contest to the above criminal conduct; and

iii. terminate any and all ownership, employment and contractual relationships with any person or entity that has been convicted, pled guilty to, or pled no contest to the above criminal conduct.

b. Failure to do so on the part of the provider or provider-in-fact within 10 working days of when the provider or provider-in-fact knew or should have known of any violation of this provision by the provider, provider-in-fact, their agents or affiliates is a violation of §4147.A.4.

c. If five years have passed since the completion of the sentence and no other criminal misconduct by that person has occurred during that five-year period, this provision is not violated. Criminal conduct which has been pardoned does not violate this provision.

11. Having been convicted of, pled guilty to, or pled no contest to, in any federal court, state court, or court in any territory of the United States to any of the following criminal conduct, attempt to commit or conspire to commit any of the following crimes:

a. bribery or extortion;

b. sale, distribution, or importation of a substance or item that is prohibited by law;

c. tax evasion or fraud;

d. money laundering;

e. securities or exchange fraud;

f. wire or mail fraud;

g. violence against a person;

h. act against the aged, juveniles or infirmed;

i. any crime involving public funds; or

j. other similar felony criminal conduct.

i. The provider and provider-in-fact after they knew or should have known of same have an affirmative duty to:

(a). inform BHSF in writing of any such criminal charges, convictions, or pleas on the part of the provider, provider-in-fact, their agents, or their affiliates;

(b). not hire, contract with, or affiliate with any person or entity who has engaged in any such criminal misconduct; and

(c). terminate any and all ownership, employment and contractual relationships with any person or entity that has engaged in any such criminal misconduct.

ii. Failure to do so on the part of the provider or provider-in-fact within 10 working days of when the provider or provider-in-fact knew or should have known of any violation of this provision by the provider, provider-in-fact, their agents or their affiliates is a violation of §4147.A.4.

iii. If five years have passed since the completion of the sentence and no other criminal misconduct by that person has occurred during that five-year period, this provision is not violated. Criminal conduct that has been pardoned does not violate this provision.

12. Being found in violation of or entering into a settlement agreement under this state's Medical Assistance Program Integrity Law, the Federal False Claims Act, Federal Civil Monetary Penalties Act, or any other similar civil statutes in this state, in any other state, United States or United States territory.

a. Relating to violations of this provision, the provider and provider-in-fact after they knew or should have known have an affirmative duty to:

i. inform BHSF in writing of any violations of this provision on the part of the provider, provider-in-fact, their agents or their affiliates;

ii. not hire, contract with, or affiliate with any person or entity who has violated this provision; and

iii. terminate any and all ownership, employment or contractual relationships with any person or entity that has violated this provision.

b. Failure to do so on the part of the provider or provider-in-fact within 10 working days of when the provider or provider-in-fact knew or should have known of any violation of this provision by the provider, provider-in-fact, their agents or affiliates is a violation of §4147.A.4.

c. If a False Claims Act action or other similar civil action is brought by a Qui-Tam plaintiff, no violation of this provision has occurred until the defendant has been found liable in the action.

d. If five years have passed from the time a person is found liable or entered a settlement agreement under the False Claims Act or other similar civil statute and the conditions of the judgment or settlement have been satisfactorily fulfilled, no violation has occurred under this provision.

13. Failure to correct the deficiencies or problem areas listed in a notice of sanction, or failure to meet the provisions of a corrective action plan or failure to correct deficiencies in delivery of goods, services, or supplies after

receiving written notice to do so from the secretary, director of BHSF, or director of Program Integrity.

14. Having presented, causing to be presented, attempting to present, or conspiring to present false, fraudulent, fictitious, or misleading claims or billings for payment or reimbursement to the Medical Assistance Program through BHSF or its authorized fiscal intermediary for goods, services, or supplies, or in documents related to a cost report or other similar submission.

15. Engaging in the practice of charging or accepting payments, in whole or in part, from one or more recipients for goods, services, or supplies for which the provider has made or will make a claim for payment to the Medicaid Program, unless this prohibition has been specifically excluded within the program under which the claim was submitted or will be made, or the payment by the recipient is an authorized copayment or is otherwise specifically authorized by law or regulation. Having engaged in practices prohibited by R.S.46:438.2 or the federal anti-kickback or anti-referral statute is also a violation of this provision.

16. Having rebated or accepted a fee or a portion of a fee or anything of value for a Medicaid recipient referral, unless this prohibition has been specifically excluded within the program or is otherwise authorized by statute or regulation, rule, policy, criteria, or procedure of the department through BHSF. Having engaged in practices prohibited by R.S. 46:438.2 or the federal anti-kickback or anti-referral statute is also a violation of this provision.

17. Paying to another a fee in cash or kind for the purpose of obtaining recipient lists or recipients names, unless this prohibition has been specifically excluded within the program or is otherwise authorized by statute or regulation, rule, policy, criteria or procedure of the department through BHSF. Using or possessing any recipient list or information, which was obtained through unauthorized means, or using such in an unauthorized manner. Having engaged in practices prohibited by R.S. 46:438.2 or R.S. 46:438.4 or the federal anti-kickback or anti-referral statute.

18. Failure to repay or make arrangements to repay an identified overpayment or otherwise erroneous payment within 10 working days after the provider or provider-in-fact receives written notice of same. Failure to pay any and all administrative or court ordered restitution, civil money damages, criminal or civil fines, monetary penalties or costs or expenses is also a violation of this provision. Failure to pay any assessed provider fee or payment is also a violation of this provision.

19. Failure to keep or make available for inspection, audit, or copying records related to the Medicaid Program or one or more of its programs for which the provider has been enrolled or issued a provider number or has failed to allow BHSF or its fiscal intermediary or any other duly authorized governmental entity an opportunity to inspect, audit, or copy those records. Failure to keep records required by Medicaid or one of its programs until payment review has been conducted is also a violation of this provision.

20. Failure to furnish or arrange to furnish information or documents to BHSF within five working days after receiving a written request to provide that information to BHSF or its fiscal intermediary.

21. Failure to cooperate with BHSF, its fiscal intermediary or the investigating officer during the post-payment or prepayment process, investigative process, informal hearing or the administrative appeal process or any other legal process or making, or caused to be made, a false or misleading statement of a material fact in connection with the post-payment or prepayment process, corrective action, investigation process, informal hearing or the administrative appeals process or any other legal process. The exercising of a constitutional or statutory right is not a failure to cooperate. Requests for scheduling changes or asking questions are not grounds for failure to cooperate.

22. Making, or causing to be made, a false, fictitious or misleading statement or making, or caused to be made, a false, fictitious or misleading statement of a fact in connection with the administration of the Medical Assistance Program which the person knew or should have known was false, fictitious or misleading. This includes, but is not limited to, the following:

a. claiming costs for non-covered non-chargeable services, supplies, or goods disguised as covered items;

b. billing for services, supplies, or goods which are not rendered to person(s) who are eligible to receive the services, supplies, or goods;

c. misrepresenting dates and descriptions and the identity of the person(s) who rendered the services, supplies, or goods;

d. duplicate billing that are abusive, willful, or fraudulent;

e. upcoding of services, supplies, or goods provided;

f. misrepresenting a recipient's need or eligibility to receive services, goods, or supplies ;

g. improperly unbundling goods, services, or supplies for billing purposes;

h. misrepresenting the quality or quantity of services, goods, or supplies;

i. submitting claims for payment for goods, services, and supplies provided to non-recipients if the provider knew or should have known that the individual was not eligible to receive the good, supply, or service at the time the good, service, or supply was provided or billed;

j. furnishing or causing to be furnished goods, services, or supplies to a recipient which:

i. are in excess of the recipient's needs;

ii. were or could be harmful to the recipient;

iii. serve no real medical purpose;

iv. are of grossly inadequate or inferior quality;

v. were furnished by an individual who was not qualified under the applicable Medicaid Program to provide the good, service, or supply;

vi. the good, service, or supply was not furnished under the required programmatic authorization; or

vii. the goods, services, or supplies provided were not provided in compliance with the appropriate licensing or certification board's regulations, rules, policies, or procedures governing the conduct of the person who provided the goods, services, or supplies;

k. providing goods, services, or supplies in a manner or form that is not within the normal scope and range of the standards used within the applicable profession; or

l. billing for goods, services, or supplies in a manner inconsistent with the standards established in relevant billing codes or practices.

23. In the case of a managed care provider or provider operating under a voucher, notwithstanding any contractual agreements to the contrary, failure to provide all medically necessary goods, services, or supplies of which the recipient is in need of and entitled to.

24. Submitting bills or claims for payment or reimbursement to the Medicaid Program through BHSF or its fiscal intermediary on behalf of a person or entity which is serving out a period of suspension or exclusion from participation in the Medical Assistance Program or one of its programs, Medicare, publicly funded health care, or publicly funded health insurance program in any other state or territory of the United States.

25. Engaging in a systematic billing practice which is abusive or fraudulent and which maximizes the costs to the Medicaid Program after written notice to cease such billing practice(s).

26. Failure to meet the terms of an agreement to repay or settlement agreement entered into under this state's Medical Assistance Program Integrity Law or this regulation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1637 (September 1999), repromulgated LR 29:590 (April 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:2778 (November 2012).

§4149. Scope of a Violation

A. Violations may be imputed in the following manner.

1. The conduct of a provider-in-fact is always attributable to the provider. The conduct of a managing employee is always attributable to the provider and provider-in-fact.

2. The conduct of an agent of the provider, billing agent, or affiliate of the provider may be imputed to the provider or provider-in-fact if the conduct was performed within the course of his duties for the provider or was effectuated by him with the knowledge or approval of the provider or provider-in-fact.

3. The conduct of any person or entity operating on behalf of a provider may be imputed to the provider or provider-in-fact.

4. The provider and provider-in-fact are responsible for the conduct of any and all officers, employees, contractors, or agents of the provider. The conduct of these persons or entities may be imputed to the provider or provider-in-fact.

5. A violation under one Medicaid number may be extended to any and all Medicaid numbers held by the provider or provider-in-fact or which may be obtained by the provider or provider-in-fact.

6. Recoupments or recoveries may be made from any payments or reimbursement made under any and all provider numbers held by or obtained by the provider or provider-in-fact.

7. Any sanctions, including recovery or recoupment, imposed on a provider or provider-in-fact shall remain in effect until its terms have been satisfied. Any person or entity who purchases, merges or otherwise consolidates with a provider or employs or affiliates a provider-in-fact, agent of the provider or affiliate of a provider who has had sanctions imposed on it under this regulation assumes liability for those sanctions, if the person or entity knew or should have known about the existence of the sanctions, and may be subject to additional sanctions based on the purchase, merger, consolidation, affiliation or employment of the sanctioned provider or provider-in-fact.

8. A provider or provider-in-fact who refers a recipient to another for the purpose of providing a good, service, or supply to a recipient may be held responsible for any or all over-billing by the person to whom the recipient was referred provided the referring provider or person knew or should have known that such over-billing was likely to occur.

9. Providers which are legal entities, i.e., clinics, corporations, HMOs, PPOs, etc., may be held jointly liable for the repayment or recoupment of any person within that legal entity if it can be shown that the entity received any economic benefit related to the overpayment.

10. Withholdings of payments imposed on a provider may be extended to any or all provider numbers held or obtained by that provider or any provider-in-fact of that provider.

11. A recoupment, fine, recovery or penalty, which is owed to the department by a provider or provider-in-fact, can be imputed to a group and/or entity to which the provider or provider-in-fact is linked.

B. Attributing, imputing, extension or imposing under this provision shall be done on a case-by-case basis with written reasons for same.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1637 (September 1999), repromulgated LR 29:596 (April 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:2783 (November 2012).

Subchapter E. Administrative Sanctions, Procedures and Processes

§4161. Sanctions for Prohibited Conduct

A. Any or all of the following sanctions may be imposed for any one or more of the above listed kinds of prohibited conduct, except as provided for in this Chapter 41:

1. issue a warning to a provider or provider-in-fact or other person through written notice;

2. require that the provider or provider-in-fact, their affiliates, and agents receive education and training in laws, rules, policies, criteria and procedures, including billing, at the provider's expense;

3. require that the provider or provider-in-fact receive prior authorization for any or all goods, services or supplies under the Medicaid Program or one or more of its programs;

4. require that some or all of the provider's claims be subject to manual review;

5. require a provider or provider-in-fact to post a bond or other security or increase the bond or other security already posted as a condition of continued enrollment in the Medicaid Program or one or more of its programs;

6. require that a provider terminate its association with a provider-in-fact, agent of the provider, or affiliate as a condition of continued enrollment in the Medicaid Program or one or more of its programs;

7. prohibit a provider from associating, employing or contracting with a specific person or entity as a condition of continued participation in the Medicaid Program or one or more of its programs;

8. prohibit a provider, provider-in-fact, agent of the provider, billing agent or affiliate of the provider from performing specified tasks or providing goods, services, or supplies at designated locations or to designated recipients or classes or types of recipients;

9. prohibit a provider, provider-in-fact, or agent from referring recipients to another designated person or purchasing goods, services, or supplies from designated persons;

10. recoupment;

11. recovery;

12. impose judicial interest on any outstanding recovery or recoupment;

13. impose reasonable costs or expenses incurred as the direct result of the investigation or review including, but not limited to, the time and expenses incurred by departmental employees or agents and the fiscal intermediary's employee or agent;

14. exclusion from the Medicaid Program or one or more of its programs;

15. suspension from the Medicaid Program or one or more of its programs pending the resolution of the department's administrative appeals process;

16. require the forfeiture of a bond or other security;

17. impose an arrangement to repay;

18. impose monetary penalties not to exceed \$10,000;
or

19. impose withholding of payments.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1644 (September 1999), repromulgated LR 29:598 (April 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:2783 (November 2012).

§4163. Scope of Sanctions

A. Sanction(s) imposed can be extended to other persons or entities and to other provider numbers held, or obtained by the provider in the following manner.

1. Sanction(s) imposed on a provider or provider-in-fact may be extended to a provider or provider-in-fact.

2. Sanction(s) imposed on an agent of the provider or affiliate of the provider may be imposed on the provider or provider-in-fact if it can be shown that the provider or provider-in-fact knew or should have known about the violation(s) and failed to report the violation(s) to BHSF in a timely manner.

3. Sanction(s) imposed on a provider or provider-in-fact arising out of goods, services, or supplies to a referred recipient may also be imposed on the referring provider if it can be shown that the provider or provider-in-fact knew or should have known about the violation(s) and failed to report the violation(s) to BHSF in writing in a timely manner.

4. Sanction(s) imposed under one provider number may be extended to all provider numbers held by or which may be obtained in the future by the sanctioned provider or provider-in-fact, unless and until the terms and conditions of the sanction(s) have been fully satisfied.

5. Sanction(s) imposed on a person remains in effect unless and until its terms and conditions are fully satisfied. The terms and conditions of the sanction(s) remain in effect

in the event of the sale or transfer of ownership of the sanctioned provider.

a. The entity or person who obtains an interest in, merges with or otherwise consolidates with a sanctioned provider assumes liability and responsibility for the sanctions imposed on the purchased provider including, but not limited to, all recoupments or recovery of funds or arrangements to repay that the entity or person knew or should have known about.

b. An entity or person who employs or otherwise affiliates itself with a provider-in-fact who has been sanctioned assumes the liability and responsibility for the sanctions imposed on the provider-in-fact that the entity or person knew or should have known about.

B. Exclusion from participation in the Medicaid Program precludes any such person from submitting claims for payment, either personally or through claims submitted by any other person or entity, for any goods, services, or supplies provided by an excluded person or entity. Any payments, made to a person or entity which are prohibited by this provision, shall be immediately repaid to the Medical Assistance Program through BHSF by the person or entity which received the payments.

C. No provider shall submit claims for payment to the department or its fiscal intermediary for any goods, services, or supplies provided by a person or entity within that provider who has been excluded from the Medical Assistance Program or one or more of its programs for goods, services, or supplies provided by the excluded person or entity under the programs which it has been excluded from. Any payments, made to a person or entity, which are prohibited by this provision, shall be immediately repaid to the Medical Assistance Program through BHSF by the person or entity which received the payments.

D. When these provisions are violated, the person or entity which committed the violations may be sanctioned using any and all of the sanctions provided for in this Chapter.

E. Extending of sanctions must be done on a case-by-case basis.

F. The provisions in R.S. 46:437.10 shall apply to all sanctions and withholding of payments imposed pursuant to this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1645 (September 1999), repromulgated LR 29:598 (April 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:2784 (November 2012).

§4165. Imposition of Sanction(s)

A. The decision as to the sanction(s) to be imposed shall be at the discretion of the director of BHSF or his/her designee and the director of Program Integrity except as

provided for in this provision, unless the sanction is mandatory. In order to impose a sanction, the director of BHSF or his/her designee and the director of Program Integrity must concur. One or more sanctions may be imposed for a single violation. The imposition of one sanction does not preclude the imposition of another sanction for the same or different violations.

B. At the discretion of the director of BHSF or his/her designee and the director of Program Integrity, each occurrence of misconduct may be considered a violation or multiple occurrences of misconduct may be considered a single violation or any combination thereof.

C. The following factors may be considered in determining the sanction(s) to be imposed:

1. seriousness of the violation(s);
2. extent of the violation(s);
3. history of prior violation(s);
4. prior imposition of sanction(s);
5. prior provision of education;
6. willingness to obey program rules;
7. whether a lesser sanction will be sufficient to remedy the problem;
8. actions taken or recommended by peer review groups or licensing boards;
9. cooperation related to reviews or investigations by the department or cooperation with other investigatory agencies; and
10. willingness and ability to repay identified overpayments.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law)

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1645 (September 1999), repromulgated LR 29:599 (April 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:2784 (November 2012).

§4167. Mandatory Sanctions

A. Mandatory Exclusion from the Medical Assistance Program. Notwithstanding any other provision to the contrary, the director of BHSF and the director of Program Integrity have no discretion and shall exclude the provider, provider-in-fact or other person from the Medical Assistance Program if the violation involves one or more of the following:

1. a conviction, guilty plea, or no contest plea to a criminal offense(s) in federal or Louisiana state court-related, either directly or indirectly, to participation in either Medicaid or Medicare;
2. has been excluded from Medicare; or

3. has failed to meet the terms and conditions of a repayment agreement, settlement or judgment entered into under this state's Medical Assistance Program Integrity Law.

B. In these situations (Paragraphs A.1-3 above), the exclusion from the Medical Assistance Program is automatic and can be longer than, but not shorter in time than, the sentence imposed in criminal court, the exclusion from Medicaid or Medicare or time provided to make payment.

1. The exclusion is retroactive to the time of the conviction, plea, exclusion, the date the repayment agreement was entered by the department or the settlement or judgment was entered under this state's Medical Assistance Program Integrity Law.

2. Proof of the conviction, plea, exclusion, failure to meet the terms and conditions of a repayment agreement, or settlement or judgment entered under this state's Medical Assistance Program Integrity Law can be made through certified or true copies of the conviction, plea, exclusion, agreement to repay, settlement, or judgment or via affidavit.

a. If the conviction is overturned, plea set aside, or exclusion or judgment is reversed on appeal, the mandatory exclusion from the Medical Assistance Program shall be removed.

b. The person or entity that is excluded from the Medical Assistance Program under this Subsection B is entitled to an administrative appeal of a mandatory exclusion.

c. The facts and law surrounding the criminal matter, exclusion, repayment agreement or judgment which serves as the basis for the mandatory exclusion from the Medical Assistance Program cannot be collaterally attacked at the administrative appeal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1646 (September 1999), repromulgated LR 29:599 (April 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:2784 (November 2012).

§4169. Effective Date of a Sanction

A. All sanctions, except exclusion, are effective upon the issuing of the notice of the results of the informal hearing. The filing of a timely and adequate notice of administrative appeal does not suspend the imposition of a sanction(s), except that of exclusion. In the case of the imposition of exclusion from the Medicaid Program or one or more of its programs, the filing of a timely and adequate notice of appeal suspends the exclusion. A sanction becomes a final administrative adjudication if no administrative appeal has been filed, and the time for filing an administrative appeal has run. Or in the case of a timely filed notice of administrative appeal, a sanction(s) becomes a final administrative adjudication when the order on appeal has been entered by the secretary. In order for an appeal to be

filed timely it must be sent to the Division of Administrative Law within 30 days from the date of receipt of the letter informing the person of the results of the informal discussion.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1646 (September 1999), repromulgated LR 29:600 (April 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:2785 (November 2012).

Subchapter F. Withholding

§4177. Withholding of Payments

A. The director of BHSF or his/her designee and the director of Program Integrity may initiate the withholding of a portion of or all payments or reimbursements to be made to a provider for the purpose of protecting the interest and fiscal integrity of the Medicaid Program if, during the course of claims review, the director of BHSF or his/her designee and the director of Program Integrity have a reasonable expectation:

1. that an overpayment to a provider may have occurred or may occur;
2. that a provider or provider-in-fact has failed to cooperate or attempted to delay or obstruct an investigation; or
3. has information that fraudulent, willful or abusive practices may have been used; or
4. that willful misrepresentations may have occurred.

B. Payments to the provider may be withheld if the director of BHSF or his/her designee and the director of Program Integrity has been informed in writing by a prosecuting authority that a provider or provider-in-fact:

1. has been formally charged or indicted for crimes; or
2. is being investigated for potential criminal activities which relate to the Medicaid Program or one or more of its programs or Medicare.

C. If the director of BHSF or his/her designee and the director of Program Integrity has been informed in writing by any governmental agency or authorized agent of a governmental agency that a provider or a provider-in-fact is being investigated by that governmental agency or its authorized agent for billing practices related to any government funded health care program, payment may be withheld.

D. Withholding of payments may occur without first notifying the provider.

E. Notice of Withholding

1. The provider shall be sent written notice of the withholding of payments within five working days of the actual withholding of the first check that is the subject of the

withholding. The notice shall set forth in general terms the reason(s) for the action, but need not disclose any specific information concerning any ongoing investigations nor the source of the allegations. The notice must:

- a. state that payments are being withheld;
- b. state that the withholding is for a temporary period and cite the circumstances under which the withholding will be terminated;
- c. specify to which type of Medicaid claims withholding is effective;
- d. inform the provider of its right to submit written documentation for consideration and to whom to submit that documentation; and
- e. inform the provider of its right to an administrative appeal.

2. Failure to provide timely notice of the withholding to the provider or provider-in-fact may be grounds for dismissing or overturning the withholding.

F. Duration of Withholding

1. All withholding of payment actions under this Chapter will be temporary and will not continue after:

- a. the director of BHSF or his/her designee and the director of Program Integrity has determined that insufficient information exists to warrant the withholding of payments;
- b. recoupment or recovery of overpayments has been imposed on the provider;
- c. the provider or provider-in-fact has posted a bond or other security deemed adequate to cover all past and future projected overpayments; and
- d. the notice of the results of the informal hearing.

2. In no case shall withholding remain in effect past the issuance of the notice of the results of the informal hearing, unless the withholding is based on written notification by an outside agency that an active and ongoing criminal investigation is being conducted or that formal criminal charges have been brought. In that case, the withholding may continue for as long as the criminal investigation is active and ongoing or the criminal charges are still pending, unless adequate bond or other security has been posted with BHSF.

G. Amount of the Withholding

1. If the withholding of payment results from projected overpayments, then when determining the amount to be withheld, the ability of the provider to continue operations and the needs of the recipient serviced by the provider shall be taken into consideration by the director of BHSF and the director of Program Integrity. In the event that a recipient cannot receive needed goods, services or supplies from another source, arrangements shall be made to assure that the recipient can receive goods, supplies, and services. The burden is on the provider to demonstrate that absent that provider's ability to provide goods, supplies, or services to

that recipient, the recipient could not receive needed goods, supplies, or services. Such showing must be made at the informal hearing.

2. The amount of the withholding shall be determined by the director of BHSF or his/her designee and the director of Program Integrity. The provider should be notified of the amount withheld every 90 days from the date of the issuing of the Notice of Withholding until the withholding is terminated or the results of the informal hearing are issued, whichever comes first.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1646 (September 1999), repromulgated LR 29:600 (April 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:2785 (November 2012).

§4179. Effect of Withholding on the Status of a Provider or Provider-in-Fact with the Medical Assistance Program

A. Withholding of payments does not, in and of itself, affect the status of a provider or provider-in-fact. During the period of withholding, the provider may continue to provide goods, services, or supplies and continue to submit claims for them, unless the provider has been suspended or excluded from participation. Any and all amounts withheld or bonds or other security posted may be used for recovery, recoupment or arrangements to pay.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1647 (September 1999), repromulgated LR 29:601 (April 2003).

**Subchapter G. Suspension of
Medicaid Payments Pending
Investigation of Credible Allegations
of Fraud**

§4181. General Provisions

A. Basis for Suspension

1. The director of BHSF and the director of Program Integrity must suspend all Medicaid payments to a provider after it determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid Program against a provider unless it has good cause to not suspend payments or to suspend payment only in part.

2. The director of BHSF and the director of Program Integrity may suspend payments without first notifying the provider of its intention to suspend such payments.

3. A provider is entitled to an administrative review of the suspension of payment.

B. Notice of Suspension

1. The director of BHSF and the director of Program Integrity must send notice of its suspension of Medicaid payments within the following timeframes:

a. five days of taking such action unless requested in writing by a law enforcement agency to temporarily withhold such notice; and

b. 30 days if requested by law enforcement in writing to delay sending such notice, which request for delay may be renewed in writing up to twice and in no event may exceed 90 days.

2. The notice must include or address all of the following:

a. Medicaid payments are being suspended in accordance with 42 CFR 455.23;

b. set forth the general allegations as to the nature of the suspension action, but need not disclose any specific information concerning an ongoing investigation;

c. state that the suspension is for a temporary period, and cite the circumstances under which the suspension will be terminated;

d. specify, when applicable, to which type(s) of Medicaid claims or business units of a provider suspension is effective;

e. inform the provider of the right to submit written evidence for consideration by the director of BHSF and the director of Program Integrity; and

f. inform the provider of their right to a administrative appeal.

C. Duration of Suspension

1. All suspension of payment actions under this Section will be temporary and will not continue after either of the following:

a. legal proceedings related to the provider's alleged fraud are completed; or

b. the director of BHSF and the director of Program Integrity or the prosecuting authorities determine that there is insufficient evidence of fraud by the provider.

D. Good Cause Not to Suspend Payments. The director of BHSF and the director of Program Integrity may find that good cause exists not to suspend payments, or not to continue a payment suspension previously imposed, to a provider against which there is an investigation of a credible allegation of fraud if any of the following are applicable.

1. Law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.

2. Other available remedies implemented by BHSF or Program Integrity more effectively or quickly protect Medicaid funds.

3. The director of BHSF and the director of Program Integrity determine, based upon the submission of written evidence by the provider that is the subject of the payment suspension, that the suspension should be removed.

4. Recipient access to items or services would be jeopardized by a payment suspension because of either of the following:

a. a provider is the sole community physician or the sole source of essential specialized services in a community; or

b. a provider serves a large number of recipients within a HRSA-designated medically underserved area.

5. Law enforcement declines to certify that a matter continues to be under investigation.

6. The director of BHSF and the director of Program Integrity determine that payment suspension is not in the best interest of the Medicaid program.

E. Good Cause to Suspend Payment Only in Part. The director of BHSF and the director of Program Integrity may find that good cause exists to suspend payments in part, or to convert a payment suspension previously imposed in whole to one only in part, to a provider against which there is an investigation of a credible allegation of fraud if any of the following are applicable.

1. Recipient access to items or services would be jeopardized by a payment suspension because of either of the following:

a. a provider is the sole community physician or the sole source of essential specialized services in a community; or

b. a provider serves a large number of recipients within a HRSA-designated medically underserved area.

2. The director of BHSF and the director of Program Integrity determines, based upon the submission of written evidence by the provider that is the subject of a whole payment suspension, that such suspension should be imposed only in part.

3. The credible allegation of fraud focuses solely and definitively on only a specific type of claim or arises from only a specific business unit of a provider and the director of BHSF and the director of program integrity determine and document in writing that a payment suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid.

4. Law enforcement declines to certify that a matter continues to be under investigation.

5. The director of BHSF and the director of Program Integrity determine that payment suspension only in part is in the best interest of the Medicaid Program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:2786 (November 2012).

Subchapter H. Arrangements to Repay

§4187. Arrangement to Repay

A. Arrangements to repay may be mutually agreed to or imposed as a sanction on a provider, provider-in-fact or other person. Arrangements to repay identified overpayments, interest, monetary penalties or costs and expenses should be made through a lump sum single payment within 60 days of reaching or imposing the arrangement to repay. However, an agreement to repay may contain installment terms and conditions. In such cases, the repayment period cannot extend two years from the date the agreement is reached or imposed, except that a longer period may be established by the secretary or director of BHSF. In such a case the agreement to repay must be signed by the secretary or director of BHSF.

B. All agreements to repay must contain at least:

1. the amount to be repaid;
2. the person(s) responsible for making the repayments;
3. a specific time table for making the repayment;
4. if installment payments are involved, the date upon which each installment payment is to be made; and
5. the security posted to assure that the repayments will be made, and if not made, the method through which the security can be seized and converted by Medicaid.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR. 23:1647 (September 1999), repromulgated LR 29:601 (April 2003).

Subchapter I. Corrective Actions

§4195. Corrective Actions Plans

A. The following procedures are established for the purpose of attempting to resolve problems prior to the issuing of a notice of sanction or for resolution during the informal hearing or administrative hearing.

1. Corrective Action Plan-Notification

a. The director of BHSF and the director of Program Integrity may at any time issue a notice of corrective action to a provider or provider-in-fact, agent of the provider, or affiliate of the provider. The provider, provider-in-fact, agent of the provider, or affiliate of the provider shall comply with the corrective action plan within 10 working days of receipt of the corrective action plan. The purpose of a corrective action plan is to identify potential problem areas and correct them before they become

significant discrepancies, deviations or violations. This is an informal process.

i. The provider, provider-in-fact, agent of the provider, or affiliate of the provider must submit their agreement with the corrective action plan in writing, signed by the provider, the provider-in-fact, agent of the provider, or affiliate of the provider.

b. Corrective action plans are also used to resolve matters at or before the informal hearing or administrative appeal process. When so used they serve the same function as a settlement agreement.

2. Corrective Action Plan-Inclusive Criteria. The corrective action plan must be in writing and contain at least the following:

- a. the nature of the discrepancies or violations;
- b. the corrective action(s) that must be taken; and
- c. notification of any action required of the provider, provider-in-fact, agent of the provider, billing agent or affiliate of the provider.

3. Corrective Action Plans-Restrictions. Corrective actions, which may be included in a corrective action plan, are the following:

- a. issuing a warning through written notice or consultation;
- b. require that the provider, provider-in-fact, agent of the provider, or affiliate receive education and training in the law, rules, policies, criteria and procedures related to the Medical Assistance Program, including billing practices or programmatic requirements and practices. Such education or training is at the provider or provider-in-fact's expense;
- c. require that the provider receive prior authorization for any or all goods, services, or supplies to be rendered;
- d. place the provider's claims on manual review status before payment is made;
- e. restrict or remove the provider's privilege to submit bills or claims electronically;
- f. impose any restrictions deemed appropriate by the director of BHSF and the director of Program Integrity; or
- g. any other items mutually agreed to by the provider, provider-in-fact, agent of the provider, billing agent, affiliate of the provider or other person and the director of BHSF or the director of Program Integrity, including, but not limited to, one or more of the sanctions listed in this Chapter and an agreement to repay.

4. Only restrictions in Subparagraphs A.3.a-f above can be imposed on a provider, provider-in-fact, agent of the provider, billing agent, or affiliate of the provider without their agreement. Any other items included in a corrective action plan must be mutually agreed to among the parties to the corrective action plan.

5. No right to an informal hearing or administrative appeal can arise from a corrective action plan, unless the corrective action plan violates the provisions of this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1648 (September 1999), repromulgated LR 29:601 (April 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:2787 (November 2012).

Subchapter J. Informal Hearing Procedures and Processes

§4203. Informal Hearing

A. A provider, provider-in-fact, agent of the provider, billing agent, affiliate of the provider or other person who has received a notice of sanction or notice of withholding of payment shall be provided with an informal hearing if that person makes a written request for an informal hearing within 15 days of receipt of the notice. The request for an informal hearing must be made in writing and sent in accordance with the instruction in the notice. The time and place for the informal hearing will be set out in the notice of setting of the informal hearing.

B. The informal hearing is designed to provide the opportunity:

1. to provide the provider, provider-in-fact, agent of the provider, billing agent, the affiliate of the provider or other person an opportunity to informally review the situation;

2. for BHSF to offer alternatives based on information presented by the provider, provider-in-fact, agent of the provider, billing agent, affiliate of the provider, or other person, if any; and

3. for the provider, provider-in-fact, agent of the provider, billing agent, affiliate of the provider or other person to evaluate the necessity for seeking an administrative appeal. During the informal hearing, the provider, provider-in-fact, agent of the provider, billing agent, affiliate of the provider or other person may be afforded the opportunity to talk with the department's personnel involved in the situation, to review pertinent documents on which the alleged violations are based, to ask questions, to seek clarification, to provide additional information and be represented by counsel or other person. Upon agreement of all parties, an informal discussion may be recorded or transcribed.

C. Notice of the Results of the Informal Hearing. Following the informal hearing, BHSF shall inform the provider, provider-in-fact, agent of the provider, billing agent, affiliate of the provider or other person in writing of the results which could range from canceling, modifying, or upholding the any or all of the violations, sanctions or other actions contained in a notice of sanction or notice of withholding of payments and the provider, provider-in-fact,

agent of the provider, billing agent, affiliate of the provider or other person's right to an administrative appeal. The notice of the results of the informal hearing must be signed by the director of BHSF or his/her designee and the director of Program Integrity.

1. The provider, provider-in-fact, agent of the provider, billing agent, affiliate of the provider or other person has the right to request an administrative appeal within 30 days of the receipt of the notice of the results of the informal hearing. At any time prior to the issuance of the written results of the informal hearing, the notice of corrective action or notice of administrative sanction or withholding of payment may be modified.

a. If a finding or reason is dropped from the notice, no additional time will be granted to the provider, provider-in-fact, agent of the provider, billing agent, affiliate of the provider or other person to prepare for the informal hearing.

b. If additional reasons or sanctions are added to the notice prior to, during or after the informal hearing, the provider, provider-in-fact, agent of the provider, billing agent, affiliate of the provider or other person shall be granted an additional 10 working days to prepare responses to the new reasons or sanctions, unless the 10-day period is waived by the provider, provider-in-fact, agent of the provider, billing agent, affiliate of the provider or other person.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1648 (September 1999), repromulgated LR 29:602 (April 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:2787 (November 2012).

Subchapter K. Administrative Appeals

§4211. Administrative Appeal

A. The provider, provider-in-fact, agent of the provider, billing agent, or affiliate of the provider may seek an administrative appeal from the notice of the results of an informal hearing if the provider, provider-in-fact, agent of the provider, billing agent, or affiliate of the provider has had one or more appealable sanctions imposed upon him.

B. The notice of administrative appeal must be adequate as to form and lodged with the Division of Administrative Law within 30 days of the receipt of the notice of the results of the informal hearing. The lodging of a timely and adequate request for an administrative appeal does not affect the imposition of a sanction, unless the sanction imposed is exclusion. All sanctions imposed through the notice of the results of the informal hearing are effective upon mailing, emailing, or faxing of the notice of the results of the informal hearing to the provider, provider-in-fact, agent of the provider, billing agent, affiliate of the provider or other

person, except exclusion from participation in the Medical Assistance Program or one or more of its programs.

C. In the case of an exclusion from participation, if the director of BHSF and the director of Program Integrity determines that allowing that person to participate in the Medicaid Program during the pendency of the administrative appeal process poses a threat to the programmatic or fiscal integrity of the Medicaid Program or poses a potential threat to health, welfare or safety of any recipients, then that person may be suspended from participation in the Medicaid Program during the pendency of the administrative appeal. If the exclusion is mandatory, a threat to Medicaid Program or recipients is presumed. This determination shall be made following the informal hearing. If no informal hearing is requested, the determination shall be made after the delay for requesting an informal hearing has run.

D. Failure to lodge a timely and adequate request for an administrative appeal will result in the imposition of any and all sanctions in the notice of the results of the informal hearing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1649 (September 1999), repromulgated LR 29:603 (April 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:2787 (November 2012).

§4213. Right to Administrative Appeal and Review

A. Only the imposing of one or more sanctions can be appealed to the Division of Administrative Law.

1. The adversely effected party has the right to challenge the basis for the violation and the sanction imposed.

2. The adversely effected party must specifically state the basis for the appeal and what actions are being challenged on appeal.

B. The following actions are not sanctions, even if listed as such in the notice of sanction or notice of the results of the informal hearing, and are not subject to appeal or review by the Division of Administrative Law:

1. referral to a state, federal or professional licensing authority;

2. referral to the Louisiana Attorney General= Medicaid Fraud Control Unit or any other authorized law enforcement or prosecutorial authority;

3. referral to governing boards, peer review groups or similar entities;

4. issuing a warning to a provider or provider-in-fact or other person through written notice or consultation;

5. require that the provider, or provider-in-fact, their affiliates and agents receive education and training in laws, rules, policies, and procedures, including billing;

6. conducting prepayment review;
7. place the provider's claims on manual review status before payment is made;
8. require that the provider or provider-in-fact receive prior authorization for any or all goods, services, or supplies under the Medicaid Program or one or more of its programs;
9. remove or restrict the provider's use of electronic billing;
10. any restrictions imposed as the result of a corrective action plan;
11. any restrictions agreed to by a provider, provider-in-fact, agent of the provider, or affiliate of the provider;
12. any terms or conditions contained in an arrangement to repay which has been agreed to by a provider, provider-in-fact, agent of the provider, or affiliate of the provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1649 (September 1999), repromulgated LR 29:603 (April 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:2788 (November 2012).

Subchapter L. Rewards for Fraud and Abuse Information

§4221. Tip Rewards

A. The secretary may approve a reward of 10 percent of the actual monies recovered from a person, with a maximum reward of \$2,000 to a person who submits information to the secretary which results in a recovery under this Chapter or the provisions of the Medical Assistance Program Integrity Law.

B. The secretary shall grant rewards only to the extent monies are appropriated for that purpose from the Medical Assistance Programs Fraud Detection Fund. The approval of a reward is solely at the discretion of the secretary. In making a determination of a reward, the secretary shall consider the extent to which the tip information contributed to the investigation and recovery of monies. The person providing the information need not have requested a reward in order to be considered for an award by the secretary.

C. No reward shall be made to any person if:

1. the information was previously known to the department or criminal investigators;
2. a person planned or participated in the action resulting in the investigation;
3. a person who is, or was at the time of the tip, excluded from participation in the Medical Assistance Program or subject to recovery under this Chapter or the Medical Assistance Program Integrity Law;

4. a person who is or was a public employee or public official or person who was or is acting on behalf of the state if the person has or had a duty or obligation to report, investigate, or pursue allegations of wrongdoing or misconduct by health care providers or Medicaid recipients unless that individual has not been employed or had such duties and obligation for a period of two years prior to providing the information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4, R. S. 46:440.2 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1650 (September 1999), repromulgated LR 29:603 (April 2003).

Subchapter M. Miscellaneous

§4229. Mailing

A. Mailing refers to the sending of a hard copy via U.S. mail or commercial carrier. Sending via facsimile or email is also acceptable, so long as a hard copy is mailed. Delivery via hand is also acceptable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1650 (September 1999), repromulgated LR 29:604 (April 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:2788 (November 2012).

§4231. Confidentiality

A. All contents of claim reviews and investigations conducted under this Chapter shall remain confidential until a final administrative adjudication is entered. Prior to that, only the parties or their authorized agents and representatives may review the contents of the payment review and investigatory files, unless by law others are specifically authorized to have access to those files. These files may be released to law enforcement agencies, other governmental investigatory agencies, or specific individuals within the department who are authorized by the director of BHSF and the director of Program Integrity to have access to such information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1650 (September 1999), repromulgated LR 29:604 (April 2003).

§4233. Severability Clause

A. If any provision of this Chapter is declared invalid or unenforceable for any reason by any court of this state or federal court of proper venue and jurisdiction, that provision shall not affect the validity of the entire regulation or other provisions thereof.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1650 (September 1999), repromulgated LR 29:604 (April 2003).

§4235. Effect of Promulgation

A. This regulation, when promulgated, shall supersede any and all other departmental regulations that conflict with the provisions of this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:437.4 and 46:437.1-46:440.3 (Medical Assistance Program Integrity Law).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:1650 (September 1999), amended LR 29:604 (April 2003).

Subpart 9. Recovery

Chapter 81. Estate Recovery

§8101. Definitions

Authorized Representative—the executor or succession attorney if a succession has been opened. If there is no executor or succession attorney, an heir, family member or the decedent's last *authorized representative* listed on the decedent's most recent Medicaid application.

Cost Effectiveness—the process whereby the Medicaid agency balances and weighs that which it may reasonably expect to recover against the time and expense of recovery. Initiating estate recovery will be deemed to be cost effective when the amount reasonably expected to be recovered exceeds the cost of recovery and is greater than \$1,000.

Estate—the gross (total value) *estate* of the deceased as determined by Louisiana succession law and any interest in any property, whether movable or immovable, corporeal or incorporeal.

Heir—a descendant in the first degree.

Homestead—consists of a residence occupied by the owner and the land on which the residence is located, including any building and appurtenances located thereon, and any contiguous tracts up to a total of five acres if the residence is within a municipality, or up to a total of 200 acres of land if the residence is not located in a municipality. This same *homestead* shall be the individual's home which was occupied by the recipient immediately prior to the recipient's admission to a long term care facility or when the recipient began receiving home and community-based services.

Individual's Home—the primary place of residence of the deceased recipient which was occupied by the recipient immediately prior to the recipient's admission to a long term care facility or when the recipient began receiving home and community-based services.

Undue Hardship—an *undue hardship* shall exist when initiating estate recovery would result in placing an unreasonable burden on an heir; and if an heir's family income is 300 percent or less of the U.S. Department of Health and Human Services federal poverty level guidelines as published annually in the *Federal Register*. An *undue hardship* may exist when:

1. the estate is the sole income producing asset of an heir and income from the estate is limited;
2. recovery would result in an heir becoming eligible to receive public assistance including, but not limited to Medicaid; or
3. any other compelling circumstances that would result in placing an unreasonable financial burden on an heir.

NOTE: An *undue hardship* does not exist if the circumstances giving rise to the hardship were created by or are the result of estate planning methods under which assets were sheltered or divested in order to avoid estate recovery. It is the obligation of the heirs to prove *undue hardship* by a preponderance of the evidence.

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 30:801 (April 2004), amended LR 37:339 (January 2011).

§8103. General Provisions

A. Medicaid estate recovery is not a condition of eligibility. The applicant/recipient shall be informed at the time of application/redetermination that federal law and regulations mandate estate recovery action by the states and that medical assistance claims paid by the department may be subject to estate recovery. A notice of estate recovery is provided to the applicant as part of the application process.

B. Recovery Limits

1. Recovery can only be made after the death of the recipient's surviving spouse, if any, and only at the time when the recipient has no surviving child under age 21, or a child who is blind or disabled as defined in Section 1614 of the Social Security Act. Recovery may be deferred until the death of the surviving spouse or children reach the age of 21 or are no longer blind or disabled.

2. Recovery cannot be made for Medicare cost-sharing benefits (i.e., Part A and Part B premiums, deductibles, coinsurance, and co-payments) paid under the Medicaid State Plan.

C. Recovery Adjustments

1. Recovery may be waived in cases in which it is not cost-effective for the state to recover from the recipient's estate.

2. Recovery shall be waived if it will cause an undue hardship on any child of the deceased recipient.

3. The recovery may be lessened by reducing the estate value in consideration of reasonable and necessary documented expenses incurred by the decedent's heirs to

maintain the homestead during the period in which the recipient was in a long term care facility or received home and community-based services, if the homestead is part of the estate.

D. Recovery Notice

1. The department will seek recovery for medical assistance from the decedent's estate. The family or heirs will be given advance notice of the proposed action and the time frame in which they have the opportunity to apply for an undue hardship waiver and/or dispute the recovery.

2. A notice of Medicaid estate recovery will be served on the executor, authorized representative or succession attorney of the decedent's estate. If there is no executor, authorized representative or succession attorney, the notice will be sent to the family or the heirs. The notice shall specify the following information:

- a. the deceased recipient's name and Medicaid identification number;
- b. the action the state intends to take;
- c. the reason for the action;
- d. the dates of services associated with the recovery action and the estimated amount of the department's claim, i.e., amount to be recovered against the recipient's estate;
- e. the right to and procedure for applying for a hardship waiver;
- f. the authorized representative's right to a hearing;
- g. the method by which the authorized representative may obtain a hearing; and
- h. the time periods involved in requesting a hearing or in exercising any procedural requirements under the Medicaid Estate Recovery Program.

3. The notice shall request that copies of all succession pleadings filed in connection with the succession of the decedent, including any judgment(s) of possession be provided to the department.

a. In the event no succession has been judicially opened, the department is to be advised as to when such documents will be available and/or when the succession is expected to be opened.

E. Recovery Privilege

1. The claim of the department shall have a privilege on the total estate with a priority equivalent to an expense of last illness as prescribed in Civil Code Article 3252 et seq.

2. The department may file a proof of claim based on its privilege.

F. Recovery Exclusions

1. If an individual was insured under a qualifying long-term care insurance partnership policy and received Medicaid benefits as a result of resources being disregarded in the eligibility determination, the department shall not seek

adjustment or recovery from the individual's estate for the amount of the resources disregarded.

a. The resource disregard is determined on a 1:1 ratio. For each \$1 of a qualifying long-term care insurance partnership policy benefit, \$1 of countable resources is disregarded or excluded during the eligibility determination process.

2. The department shall not seek recovery or adjustment from an individual's estate for the amount of Medicare cost-sharing benefits paid on behalf of an individual that was enrolled in any one of the following Medicaid programs:

- a. Qualified Medicare Beneficiaries (QMB);
 - i. including individuals who are classified as QMB Plus and receive full Medicaid coverage in addition to QMB benefits;
- b. Specified Low-Income Beneficiaries (SLMB);
 - i. including individuals who are classified as SLMB Plus and receive full Medicaid coverage in addition to SLMB benefits;
- c. Qualified Disabled and Working Individuals (QDWI); or
- d. Qualified Individuals (QI).

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 30:801 (April 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:1891 (September 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:339 (January 2011).

§8105. Administrative Review

A. Informal Review and Administrative Appeal of Agency Decision. Through the informal review and administrative process, any authorized representative may request that the agency review and reconsider any or all aspects of a particular recovery matter in which he/she is involved.

1. If the authorized representative disagrees with the estimated amount and/or the basis for the estate recovery and is requesting an undue hardship waiver, the authorized representative must submit the following information to the department within 30 days of receipt of the estate recovery notice:

- a. a written request for an informal review which states the basis for the disagreement(s) along with all of the supporting documentation to substantiate the disagreement; or
- b. a completed notarized hardship waiver application along with all of the documentation needed to support the request for a hardship waiver.

2. If the authorized representative wishes to obtain a copy of the claims history upon which the recovery amount is based, the HIPPA authorization form enclosed with the recovery notice must be completed and returned to the department within five days of receipt of the recovery notice.

3. The written request for an informal review and/or hardship waiver must be post marked or delivered to the department on or before the 30th day from receipt of the estate recovery notice.

4. If the written request for an informal review and/or the completed notarized hardship waiver application along with all supporting documentation is not received within the 30 day period, the action set out in the estate recovery notice shall be the final agency decision.

5. If the written request for an informal review and/or the completed notarized hardship waiver application along with all supporting documentation is received timely, the department shall conduct an informal review of the estate recovery decision.

a. The informal review may be conducted in-person, via phone or other electronic media and/or through a review of the documentation.

b. Following the informal review, the department will issue a written notice to the authorized representative of the reason(s) for its findings and the amount owed by the estate.

B. The authorized representative shall have 30 days from the date of mailing of the estate recovery notice to seek an administrative appeal with the appropriate state administrative tribunal.

C. In addition to the provisions of this Section, any aggrieved party shall have the administrative appeal rights available pursuant to the Administrative Procedure Act.

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 30:802 (April 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:340 (January 2011).

Chapter 83. Third Party Liability

Subchapter A. Claims

§8301. Pay and Chase

A. Definition

Claim—a single document line identifying the service and/or charges for services for a single recipient from a single provider.

B. Medicaid claims for services covered under the State Plan will be cost avoided when there is probable third party liability unless the claim is for one of the following services:

1. primary preventive pediatric care diagnoses are confined to those listed under *Diagnosis Codes Related to Preventive Pediatric Care Services* at www.lamedicaid.com;

a. Individuals under age 21 qualify; and

b. Hospitals are not included and must continue to file claims with the health insurance carriers;

2. early and periodic screening, diagnosis and treatment (EPSDT) medical, vision, and hearing services;

3. EPSDT dental services;

4. EPSDT services to children with disabilities (formerly referred to as school-based health services) which result from screening and are rendered by school boards;

5. services which are a result of an EPSDT referral, indicated by entering "Y" in block 24H of the CMS-1500 claim form, sometimes called HCFA-1500, or "1" as a condition code on the UB-92 (form locators 24 through 30); and

6. services for Medicaid eligibles whose health insurance is provided by an absent parent who is under the jurisdiction of the state child support enforcement agency are subject to a "wait and see period" that was effective April 1, 2021.

a. *Wait and See*—payment of a claim only after documentation is attached to a hard copy claim and submitted to the state's fiscal intermediary demonstrating that 100 days have elapsed since the provider billed the responsible third party and remains to be paid.

C. In processing these claims, the Medicaid agency will pay the claim and seek reimbursement from liable third parties, utilizing the claims method of payment called "pay and chase".

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 13:578 (October 1978), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 17:781 (August 1991), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:848 (May 2006), amended by the Department of Health, Bureau of Health Services Financing, LR 49:1743 (October 2023).

§8303. Crossover Claims

A. The Medical Assistance Program shall provide Medicaid coverage of Medicare Part A and Part B crossover claims for dually eligible recipients with the following limitations:

1. Medicaid coverage of Medicare Part B crossover claims shall be limited to only those services covered under Title XIX (Medicaid); and

2. payment of Medicare Part A and Part B co-insurance and deductibles shall be limited to the total Medicaid allowable cost for each covered service.

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 13:92 (February 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:848 (May 2006).

Subchapter B. Data Match with Insurance Carriers

§8311. General Provisions

A. All insurance companies authorized to issue a hospital or medical expense policy, a hospital or medical service contract, an employee welfare benefit plan, a health and accident insurance policy, or any other insurance contract of this type in this state shall provide a monthly list of information to the Department of Health and Hospitals on all members who hold a comprehensive health contract.

B. The payor shall submit to DHH an initial, secure, encrypted electronic file of all members who hold comprehensive health contracts with:

1. effective dates as of the date of promulgation of this Subchapter C; and
2. processed dates before that same date.

C. The department shall treat all data in a confidential manner and protect it in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 privacy and security rules. Further, the Department shall, in a manner compliant with the HIPAA privacy and security rules, return or destroy all copies of the payor's data immediately following the match process.

D. The department shall provide a standard protocol in accordance with nationally accepted standards, and in a manner compliant with the Health Insurance Portability and Accountability Act of 1996, by which the electronic file shall be transmitted between DHH and the payor.

E. The provisions of this §8325 shall not apply to any insured whose indemnity policy benefits pay less than \$25 a day in hospital or medical benefits.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 44:14, 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 32:849 (May 2006).

Subchapter C. Newborn Notification

§8325. Definitions

Effective Date of Birth—the date of live birth of a newborn child.

Health Insurance Issuer—an insurance company, including a health maintenance organization as defined and licensed to engage in the business of insurance under Part XII of Chapter 2 of Title 22, unless preempted as a qualified employee benefit plan under the Employee Retirement Income Security Act of 1974.

Qualifying Newborn Child—a newborn child who meets the eligibility provisions for the Medicaid Program.

Third Party Liability (TPL) Notification of Newborn Child(ren) Form—the written form developed by the Department of Health and Hospitals that must be completed by the hospital to report the birth and health insurance status of a newborn 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, ERs: LR 31:1048 (May 2005), LR 31:1963 (August 2005), LR 31:2259 (September 2005), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:848 (May 2006).

§8327. Hospital Requirements

A. A hospital shall complete the Third Party Liability (TPL) Notification of Newborn Child(ren) form to report the birth and health insurance status of a qualifying newborn child either delivered in their facility, delivered under their care, or transferred to their facility after birth. The notification shall only be completed when the hospital reasonably believes that the following entities would consider the child to be a qualified newborn and insurance coverage is available to said child(ren):

1. the health insurance issuer that has issued a policy of health insurance under which the newborn child may be entitled to coverage; and
2. the Department of Health and Hospitals.

B. The TPL Notification of Newborn Child(ren) form shall be completed by the hospital and submitted to any and all applicable health insurance issuers within seven days of the birth of a newborn child. Delivery of the notification form may be established via the U.S. Mail, FAX, or e-mail.

C. The TPL Notification of Newborn Child(ren) form shall be sent to the Department of Health and Hospitals, Bureau of Health Services Financing, Third Party Liability/Medicaid Recovery within seven days of the birth of the child.

D. This notification shall not be altered, in any respect, by the hospital and shall be in addition to any other notification, process or procedure followed by the hospital. The notification shall not be done in lieu of any other required notice, process or procedure established in any other rule, manual, or policy.

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, [ERs: LR 31:1048 (May 2005), LR 31:1963 (August 2005), LR 31:2259 (September 2005), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:849 (May 2006).

Subchapter D. Provider Billing and Trauma Recovery

§8341. Definitions

Initial Lien—the first letter or other notice sent by the Medicaid Third Party Recovery Unit and the Medicaid contracted managed care entity(s) via mail to the recipient or his representative providing notification of the lien amount.

Updated Lien—the most recent letter or other notice sent by the Medicaid Third Party Recovery Unit and the Medicaid contracted managed care entity(s) via mail to the recipient or his representative, subsequent to the initial lien, providing notification of an updated lien amount.

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 33:463 (March 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:510 (March 2013), LR 40:83 (January 2014).

§8343. Introduction

A. Congress intended the Medicaid Program be the payor of last resort, requiring other available resources be used before Medicaid pays for any health care services rendered to an individual enrolled in the Medicaid Program.

B. The Department of Health and Hospitals will no longer allow providers to pursue a liable or potentially liable third party for payment in excess of the Medicaid paid amount to a provider for health care services rendered. Existing federal law preempts such an allowance.

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 33:463 (March 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:83 (January 2014).

§8347. Recipient Responsibilities

A. The claims included in the initial lien calculated by the Medicaid Third Party Liability Recovery Unit and the Medicaid contracted managed care entity(s) shall be deemed as an accurate reflection of the total amount paid by Medicaid and the Medicaid contracted managed care entity(s), unless challenged in writing by the recipient or his representative within 30 days of the date of the initial lien notification to the Medicaid recipient or his representative.

B. Any additional Medicaid payments included as the result of an updated lien shall be deemed as an accurate reflection of the total amount of the claims paid by Medicaid and the Medicaid contracted managed care entity(s), unless challenged in writing by the recipient or his representative, within 30 days of the date of the updated lien notification to the Medicaid recipient or his representative.

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 33:464 (March 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:510 (March 2013), LR 40:84 (January 2014).

§8349. Noncompliance and Violations

A. A provider who has filed and accepted Medicaid payment and who also accepts payment in excess of billed charges or a duplicate payment for the same health care services may be referred for investigation and prosecution for possible violation of either federal or state laws and may be excluded from participation in the Medicaid Program.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 33:464 (March 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:510 (March 2013), LR 40:84 (January 2014).

Subpart 11. Medicaid Expansion under the Affordable Care Act

Chapter 101. Alternative Benefit Plan

§10101. General Provisions

A. Pursuant to the Patient Protection and Affordable Care Act (P.L. No. 111-148), hereafter referred to as the Affordable Care Act (ACA), and §1937 of title XIX of the Social Security Act, the department shall expand Medicaid coverage to individuals from age 19 to 65 years old at or below 133 percent of the federal poverty level with a 5 percent income disregard as provided in 42 CFR 435.119, hereafter referred to as the new adult group.

B. Effective July 1, 2016, the department will expand Medicaid coverage to the new adult group, as defined in §1905(y)(2)(A) of title XIX of the Social Security Act, and provide a secretary-approved coverage option, hereafter referred to as the Alternative Benefit Plan (ABP), which incorporates the benefits and services covered under the Medicaid State Plan, including the essential health benefits as provided in §1302(b) of ACA. The department will utilize a federally-approved benchmark benefit package to ensure that the ABP includes benefits that are appropriate to meet the needs of the new adult group.

1. *Benchmark*—coverage is based on benefits that are at least equivalent to one of the federally statutorily specified benchmark plans.

C. The Basic Blue Cross/Blue Shield preferred provider option offered through the Federal Employees Health Benefit program (FEHBP) will be the benchmark plan used to design the ABP for the state.

D. The ABP shall provide coverage of essential health benefits pursuant to federal regulations in §1302(b) of ACA.

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 42:756 (May 2016).

§10103. Benefits and Services

A. Minimum Essential Health Benefits. Pursuant to §1302(b) of ACA, the ABP must provide the new adult group with a benchmark benefit or benchmark-equivalent benefit package that includes the required minimum essential health benefits (EHBs) provided in affordable insurance exchanges. There are 10 benefit categories and some of the categories include more than one type of benefit. The following services are considered EHBs:

1. ambulatory patient services;
2. emergency services;
3. hospitalization;
4. maternity and newborn care;
5. mental health and substance use disorder services, including behavioral health treatment:
 - a. these services shall be in accordance with the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008;
6. prescription drugs;
7. rehabilitative and habilitative services and devices;
8. laboratory services;
9. preventive services and chronic disease management; and
10. pediatric services, including oral and vision care.

a. The requirements of this service category are met through the Early and Periodic Screening, Diagnosis and Treatment Program.

B. Enrollees shall receive the full range of benefits and services covered under the ABP state plan amendment. The ABP package will incorporate the benefits and services covered under the Medicaid State Plan, including the essential health benefits as provided in §1302(b) of ACA.

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 42:756 (May 2016).

Chapter 103. Supplemental Nutrition Assistance Program Enrollment Option

§10301. General Provisions

A. Effective July 1, 2016, the department may use the Supplemental Nutrition Assistance Program (SNAP) option for streamlined enrollment of SNAP recipients who meet eligibility requirements for the new adult group.

B. In the event the SNAP enrollment option is used, the Medicaid program will not conduct a separate modified

adjusted gross income (MAGI) based income determination on SNAP participants. The department will utilize the gross income determination provided by SNAP to make the financial eligibility determination.

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 42:757 (May 2016).

Subpart 13. Electronic Health Records

Chapter 125. Incentive Payments

§12501. General Provisions

A. In accordance with the provisions of the American Recovery and Reinvestment Act of 2009, the department establishes a Medicaid electronic health record (EHR) incentive payment program to provide payments to eligible professional practitioners and hospitals that adopt, implement or upgrade certified Electronic Health Record (EHR) technology.

B. The following providers may qualify to receive Medicaid incentive payments:

1. physicians;
2. nurse practitioners;
3. certified nurse-midwives;
4. dentists;
5. physician assistants who direct a federally qualified health center (FQHC) or rural health clinic (RHC);
6. optometrists;
7. acute care hospitals, including cancer and critical access hospitals; and
8. children's specialty hospitals.

C. Eligible providers shall meet the appropriate meaningful use requirements for certified EHR systems as established by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS).

D. Payments shall be distributed through a web-based Medicaid EHR incentive payment system and at the frequency specified by the department.

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 36:2865 (December 2010), amended LR 39:505 (March 2013).

§12503. Qualifying Criteria for Professional Practitioners

A. Professional practitioners shall qualify for Medicaid incentive payments when:

1. services are rendered to the required number of patients based on the Medicaid patient volume threshold; and

2. the meaningful use requirements are met for EHR systems, based on the participation year of the program.

B. Professional practitioners shall be required to meet the minimum Medicaid patient volume threshold of 30 percent. This threshold shall be calculated as a ratio where the numerator is the total number of Medicaid patient encounters with needy individuals treated in any 90-day period in the previous calendar year and the denominator is all patient encounters over the same period of time.

1. Needy individuals shall include:

- a. Medicaid recipients;
- b. Children's Health Insurance Program recipients;
- c. patients furnished uncompensated care by the provider; and
- d. patients furnished services at no cost or on a sliding scale.

C. During the first year of program participation, the meaningful use requirements for an eligible provider are to adopt, implement, and upgrade a certified EHR system. In subsequent years' participation, providers must meet the meaningful use requirements defined by CMS at the stage that is in place at that time.

D. Incentive payments to eligible practitioners shall begin in state fiscal year (SFY) 2011 and will end in SFY 2021. The latest state fiscal year a Medicaid provider can begin the program is SFY 2016.

E. Eligible practitioners may receive incentive payments from the Medicaid Program or from the Medicare Program. Payments cannot be received from both entities simultaneously. After the initial program selection, eligible practitioners shall be allowed to change their selection only once during SFY 2012 through SFY 2014.

F. Payments are based on calendar year and may total up to \$63,750 over six years of participation. To receive the maximum total payment amount, the provider would have to initiate the program by SFY 2016.

1. Pediatricians with more than 20 percent, but less than 30 percent Medicaid patient volume, will receive two-thirds of the maximum amount.

G. Medicaid EHR incentive payments shall not be available to a hospital-based provider who furnishes 90 percent or more of his/her services in a hospital setting. This includes services furnished on an inpatient or outpatient basis and in an emergency room setting.

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 36:2866 (December 2010).

§12505. Qualifying Criteria for Hospitals

A. Hospitals shall qualify for Medicaid incentive payments when:

1. services are rendered to the required number of patients based on the Medicaid patient volume threshold; and

2. the meaningful use requirements are met for EHR systems, based on the participation year of the program.

B. Acute care hospitals shall be required to meet the minimum Medicaid patient volume threshold of 10 percent. There is no Medicaid patient volume threshold for children's hospitals.

C. Hospitals that meet Medicare's meaningful use requirements for certified EHR systems shall satisfy the meaningful use requirements for Medicaid incentive payments.

D. Incentive payments for eligible hospitals shall begin in SFY 2011. Hospitals participating in the Medicaid incentive program cannot initiate payments after SFY 2016 and payment years must be consecutive after SFY 2016.

E. Eligible hospitals may receive incentive payments from Medicare and Medicaid simultaneously.

F. Payments are based on Federal fiscal year and are calculated as follows.

1. The overall EHR amount is multiplied times the Medicaid share.

a. The overall EHR amount is the sum over four years of the base amount plus the discharge related amount applicable for each year multiplied times the transition factor applicable for each year.

b. The Medicaid share is the Medicaid inpatient bed days plus the Medicaid managed care inpatient bed days divided by the total inpatient bed days multiplied times the estimated total charges minus uncompensated (charity) care charges divided by the estimated total charges.

2. The resulting amount is the eligible hospital payment amount.

G. Payments to eligible hospitals are disbursed over a 3-6 year period. No annual payment may exceed 50 percent of the total calculation and no two-year payment may exceed 90 percent of the total calculation.

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 36:2866 (December 2010).

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE

Part II. Nursing Facilities
Subpart 1. General Provisions

Chapter 5. Admissions

§501. Preadmission Screening

A. Preadmission screening shall be performed for all individuals seeking admission to a Medicare or Medicaid-certified nursing facility, regardless of the source of payment for the nursing facility services or the individual's known diagnoses. The purpose of the preadmission screening and resident review (PASRR) process is to identify applicants or residents who have a diagnosis of serious mental illness or mental retardation (hereafter referred to as intellectual/developmental disability) and to determine whether these individuals require nursing facility services and/or specialized services for their mental condition.

1. An individual is considered to have a serious mental illness (MI) if the individual meets the requirements on diagnosis, level of impairment and duration of illness as described in federal regulations.

a. Diagnosis. The individual has a diagnosis of major mental disorder as categorized by the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM IV) or its successor.

i. A mental disorder may include schizophrenia, mood, paranoid, panic, or other severe anxiety disorder, somatoform disorder, personality disorder, other psychotic disorder, or another mental disorder that may lead to a chronic disability.

ii. A primary diagnosis of dementia, including Alzheimer's disease or a related disorder, or a non-primary diagnosis of dementia would not be included as a mental disorder unless the primary diagnosis is a major mental disorder as previously defined.

b. Level of Impairment. Within the past three to six months, the mental disorder has resulted in functional limitations in major life activities that would be appropriate for the individual's developmental stage.

c. Duration of Illness. The individual's treatment history indicates that he/she:

i. received psychiatric services more intensive than outpatient treatment more than once in the past two years; or

ii. as a result of the disorder, experienced an episode of significant disruption to the normal living situation within the last two years that either required supportive services to maintain functioning at home (or in a

residential treatment environment) or resulted in intervention by housing or law enforcement officials.

2. An individual is considered to have intellectual/developmental disability if the individual meets the criteria as described in the *American Association on Intellectual and Developmental Disabilities' Manual on Intellectual Disability: Definition, Classification, and Systems of Supports*, 11th edition, or its successor.

a. *Intellectual/Developmental Disability (I/DD)*—a disability that originates before the age of 18 and is characterized by significant limitations in both intellectual functioning (reasoning, learning, problem solving) and adaptive behavior, which covers a range of everyday social and practical skills.

b. These provisions also apply to persons with related conditions as described in federal regulations.

B. A Medicaid-certified nursing facility shall not admit a person with a diagnosis of a serious mental illness or intellectual/developmental disability without a preadmission screening.

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 Aging and Adult Services, LR 36:1010 (May 2010), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1018 (June 2018).

§503. Medical Certification

A. Evaluative data for medical certification (level of care determination) must be submitted to the Office of Aging and Adult Services (OAAS) or its designee for all initial admissions to and requests for continued stays in Medicare or Medicaid-certified nursing facilities, regardless of payer source.

1. Initial Admissions

a. Required Documents. The following documents are required for initial admission to a nursing facility. The initial admission process does not begin until all of the following documents are complete and submitted by OAAS. These documents must not be dated more than 30 calendar days prior to the date of admission and must reflect the individuals current functioning:

i. a level of care eligibility tool (LOCET) assessment;

ii. a preadmission screening and resident review (level I PASRR) form completed by a qualified health care professional. The level I PASRR form must be signed and dated on the date that it is completed. The level I PASRR form addresses the specific identifiers of MI or I/DD that indicate that a more in-depth evaluation is needed to determine the need for specialized services. The need for this in-depth assessment does not necessarily mean that the individual cannot be admitted to a nursing facility, only that the need for other services must be determined prior to admission;

(a). if the information on the level I PASRR indicates that the individual may have a diagnosis of MI and/or I/DD, and the individual meets the criteria for nursing facility level of care, the individual shall be referred to the Office of Behavioral Health or the Office for Citizens with Developmental Disabilities (the state's mental health and intellectual disability level II authorities) for a level II screening to determine if the individual requires the level of services provided by a nursing facility and whether specialized services are needed. Medical certification is not guaranteed for an individual who has been referred for a level II screening. A Medicaid-certified nursing facility shall not admit an individual identified for a level II screening until the screening has been completed and a decision is made by the level II authority;

(b). if there is no indication on the level I PASRR or in other records that the individual may have a diagnosis of MI and/or I/DD and he/she meets the criteria for nursing facility level of care, OAAS may approve the individual for admission to the nursing facility;

iii. for nursing facility admission under a specialized level of care, additional documentation that supports the need for specialized care; and

iv. OAAS or its designee may require the submittal of additional documentation to support the need for a nursing facility stay.

b. Vendor Payment. Once approval has been obtained, the individual must be admitted to the facility within 30 calendar days of the date of the approval notice. The nursing facility shall submit a completed BHSF Form 148, immediately upon admission, to the local Medicaid eligibility office and OAAS indicating the anticipated payment source for the nursing facility services. Medicaid vendor payment shall not begin prior to the date that medical and financial eligibility is established, and shall only begin once the individual is actually admitted to the facility.

2. Continued Stay Requests

a. Required documents. The following documents are required in order for OAAS or its designee to determine the need for continued services in a nursing facility. The continued stay process does not begin until all of the following documents are complete and submitted to OAAS.

i. a continued stay request form as issued by OAAS or its designee;

ii. documentation to support the request for continued stay, including the most recent MDS 3.0. A LOCET will not be accepted as sufficient evidence of medical need for an individual who has been discharged for a period of less than 14 calendar days unless:

(a). there is additional supporting documentation demonstrating a significant change in status; or

(b). the individual is seeking admission to a facility different than the facility from which they were discharged; and

iii. additional documentation as required by the level II authorities.

b. Vendor payment. Medicaid payment shall be made in accordance with the Notice of Medical Certification (BHSF Form 142) issued by OAAS or the level II authority.

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 Aging and Adult Services, LR 36:1011 (May 2010), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 43:1179 (June 2017), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 43:1179 (June 2017), LR 44:1018 (June 2018), LR 44:2166 (December 2018).

§505. Categorical Advance Group Determinations

A. In order to assure timely and appropriate care for applicants, the level II authority may make an advance group determination by category that takes into account that certain diagnoses, levels of severity of illness or need for a particular service clearly indicates the need for nursing facility admission or that the provision of specialized services is not normally needed. The applicable level II authority may make an advance group determination that nursing facility care is needed for persons in the following categories.

1. Convalescent Care. If an applicant appears to be in need of level II assessment but is hospitalized for a serious illness and needs time to convalesce before a valid level II assessment can be performed, provisions may be made for temporary medical certification for nursing facility care. The maximum period of time that a level II assessment may be delayed is 100 days. The period of convalescence allowed will be consistent with the diagnosis and medical condition of the individual.

2. Terminal Illness. Terminally ill applicants, who are not a danger to themselves or others, may be categorically approved for nursing facility admission. This categorical eligibility determination is valid for six months at a time, in accordance with the definition of terminal illness used for hospice purposes, and remains valid as long as the applicant's mental condition does not create a barrier to receiving the necessary nursing facility services.

3. Severe Physical Illness. Severely ill applicants, who are not a danger to themselves or others and whose medical

condition prevents them from engaging in specialized services, may be categorically approved for nursing facility admission. The attending physician shall determine that the applicant is unable to benefit from specialized services due to the severe level of physical impairment. This categorical determination also remains valid for six months to allow for an individualized assessment of the resident's needs. Severe physical conditions considered in this category include, but are not limited to:

- a. coma;
- b. ventilator dependence;
- c. functioning at a brain stem level;
- d. advanced chronic obstructive pulmonary disease;
- e. Parkinson's disease;
- f. Huntington's disease;
- g. amyotrophic lateral sclerosis; and
- h. congestive heart failure.

4. Provisional Admissions

a. An applicant who is not a danger to himself or others, but who exhibits symptoms of delirium, may be categorically approved for nursing facility admission pending further assessment when the delirium clears and an accurate diagnosis can be made. This categorical determination may be valid for a period not to exceed 30 days.

b. An applicant who is in an emergency situation and requires protective services may be categorically approved for nursing facility admission pending further assessment. This categorical determination may be valid for a period not to exceed seven days.

5. Respite Care. An applicant who qualifies for nursing facility care and is not a danger to self or others, but resides at home with care from a family member or other caregiver, may be categorically approved for admission in order to provide respite to the in-home caregiver. Respite provides relief to the caregiver when that individual is unable to provide care for a short period of time.

6. Dementia/ID. This category applies to applicants who are intellectually disabled or have indications of intellectual disability, but also exhibit symptoms associated with dementia. These individuals require supervision in a structured environment and a planned program of activities. This categorical determination may remain valid for a period not to exceed one year or until such time that the level II authority makes a determination that an alternative placement is more appropriate.

B. Although an advanced group determination may be made at admission, the applicable level II authority must still make a determination regarding the need for specialized services (based on an individual evaluation) for continuation of stay.

C. In each case that specialized services are determined not to be necessary, it remains the responsibility of the nursing facility to notify the appropriate agency if the resident's mental condition changes and becomes a barrier to utilizing nursing facility services, or the resident becomes a danger to himself or others.

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 Aging and Adult Services, LR 36:1011 (May 2010), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 43:1179 (June 2017).

§507. Exempted Hospital Discharges

A. An individual who is being discharged from a hospital and is seeking nursing facility admission may be exempt from preadmission screening if all of the following criteria are met:

1. the individual is being admitted to a nursing facility (NF) directly from a hospital after receiving acute inpatient care;

2. the individual requires NF services for the condition for which he or she received care in the hospital; and

3. his/her attending physician has certified before the admission to the facility that he or she is likely to require less than 30 days of nursing facility services.

B. If prior to admission, the individual does not meet the criteria for an exempted hospital discharge, then the individual will be referred to the appropriate level II authority for an assessment.

C. If after admission it becomes apparent that a longer stay is required, the nursing facility must refer the individual to the appropriate level II authority for assessment within 30 calendar days of the admission date.

1. Approval for the admission will continue to the fortieth calendar day from the date of admission pending the level II determination.

D. Exempted hospital discharges are only applicable for persons with MI and/or I/DD. This exempted discharge does not apply to any other program or for transfers between nursing facilities.

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 Aging and Adult Services, LR 36:1012 (May 2010), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1019 (June 2018).

§509. Changes in Level of Care and Status

A. The nursing facility shall notify the parish Medicaid office via the BHSF Form 148 of the following changes in a resident's circumstances:

1. change in the level of care;
2. transfer to another nursing facility;
3. change in payer source;
4. hospital/home leave and returns; or
5. discharge home, death or any other breaks in facility care.

B. The nursing facility must inform the appropriate level II authority if an individual with a diagnosis of MI and/or ID is subject to readmission or interfacility transfer and there has been a substantial change in the individual's condition, or if a level I screen was not completed or was completed incorrectly.

1. An individual is considered to be a readmission if he/she was readmitted to a facility from a hospital to which he/she was transferred for the purpose of receiving care.

2. Interfacility transfer occurs when an individual is transferred from one NF to another NF, with or without an intervening hospital stay.

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 Office of Aging and Adult Services, LR 36:1012 (May 2010), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 43:1179 (June 2017).

§511. Denials and Appeals Process

A. If an individual is determined not to need nursing facility services and is denied admission, the individual has a right to appeal the decision through the department's established appeal procedures.

1. A denial notice will be sent to the individual and he/she may use that letter to request a fair hearing.

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 Office of Aging and Adult Services, LR 36:1012 (May 2010).

Subpart 3. Standards for Payment

Chapter 101. Standards for Payment for Nursing Facilities

Subchapter A. Abbreviations and Definitions

§10101. Definitions

A. This glossary contains a comprehensive list of abbreviations and definitions used in the requirements for payment for nursing facilities.

Abuse—the infliction of physical or mental injury or causing deterioration to such an extent that the resident's health, moral, and/or emotional well being is endangered.

Cause of such deterioration may include but is not limited to the following: sexual abuse, exploitation, extortion of funds or other things of value, negligence.

Admission—the date a person enters the facility and is admitted as a resident.

Advance Directives—an instruction, such as a living will or durable power of attorney for health care, recognized under state law relating to the provisions of health care when the individual is incapacitated. Although usually done in writing state law provides that under some circumstances these directives may be orally.

Ancillary Services—services provided at or through the facility in addition to nursing services provided which includes, but is not limited to, podiatry, dental, audiology, vision, physical therapy, occupational therapy, psychological, social and planning services.

Applicant—an individual whose written application for Medicaid certification has been submitted to the agency but whose eligibility has not yet been determined.

Assistant Director of Nursing (ADON)—a licensed nurse responsible for providing assistance to the director of nursing (DON) in a nursing facility with a licensed bed capacity of 101 or more.

Attending Physician—a physician, currently licensed by the Louisiana State Board of Medical Examiners, designated by the resident or responsible party as responsible for the direction of overall medical care. This term shall also apply to any physician providing medical care for a resident in the absence of the resident's *attending physician*.

Bed Capacity—the total number of beds which can be set up in a nursing facility for the use of residents, based on bedroom criteria of square footage. The term "bed capacity" shall include isolation beds.

a. *Certified Beds*—beds certified for use for title XVIII/XIX by DHH/BHSF.

b. *Licensed Beds*—beds licensed for use by DHH/BHSF.

Bureau of Health Services Financing (BHSF)—the division within the Office of the Secretary of the Department of Health and Hospitals responsible for the administration of the Medicaid Program.

Call System—a system that audibly registers calls electronically from its place of origin (which means the resident's bed) to the place of receivership (which means the nurses' station).

Certification—a determination made by the Louisiana Department of Health and Hospitals, Bureau of Health Services Financing, Health Standards Section that a facility meets the necessary requirements to participate in Louisiana as a provider of Title XVIII (Medicare) and/or Title XIX (Medicaid) as a nursing facility.

Certified Nursing Assistant (CNA)—an individual who has completed an approved course taught by a qualified

instructor consisting of at least 40 hours classroom and 40 hours clinical and taken a state approved written/competency. As of 1/1/90, all employed nurse aides must meet these qualifications, and aides employed after that date must complete the approved course within four months of the date of employment.

Change of Ownership (CHOW)—any change in the legal entity responsible for the operation of a nursing facility.

Charge Nurse—an individual who is licensed by the state of Louisiana to practice as an RN or LPN.

Chemical Restraint—the use of any medication listed in the schedules of legend drugs under Louisiana Revised Statute 40:964 as a substance having a depressant effect on the brain or central nervous system activity in order to prohibit inappropriate movement or behavior.

Code of Federal Regulations (CFR)—a publication by the federal government containing nursing requirements which facilities must comply with to receive payment under the Medicare/Medicaid Programs.

Comfortable Temperature—the capability to maintain a temperature for all seasons between 71 degrees and 81 degrees throughout the facility.

Continued Stay—a request for medical certification beyond the date of the currently authorized period.

Controlled Drugs—drugs listed as being subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970.

Dentist—an individual currently licensed to practice dentistry in Louisiana under the provisions of current state statutes.

DHH—abbreviation for the Department of Health and Hospitals in Louisiana.

DHHS—abbreviation for the United States Department of Health and Human Services in Washington, D.C.

Dietary Manager (DM)—an individual who is a qualified dietician or a qualified food serve supervisor.

Dietitian (Qualified Consultant)—an individual certified as a registered *dietitian* by the Commission on Dietetic Registration and who is currently licensed by the Louisiana Board of Examiners in Dietetics and Nutrition.

Director of Nursing (DON)—a registered nurse licensed and registered by the state of Louisiana who directs and coordinates nursing services in a nursing facility.

Drill—the act or exercise of training employees to be familiar with the emergency actions and signals required under varied conditions.

Drug Administration—an act in which a single dose of a prescribed drug or biological is given to a resident by an authorized person in accordance with all laws and regulations governing such acts. The complete act of administration entails removing an individual dose from a

previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's orders, giving the individual dose to the proper resident, and promptly recording the time and dose given.

Drug Dispensing—an act which entails the interpretation of an order for a drug or biological and, pursuant to the order, the proper selection, measuring, labeling, packaging, and issuance of the drug or biological for a resident or for a service unit of the facility by a licensed pharmacist, physician or dentist.

Existing Buildings—for purposes of ANSI standard No. A 117.1 and minimum patient room size [see 405.1134 (c) and (e)] in nursing facilities or parts thereof whose construction plans are approved and stamped by the appropriate state agency responsible therefore before October 28, 1971.

Facility—an institution which provides services to residents which includes a Medicare skilled nursing *facility* (SNF), a swing bed hospital, and/or a nursing *facility* (NF).

Facility Administrator—an individual currently licensed and registered with the Board of Examiners for Nursing Facility Administrators and is engaged in the daily administration of a nursing facility.

Fiscal Intermediary—the private fiscal agent with which DHH contracts to operate the Medicaid management information system (MMIS). It processes the title XIX (Medicaid) claims for services provided under the Medicaid Program and issues appropriate payment.

Governing Body—board of directors, board of trustees, or any other comparable designation of an individual or group of individuals who have the purpose of owning, acquiring, constructing, equipping, operating and/or maintaining a nursing facility and exercising control over the affairs of said nursing facility.

Health Care Financing Administration (HCFA)—a division under DHHS responsible for administering the Medicare Program and overseeing and monitoring the state's Medicaid Program.

HSS—Health Standards Section of the Bureau of Health Services Financing.

Licensed Practical Nurse (LPN)—an individual currently licensed by the Louisiana State Board of Nurse Examiners for Practical Nurses.

Long Term Care (LTC)—*long term care* is a set of health care, personal care, and social services delivered over a sustained period of time to persons who have lost, or never acquired, some degree of physical or cognitive capacity, as measured by an index of functional ability.

MAR—abbreviation for medication administration record.

MDS—abbreviation for minimum data set.

Medicaid—*Medicaid* assistance provided under the state plan approved under title XIX of Social Security Act.

Medicaid Agency—the single state agency responsible for the administration of the Medicaid Program. In Louisiana, the Department of Health and Hospitals is the single state agency.

Medical Director—a physician licensed in Louisiana who directs and coordinates medical care in a nursing facility.

Medical Record Practitioner (MRP)—qualified consultant. A person who:

a. is eligible for certification as a registered record administrator (RRA), or an accredited record technician (ART), by the American Record Association under its requirements in effect on the publication of this provision; or

b. is a graduate of a school of medical record science that is accredited jointly by the Council on Medical Education of the American Medical Association and the American Medical Record Association.

Misappropriation of Resident Property—to take possession of, without permission, a resident's personal belongings.

Neglect—neglect is defined as the facility's of employee's failure to provide the proper or required medical care, nutrition, or other care necessary for an applicant/resident's well-being.

Non-Nursing Personnel—facility staff not assigned to give residents direct personal care. This includes administrators, secretaries, activity coordinators, social services designers, bookkeepers, cooks, janitors, maids, laundry workers, and yard maintenance workers.

Nursing Facility (NF)—the term “nursing facility” or “home” shall mean a private home, institution, building, residence, or other place serving two or more persons who are not related by blood or marriage to the administrator, whether operated for profit or not, and including those places operated by a political subdivision of the State of Louisiana which undertakes, through its ownership or management, to provide maintenance, personal care, or nursing for persons who, by reason of illness or physical infirmity or age, are unable to properly care for themselves. The term does not include the following:

a. a home, institution, or other place operated by the federal government or agency, thereof, or by the State of Louisiana;

b. a hospital, sanitarium, or other medical institution whose principal activity or business is the diagnosis, care, and treatment of human illness through the maintenance and operation of organized facilities thereof;

c. a hospital, sanitarium, or other institution whose principal activity or business is the care and treatment of persons suffering from tuberculosis or from mental diseases;

d. any municipal, parish, or private child welfare agency, maternity hospital, or lying-in-home required by law to be licensed by some other department or agency;

e. any sanitarium or institution conducted by and for Christian Scientists who rely on the practice of Christian Science for treatment and healing.

Nursing Personnel—registered nurses, registered nurse applicants, graduate practical nurses, licensed practical nurses, clinical nurse associates, and ward clerks.

PASAAR—acronym for pre-admission screening and annual resident review.

Pharmacist—a person who:

a. is licensed as a *pharmacist* by the state in which he or she is practicing; and

b. has training or experience in the specialized functions of institutional pharmacy, such as residencies in hospital pharmacy, seminars on institutional pharmacy, and related training programs.

Physical Restraint—any manual method, physical or mechanical device material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to the body. It may include a geriatric chair, a locked room unless requested by the resident, bedrails, or any facility practice that meets the definition of a restraint.

Physician—an individual currently licensed by the Louisiana State Board of Medical Examiners.

Plan of Care—the coordinated, integrated treatment plan developed for each resident. It includes each discipline's approach to a specific problem/need, i.e., physician, nursing, social activities, dietary, rehabilitative, etc. Each discipline's approach is a component of the overall plan of care, e.g., social services component of the overall plan of care.

RAI—abbreviation for resident assessment instrument.

RAPS—abbreviation for resident assessment protocol summary.

Recipient—an individual who has been determined eligible for Medicaid.

Regional Health Standards Section—a team of Bureau of Health Services Financing professional staff responsible for conducting licensing and Medicare/Medicaid certification/recertification surveys in nursing facilities, as well as, complaint investigations, and other on-site inspections as needed. These professionals are also responsible for admission review functions in the title XIX nursing facilities and the determination of the medical necessity for levels of care for Medicaid applicants/recipients.

Registered Nurse (RN)—an individual currently licensed by the Louisiana State Board of Nurse Examiners for Registered Nurses. This includes *registered nurse* applicants.

Representative Payee—an individual designated by the Social Security Administration to receive and disburse benefits in the best interest of and according to the needs of the resident.

Resident—an individual admitted to the nursing facility by and upon the recommendation of a physician and who is to receive the medical and nursing care ordered by the physician.

Resident Activities Director (RAD)—an individual certified as a *resident activity director* to direct the activity services of the nursing facility.

SNF—abbreviation for skilled nursing facility (Medicare only).

Social Service Designee (SSD)—an individual responsible for arranging or directly providing medically-related social services. (See responsibilities and qualifications under social services section.)

Sponsor—an adult relative, friend, or guardian of a resident who has an interest or responsibility in the resident's welfare.

Staffing—a joint meeting of the resident/responsible party and the facility's staff members involved in planning and implementing the overall plan of care.

SW—abbreviation for social worker.

Vendor Number—a seven digit number assigned to a licensed and certified provider who has enrolled with the state to participate in the Medicaid Program and receive payment for services rendered.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996), amended LR 23:970 (August 1997), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1019 (June 2018).

Subchapter B. General Provisions

§10103. Certification

A. Certification of title XVIII (Medicare)/ skilled nursing facilities (SNF). DHH shall obtain a certification notice from the Secretary of the Department of Health and Human Services (DHHS) that verifies a skilled nursing facility is qualified to participate in the Title XVIII Program. The facility shall request a certification packet from BHSF/HSS state office.

B. Certification of Title XIX (Medicaid)/Nursing Facilities (NF)

1. To participate in title XIX (Medicaid Program), a nursing facility must have facility need review approval, be enrolled as a provider, and be in compliance with the requirements for participation established by federal regulations. A nursing facility may participate in the Medicaid program by meeting the requirements.

2. A facility must obtain licensure of the beds prior to or in conjunction with the request for certification of beds. Licensure of beds is performed by BHSF/HSS. For Medicaid

Program participation, all beds to be certified in the Medicaid Program shall be licensed nursing facility beds.

3. Instructions and forms are contained in the packet for the NF to follow to initiate the certification process. These include but are not limited to the following.

4. Facility Need Review. Facility need review approval must be obtained for Medicaid participation. The facility shall secure approval from the Facility Need Review Program to certify that there is no cause to deny the facility from participation in the Medicaid program on the basis of need. The approval shall designate the appropriate name of the legal entity operating the facility and the number of beds eligible for Medicaid program enrollment. If the approval is not issued in the complete name of the legal entity operating the facility, evidence shall be provided to verify that the legal entity which obtained the original approval is the same legal entity operating the facility.

5. Disclosure Requirement

a. As part of the certification requirement, all Medicaid Program participating facilities shall supply BHSF/HSS with a completed Disclosure of Ownership Control Interest statement, HCFA 1513, which requires information as to the identity of the following individuals:

i. each person having a direct or indirect ownership interest in the facility of five percent or more;

ii. each owner (in whole or in part) with a five percent interest in any property, assets, mortgage, deed of trust, note, or other obligation secured by the facility;

iii. each officer and director when a facility is organized as a corporation;

iv. each partner when a facility is organized as a partnership; and

v. within 35 days from the date of request, the provider shall submit full and complete information, as specified by the BHSF, regarding the following:

(a) the ownership of any subcontractor with whom the facility has had more than \$25,000 in business transactions during the previous 12 months; and

(b) information as to any significant business transactions between the facility and the subcontractor or wholly owned suppliers during the previous five years.

b. The Department of Health and Hospitals Health Standards Section shall arrange for on-site surveys for compliance with Medicaid and title VI (civil rights), life safety, and sanitation. The effective date of certification can be no earlier than the completion date of the survey, assuming all requirements are met. If requirements are not met at the time of survey, then the certification date may be delayed at the discretion of the state agency either until the facility signs an acceptable plan of correction or a follow-up visit verifies substantial compliance.

6. Change in Certification

a. A facility wishing to change its participation from Medicare/Medicaid (SNF-NF) to Medicaid (NF) or from Medicaid (NF) to Medicare/Medicaid (SNF-NF) shall submit to the Health Standards Section a letter of intent. Once the facility has been determined eligible to participate, the Medicaid Program (Medicaid) provider agreement will be amended accordingly.

b. Bed certification change - a facility wishing to change the number of beds in either category (Medicare or Medicaid) shall submit to DHH a letter of intent.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10105. Provider Enrollment

A. In order to participate as a provider of nursing services under Medicaid, a facility must meet certification requirements and enter into a provider agreement with the Department of Health and Hospitals. A provider agreement is the basis for payments by the Bureau of Health Services Financing. The execution of provider agreement and the assignment of the provider's Medicaid vendor number is contingent upon the following criteria.

1. The facility shall request a Medicaid enrollment packet from the BHSF/HSS Provider Enrollment Unit. The information listed below shall be returned as soon as it is completed.

a. Two copies of the provider agreement form which shall bear the signature of the person legally designated to enter into the contract with DHH;

b. One copy of the provider enrollment form, PE 50, which shall be completed in accordance with accompanying instructions and bear the signature of the administrator or authorized representative;

c. An addendum to the above provider agreement shall be completed if the facility chooses to provide any of the following enhanced levels of care:

- i. a skilled-infectious disease (S-ID);
- ii. skilled-technology dependent care (S-TDC);
- iii. skilled/neurological rehabilitation treatment program (S-NRTP).

B. Effective date of the provider enrollment agreement. The effective date of the provider agreement shall be determined as follows.

1. If all federal requirements (health and safety standards) including facility need review approval requirements specified above are met on the day of the Health Standards Section survey, then the effective date of the provider agreement is the date the on-site survey is completed.

2. If all requirements as specified in one above are not met on the day of the HSS survey, then the effective date of the provider agreement is the earlier of the following dates:

- a. the date on which the provider meets all requirements; and
- b. the date on which the provider submits a corrective action plan acceptable to the HSS.

3. Upon receipt of the above documentation/verification, Bureau of Health Services Financing-Health Standards Section Provider Enrollment Unit will assign a vendor number for billing purposes along with the issuance of the Provider Agreement. The Fiscal Intermediary will be notified accordingly.

C. Provider Agreement Time Periods. The provider agreement shall meet the following criteria in regard to time periods.

- 1. It shall not exceed 14 months;
- 2. It shall coincide with the certification period set by the Health Standards Section Survey Unit; and

EXCEPTION: If HSS has adequate documentation showing "good cause", it may make an agreement and certification period for less than 12 months.

3. After a provider agreement expires, payment may be made to a facility for up to 30 days.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10107. Change in Ownership

A. Assignment of Agreement

1. As a temporary measure during a change of ownership, the Bureau of Health Services Financing-Health Standards Section shall automatically assign the provider agreement and certification to the new owner. The new owner shall comply with all participation prerequisites simultaneously with the ownership transfer. Failure to promptly comply with these prerequisites may result in the interruption in vendor payment. The new owner shall be required to complete a new provider enrollment application.

2. Such an assignment is subject to all applicable statutes, regulations, terms, and conditions under which it was originally issued including, but not limited to, the following:

- a. any existing corrective action plan;
- b. any expiration date;
- c. compliance with applicable health and safety standards;
- d. compliance with the ownership and financial interest disclosure requirements;
- e. compliance with civil rights requirements;

- f. any facility need review rules that are applicable;
- g. compliance with any additional requirements imposed by the Bureau of Health Services Financing, Health Services Section.

B. Continued Participation. For a facility to remain eligible for continued participation after a change of ownership, the facility shall meet all the following criteria:

- 1. state licensing requirements;
- 2. all Medicaid certification requirements;
- 3. Medicaid provider enrollment requirements including completion of a signed contract with DHH; and
- 4. compliance with title VI of the Civil Rights Act.

C. Ten Percent Withholding—Release of Payments

1. When a change of ownership occurs, a minimum of ten percent of the final vendor payment to the old legal entity is withheld pending the fulfillment of the following requirements:

a. Completion of a limited scope audit of the residents' funds account and the disposition requirements for nurse aide training funds with findings and any recommendations of a qualified accountant of the old legal entity's choice submitted to the BHSF Institutional Reimbursement Section. Old legal entities have 60 days to submit the audit findings to the Bureau of Health Services Financing Institutional Reimbursement Section once the section notifies the old owner that a limited scope audit is required. Failure of the old legal entity to comply is considered a class E violation and will result in fines as outlined in the Subchapter L entitled Sanctions.

b. The facility's compliance with the recommendations of the limited scope audit and the disposition requirements for nurse aide training funds with the following two exceptions.

i. If the new legal entity disputes the findings of the limited scope audit, said entity may engage an independent auditor and submit any findings and recommendations to the BHSF Institutional Reimbursement Section for review. In such instances, the independent auditor must certify his independence and submit a written opinion to the Bureau of Health Services Financing Institutional Reimbursement Section.

ii. New owners may provide the Bureau of Health Services Financing- Health Standards Section with a notarized document attesting that they shall be responsible for completion of and compliance with the limited scope audit and the disposition requirements for nurse aide training funds. New owners have 60 days to submit the audit findings to Bureau of Health Services Financing Institutional Reimbursement Section once the section notifies the new owner that a limited scope audit is required.

NOTE: Failure of the new owner to comply is considered a class E violation and will result in fines as outlined in the Subchapter L entitled Sanctions.

c. Submittal of an acceptable cost report by the old legal entity to Bureau of Health Services Financing Program Operations Section covering the period to the date of ownership change.

2. Once these requirements are met, the portion of the payment withheld shall be released by the Bureau of Health Services Financing Program Operations Section.

NOTE: If a SN-ID or SN-TDC changes ownership, the ten percent will not be released until the above requirements are met and after cost settlement.

D. Notification to Fiscal Intermediary. Upon notification of the ownership transfer and the new owner's licensure, the Bureau of Health Services Financing- Health Standards Section Provider Enrollment Unit shall notify the fiscal intermediary regarding the effective dates of payment and to whom payment is to be made.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10109. Withdrawal from the Medicaid Program

A. A facility may involuntarily or voluntarily lose its participating status in the Medicaid Program. When a facility loses its participating status in the Medicaid Program, a minimum of ten percent of the final vendor payment to the facility is withheld pending the fulfillment of the following requirements:

1. completion of a limited scope audit of the residents' funds account and the disposition requirements for nurse aide training funds with findings and any recommendations of a qualified accountant of the facility's choice submitted to the BHSF Institutional Reimbursement Section. The facility has 60 days to submit the audit findings to the BHSF Institutional Reimbursement Section once the section notifies the facility that a limited scope audit is required. Failure of the facility to comply is considered a class E violation and will result in fines as outlined in the Subchapter L entitled sanctions;

2. the facility's compliance with the recommendations of the limited scope audit and the disposition requirements for nurse aide training funds;

3. submittal of an acceptable final cost report by the facility to BHSF Program Operations Section.

B. Once these requirements are met, the portion of the payment withheld shall be released by BHSF Program Operations.

NOTE: If a SN-ID or SN-TDC withdraws from the Medicaid Program, the 10 percent will not be released until the above requirements are met and after cost settlement.

C. In situations where a facility either voluntarily or involuntarily discontinues its operations or participation in the Medicaid Program, residents, residents legal representative or sponsor, and other appropriate agencies or individuals shall be notified as far in advance of the effective date as possible to ensure an orderly transfer and continuity

of care. The owner or administrator shall submit written notice of withdrawal to BHSF/HSS at least 30 days in advance of a voluntary withdrawal.

D. If the facility is closing its operations, plans shall be made for transfer. If the facility is voluntarily or involuntarily withdrawing from Medicaid Program participation, the resident has the option of remaining in the facility on a private-pay basis.

E. Payment Limitation

1. Payments may continue for residents up to 30 days following the effective date of the facility's certification of non-compliance.

2. The payment limitation also applies to Medicaid applicants and recipients admitted prior to the certification of non-compliance notice.

3. Payment is continued only if the facility totally cooperates in the orderly transfer of applicants/recipients to other Medicaid facilities or other placements of their choice.

NOTE: The facility shall not admit new Medicaid applicants/recipients after receiving the certification of non-compliance notice. There shall be no payment approved for such an admittance.

4. DHH may cancel the provider agreement if and when it is determined that the facility is in material breach of contract.

F. Facility Certification of Non-Compliance

1. When the DHH Bureau of Health Services Financing, Health Standards Section determines that a facility no longer meets state and federal Medicaid certification requirements, action is taken. Usually an advance certification of non-compliance date is set unless residents are in immediate danger.

2. Certification of Non-Compliance Notice

a. On the date the facility is notified of its certification of non-compliance, DHH shall immediately begin notifying residents, residents legal representative or sponsor, and other appropriate agencies or individuals of the action and of the services available to ensure an orderly transfer and continuity of care.

b. The process of certification of non-compliance requires concentrated and prompt coordination among the following groups:

- i. the BHSF Health Standards regional office;
- ii. the parish office of DHH BHSF, Medicaid Program;
- iii. the facility; and
- iv. other offices as designated by DHH.

c. This coordination effort shall have the following objectives:

- i. protection of residents;

ii. assistance in finding the most appropriate placements when requested by residents and/or responsible parties; and

iii. timely termination of vendor payment upon the resident's discharge from the facility.

NOTE: The facility still retains its usual responsibility during the transfer/discharge process to notify the parish office of DHH/BHSF Medicaid Program promptly of all changes in the resident's status.

3. Transfer Team. DHH shall designate certain staff members as a transfer team when a mass transfer is necessary. Their responsibilities shall include supervising transfer activities in the event of a proposed facility certification of non-compliance with Medicaid participation. The following procedures shall be taken by or under the supervision of this team.

a. Supervision and Assistance. When payments are continued for up to 30 days following certification of non-compliance, the transfer team shall take the following actions:

- i. supervise the facility certification of non-compliance and transfer of its Medicaid residents;
- ii. determine the last date for which vendor payment for resident care can be made; and
- iii. assist in making the most appropriate arrangements for the residents, providing the team members' names as contact persons if such help is needed.

b. Effecting the Transfer. To ensure an orderly transfer or discharge, the transfer team shall also be responsible for performing the following tasks:

- i. they shall meet with appropriate facility administrative staff and other personnel as soon as possible after termination of a provider agreement to discuss the transfer planning process;
- ii. they shall identify any potential problems;
- iii. they shall monitor the facility's compliance with transfer procedures;
- iv. they shall resolve disputes in the resident's best interest; and
- v. they shall ensure that the facility takes an active role in the transfer planning.
- vi. the local ombudsman and advocacy agencies shall be notified.

Note: The facility's failure to comply with the transfer team's requests may result in denial of reimbursement during the extension period.

c. Provisions for Resident Services During Transfer or Discharge. DHH has the following responsibilities:

- i. to provide social services necessary in the transfer or discharge plan or otherwise necessary to ensure an orderly transfer or discharge in accordance with the State Plan of the Medicaid Program; and

ii. to obtain other services available under Medicaid.

d. Parish DHH/BHSF Medicaid Program Responsibilities: Applicant/Recipient Status Listing. The parish office of DHH/BHSF Medicaid Program shall maintain a listing of each applicant/recipient's status as authorization forms are submitted regarding transfer or discharge. At the conclusion of the 30 day period referred to above, the transfer team shall submit a report to the office of DHH/BHSF Medicaid Program, outlining arrangements made for all Medicaid applicants/recipients.

e. Resident Rights. Nothing in the transfer or discharge plan shall interfere with the existing bill of rights.

G. Recertification of an Involuntary Withdrawal. After involuntary certification of non-compliance, a facility cannot participate as a provider of Medicaid services unless the following conditions are met:

1. the reasons for the certification of non-compliance of the contract no longer exist;
2. reasonable assurance exists that the factors causing the certification of non-compliance will not recur;
3. the facility demonstrates compliance with the required standards for a 60 day period prior to reinstatement in a participating status; and
4. the initial survey verifies that residents are receiving proper care and services;
5. certification requirements for swing bed hospitals. Small rural hospitals may certified to provide Medicaid nursing facility services if all of the following conditions are met:
 - a. the hospital has a valid agreement as a title XVIII (Medicare) provider of swing bed services;
 - b. the hospital has fifty hospital beds or fewer, excluding beds for newborns and beds in intensive care type in residents units;
 - c. the hospital is located in an area not designated as "urban" in the most recent census;
 - d. a facility need review approval has been granted;
 - e. the hospital is not operating under a waiver of the hospital requirements for 24 hour nursing services;
 - f. the hospital has a valid title XIX (Medicaid) agreement as a provider of acute care hospital services;
 - g. the hospital has not had a swing bed title XVIII (Medicare) or Title XIX (Medicaid) approval terminated within two years previous to application;
 - h. a provider of swing bed services shall comply with conditions for title XIX (Medicaid) participation as both acute care hospital and Medicaid nursing facility; however, a lack of compliance with nursing facility requirements does not affect participation as a provider of acute care hospital services;

i. hospitals seeking to enroll as swing bed facilities on or after July 9, 1987 shall also meet the following criteria:

- i. possess a current nursing home license;
- ii. be administered by a licensed Nursing Home Administrator;
- iii. meet the need and resource goals as established in facility need review regulations; and
- iv. list enrollment to ten percent of bed capacity.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

Subchapter C. Administration

§10111. Introduction

A. A facility shall be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. It shall be responsible for ensuring that all services provided to the residents by professional staff meet ethical and professional standards governing the profession.

B. Licensure. A facility must be licensed under applicable state and local laws.

C. Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable federal, state and local laws, regulations and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.

D. Relationship to Other HSS Regulations. In addition to compliance with the regulations set forth in this sub-part, facilities are obliged to meet the applicable provisions of other HSS regulations, including but not limited to those pertaining to:

1. nondiscrimination on the basis of race, color, or national origin (45 CFR page 80);
2. nondiscrimination on the basis of handicap (45 CFR page 84);
3. nondiscrimination on the basis of age (45 CFR Part 91);
4. protection of human subjects of research (45 CFR page 46); and
5. fraud and abuse (42 CFR Part 455).

E. Although these regulations are not in themselves considered requirements under this part their violation may result in termination or suspension of, or the refusal to grant or continue payment with federal funds.

F. Nursing facilities shall meet the following criteria.

1. **Compliance.** Facilities shall be in compliance with title VI of the Civil Rights Act of 1964 and shall not discriminate, separate, or make any distinction in housing, services, or activities based on race, color, or national origin.

2. **Community Notification.** Facilities shall notify the community that admission to the facility, resident care services, and other activities are provided without regard to race, color, or national origin. Notice to the community may be physicians, local health and welfare agencies, paramedical personnel, and public and private organizations having interest in equal opportunity or by notices in the local newspaper.

a. Residents shall not be asked if they are willing to share a room with a person of another race, color, or national origin.

b. Resident transfers shall not be used to evade compliance with title VI of the Civil Rights Act of 1964.

3. **Open Admission Policy.** An open admission policy and desegregation of facilities shall be required, particularly when the facility previously excluded or primarily served residents of a particular race, color, or national origin. Facilities which exclusively serve residents of one race have the responsibility for taking corrective action, unless documentation is provided that this pattern has not resulted from discriminatory practices.

4. **Restricted Occupancy.** A facility owned or operated by a private organization may restrict occupancy to members of the organization without violating Civil Rights compliance, provided membership in the organization and admission to the facility is not denied on the basis of race, color, or national origin.

5. **Resident Services.** All residents shall be provided medical, non-medical, and volunteer services without regard to race, color, or national origin. All administrative, medical and non-medical services are covered by this requirement.

6. **Facility Personnel.** Attending physicians shall be permitted to provide resident services without regard to race, color, or national origin.

a. Other medical, paramedical, or non-medical persons, whether engaged in contractual or consultative capacities, shall be selected and employed in a non-discriminatory manner.

b. Opportunity shall not be denied to qualified persons on the basis of race, color, or national origin.

c. Dismissal from employment shall not be based upon race, color, or national origin.

G. Facilities shall comply with section 504 of the Rehabilitation Act of 1973 which states the following: No qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from federal financial assistance.

H. **Governing Body.** The facility must have a governing body or designated persons functioning as a governing body that is legally responsible for establishing and implementing policies regarding the management and operation of the facility.

1. The governing body appoints the administrator who is:

a. licensed by the state where licensing is required; and

b. responsible for management of the facility.

I. **Staffing.** There are staff sufficient in number and qualifications on duty all hours of each day to carry out the policies, responsibilities, and program of the facility. The numbers and categories of personnel are determined by the number of residents and their particular needs in accordance with guidelines in this manual.

J. **Policies and Procedures.** There are written policies and procedures available to staff, residents, and the public which govern areas of service provided by the facility.

K. **In-service Education Program.** There is an orientation program for all new employees that includes review of all facility policies. Each employee receives appropriate orientation to the facility and its policies and to his position and duties. An in-service education program is planned and conducted for the development and improvement of skills of all the facility's personnel. In-service training includes at least prevention and control of infections, fire prevention and safety, accident prevention, confidentiality of resident information, and preservation of resident dignity, including protection of his privacy and his personal and privacy rights. Records are maintained which indicate the content of and attendance at such staff development programs.

1. Ongoing education programs include orientation and in-service training appropriate for each employee.

2. Records indicate content and attendance at staff development programs.

L. **Personnel Policies and Procedures.** The governing body, through the administrator, is responsible for implementing and maintaining written personnel policies and procedures that support sound resident care and personnel practices. Personnel records are current and available for each employee and contain sufficient information to support placement in the position to which assigned. Written policies for control of communicable diseases are in effect to ensure that employees with symptoms or signs of communicable disease or infected skin lesions are not permitted to work and that a safe and sanitary environment for residents and personnel exists and incidents and accidents to residents and personnel are reviewed to identify health and safety hazards. Employees are provided or referred for annual health evaluations.

M. **Development and Review of Resident Care Policies.** The administrator or his designee is responsible, in writing, for the execution of such policies.

N. Quality Assurance. Each facility must have a quality assessment and assurance committee. Members must include:

1. director of nursing services;
2. physician designated by facility; and
3. at least three other members of the facility staff.

a. This committee meets at least quarterly to identify issues with respect to which quality assessments and assurance activities are necessary.

b. This committee develops and implements appropriate plans of action to correct identified quality deficiencies.

c. DHH or DHHS may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

d. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions and/or citations on Form 2567.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10113. Infection Control

A. The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection using Centers for Disease Control guidelines where available.

B. Infection Control Program (ICP). An ICP must be established in the facility which identifies who:

1. investigates, controls, and prevents infections in the facility;
2. decides what procedures, such as isolation, should be applied to an individual resident; and
3. maintains a record of incidents and corrective actions related to infections.

C. Preventing Spread of Infection

1. When the staff members designated by the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.

2. The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food if direct contact will transmit the disease.

3. The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional standards.

4. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

5. Universal precautions shall be used for residents regardless of diagnosis and/or condition.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10115. Physical Environment and Sanitation

A. The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public as set forth below.

B. Favorable Environment for Residents. Resident living areas are designed and equipped for the comfort and privacy of the resident. Each room is equipped with or conveniently located near adequate toilet and bathing facilities appropriate in number, size, and design to meet the needs of residents. Each resident room contains a suitable bed and functional furniture appropriate to the residents needs.

C. Hot Water. An adequate supply of hot water for resident use is available. Temperature of hot water at plumbing fixtures used by residents is automatically regulated by control valves to assure a temperature between 110 degrees and 120 degrees Fahrenheit at the faucet outlet.

D. Isolation Techniques. Written effective procedures in aseptic and isolation techniques are followed by all personnel. Procedures are reviewed annually and revised when necessary for effectiveness and improvement.

E. Housekeeping. The facility employs sufficient housekeeping personnel and provides all necessary equipment to maintain a safe, clean, and orderly interior. An employee is designated full-time responsibility for this service and for supervision and training of housekeeping personnel. A facility that has a contract with an outside resource for housekeeping services may be found to be in compliance with this standard provided the facility and/or outside resources meet the requirements of the standard.

F. Maintenance of Equipment, Building, and Grounds. The facility establishes a preventive maintenance program to ensure that equipment is operative and that the interior and exterior of the building are clean and orderly. All essential mechanical, electrical, and resident care equipment is maintained in safe operating condition.

G. Nursing Unit. Each nursing unit has at least the following basic service areas: Nurses station, storage and preparation area(s) for drugs and biologicals, and utility and storage rooms that are adequate in size, conveniently located, and well lighted to facilitate staff functioning. The nurses station is equipped to register residents' calls through a communication system from resident areas, including rooms and toilet and bathing facilities.

H. Environment. The facility must provide:

1. a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible;

2. housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

3. clean bed and bath linens that are in good condition;

4. private closet space in each resident room with clothes rack and shelves and/or drawers accessible to the resident;

5. adequate and comfortable lighting levels in all areas;

6. comfortable and safe temperature levels. The facility must provide the capability to maintain a temperature for all seasons between 71 degrees and 81 degrees throughout all occupied resident areas; and

7. for the maintenance of comfortable sound levels.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

Subchapter D. Resident Care Services

§10117. Administrative Services

A. Facility Administrator. All facilities are required to have full-time administrators. "Full-time" administrators are persons who are licensed, currently registered and engaged in the day to day management of the facility. A full-time employee functioning in an administrative capacity shall be authorized in writing to act in the administrator's behalf when he/she is absent or when the administrator is functioning as a full-time administrator for two facilities. The administrator's duties shall conform to the following standards.

1. Administrative/management activities shall be the major function of the duties required. The administrator is responsible for the management of the facility.

2. An adequate and reasonable amount of time shall be spent on the premises of the facility. The activity must be the major functions of the person performing the act.

3. A major portion of the time, referred to above, shall be spent during the normal work week of the facility's personnel.

B. Restrictions

1. No individual may function as a full-time administrator for more than two nursing facilities. When a full-time administrator is engaged in the management of two nursing facilities, the facilities' sizes and proximity to one another have considerable bearing on the administrator's ability to adequately manage the affairs of both nursing facilities. The response time to either facility shall be no

longer than one hour. If the administrator does serve two facilities, he must spend 20 hours per week at each facility.

2. The full-time administrator of a multi-story facility shall not function as an administrator of another nursing facility. The administrator or his designee is responsible, in writing, for the execution of all policies and procedures. If a change occurs in the individual who is the administrator of a nursing facility, notice shall be provided to BHSF Health Standards Section at the time the change occurs by the facility administrator or, in the absence of an administrator, by the governing body of the facility. Notice shall include the identity of all individuals involved and the specific changes which have occurred. Failure to provide written notice by certified mail within 30 calendar days from the date a change occurs will result in a class C civil money penalty (refer to Subchapter L, Sanctions).

D. The bureau shall allow long term care facilities 30 days from the date of change in the position to fill the resulting vacancy in the administrator position. There shall be no waiver provisions for this position. The governing body of the facility shall appoint a facility designee charged with the general administration of the facility in the absence of a licensed administrator.

E. Failure to fill a vacancy to or notify the Bureau in writing by the thirty-first day of vacancy that the administrator position has been filled shall result in a class C civil money penalty (refer to Subchapter L, Sanctions).

F. Assistant Administrator. A nursing facility with a licensed bed capacity of 161 or more beds must employ an assistant administrator. An assistant administrator shall:

1. be a full-time employee; and
2. function in an administrative capacity.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10119. Physician Services

A. Medical Director. The nursing facility shall have a written agreement with a physician who shall serve as the medical director on a full-time or part-time basis. Whether the physician is employed full-time or part-time shall be based on the residents' needs.

1. The medical director shall not have peer restriction in regard to overseeing total medical care.

2. The medical director is responsible for:

- a. implementation of resident care policies; and
- b. coordination of medical care in the facility.

3. Residents shall be admitted to a facility only with a physician's order, and medical care shall be under a physician's supervision. Each resident shall have freedom of choice of physicians.

B. **Physician Supervision; Ongoing Care.** All facilities shall develop policies and procedures to ensure that each resident's health care is under a Louisiana physician's continuing supervision. Each resident must remain under the care of a physician. The care of every skilled/NRTP resident shall be under the supervision of a licensed physiatrist, certified in physical medicine and rehabilitation.

C. A physician visit is considered timely if it occurs not later than ten days after the date the visit was required. At the option of the physician, required visits after the initial visit may be made by a physician assistant, nurse practitioner or clinical nurse specialist. Otherwise, all physician visits shall be made by the physician personally. This does not relieve the physician of his/her obligation to visit a resident when the resident's medical condition makes that visit necessary.

D. Physicians may delegate tasks to a physician's assistant, nurse practitioner, or clinical nurse specialist who:

1. meets the applicable definitions as outlined in 42 CFR 491.2;
2. is acting within the scope of practice as defined by state law; and
3. is under the supervision of a physician.

E. A physician may not delegate a task when the regulations specify that the physician shall perform it personally or when the delegation is prohibited under state law or by the facility's own policies.

F. The facility shall provide or arrange for the provision of physician services 24 hours a day in case of emergency.

G. **Alternate Physicians.** When continuing care by the attending physician is interrupted by that physician's illness or vacation, the attending physician shall arrange for a designated attending physician to provide coverage.

H. **Frequency of Visits.** Physician visits shall conform to the following schedule.

1. For SNFs and NFs the resident shall be seen at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter.

I. **Physician Responsibilities.** The attending physician's services shall include but shall not be limited to the following:

1. making arrangements for the resident's medical care when he/she is not available;
2. performing an examination when visiting and recording the findings in the medical record;
3. reviewing a resident's total program of care, including medication treatment regimen and comprehensive care plan at least once every 90 days; and
4. signing and dating all orders;
5. ordering and/or performing the following:
 - a. medications;

- b. diagnostic tests;
- c. specialized rehabilitative services;
- d. treatment procedures;
- e. medical appliances;
- f. psychosocial services;
- g. discharge evaluations;

6. entering legible progress notes in the medical record, signing and dating his/her entry at each visit;

7. discussing new treatments, medications, and discharge potential and/or plans with the resident, if at all possible;

8. updating the medical record with any subsequent diagnosis which the resident may have acquired since admission and ensuring that all pertinent diagnoses are recorded in one place in the medical record; and

9. giving telephone orders only to physicians, pharmacists, physician's assistants and licensed nurses. The physician shall sign telephone orders within seven days;

10. ordering rehabilitative services with a written plan of care under the following conditions:

- a. in consultation with appropriate therapist(s) and the nursing service staff; and

- b. with progress being reviewed after the rehabilitative care plan implementation being re-evaluated with the therapist(s) as necessary but at least every 30 days.

J. **Physician's Signature.** Whenever a physician's signature is required, the actual signature shall be written. The physician may use initials only if an original legend sheet with a full signature and the initials which will be used is placed on the record. Use of signature stamps by physicians is allowed when the signature stamp is authorized by the individual whose signature the stamp represents. The administration office of the nursing facility should have on file a signed statement to the effect that he/she is the only one who has the stamp and uses it. There is no delegation to another individual.

1. Electronic signatures, where automated, are acceptable. Orders may be faxed if:

- a. original orders are retained by the physician and provided if requested, or sent to facility at a later date; and

- b. the facility should photocopy fax to prevent fading of document over time.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10121. Nursing Services

A. The facility shall provide an organized nursing service with a sufficient number of licensed and unlicensed qualified nursing personnel to meet the total nursing needs of all

residents in accordance with the resident care policies of the facility on a 24 hour basis.

1. The facility shall provide:

a. policies that are designed to ensure that each resident:

i. receives treatments, medications, diets as prescribed, rehabilitative nursing care as needed;

ii. receives care to prevent pressure sores and deformities;

iii. is kept comfortable, clean, and well-groomed;

iv. is protected from accident, injury, and infection; and

v. is encouraged, assisted, and trained in self-care and group activities.

b. Assurance that all nursing personnel are assigned duties consistent with their education and experience and based on the characteristics of the resident load; and

c. Weekly time schedules which indicate the number and classification of nursing personnel, including relief personnel who worked in each unit for each tour of duty.

B. Director of Nursing Services. all nursing facilities shall have a director of nursing (DON) who is a qualified registered nurse employed full-time and regularly assigned to the day shift.

1. The director of nursing must have, in writing, administrative authority, responsibility and accountability for the functions, activities, and training of the nursing services staff.

2. The director of nursing may serve only one facility in the capacity of director of nursing.

3. If a change occurs in the individual who is the director of nursing, notice shall be provided by the facility administrator (or governing body in absence of administrator) to BHSF/HSS at the time the change occurs. Notice shall include the identity of all individuals involved and the specific changes which have occurred. Failure to provide written notice by certified mail within 30 calendar days from the date a change occurs, will result in a Class C civil money penalty. (Refer to Subchapter L Sanctions.)

4. The Bureau shall allow long term care facilities 30 days from the date of change in the position of director of nursing to fill a resulting vacancy. In the interim, an RN must be assigned the responsibility of the DON position. Waiver of the 30 day time limit may be granted by the Bureau if:

a. The facility demonstrates to the satisfaction of the bureau that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities) to recruit a director of nursing.

b. The Bureau determines that a waiver of the director of nursing will not endanger the health and safety of individuals staying in the facility.

5. Failure to fill a vacancy or to notify the Bureau in writing that the director of nursing position (where no waiver has been granted) has been filled by the thirty-first day of vacancy (or expiration of any waiver granted) shall result in a class C civil money penalty. (Refer to Sanctions.)

6. The bureau shall retain the right to apply any other applicable remedies.

C. Assistant Director of Nursing. If the director of nursing has administrative responsibilities or the nursing facility has a licensed bed capacity of 101 or more, the facility shall have a full-time assistant director of nursing (ADON).

D. RN Coverage. A nursing facility shall use the services of an RN for at least 8 consecutive hours a day, seven days a week. When seven-day RN coverage cannot be provided, the facility must notify Health Standards Section following guidelines outlined for the separation of the director of nursing.

E. Waiver. If a facility is unable to obtain the seven-day RN coverage the facility may request a waiver. To obtain a waiver for the seven-day RN coverage, the facility shall submit a written request to the regional office which includes:

1. proof that diligent efforts have been made to recruit appropriate personnel. Newspaper invoices with the ad attached shall be submitted and the hourly salary offered and any other benefits offered;

2. names and phone numbers of RN's interviewed for the job.

a. Upon receipt of this information, the regional office will review the level of care of the residents in the facility and make a determination that approval of the waiver would/would not endanger the health or safety of the residents staying in the facility. The regional office will make a recommendation to the state office to approve/deny the waiver.

b. The facility will be notified, in writing, as to the approval/denial of the waiver by state office. Although a facility is granted a waiver, the facility shall continue to recruit for an RN on a continuous basis to fill the position.

c. A waiver approval will expire after one year or upon the next standard survey.

d. The nursing facility that is granted such a waiver by the state notifies residents of the facility (or where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.

e. When a waiver for seven-day RN coverage has been granted, the facility cannot train nursing assistants.

F. Waiver in a Skilled Nursing Facility or Dually Certified SNF/NF. The secretary of DHHS may waive the requirement that a SNF provide the services of a registered nurse for more than 40 hours a week, including a director of nursing if the secretary finds that the facility:

1. is located in a rural area and the supply of SNF services in the area is not sufficient to meet the needs of individuals residing in the area;

2. has one full-time registered nurse who is regularly on duty at the facility 40 hours a week; and

3. has only residents whose physicians have indicated through written orders that they do not require the services of a registered nurse or physician for a 48 hour period, or has made arrangements for a registered nurse or physician to spend time at the facility to provide necessary skilled nursing services on days when the regular full-time registered nurse is not on duty.

a. To apply for a waiver of registered nurse coverage in a skilled nursing facility, the provider should send a written request to: Health Care Financing Administration, Regional Office VI, 1200 Main Tower Building, Dallas, Texas 75202, attn: Mr. Mitchell Chunn.

b. Facilities providing the following levels of care may not request a waiver for seven-day RN coverage:

- i. skilled—NRTP;
- ii. skilled—ID; or
- iii. skilled—TDC.

G. Charge Nurse. A registered nurse, or a qualified licensed practical (vocational) nurse shall be designated as charge nurse by the DON for each tour of duty and is responsible for supervision of the total nursing activities in the facility during each tour of duty.

1. A director of nursing may not serve as charge nurse in a facility with an average daily total occupancy of 60 or more residents.

2. The charge nurse delegates responsibility to nursing personnel for the direct nursing care of specific residents during each tour of duty on the basis of staff qualifications, size/physical layout of the facility, characteristics of resident load, and emotional, social, and nursing care needs of the residents.

H. Certified Nursing Assistants (CNA). A nursing facility shall not use any individual who is not a certified nursing assistant in the facility on or after October 1, 1990 for more than four months unless the individual has completed a training and competency evaluation program or competency evaluation program approved by the state agency. For additional information, refer to the Chapter on nurse aide training.

I. Clerical Staff. Effective September, 1991 all facilities shall employ two full-time clerical employees.

J. Other Nursing Services. Nursing services shall be provided to the resident to ensure that the needs of the resident are met. These services include the following:

1. Drug Administration. Medications shall be administered only by a licensed physician, licensed/applicant nurse, or the resident (with the approval of the ID team as documented in the comprehensive care plan.)

2. The facility should be cognizant of the mental status of the resident's roommate(s) or other potential problems which could result in abuses with drugs used for self-administration.

3. Medications shall be administered in accordance with the facility's established written procedures and the written policies of the pharmaceutical services committee to ensure the following criteria are met:

a. Drugs to be administered are checked against physician's orders.

b. The resident is identified before administering the drug.

c. All medications/treatments are administered and properly charted in accordance with nursing practice standards. The reason for each medication omission shall be recorded in the resident's active medical record.

i. The drug dosage shall be prepared, administered, and recorded by the same person.

ii. Medications prescribed for one resident shall not be administered to any other person.

iii. Medication errors and adverse drug reactions shall be immediately reported to the attending physician and recorded in the medical record.

iv. Current medication reference texts or sources shall be kept in all facilities.

4. Automatic Stop Orders. Medications not specifically limited as to time or number of doses when ordered shall be controlled by automatic stop orders or other methods in accordance with written policies. The attending physician must be notified of an automatic stop order prior to the last dose so that (s)he may decide if the administration of the drug or biological is to be continued or altered.

5. Self Administration. Self administration of medication is allowed only in accordance with orders of resident's attending physician, in conjunction with the ID team, when documented in the comprehensive care plan.

6. Drug Orders. Medications shall be ordered by the attending physician verbally or in writing.

a. Verbal medication orders shall be:

i. given only to a licensed/applicant nurse, pharmacist, physician's assistant, nurse practitioner, clinical nurse specialist or another physician;

ii. immediately recorded, fully dated, and signed by the individual receiving the order;

iii. fully dated and signed by the physician within seven days; and

iv. Category II controlled substances must be confirmed in writing within 72 hours and may be given only in an emergency (controlled substance as of 1970).

7. Standing orders, if used, shall be placed in each resident's record and shall be signed by the resident's attending physician and fully dated. These orders shall be reviewed, signed, and fully dated at least annually.

8. Activities of Daily Living (ADL). Based on the comprehensive assessment of a resident, the facility shall ensure that:

a. a resident's abilities in activities of daily living (ADLs) do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable;

b. activities of daily living (ADLs) include the ability to do the following:

i. bathe, dress and groom;

ii. transfer and ambulate;

iii. toilet;

iv. eat; and

v. to use speech, language or other functional communication system.

c. A resident who is unable to carry out activities of daily living shall receive the necessary services to maintain good nutrition, grooming and personal/oral hygiene.

d. A resident is to be given the appropriate treatment and services to maintain or improve his/her functional status and abilities to perform their ADLs.

9. Vision and Hearing. The residents shall receive proper treatment and assistive devices to maintain vision and hearing abilities. The facility shall assist the resident in making appointments and arranging for transportation to and from appointments and in locating assistance from community and charitable organizations when payment is not available through Medicaid, Medicare, or private insurance.

10. Pressure Sores. A resident who enters a facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they are unavoidable. A resident having pressure sores shall receive necessary treatment and services to promote healing, prevent infection, and prevent sores from developing unless the individual's clinical condition demonstrates that they were unavoidable.

11. Urinary Incontinence. A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary. A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much

normal bladder function as possible and prevent skin breakdown.

12. Restorative Nursing Care. Nursing services shall be provided in accordance with the needs of the residents and restorative nursing care is provided to each resident to achieve and maintain the highest possible degree of function, self-care, and independence. Restorative nursing care services must be performed daily for those residents who require such service.

13. Range of Motion. A resident who enters the facility with full range of motion (ROM) should not experience reduction in ROM unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. A resident with limited ROM must receive appropriate treatment and services to increase/maintain or prevent further decrease in range of motion.

14. Psychological Functioning. A resident who displays psychosocial adjustment difficulty shall receive appropriate treatment and services to achieve as much remotivation and reorientation as possible. A resident whose assessment did not reveal a psychosocial adjustment difficulty should not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behavior unless the resident's clinical condition demonstrates that such a pattern was unavoidable.

15. Naso-Gastric-Gastrostomy Tubes. A resident who has been able to eat an adequate diet with assistance should not be fed by naso-gastric (NG) tube unless the resident's clinical condition demonstrates that the use of NG tube was unavoidable.

a. A resident who is fed by NG or gastrostomy tubes shall receive the appropriate treatment and services to prevent:

i. aspiration pneumonia;

ii. diarrhea and vomiting;

iii. dehydration and metabolic abnormalities;

iv. nasal pharyngeal ulcers.

b. Feedings shall be provided to restore normal feeding function if possible.

16. Accidents. The resident's environment shall remain as free of accident hazards as possible. Each resident shall receive adequate supervision and assistive devices to prevent accidents.

17. Nutrition. Each resident shall be maintained within acceptable parameters of nutritional states such as body weight and protein levels unless the resident's clinical condition demonstrates that this is not possible. In instances where a nutritional problem has been identified, the resident shall be assessed for the need of a therapeutic diet. A therapeutic diet must be prescribed by the attending physician.

18. Hydration. Each resident must receive sufficient fluid intake to maintain proper hydration and health.

19. Special Needs. Residents must receive proper treatment and care for the following:

- a. injections;
- b. parenteral and enteral fluids;
- c. colostomy, ureterostomy, or ileostomy care;
- d. tracheostomy care;
- e. tracheal suctioning;
- f. respiratory care;
- g. podiatric care; and
- h. prosthesis.

NOTE: Resident's rights and/or advance directives may supersede the above standards.

K. Release of a Body by a Registered Nurse. In the absence of a physician in a setting other than an acute care facility, when an anticipated death has apparently occurred, registered nurses may have the decedent removed to the designated funeral home in accordance with the standing order of a medical director/consultant setting forth basic written criteria for a reasonable determination of death. This is not applicable in cases where the death was unexpected.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996), amended LR 23:970 (August 1997).

§10123. Comprehensive Assessment

A. The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity and needs, in relation to a number of specified areas. Comprehensive assessments must:

1. be based on a uniform data set (resident assessment instrument); and
2. describe the resident's capability to perform daily life functions and significant impairments in functional capacity;
3. include the following information:
 - a. medically defined conditions and prior medical treatment;
 - b. medical status measurements;
 - c. physical and mental functional status;
 - d. sensory and physical impairments;
 - e. nutritional status and requirements;
 - f. special treatment and procedures;
 - g. mental and psychosocial status;
 - h. discharge potential;
 - i. dental condition;

- j. activities potential;
- k. rehabilitation potential;
- l. cognitive status; and
- m. drug therapy.

B. Frequency. The assessment must be conducted no later than 14 days after admission for new admissions.

1. A reassessment must be completed after a significant change in the resident's physical and/or mental condition.

2. A reassessment must be conducted at least once every 12 months/annually.

3. Residents must be examined and assessments must be reviewed every three months and revised as appropriate to assure the continued accuracy of the assessment.

C. Coordination of Assessments with Pre-admission Screening. The facility must coordinate assessments with the state-required pre-admission screening program to the maximum extent practicable to avoid duplicate testing and effort.

D. Accuracy of Assessments. To assure accuracy, the assessments:

1. must be conducted or coordinated with the appropriate participation of health professional;
2. must be conducted or coordinated by a registered nurse who signs and certifies completion of the assessment; and
3. must have each individual who completes a portion of the assessment sign and certify the accuracy of that portion of the assessment.

E. Penalty for Falsification

1. Any individual who willfully and knowingly certifies (or causes another individual to certify) a material and false statement is subject to civil money penalties.

2. Clinical disagreement does not constitute a material and false statement.

3. If the state determines under survey, or otherwise, that there has been knowing and willful certification of false statements, the state may require that the residents' assessments be conducted by individuals independent of the facility. The independent assessors must be approved by the state. The total cost of this independent assessment is the sole responsibility of the facility. Additionally, all independent assessments are not considered necessary expenditures of the facility.

F. Utilization—Resident Assessment Instrument (RAI)

1. Components of comprehensive assessment (RAI):
 - a. minimum data set (MDS);
 - b. triggers legend;
 - c. care area assessment; and

- d. utilization guidelines;
- e. alteration of MDS information—MDS information collected may be altered until the twenty-first day after admission for the following reasons:

- i. information not available to staff completing section because the resident is unable to provide necessary information and family members must make an appointment to participate;

- ii. further observation and interaction with the resident reveals a need to alter the assessment;

- iii. at admission, the resident's condition is unstable and the illness or chronic problem is controlled by the twenty-first day.

2. If the MDS must be altered up to the twenty-first day, then the assessor shall show these changes on the admission assessment and shall initial and date such amendments.

3. The MDS may not be altered after the twenty-first day. If a change has occurred, a new MDS must be completed.

4. Significant change defined:

- a. deterioration in two or more activities of daily living, communication, and/or cognitive abilities that appear permanent;

- b. loss of ability to freely ambulate or to use hands to grasp a small object to feed or groom oneself, such as spoon, toothbrush or comb;

- c. deterioration in behavior, mood, and/or relationships that has not been reversed;

- d. deterioration in a resident's health status where this change places the resident's life in danger, is associated with serious clinical complications, or is associated with an initial new diagnosis of a condition that is likely to affect the resident's physical, mental, or psychosocial well-being over a prolonged period of time;

- e. onset of a significant weight loss (five percent in last 30 days or ten percent in last 180 days); and

- f. a marked and sudden improvement in the resident's status.

5. Document in medical record the initial identification of a significant change in status. Once it has been determined that the resident's change in status is likely to be permanent, complete a full comprehensive assessment within 14 days of that determination.

6. Quarterly Assessment and Optional Progress Notes—to track resident status between assessments and to ensure monitoring of critical indicators of the gradual onset of significant declines in resident status, a registered nurse:

- a. must examine the resident;

- b. review the MDS core elements as outlined in the HSS Form Quarterly RA Review:

- i. Section B—Items 2 and 4;
- ii. Section C—Items 4 and 5;
- iii. Section E—Items 1 b-f and 3A;
- iv. Section F—Item 1;
- v. Section J—Note only disease diagnosis in last 90 days;
- vi. Section L—Item 2C;
- vii. Section O—Item 4;
- viii. Section P—Item 3;

7. Triggers—Level of measurement (coding categories) of MDS elements that identify residents who require evaluation using the care area assessment (CAA) process.

G. Care Area Assessment (CAA) Process and Care Planning

1. CAAs are triggered responses to items coded on the MDS specific to a resident's possible problems, needs or strengths.

2. The CAA process provides:

- a. a framework for guiding the review of triggered areas;

- b. clarification of a resident's functional status and related causes of impairments; and

- c. a basis for additional assessment of potential issues, including related risk factors.

3. The CAA must:

- a. be conducted or coordinated by a registered nurse (RN) with the appropriate participation of health professionals;

- b. have input that is needed for clinical decision making (e.g., identifying causes and selecting interventions) that is consistent with relevant clinical standards of practice; and

- c. address each care area identified under CMS's RAI Version 3.0 Manual, section 4.10, Table 10 (The Twenty Care Areas).

4. CAA documentation should indicate:

- a. the basis for decision making;

- b. why the finding(s) require(s), or does not require, an intervention; and

- c. the rationale(s) for selecting specific interventions.

H. Effective for assessments with assessment reference dates of October 1, 2023 and after, the department mandates the use of the optional state assessment (OSA) item set. The OSA item set is required to be completed in conjunction with each assessment and at each assessment interval

detailed within this Section. The OSA item set must have an assessment reference date that is identical to that of the assessment it was performed in conjunction with.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and R.S. 46:2742.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996), amended by the Department of Health, Bureau of Health Services Financing, LR 46:695 (May 2020), LR 46:1684 (December 2020), LR 50:219 (February 2024).

§10125. Comprehensive Care Plan

A. Basis for the Comprehensive Care Plan. All services in a facility shall be provided in accordance with a physician's written order which shall be developed either before admission or before authorization for payment. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and psychosocial needs that are identified in the comprehensive assessment.

1. The comprehensive assessment shall be developed for residents within 14 days of admission. Written comprehensive care plans shall be developed within seven days of the comprehensive assessment and no later than 21 days of admission. Thereafter, care plans must be updated at least quarterly or when a significant change in the resident's condition occurs.

2. Individual comprehensive care plans shall:

a. be prepared by an interdisciplinary (ID) team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs;

b. include the resident, resident's family or legal representative, to the extent practicable in the participation of the care planning process;

c. be periodically reviewed and revised by a team of qualified persons after each assessment and/or quarterly review. This requirement is a review for both ICF and SNF. Neurological Rehabilitative Treatment Program (NRTP) levels of care shall be reviewed every 30 days;

d. be located in the medical record and accessible for use by all licensed nursing personnel and any staff directly involved in the integrated care;

e. serve as the primary communication tool among disciplines to ensure that services are coordinated and that the approaches of the various disciplines are integrated;

f. be written in a language understandable to all staff directly involved in the resident's care and the resident in so far as possible; and

g. document that all services ordered are being rendered and properly recorded.

3. Documentation of quarterly staffing must be on the MDS quarterly Review Form as a comparable computerized

document. The documentation shall indicate the date of the staffing and who was in attendance.

B. Contents of the Comprehensive Plan of Care

1. The plan of care shall include the following information:

a. identification of all problems and needs according to the resident assessment protocol document as well as any other identified problems;

b. the goals to be accomplished by the resident. These goals shall be:

- i. specific;
- ii. reasonable; and
- iii. measurable;

c. the specific goals regarding discharge. The discharge plans shall:

i. reflect exploration of likely discharge possibilities;

ii. ensure that residents have planned programs of post discharge continuing care which take their needs into account to the extent practicable;

iii. be developed and reviewed in accordance with the facility's written discharge planning procedures;

d. the expected resolution or review date specified for each problem or need;

e. the prescribed integrated, resident specific therapies and treatments designed to help residents achieve their goals;

f. individual or professional services staff responsible for each service prescribed in the plan;

g. all participating staff shall be identified by name and title, when signing the plan of care;

h. all participating staff and the resident, whenever possible, sign and date the following:

i. the initial plan of care; and

ii. each subsequent review. If the resident refuses to sign the plan of care, this fact should be documented for the medical record;

i. physician orders for diet;

j. the daily and weekly time frames for each service included in the plan for residents receiving either complex care or rehabilitation under NRTP (Neurological Rehabilitation Treatment Program).

C. Discharge Summary. When a facility anticipates a discharge, a resident must have a discharge summary that includes:

1. a recapitulation of the resident's stay;

2. a final summary of the resident's status to include medical history, current diagnosis/condition, medical status

measurements, functional status, cognitive status, any impairments, nutritional status/requirements, drug therapy, special treatment, procedures, psychosocial status and rehabilitation potential;

3. must be legible and available for release to authorized persons and agencies with the consent of the resident and/or legal representative; and

4. must be developed with the participation of the resident and his/her family, which will assist the resident in adjusting to a new living environment to the extent practicable.

D. **Physician Involvement and Responsibilities in the Comprehensive Plan of Care.** A physician is responsible for approving each resident's initial integrated plan of care and each subsequent revision.

1. The physician's approval shall be documented in one of the following places:

- a. the plan of care;
- b. the order sheet;
- c. the progress notes.

2. The documentation referred to above shall be signed and fully dated. The physician may use initials to document review of the plan only if an original legend sheet with a full signature and the initials which will be used is placed on each record.

3. The physician shall review the comprehensive care plan at 90 day intervals.

E. **Quarterly Assessment and Optional Progress Notes.** The nursing facility must examine each resident no less than once every three months (quarterly) and, as appropriate, to revise the resident's assessment to assure the continued accuracy of the assessment.

1. The quarterly assessments are recorded on the minimum data set quarterly assessment form and may be supplemented by progress notes which reflect the on-going condition and needs of the residents. The quarterly assessments replace all other monthly summaries.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10127. Pharmacy Services

A. The facility must arrange for the provision of pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident. Prescription drugs not covered by Medicaid or Medicare shall be at the expense of the resident. However, every attempt should be made to get the attending physician to order a covered medication before the resident incurs any expense.

1. The facility shall provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement with an outside resource.

2. The arrangement/agreement with an outside resource shall specify in writing that the facility assumes responsibility for:

- a. obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and
- b. the timeliness of the service.

B. **Pharmacist or Pharmaceutical Consultant.** Facilities shall employ or obtain the services of a licensed pharmacist. The Pharmacist/Consultant shall be expected to:

1. provide consultation (at least 1 hour per quarter) on all aspects of the provision of pharmacy services in the facility to insure compliance with all state and federal regulations pertaining to Pharmacy Practice;

2. establish a system of recording the receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation;

3. determine that drug records are in order and that an account of all controlled drugs is maintained and monthly reconciled;

4. perform drug monitoring;

5. identify drug errors;

6. alert the facility to drug recalls; and

7. be aware of adverse reactions/allergic reactions;

a. every 30 days the staff pharmacist or pharmaceutical consultant in nursing facilities shall conduct drug regimen reviews. Additionally, (s)he shall ensure compliance with drug record requirements and compliance with accounting requirements for controlled drugs;

b. the staff pharmacist or pharmaceutical consultant shall notify the attending physician if changes are appropriate;

c. the pharmacist shall report all irregularities to the attending physician or the Director of Nursing or both and these reports must be acted upon. The physician or director of nursing must verify that the irregularity has been noted, even if no changes are made, by initialing and dating;

d. the facility shall maintain a pharmaceutical committee which develops written policies and procedures for safe and effective drug therapy, distribution, control and use;

e. **Pharmaceutical Committee:**

i. the committee shall be composed of at least the pharmacist, director of nursing, the administrator and one physician;

ii. the committee oversees the pharmaceutical services in the facility, makes recommendations for

improvement and monitors the services to ensure accuracy and adequacy;

iii. the committee meets at least quarterly and documents its activities, findings, and the adequacy of the drug program at the nursing facility;

iv. when medications are recorded or placed in unidose by pharmacist, expiration dates shall comply with pharmaceutically accepted practices;

v. the pharmaceutical committee and the facility assessment and assurance committee may be the same committee as long as all requirements are met.

C. Drug Therapy. The facility must ensure that:

1. for each drug ordered for residents there shall be a diagnosis or condition to validate the use of the drug;

2. residents shall not receive antipsychotic drugs unless the drug therapy is necessary to treat a specific condition;

3. residents who receive antipsychotic drugs should receive gradual dose reductions or behavioral programming unless clinically contraindicated in an effort to discontinue these drugs;

4. the facility shall be free of significant medication error rates; and

5. residents shall be free of any significant medication errors.

D. Approved Drugs and Biologicals. Only approved drugs and biologicals are used.

1. Such drugs and biologicals are:

a. included or approved for inclusion in the United States Pharmacopeia, National Formulary, or United States Homeopathic Pharmacopeia; or

b. included or approved for inclusion in AMA Drug Evaluations or Accepted Dental Therapeutics, except for any drugs and biologicals unfavorably evaluated therein; or

c. not included nor approved for inclusion in the compendia listed in the above paragraphs but may be considered approved if such drugs:

i. were furnished to the resident during his prior hospitalization, and

ii. Were approved for the use during a prior hospitalization by the hospital's pharmacy and drug therapeutics committee (or equivalent), and

iii. Are required for the continuing treatment of the resident in the facility.

E. Labeling of Drugs and Biologicals. The labeling of drugs and biologicals is based on currently accepted professional principles and includes the resident's full name, physician's name, full name of pharmacist dispensing, prescription number, name and strength of drug, date of issue, expiration date of all time-dated drugs, name, address, and telephone number of pharmacy issuing the drug,

appropriate accessory and cautionary instructions. Non-legend or over-the-counter drugs may be labeled by the facility with resident's full name and room number not to obscure lot number and expiration date.

1. Medication containers which have soiled, damaged, incomplete, illegible, or makeshift labels are to be returned to the issuing pharmacist or pharmacy for relabeling or disposal. Containers which have no labels are to be destroyed in accordance with State and Federal laws.

2. An approved emergency medication kit shall be readily available and have a permit issued by the State Pharmacy Board. Facility must have definition of bonafide emergency in its policies and procedures.

3. The medications of each resident are to be kept and stored in their originally received containers. Transferring between containers is forbidden except by registered pharmacists.

4. A narcotic record shall be maintained which lists on separate sheets for each type and strength of narcotic the following information:

a. date;

b. time administered;

c. name of resident;

d. dose;

e. physician's name;

f. signature of person administering dose; and

g. balance (i.e. Barbiturates, non-narcotic analgesics and hypnotic).

5. Poisons and medications for "external use only" shall be kept in locked area separate from internal medications.

6. Medications no longer in use are to be disposed of or destroyed in accordance with Federal and State laws and regulations.

7. Expired medications shall be removed from usage and properly disposed of.

F. Storage of Drugs and Biologicals. Drugs and biologicals shall be stored in accordance with State and Federal laws. Drugs and biologicals must be stored in locked compartments and under proper temperature controls. Only authorized personnel shall be permitted access to the keys.

1. Separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 shall be provided.

2. Other drugs subject to abuse must be secure except when a single unit package drug distribution system is used in which the quantity stored is minimal and a missing dose can be readily detected.

H. Ordering of Medications. The facility shall neither expect, accept, nor require any provider to give a discount or rebate for prescription services rendered by pharmacists.

1. The facility may order at least a one-month supply of medications from a pharmacy of the resident's choice unless the attending physician specifies that a smaller quantity is necessary for a special medical reason. If a one-month supply is less than 100 unit doses, then 100 unit doses may be ordered.

2. The facility administrator or the authorized representative shall certify receipt of prescribed medications by signing and dating the pharmacy bill.

I. Unnecessary Drugs

1. Each resident's drug regimen is free of unnecessary drugs. For each drug ordered for residents there must be a diagnosis or condition to validate the use of the drug.

2. Residents shall not receive antipsychotic drugs unless the drug therapy is necessary to treat a specific condition. There shall be documentation in the chart that the resident is being monitored for side effects.

3. Residents who receive antipsychotic drugs should receive gradual dose reductions or behavioral programming unless clinically contraindicated in an effort to discontinue these drugs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10129. Dietetic Services

A. A designated full-time staff member suited by training and experience in food management and nutrition shall be responsible for supervision of dietary services. If the designated staff member is not a qualified dietitian, he/she shall serve as the dietary manager and shall function with frequent, regularly scheduled consultation from a person who is a qualified dietitian. A minimum consultation time shall be not less than eight hours per month and as needed to ensure nutrition needs of residents are addressed timely. A copy of the consultant's contract shall be available to the State Survey Agency for review. In addition, the facility shall employ sufficient supportive personnel competent to carry out the functions of the dietetic service. Food service personnel shall be on duty daily for a period of 12 or more continuous hours.

B. Dietitian

1. The facility shall employ a qualified dietitian either full-time, part-time or on a consultant basis.

2. If a qualified dietitian is not employed full time, the facility shall designate a person to serve as the dietary manager.

3. A qualified dietitian is one who is qualified based upon registration by the Commission on Dietetics of the

American Dietetic Association and licensure by the Louisiana Board of Examiners in Dietetics and Nutrition.

C. Dietary Manager. (S)he is a person who is one of the following:

1. a qualified dietitian;
2. a graduate of a dietetic technician program, correspondence or classroom, approved by the American Dietetic Association;
3. has successfully completed a course of study, by correspondence or otherwise, which meets the minimum eligibility requirements for membership in the Dietary Managers' Association
4. has successfully completed a training course at a state approved school, vocational or university, which includes course work in foods and food service, supervision, and diet therapy. Documentation of an eight hour course of formalized instruction by the employing facility's consultant dietitian in therapeutic diets is permissible if the course of study meets on the foods and food service and supervision requirements or
5. is currently enrolled in an acceptable course which will qualify an individual upon completion.

D. Dietary Consultant

1. If the staff members designated as food service supervisors are not qualified dietitians, they shall be required to schedule a minimum of eight hours of consultation per month with qualified dietitians.

2. The facility must employ sufficient support personnel competent to carry out the functions of the dietary service.

E. Menus. Menus must:

1. meet the nutritional needs of the residents in accordance with the recommended dietary allowance of the Food and Nutrition Board of the National Research Council, National Academy of Sciences;
2. be prepared in advance; and
3. be followed.
4. Menu changes are acceptable provided the above requirements are met. Records of menus as actually served are retained for six months.

F. Food. Food must be:

1. prepared by methods that conserve nutritive value, flavor and appearance;
2. palatable, attractive and at the proper temperature;
3. prepared in a form designed to meet individual needs; and
4. substituted for residents who refuse food served and the substitutes offered shall be of similar nutritional value.

5. Therapeutic diets must be prescribed by the attending physician.

G. Frequency of Meals. At least three meals shall be served daily at regular times comparable to normal mealtimes of the community.

1. There must be no more than 14 hours between a substantial evening meal and breakfast the following morning except as provided below:

a. bedtime snacks must be offered each evening; and

b. when a nourishing snack is provided at bedtime up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.

H. Assistive Devices. The facility must provide special eating equipment and utensils for residents who need them.

I. Sanitary Conditions. The facility must:

1. procure food from sources approved or considered satisfactory by federal, state, or local authorities;

2. store, prepare, distribute, and serve food under sanitary conditions; and

3. dispose of garbage and refuse properly.

J. Diets. If the facility accepts or retains individuals in need of medically prescribed special diets, the menus for such diets are to be prescribed by the attending physician and planned by a professionally qualified dietitian. A current therapeutic diet manual approved by the dietitian shall be readily available to attending physicians, nursing staff, and dietetic service personnel.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10131. Social Services

A. A NF with more than 120 beds must employ a full-time qualified social service director with the following qualifications:

1. a bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and

2. one year of supervised social work experience in a health care setting working directly with individuals; or

3. a similar professional degree in a field such as counseling, special education, sociology, or psychology.

B. A NF with 120 beds or less shall designate at least one staff member as social service designee (SSD). The SSD need not have any special educational background.

1. The individual responsible for provision of social services shall:

a. arrange for social services from outside sources or by furnishing the services directly;

b. integrate social services with other elements of the plan or care; and

c. complete a social history.

C. Social History. The SSD shall complete, date, and sign a social history on applicants/residents within seven days after their admission. The history shall include but shall not be limited to the following information:

1. background:

a. age, sex, and marital status;

b. birthplace;

c. religion;

d. cultural and ethnic background;

e. occupation;

f. education;

g. special training or skills; and

h. primary language;

2. social functioning:

a. living situation and address before admission;

b. names and relationships with family and friends;

c. involvements with organizations and individuals within the community;

d. feelings about placement in the nursing facility.

C. Social Needs Assessment

1. The SSD shall also identify and document the needs and medically related social/emotional problems within 14 days after admission.

2. The social services assessment shall become a component of the plan of care written in conjunction with other disciplines and shall be filed in the active medical record.

3. If the initial social assessment concludes that there are no problems or unmet social needs, the social assessment shall state that no social services are required.

D. Participation in Interdisciplinary Staffing. The SSD shall participate in the interdisciplinary staffing.

E. Social Services Progress Notes. Social services progress notes shall:

1. be recorded as often as necessary to document services provided, but at least every 90 days (quarterly) in NF's and as often as necessary to describe changes in social conditions;

2. document the degree of involvement of family and friends, interaction with staff and other residents, and adjustment to the facility and roommate(s);

3. reflect the social needs and functioning;
4. document services in the plan of care are actually being provided; and
5. remain in the active medical chart for three to six months.

NOTE: The facility shall establish policies and procedures for ensuring the confidentiality of all social information. Records shall reflect each referral to an outside agency and shall include the applicant/resident's written consent to release the information.

NOTE: The Same Qualifications Apply to Medicare Skilled Nursing Facilities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10133. Activity Services

A. The facility shall provide an ongoing activities program designed to stimulate and promote the physical, social, emotional, and intellectual well-being of each resident and encourage normal activity and return to self care.

B. Resident Activity Director. The facility's activities program shall be under the direction of the resident activity director (RAD).

1. The nursing facility shall have at least one RAD. An additional RAD per resident census in excess of 100 shall be required. The RAD employees shall be full-time or sufficient full-time equivalent employees shall be maintained to comply with these standards. Regardless of the number of RAD employees required, one full-time RAD shall be certified.

2. Responsibilities of the RAD include the following tasks:

- a. scheduling and coordinating group activities and special events inside and outside the facility;
- b. developing and using outside resources and actively recruiting volunteers to enhance and broaden the scope of the activities program;
- c. posting monthly activity calendars in places where applicants/residents and staff can easily see them;
- d. planning and implementing individual and group activities designed to meet the applicants/residents' needs and interests.

3. A resident activity director may be one of the following individuals:

- a. a qualified therapeutic recreation specialist:
 - i. who is certified with the National Council on Therapeutic Recreation Certification; and
 - ii. eligible for certification as therapeutic recreation specialist by a recognized accrediting body on August 1, 1989;

- b. a person having the following experience:
 - i. two years of experience in a social or recreational program within the last five years;
 - ii. one year of the experience shall have been gained as a full-time employee in a health care setting involving resident activities programs;
- c. a qualified occupational therapist or occupational therapy assistant;
- d. An individual who has completed a training course approved by the Department.
- e. An individual who is enrolled in a training course approved by the department.

NOTE: Prior to the effective date of this document the Resident Activity Director (RAD) was referred to as Patient Activities Coordinator (PAC) or Patient Activity Director (PAD).

C. Activities Assessments

1. Within 14 days after admission, the RAD shall complete a written assessment of each resident's interests and hobbies and note any illnesses or physical handicaps which might affect participation in activities.

2. The activities assessment shall:

- a. become the basis for the activities component of the plan of care;
- b. be signed, dated, and filed with other elements in the medical record;
- c. identify specific problem/need areas along with specific approaches formulated to meet the problems/needs; and
- d. be included in the interdisciplinary staffing.

C. Activity Services Progress Notes. Activity services progress notes shall:

1. be written to document the services provided and/or changes in activity needs or approaches at least every 90 days (quarterly); and
2. document the activity level of residents, specifically describing their day to day activities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10135. Medical Records

A. The facility shall maintain medical records which include clinical, medical, and psychosocial information on each resident.

1. These records must be:
 - a. complete;
 - b. accurately documented;

- c. readily accessible; and
- d. systematically organized.

2. Facilities shall have written policies and procedures governing access to, duplication of, and dissemination of information from the resident's personal and medical records.

B. Availability of Records

1. The facility shall make necessary records available to appropriate state and federal personnel at reasonable times. Records shall include but shall not be limited to the following:

- a. personal property and financial records; and
- b. all medical records

NOTE: This includes records of all treatments, drugs, and services for which vendor payments have been made, or which are to be made, under the Medical Assistance Program. This includes the authority for and the date of administration of such treatment, drugs, or services. The facility shall provide sufficient documentation to enable DHH to verify that each charge is due and proper prior to payment.

c. All other records which DHH finds necessary to determine a facility's compliance with any federal or state law, rule, or regulation promulgated by the Department of Health and Human Services (DHHS) or by DHH.

2. Overall supervisory responsibility for the resident record service is assigned to a responsible employee of the facility. If the resident record supervisor is not a qualified medical record practitioner, this person functions with consultation from a person so qualified minimum consultation time shall not be less than one hour per quarter.

C. Availability of Medical Records to Facility Staff. The facility shall ensure that medical records are available to licensed staff directly involved with the resident's care.

D. Confidentiality. Facilities shall ensure confidential treatment of personal and medical records, including information contained in automatic data banks. The written consent of the resident or his/her legal representative shall be required for the release of information to any persons not otherwise authorized under law to receive it.

E. Protection of Records. The facility shall protect records against loss, damage, destruction, and unauthorized use.

F. Retention of Records. The facility shall retain records for:

- 1. in the case of minors, three years after they become 18 years of age; and
- 2. six years after the date of discharge.

G. Components of Medical Records. Each medical record shall consist of the active medical chart and the facility medical files or folders.

1. Active Medical Charts

a. The active medical charts shall contain the following information:

- i. three to six months of current pertinent information relating to the active ongoing medical care;
- ii. physician certification of each medical assistance admission;
- iii. physician recertification that the resident required the services of the facility;
- iv. certification that each plan of care has been periodically reviewed and revised; and
- v. if the facility is aware that an resident has been interdicted, a statement to this effect shall be noted in a conspicuous place in the active medical chart.

2. Medical Files. As the active chart becomes bulky, the outdated information shall be removed and filed in the facility's medical files or folders.

H. Contents of Medical Records. An organized active record system shall be maintained for each resident. It shall include the following identifying information:

- 1. full name;
- 2. home address, including street address, city, parish, and state;
- 3. social security number;
- 4. medical identification number;
- 5. medicare claim number, if applicable;
- 6. marital status;
- 7. date of birth;
- 8. sex;
- 9. religious preference;
- 10. birthplace;
- 11. father's name;
- 12. mother's maiden name;
- 13. name, address, and telephone number of referral agency or hospital;
- 14. personal attending physician and alternate, if possible;
- 15. choices of other service providers;
- 16. name and address of next of kin or other legal representative or sponsor;
- 17. admitting diagnosis;
- 18. current diagnosis, including primary and secondary DSM III diagnosis, if applicable;
- 19. date of death;
- 20. cause of death;
- 21. diagnosis at death;

22. copy of death certificate;
23. disposition of body;
24. name of funeral home, if appropriate; and
25. any other useful identifying information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10137. Ancillary Services.

A. Dental Services

1. The facility shall assist residents in obtaining routine and 24 hour emergency dental care to meet needs of each resident.

2. Routine dental services are defined as including dentures, relines and repairs to dentures, and some oral surgeries. Medicaid residents may be charged for dental services which are not covered services, i.e., extraction, fillings, etc. For residents who are unable to pay for needed dental services, the facility should attempt to find alternative funding sources or alternative service delivery systems.

3. The facility shall, if necessary, assist the resident in making appointments and arranging for transportation to and from the dentist office.

4. The facility is responsible for promptly referring residents with lost or damaged dentures to a dentist who participates in the Medicaid Program.

5. The Medicaid participating dentist should be contacted to give specific information as to what dental services are Medicaid-covered services, when prior approval is necessary, and what dental procedures are not reimbursable by Medicaid.

B. Radiology and Other Diagnostic Services

1. The facility shall arrange for the provision of radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services and shall:

- a. arrange for the provisions of radiology and other diagnostic services only when ordered by the attending physician;
- b. promptly notify the attending physician of the findings;
- c. assist resident in making transportation arrangements to and from the source of service as needed;
- d. file in the resident's clinical record signed and dated reports of X-ray and other diagnostic services.

2. If the facility provides its own diagnostic services, the services shall meet the applicable conditions of participation of hospitals contained in 42 CFR 482.26.

3. If the facility does not provide diagnostic services, it shall have an agreement to obtain these services from a

provider or supplier that is approved to provide these services under the Medicare/Medicaid Program.

C. Laboratory Services.

1. The facility must arrange for the provision of clinical laboratory services to meet the needs of the residents. The facility is responsible for the quality and timeliness of the services and shall:

- a. provide or obtain laboratory services only when ordered by the attending physicians;
- b. promptly notify the attending physician of the findings; and
- c. Assist resident in making transportation arrangements to and from the services as needed.

2. A facility performing any laboratory service or test must have appealed to HCFA or received a certificate of waiver or a certificate of registration.

3. An application for a certificate of waiver may be needed if the facility performs only the following tasks on the waiver list:

- a. dipstick or table reagent urinalysis;
- b. fecal occult blood;
- c. erythrocyte sedimentation rate;
- d. hemoglobin;
- e. blood glucose by glucose monitoring
- f. devices cleared by FOA specifically for home use;
- g. spun micro hematocrit;
- h. ovulation test; and
- i. pregnancy test.

4. Appropriate staff shall file in the residents' clinical record signed and dated reports of clinical laboratory services.

5. If the facility provides its own laboratory services, the services shall meet the applicable conditions for coverage of services furnished by independent laboratories.

6. If the facility provides blood bank and transfusion services it shall meet the applicable conditions for independent laboratories and hospital laboratories and hospital laboratories at 42 CFR 482.27.

7. If the facility laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory shall be approved for participation in the Medicare Program either as a hospital or an independent laboratory.

8. If the facility does not provide laboratory services on site, it shall have an agreement to obtain these services from a laboratory that is approved for participation in the Medicare Program either as a hospital or as an independent laboratory.

D. Specialized Rehabilitative Services

1. A facility must provide or obtain rehabilitation services such as physical therapy, occupational therapy, and speech therapy to every resident when the physician deems it necessary.

2. Specialized rehabilitative services are considered a facility service and are, thus, included within the scope of facility services. They must be provided to residents who need them even when the services are not specifically enumerated in the State Plan. No fee can be charged a Medicaid resident for specialized rehabilitative services because they are covered facility services.

3. If specialized rehabilitation services are required in the resident's comprehensive plan of care, the facility shall:

- a. provide the services;
- b. obtain the required services from an outside resource through contractual arrangement with a person or agency who is qualified to furnish the required services.

4. Arrangements or agreements pertaining to services furnished by outside resources shall specify in writing that the facility assumes responsibility for:

- a. obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and
- b. the timeliness of the service.

5. Specialized rehabilitation services shall be provided under the written order of a physician by qualified personnel.

E. Non-Emergency Transportation for Medical Appointments

1. It is the responsibility of the nursing facility to arrange for or provide its residents with non-emergency transportation to all necessary medical appointments when use of an ambulance is not appropriate. This includes wheelchair bound residents and those residents going to therapies and hemodialysis. Transportation shall be provided to the nearest available qualified provider of routine or specialty care within reasonable proximity to the facility. Residents can be encouraged to utilize medical providers of their choice in the community in which the facility is located when they are in need of transportation services. It is also acceptable if the facility or legal representative/sponsor chooses to transport the resident.

2. If non-emergency transportation is required, and it is medically necessary for the resident to be transported to a necessary medical appointment by ambulance, the nursing facility will be responsible for contacting the appropriate managed care organization (MCO) or fee-for-service (FFS) transportation representative and submitting the completed Certification of Ambulance Transportation form to the MCO or FFS representative prior to the scheduled pick-up time.

F. Attendants During Travel. The facility is required when medically appropriate, to provide an attendant if the

resident or the responsible party cannot arrange for an attendant. Under no circumstances shall the facility require the resident or responsible party to pay for an attendant. However, if a resident is being admitted to a hospital and transportation is via ambulance, then an attendant is not necessary.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996), amended by the Department of Health, Bureau of Health Services Financing, LR 47:371 (March 2021).

§10139. Hospice Services.

A. Effective July 1, 1993, a Louisiana nursing facility (NF) resident who is eligible for both Medicare and Medicaid can elect the Medicare hospice benefit if the nursing facility is being or will be reimbursed for the resident's care by Medicaid.

B. Hospice care focuses on assuring the quality of the terminal resident's remaining life rather than on trying to prolong the length of that life. It is a program of palliative (control of pain and symptoms) and supportive services which provides physical, psychological, social and spiritual care for dying persons and families.

C. Hospice Admission Criteria

1. Resident is enrolled in Medicare Part A and is Medicaid eligible or in applicant status.

2. A prognosis of six months or less confirmed by the attending physician. The prognosis of the terminal illness must be in terms of days, weeks, or months.

3. Election of the hospice benefit must be made by the competent resident or family member in the order described by Louisiana law for the non-competent resident.

4. Care goal must be palliative and not curative.

5. Resident shall be under the care of an attending physician who consents to the Hospice admission and who will continue to assume responsibility for medical care.

6. The resident lives in a nursing facility within the Hospice service area.

7. Final determination of medical eligibility for admission to hospice is made by the Health Standards Section of the Bureau of Health Services Financing.

D. Provider Responsibilities. The nursing facility and the hospice shall have a contractual agreement outlining the specific responsibilities of each entity which shall include but is not limited to:

1. eligible residents;
2. services to be furnished by the Hospice;
3. services to be furnished by the nursing facility;
4. cooperation in professional management;

5. financial responsibility;
6. provider of first choice;
7. public relations;
8. compliance with government regulations;
9. terms of agreement; and
10. indemnification and limit of liability.

E. This agreement shall commence as of the date appearing and continue until terminated by either party by giving 30 days written notice to the other party. This agreement may be amended by mutual agreement of the NF and Hospice.

F. The NF and Hospice shall continue to meet all federal regulations for certification and state requirements for licensure.

G. The resident who is receiving Hospice in the NF will be subject to surveys for both the Long Term Care and Hospice programs.

H. **Medicaid Reimbursement.** When a dually eligible resident elects the Medicare hospice benefit and the hospice and the nursing facility have a written agreement under which the hospice is responsible for the professional management of the resident's hospice care and the NF agrees to provide room and board to the resident, the Medical Assistance Program will pay the hospice an amount equal to the per diem for NF care. Medicaid payment to the NF is discontinued when payment to the hospice begins. Discharge and admission forms (Form 148) are filed by the NF and the hospice provider effecting the transfer.

1. With respect to the management of a resident's terminal illness, the NF shall:

- a. notify Hospice of changes in the resident's condition; and
- b. make records of care and services to the resident available to Hospice.

2. The NF may continue to collect the resident's personal liability income (PLI) to be applied to the Medicaid per diem.

I. **Admission Review.** The following procedures shall be followed when the Hospice benefit is elected by the dually eligible resident currently residing in the NF:

1. The NF shall:

- a. discontinue billing Medicaid on the date the hospice is elected and an agreement between NF and Hospice is signed and effectuated;
- b. notify the Health Standards Regional Office and respective parish office by Form 148 that the resident is being placed in the Hospice category on effective date; and
- c. provide the hospice provider a copy of Form 148 indicating the date of transfer to Hospice.

2. The Hospice is responsible for submitting the following information to the Health Standards Regional Office for review:

- a. the attending physician's referral confirming prognosis of less than six months and to approve the hospice admission;
- b. the hospice RN assessment;
- c. the plan of care;
- d. Form 148 to indicate the effective date of admission to hospice care, and a copy of Form 148 from the NF indicating the date of transfer for those residents who are already placed in a NF.

3. The following procedures shall be followed when the Hospice benefit is elected by an individual prior to admission to the NF:

a. The NF shall submit Form 148, 90-L, and PASARR-1 to the Health Standards Regional Office for review.

NOTE: Form 148 will specify the level of care, effective date of admission and add the notation at the bottom of the admission section that the resident is entering the hospice at the same time. Representatives of both the NF and the Hospice should sign Form 148 at the bottom.

b. The Hospice shall submit the following information to the Health Standards Regional Office for review:

- i. the attending physician's referral confirming prognosis of less than six months and to approve the hospice admission;
- ii. the hospice RN assessment
- iii. the plan of care.

J. **Provider of First Choice.** The NF retains the right to decide if it wishes to offer the option of Hospice. If Hospice is offered, the NF agrees to exert its best efforts to promote the use of Hospice home care services by directing the personnel of the NF to refer all terminally ill residents, subject to the informed consent of the resident and the approval of the attending physician, to the Hospice. If the NF chooses not to offer Hospice and a resident wishes to receive the services, the resident shall be informed that Hospice is not available in the NF and assist with arrangements for transfer to another facility that offers the service if they so choose.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10141. Mental Health Rehabilitation Services

A. Mental health rehabilitation services are defined as medically necessary services which can reasonable be expected to reduce the resident's disability resulting from mental illness and to restore the individual to his/her best possible functional level in the community. The services are

provided outside of a mental institution (or distinct part psychiatric unit) on an as needed basis to assist residents in coping with the symptoms of their illnesses, minimizing the disabling effects of mental illness on their capacity for independent living, and preventing or limiting periods of in-resident treatment. These services are an optional Medicaid service authorized under section 440.130(d) of the Code of Federal Regulations. Residents in nursing facilities shall have been identified as needing these services through the pre-admission screening and annual resident review process (PASARR).

B. Mental health rehabilitation services must be ordered by a physician and provided by or under the supervision of a qualified mental health professional according to a rehabilitation care plan which includes the comprehensive mix of services recommended by the physician and the QMHP.

C. Mental health rehabilitation services consist of the planning, delivery, and management of mental health therapeutic services. These services differ from those provided under the Medicaid Clinic Option by the location(s) in which they are provided. Mental health rehabilitation services are not restricted to a community mental health clinic or an in-resident setting. They may be provided in community settings or in any facility which does not provide mental health services as part of its program. They differ from case management services for the chronically mentally ill which involve arranging access to and coordinating a wide range of services of which mental health rehabilitation is only a party.

D. Mental Health Definitions

1. Specialized Services for Mental Illness. Specialized services for the treatment of mental illness are those services for people with mental illness whose needs are such that continuous supervision, treatment, and training by qualified mental health personnel (QMHP's) is necessary, and/or for persons who are experiencing an acute episode of serious mental illness. These services are beyond the scope of services provided by the nursing facility, and require high degree of intensity. These services, combined with the services provided by the nursing facility, result in the continuous and aggressive implementation of a plan of care.

2. The following are specialized services as described above:

a. Mental Health Rehabilitation Management—Services provided according to a care plan developed by a licensed professional who is a QMHP, in conjunction with a physician.

b. Psychiatric, psychosocial, psychological and other evaluations or assessments—Discipline: Specific information gathered and integrated for diagnosis, establishment of specific treatment goals, analysis of programs, and/or updating the care plan and goals, evaluating and ordering medications. This may include development and implementation of a behavior program on an intensive basis.

c. Individual, group, and/or family therapy—Face-to-face structured, time-limited, and verbal interactions between counselors or therapists and person(s) receiving the service.

d. Psychosocial skills training—Services specified in the individual's plan of care to be provided by a QMHP or paraprofessionals under the supervision of a QMHP, with focus on the remediation of mental and functional disabilities through skills training and/or supportive interventions.

e. Training in ADL's—Activities which enhance or develop the resident's basic daily living skills.

f. In-resident psychiatric services—Highly restricted, intensive and supervised services in a hospital setting reserved for extreme situations for individuals exhibiting an exacerbation of an acute disturbance or difficult ongoing problems.

3. Medication management is not a billable service for a nursing facility resident.

E. Services of a Lesser Intensity for Mental Illness. Services may be provided at a lesser intensity and frequency and level of aggressiveness for the treatment of mentally ill persons who are in need of some types of services for their condition. These services are within the scope of services which are provided or arranged by the nursing facility. They are intended to help nursing facility residents with a diagnosis of mental illness to achieve the highest possible level of mental and psychosocial well being.

1. The following are examples of services of a lesser intensity:

a. medical management, including medication management (provided by the nursing facility), as specified in the resident's plan of care: Services designed for the individual, taking into account the resident's total needs and problems, including prescribing, administering, and monitoring all medications;

b. counseling regarding adjustment to the nursing facility, interpersonal relations, and family involvement (provided by the nursing facility): Short term counseling designed to assist the resident in his adjustment to the facility;

c. training and support to maintain functional level (provided by the nursing facility) as specified in the resident's plan of care: Activities tailored to the individual's physical, emotional, and social needs, including ADL's, independent living skills, and communication skills, which may include coordination with primary therapist(s), follow through, and support of a behavior program;

d. social services support (provided by the nursing facility): Activities and/or services tailored to the individual's social needs, in consideration of the total medical needs such as transportation, referrals to other agencies or community programs, or assistance in obtaining medical appliances and devices;

e. age and functional level activity program (provided by the nursing facility) as specified in the resident's plan of care: Activities designed individually to address the needs of the resident, such as structured work and leisure activities.

F. Mental Health Rehabilitation Option in Nursing Facilities. Criteria for participation in program:

1. resident shall be an adult with chronic mental illness. The program is not for persons who are newly diagnosed with a mental illness;
2. the attending physician shall order the assessment and sign off on the plan of care when developed by the agency which will be providing services;
 - a. documentation to be maintained by the facility:
 - i. the rehabilitation agency will obtain consent from the resident to gain access to information in the facility medical record;
 - ii. a BCSW will do a psychosocial evaluation in order to develop a plan of care;
 - iii. the plan of care will be developed and incorporated into the medical record. This process should include the resident, residents legal representative or sponsor, and facility staff;
 - iv. the plan of care should be updated every 90 days;
 - v. there should be documentation of symptoms and progress or lack of progress toward goals.

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HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

Subchapter E. Reserved

Subchapter F. Vendor Payments

§10147. General Provisions

A. Residents Receiving Care Under Title XIX (Medicaid) Only

1. The BHSF Medicaid Program shall determine the resident's applicable income (liability when computing facility vendor payments. Vendor payments are subject to the following conditions.
 - a. Vendor payments shall begin with the first day the resident is determined categorically and medically eligible or the date of admission, if later.
 - b. Vendor payments shall be made as determined by the facility per diem rate less the resident's per diem applicable income for the number of eligible days.
 - c. If a resident transfers from one facility to another, the vendor payments to each facility is the facility's per diem rate for the number of days in the facility, less the resident's

per diem applicable income for the total number of days in each facility.

2. Retroactive Payment. When individuals enter a facility before their Medicaid eligibility has been established, payment for facility services is made retroactive to the first date of eligibility after admission.

3. Resident Personal Care Income. The facility shall not require that any part of a resident's personal care income be paid as a part of the facility's fee. Personal care income is an amount set aside from a resident's available income to be used for personal needs. The amount is determined by the Department of Health and Hospitals.

a. The facility shall not permit tips for services rendered by facility employees.

B. Residents Receiving Care Under Title XVIII (Medicare). Resident income shall not be considered in determining vendor payments for a period of up to 100 days provided he/she remains eligible for Title XVIII-A (Medicare). This also includes the period for which coinsurance is being paid by the Medicaid Program.

C. Timely Filing For Reimbursements. Vendor payments cannot be made when more than 12 months have elapsed between the month of initial service and submittal of a claim for these services. Payment of claims more than 12 months old require the approval of the Bureau of Health Services Financing Program Operations Section.

D. Temporary Absence of the Resident; No Evacuation. Payment procedures for periods of temporary absence are subject to the following conditions.

1. The facility keeps a bed available for the resident's return and provides notification in accordance with the Bed Reservation Policy requirements in the chapter entitled *Transfer and Discharge Procedures*.

2. The absence is for one of the following reasons:

- a. hospitalization for an acute condition including psychiatric stays, which does not exceed 5 days per hospitalization;
- b. home leave.

NOTE: Payment cannot be mad for hospital leave days while a resident is receiving swing bed SNF services.

3. When the hospital has determined that discharge is appropriate for a resident who had been admitted to the hospital from a nursing facility, the nursing facility shall readmit this resident on the date the physician writes the discharge regardless of the hour of the day or the day of the week. This includes holidays and weeks.

4. Payment will not be made to the nursing facility for hospital leave days beyond the date of the physician's date of discharge from the hospital.

5. Home leave (leave of absence), is defined as a visit with relatives or friends which does not exceed 9 days per calendar year. Institutionalization is not broken if the

absence does not exceed 14 days and if the facility has not discharged the resident.

NOTE: Elopements (unauthorized absences under the plan of care) count against allowable home leave days.

6. The period of absence shall be determined by counting the first day of absence as the day the resident leaves the facility.

7. Only a period of 24 continuous hours or more shall be considered an absence. Likewise, a temporary leave of absence for hospitalization or home visit is broken only if the resident returns to the facility for 24 hours or longer.

8. Upon admission, a resident must remain in the facility at least 24 hours in order for the facility to submit a payment claim for a day of service or reserve a bed.

EXAMPLE: A resident admitted to a nursing facility in the morning and transferred to the hospital that afternoon would not be eligible for any vendor payment for facility services.

9. If a resident transfers from one facility to another, the unused home leave days for that calendar year also transfer. No additional leave days are allocated.

10. The facility shall promptly notify the Parish/Regional BHSF Office of absences beyond the applicable, 14, 5, or 4 day limitations.

E. Temporary Absence Due To Evacuation. When local conditions require evacuation of residents in nursing facilities, the following payment procedures apply.

1. When the resident is evacuated for less than twenty four (24) hours, the monthly vendor payment to the facility is not interrupted.

2. When the staff is sent with the resident(s) to the evacuation site, the monthly vendor payment to the facility is not interrupted.

3. When the resident is evacuated to family or friend's home, at the facility's request, the facility shall not submit a claim for a day of service or leave day, and patient liability shall not be collected.

4. When the resident goes home at the family's request or on their own initiative, a leave day shall be charged.

5. When the resident is admitted to the hospital for the purpose of evacuation of the nursing facility, Medicaid payment shall not be made for the hospital charges.

F. Resident Deposits. A facility shall neither require nor accept an advance deposit from a resident whose Medicaid eligibility has been established.

EXCEPTION: A facility may require an advance deposit for the current month only on the part of the total payment which is the resident's liability.

1. If advance deposits or payments are required from residents or residents legal representative or sponsor upon admission when Medicaid eligibility has not been established, then such a deposit shall be refunded or credited to the person upon receipt of vendor payment.

2. Credit on the facility's books in lieu of a refund to the resident or resident's legal representative or sponsor is acceptable within the following limitations:

a. Such credit shall not exceed an amount equal to the resident's liability for 60 days following the date the resident was determined eligible for Medicaid.

b. Any deposit exceeding such an amount shall be refunded within five working days to the resident or resident's legal representative or sponsor.

G. Refunds to Bureau of Health Services Financing Medicaid Program

1. A Non-Participating Facility. Vendor payments made for the services performed while a facility is in a non-participating status shall be refunded to the Department of Health and Hospitals, Office of Management and Finance. The refund shall be made payable to the Bureau of Health Services Financing Medicaid Program.

2. A Participating Facility. A currently participating Medicaid facility shall correct billing or payment errors by the use of appropriate Adjustment/Void or Resident Liability (PLI) adjustment form.

H. Refunds to Residents. Advance payments for a resident's liability (applicable income) shall be refunded promptly if he/she leaves the facility before the end of the month. The facility shall adhere to the following procedures for the refunds.

1. The proportionate amount for the remaining days of the month shall be refunded to the resident or the resident's legal representative or sponsor no later than the end of the month following discharge. If the resident has not yet been certified, then the procedures spelled out in Refunds to Residents, paragraph one, shall apply.

2. No penalty shall be charged to the resident or resident's legal representative or sponsor even if the circumstances surrounding the discharge occurred as follows:

a. without prior notice;

b. within the initial month; and

c. within some other "minimum stay" period established by the facility.

3. Proof of refund of the unused portion of the applicable income shall be furnished to the BHSF Medicaid Program upon request.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10149. Services and Supplies

A. Regulations pertaining to this subsection are incorporated under the state plan for the Medicaid program and included in the Medicaid Eligibility Manual (MEM).

PUBLIC HEALTH—MEDICAL ASSISTANCE

B. Services and Supplies Included. The nursing facility shall be responsible for providing the following services, supplies, and equipment to Medicaid residents:

1. room, board, and therapeutic diets; and
2. food supplements or food replacements, including at least one brand of each type (i.e., regular, high fiber, diabetic, high nitrogen).

NOTE: This does not include enteral/parenteral nutrients, accessories and/or supplies.

3. General services as listed below:

- a. professional nursing services;
- b. an activities program with daily supervision of such activities;
- c. medically-related social services; and
- d. other services provided by required staff in accordance with the plan of care.

4. Personal Care Need. The facility shall provide personal hygiene items and services when needed by residents to include:

- a. hair hygiene supplies;
- b. comb;
- c. brush;
- d. bath soap;
- e. disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection;
- f. razors;
- g. shaving cream;
- h. toothbrush;
- i. toothpaste;
- j. denture adhesive;
- k. denture cleaner;
- l. dental floss;
- m. moisturizing lotion;
- n. tissues;
- o. cotton balls;
- p. cotton swabs;
- q. deodorant;
- r. incontinence supplies;
- s. sanitary napkins and related supplies;
- t. towels;
- u. washcloths;
- v. hospital gowns;
- w. hair and nail hygiene services;

- x. bathing;
- y. basic personal laundry;
- z. incontinence care.

NOTE: Special hair cuts, permanent waves, and other such services, which are provided by a licensed barber or beautician at the request of the resident shall be paid directly by residents from their personal funds, or by their legal representative or sponsors, unless provided as a free service by the facility.

5. Drugs

a. Over the counter drugs are part of pharmaceutical services that the nursing facility is responsible for providing when it is specified in the resident's plan of care. If the prescribing physician does not specify a particular brand in the written order, a generic equivalent is acceptable. If the physician specified a particular brand, the nursing facility would have to incur the cost of providing that drug. If the physician does not specify a particular brand, but the resident insists on receiving a particular brand, the nursing facility is not required to provide the requested drug. However, if the facility honors the resident's request, it may, after giving appropriate notice, make a charge to the resident's funds for the difference between the cost of the requested item and the cost of the generic.

b. Prescription drugs prescribed by the attending physician shall be filled by the Pharmacy. Reimbursement shall be made as follows.

i. The pharmacy shall submit claims to the state Medicaid program for drugs covered under the program.

ii. The resident is financially responsible for prescription drugs not covered under the Medicaid program. The limit of the liability is from the resident's resources. A legal representative or sponsor cannot legally be held personally liable for the resident's debt; such person can only be required to pay the resident's debts from the resident's funds. Prior to charging a resident, for a medication, the prescribing physician should be notified that it is not covered by the Medicaid program and asked if an equivalent alternative that is covered can be prescribed. A resident should not be denied a needed medication simply because of inability to pay.

6. Wheelchairs

a. Standard Wheelchair. Standard wheelchairs shall be provided in adequate numbers to meet the temporary mobility or general transportation needs of residents.

b. Customized Wheelchairs. Customized wheelchairs may be obtained for Medicaid recipients with prior authorization through the DME program of Medicaid. If this is not an option for the resident, the nursing facility shall attempt to arrange for the provision of customized wheelchairs as needed through family, community resources, etc. Customized wheelchairs purchased by the nursing facility shall be allowable in the cost report. Repairs to a wheelchair owned by a resident are not the responsibility of the facility. For residents who are unable to pay for such

repairs, the facility shall assist them in finding alternative funding sources.

7. Other. The facility shall also provide an adequate number of the following items:

- a. standard, adjustable walkers;
- b. crutches;
- c. over-bed tables;
- d. bedside commodes;
- e. lifts;
- f. restraints;
- g. sheepskins or similar decubitus prevention and treatment devices;
- h. mechanical supports such as Posey vest-type;
- i. suction machines for general use (DME Program will purchase, with prior approval, suction machines and other related equipment for those residents meeting the DME program need requirements);
- j. glucometers and diabetic supplies;
- k. blood pressure cuffs;
- l. stethoscopes;
- m. other such items which are generally a part of nursing facility treatment.

NOTE: A facility is not required to provide clothing except in emergency situations. If provided, it shall be of reasonable fit.

C. Medical Supplies. The facility shall provide the following apparatus:

- 1. all types of syringes and needles;
- 2. I-V set-ups;
- 3. tubing and bags of all kinds except those provided through other funding sources;
- 4. gauze;
- 5. bandages;
- 6. thin film wound dressings (Tegaderm, Duoderm, and similar products); and
- 7. non-adhering dressings (Telfa or similar products).

D. Incontinent Care and Supplies. The facility must provide incontinent supplies as needed to meet the needs of residents. The cost shall not be passed on to the resident or resident's legal representative or sponsor as it is included in the reimbursement rate. Neither shall such items be billed to other payment sources when reimbursement is being made by Medicaid through the rate as this constitutes a duplication of billing. If, however, the family or resident elects to purchase supplies other than what is provided by the facility, the facility is not obligated to pay for such supplies.

E. Catheters. The facility shall provide all supplies needed to perform intermittent catheterization.

EXCEPTION: Facilities are not required to provide supplies used for inserting indwelling catheters. These indwelling catheters and catheter trays may be purchased through the Medicaid Pharmacy Program or through Medicare if the resident is eligible for Medicare Part B.

F. Laundry. The facility shall provide laundry services, including personal laundry, for residents.

EXCEPTION: Dry cleaning and/or laundering of hand-washable garments is not a provision of this service.

G. Oxygen. The facility shall provide oxygen for use on a temporary or emergency basis. The facility shall also be responsible for arranging for oxygen required on a long term basis. With prior approval and when the resident's condition requires, based on specific criteria of blood gases at room air, the Medicaid program will purchase or rent an oxygen concentrator.

H. Services and Supplies Excluded. Listed below are general categories and examples of items and services that the facility may charge to residents if they are requested:

- 1. telephone;
- 2. television/radio for personal use;
- 3. personal comfort items, including smoking materials, notions and novelties, and confections;
- 4. cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare;
- 5. personal clothing;
- 6. personal reading matter;
- 7. gifts purchased on behalf of a resident;
- 8. flowers and plants;
- 9. non-covered special care services such as privately hired nurses or aides;
- 10. private room, except when therapeutically required (for example, isolation for infection control); and
- 11. specially prepared food requested instead of the food generally prepared by the facility.

I. Requests For Items and Services

- 1. The facility shall not charge a resident (or his or her representative) for any item or service not requested by the resident.
- 2. The facility shall not require a resident (or his or her representative) to request any item or service as a condition of admission or continued stay.
- 3. The facility shall inform the resident (or his or her representative) requesting an item or service for which a charge will be made, that there will be a charge for the item or service and what the charge will be.
- 4. A facility's general accommodations are rooms shared by two or more residents. Private rooms are not included in the vendor payments.

J. Ventilator Equipment

1. The Louisiana Medicaid Program will cover ventilator equipment required by dually eligible Medicare and Medicaid recipients in nursing facilities as this is not a covered service under Medicare. Medicaid cannot provide this equipment to individuals in a skilled nursing facility until after 20 days have elapsed from the nursing facility admit date.

2. Department of Health and Hospitals encourages the nursing facility staff to work with families in returning life-saving equipment (such as ventilators) to the nursing facility for use by other Medicaid residents.

K. Multiple Billing and Arrangements For Services Not Included in The Vendor Payment. The facility shall not bill the resident or responsible party for services or supplies included in the vendor payment.

1. All Medicaid benefits available must be utilized before residents or responsible parties can be charged for services in the facility. This includes payment for reserving beds.

a. The nursing facility may bill residents or their responsible parties for reserving beds after the Medicaid Program limits at the Medicaid rate are exceeded.

b. Facilities shall not impose policies regarding bed reservations which are more restrictive than BHSF regulations.

L. Oxygen Concentrator. The facility may request authorization for payment of an oxygen concentrator from the Durable Medical Equipment Program.

1. The medical criteria used to determine need follows the same requirements established by Medicare.

2. The medical criteria used is available in written form from the Health Standard Regional Office upon request.

NOTE: Items purchased through the Medicaid Durable Medical Equipment (DME) Program shall not be included in the facility's cost report.

M. Colostomy Bags and Colostomy Equipment. These items may be purchased with prior authorization from the Medicaid Program or through Medicare if the patient is eligible for Medicare Part B.

N. Payor of Last Resort. Medicaid is the payor of last resort. Charges shall not be made to the Medicaid Program for any benefits for which the resident is eligible under Title XVIII (Medicare) or other third party insurance coverage.

O. Sitters. A facility shall neither expect nor require a resident to have a sitter. The use of sitters shall be entirely at the discretion of the resident or his legal representative or sponsor. Family members may also elect to use sitters unless the resident or his/her legal representative or sponsor expresses a contrary intent.

1. The facility shall not be responsible for paying the sitter.

2. A sitter shall be expected to abide by the facility's rules and regulations, including health standards and professional ethics. The facility shall provide written notice of violations to the resident, his/her legal representative or sponsor any family member who hired the sitter and to the BHSF-HSS Regional Office.

3. Presence of a sitter does not absolve the facility of its full responsibility for the resident's care.

4. Office of Secretary to furnish the Bureau of Health Services Financing-Health Standards Section with an initial cost report from the date of purchase or lease to the new fiscal year end selected by the new legal entity. Thereafter, the facility shall file a cost report annually on the purchaser's designated year end.

P. Cost Report. Facilities shall be required to submit cost reports within 90 days from their fiscal year end. A separate report must be completed and submitted for all related: a) home office, b) central office and/or, c) management company costs included in the nursing home cost report. Facilities may select any annual period of cost reporting purposes. However, once a facility has made a selection and reported accordingly, the cost report is to be submitted on the same due date unless a change in the reporting period is approved by the BHSF.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10151. Cost Reports

A. Initial Cost Report. The initial cost report submitted by all providers of Long Term Care services under the Medicaid Program shall be based on the most recent fiscal year end.

1. An exception to the initial cost report requirement may be recognized on an individual basis upon request by the provider prior to the due date. If an exception is allowed, the provider shall attach to the cost report a statement fully describing the nature of the exception for which written permission was requested and granted.

2. For the initial reporting period only, the provider may allocate costs to the various cost centers on a reasonable basis if the required departmental cost breakdown is not available.

B. Subsequent Cost Reports. Subsequent cost reports shall be submitted annually by each provider within 90 days of the close of its normal fiscal year end.

C. Changes of Ownership. In the event of a change in ownership of the facility, the old entity operating the facility shall be required to submit a final cost report from the date of its last fiscal year end to the date of sale or lease.

1. If the new legal entity continues the operations of the facility as a provider of Medicaid services, the new legal entity shall be required to furnish the BHSF-HSS with an

initial cost report from the date of purchase or lease to the new fiscal year end selected by the new legal entity.

EXAMPLE: Ms. New purchased Facility A from Mr. Old on September 1, 1985. Facility A's fiscal year end prior to the sale was December 31. Mr. Old is required to file a cost report for the period January 1, 1985 through August 31, 1985. If Ms. New decides to change Facility A's fiscal year end to June 30, her first report shall be due for the 10 month period ending June 30, 1986 and annually thereafter.

a. Furthermore, when a facility changes ownership on or after October 1, 1985, the Consolidated Omnibus Budget Reconciliation Act limits evaluation of facility assets to the acquisition costs of the previous owner increased by 50 percent of the Consumer Price Index or 50 percent of Nursing Facility Construction Cost Index, whichever is lower.

b. In auditing cost reports, DHH will apply this HIM-15 regulation in determining actual cost applicable to sales.

c. If full disclosure of the facts has not been made to the Department of Health and Hospitals and the Department of Health and Hospitals approves a transaction, such approval is qualified on the basis of the facts presented. Any questions concerning a relatedness situation should be directed in writing to Bureau of Health Services Financing.

2. New Facilities

a. A new facility is defined as a newly constructed facility, a facility not currently participating in the Medicaid program or a Medicaid program facility which has been certified for a higher level of care.

b. A new facility may select an initial cost reporting period of at least one month but not to exceed 13 months.

c. Thereafter, the cost reports shall be submitted as in subsequent cost reports described above.

EXAMPLE: A new facility began Medicaid participation on September 15, 1985. The owner wishes to adopt a reporting period ending September 30. The owner must file a report for the period September 15, 1985 to September 30, 1986. He/She cannot file a report for the 15-day period ending September 30, 1985.

NOTE: Facilities purchased as ongoing concerns are not considered new facilities for Medicaid purposes.

3. Final Cost Reports. When a provider ceases to participate in the Medicaid Program, he/she must file a cost report covering a period up to the effective date the facility ceases to participate in the program. Depending upon the circumstances involved in the preparation of the provider's final cost report, the provider may file for a period not less than one month and not more than 13 months.

4. Due Date Extensions. If the facility experiences unavoidable difficulties in preparing its cost report by the prescribed due date, one 30 day extension may be permitted upon written request to the Bureau of Health Services Financing Medicaid Program prior to the due date. Extensions beyond the 30 day time limit may be approved for situations beyond the facility's control. An extension of

the cost report due date cannot be granted when the provider agreement is terminated or a change in ownership occurs.

5. Basis of Accounting.

a. All cost report information shall be submitted in accordance with generally accepted accounting principles (GAAP) as well as state and federal regulations. The accrual method of accounting is the only acceptable method for private providers. State institutions shall be allowed to submit data on the cash basis.

b. General ledger accounts should follow the Chart of Accounts previously provided each participating facility.

8. Related Party Transactions. Chapter 10 of HIM-15 explains the treatment of cost(s) applicable to services, facilities, and supplies provided to the facility by organizations related by common ownership or control. The Medicaid Cost Report can only include the actual cost(s) to the related organization for those services, facilities, and supplies. The cost(s) must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

9. Cost Report Form. The cost report form shall be used by all private providers of nursing facility services. State institutions shall use the same form with additional information for covered ancillary services. All providers shall determine allowable costs utilizing the Standards for Payment Manual and the Medicare Provider Reimbursement Manual (HIM-15) instructions provided with the cost report form.

10. Financial Records. All providers who elect to participate in the Medicaid Program shall maintain all financial and statistical information necessary to substantiate cost data for three years following submission of the cost report or until all audit exceptions are resolved, whichever period is longer. All providers are required to make these records available upon demand to representatives of the state or federal health agencies or their contractual representatives.

11. Allowable Costs

a. Allowable costs for reimbursement to Long Term Care Facilities providing services under Medicaid shall follow the general provisions outlined in the HIM-15.

b. For costs to be allowable, they must be reasonable and related to resident care. The reasonableness of all allowable costs shall be assessed by the BHSF with input from the Audit Contractor, industry representatives, and other interested parties.

c. Allowable cost limits are listed below. More comprehensive explanations of these allowable costs are included in the HIM-15.

12. Salaries. Allowable costs for salaries for Administrator, Assistant Administrator, and other facility managers are limited to the maximum set by the state based on the audit contractors review of cost reports statewide, regardless of the size of the nursing facility.

PUBLIC HEALTH—MEDICAL ASSISTANCE

13. Related Travel Expenses. Reasonable travel expenses are allowable only as related to administration of the facility and resident care.

14. Insurance. Insurance rates are allowable for ordinary and necessary coverage and shall be limited to a reasonable price in addition to any interim increases initiated by the insurance company.

15. Interest. Necessary and proper interest on both current and capital indebtedness is allowable and shall be limited to that which can be specifically related to the purchase of an asset or is necessary for the operation of the facility.

16. Motor Vehicles. Depreciation and interest expenses are allowable for certain types of motor vehicles if limited to the statewide average list price published at the beginning of each fiscal year by the Bureau of Health Services Financing. This list includes a new standard size auto or van depreciated over 36 months at the prevailing new auto interest rate charged by lending institutions.

a. Lease costs are limited to charges over 36 months by bank-related leasing companies or actual lease costs, whichever is less.

b. Vehicle taxes, tags, titles and insurance charges may be claimed as an allowable cost in the year paid.

c. All use of such vehicles shall be related to patient care or administration of the facility.

d. The following types of vehicles are specifically disallowed:

- i. recreational vehicles;
- ii. pickup trucks equipped for camping; and
- iii. airplanes and boats.

17. Rent. Rents paid to unrelated parties in accordance with HIM-15 are allowable costs. Rental payments between related parties are not allowable costs. Costs of ownership, such as depreciation, interest, etc. may be included in the cost report.

18. Dues. Reasonable dues to one professional trade association or organization are considered an allowable cost.

19. Management Fees and Central Office Overhead

a. Contracts for management services are allowable costs. They shall specify exactly what services are covered by the fee.

b. The charges by a related management firm are limited to actual cost which shall not exceed what the service would cost from unrelated management companies.

NOTE: If a facility's management fees/central office overhead costs are the results of related party transactions, the provider shall submit a separate cost report for the related management company/central office. Salaries shall be limited to Civil Service maximums.

20. Nurse Assistant Training. There shall be a supplemental cost report for nurse aide training and these costs shall not be included in the regular cost report.

21. Owner's Compensation. All types of owners' compensation costs are allowable based on the following limitations.

a. The position filled by the owner is normal to the industry.

b. The salary paid to the owner is in line with employees' salaries for similar positions as shown in the paragraph entitled Salaries.

c. Facility records document shows that the owner does perform the service for which he/she is being compensated.

22. Depreciation. Only the straight-line method of depreciation shall be allowed.

NOTE: Depreciation of assets being used by a vendor at the time he enters the Medicaid program is allowed. This applies even though such assets be fully or partially depreciated on the vendor's books. As long as an asset is being used, its useful life is considered not to have ended. Consequently, the asset is subject to depreciation based on a revised estimate of the asset's useful life as determined by the provider and approved by the Medicaid program.

23. Costs Not Allowable

a. Dues paid to more than one professional trade association or organization, bad debts, unreasonable costs, costs not related to resident care, fines and penalties, and related party costs in excess of actual costs are examples of unallowable costs.

b. Nursing facilities are not to show any cost relating to ventilator equipment in their cost reports to Bureau of Health Services Financing.

c. In cases where nursing service expense at the various levels of care is not kept separate, the following formula may be used for allocating these costs:

i. step one, multiply the number of resident days at each level of care by the weighted factor;

NOTE: The factor represents the number of nursing hours required per patient day at each level of care.

ii. step two, compute the weighted percentage of patient days for each level of care;

iii. step three, apply the percentage computed in step two to the total nursing service expense for the period;

iv. step four, the result obtained in step three is carried to the appropriate schedule of the cost report.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10153. Audits, Inspections, Reviews

A. General. Facilities shall be subject to audits, inspections of the quality of care provided, and review of each applicant/recipient's need for SN-NRTP, SN-TDC, SN-ID, SN, IC I, or IC II services.

B. Audits. All nursing facility providers participating in the Medicaid Program shall be subject to audit. A sufficient representative sample of each type of Long Term Care provider shall be fully audited to ensure the fiscal integrity of the program and compliance with program regulations governing reimbursement. Limited scope and exception audits shall be conducted as needed. The facility shall retain such records or file as required by the Department of Health and Hospitals-Bureau of Health Services Financing and shall have them available for inspection for three years from the date of service or until all audit exceptions are resolved, whichever period is longer.

NOTE: If the department's limited scope audit of the residents' Personal funds account indicate a material number of transactions were not sufficiently supported or material non-compliance, the department shall initiate a full scope audit of the account. The cost of the full scope audit shall be withheld from the vendor payments. (Refer to Subchapter L, Sanctions and Appeal Procedures.)

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

Subchapter G. Levels of Care**§10154. Nursing Facility Level of Care Determinations**

A. The purpose of the level of care (LOC) determination is to assure that individuals meet the functional and medical necessity requirements for admission to and continued stay in a nursing facility. In addition, the LOC determination process assists persons with long-term or chronic health care needs in making informed decisions and selecting options that meet their needs and reflect their preferences.

B. In order for an individual to meet nursing facility level of care (NFLOC), functional and medical eligibility must be met as set forth and determined by the Office of Aging and Adult Services (OAAS). The functional and medical eligibility process is frequently referred to as the "nursing facility level of care determination."

C. OAAS shall utilize prescribed screening and assessment tools to gather evaluation data for the purpose of determining whether an individual has met the nursing facility level of care requirements as set forth in this Subchapter.

D. Individuals who are approved by OAAS, or its designee, as having met NFLOC must continue to meet medical and functional eligibility criteria on an ongoing basis.

E. A LOC screening conducted via telephone shall be superseded by a face-to-face LOC assessment, or audit

review LOC determination as determined by OAAS or its designee.

F. If on an audit review or other subsequent face-to-face LOC assessment, the LOC findings are determined to be incorrect or it is found that the individual no longer meets level of care, the audit or subsequent face-to-face LOC assessment findings will prevail.

G. The department may require applicants to submit documentation necessary to support the nursing facility level of care determination.

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, Division of Long Term Supports and Services, LR 32:2083 (November 2006), amended by the Office of Aging and Adult Services, LR 34:1032 (June 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:341 (January 2011), LR 39:1471 (June 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 48:2130 (August 2022).

§10155. Standards for Levels of Care

A. Classifications of care are established to ensure placement of residents in Long Term Care Facilities with available and appropriate resources to meet their social psychological, psychological, and biophysical needs.

B. Classifications of care are established with consideration of the resident as a person with innate dignity and worth as a human being.

C. Classifications of care are defined and established so that a resident's total needs, the complexity of the services rendered, and the time required to render these services be assessed in determining placement.

D. Classifications of care are established to prevent placement of residents in facilities where they would present a danger to themselves or other residents.

E. Classifications of care are established to maintain health care so residents achieve a reasonable recovery, maintain a current level of wellness, or experience minimal health status deterioration.

F. Facility Submission of Data. Evaluative data for medical certification for IC I, IC II, and SNF levels of care shall be submitted to the appropriate Bureau of Health Services Financing-Health Standards, Admission Review Unit. This includes data for the following situations:

1. initial applications and reapplication;
2. applications for residents already in long term care facilities;
3. transfers of residents from one level to another;
4. transfer of residents between facilities; and
5. applications for residents who are residents in a mental health facility.

a. All applicants for admission to a nursing facility must be screened for indications of mental illness or mental retardation prior to admission to the nursing facility. This is done by submitting the information requested on Forms 90-L and PASARR-1.

G. Nursing Hours Required

1. The facility will staff for any residents on pass and/or bed hold for hospitalization.

2. Private pay residents must be staffed at the highest level of care unless the level of care is determined by the attending physician.

3. The facility shall provide a minimum nurse staffing pattern and ratio for each level of care as follows.

a. Skilled service shall provide a minimum nurse staffing pattern over a 24 hour period at a ratio of 2.6 hours per skilled resident.

b. Intermediate care services shall provide a minimum licensed nurse staffing pattern over a 24 hour period of 2.35 hours per resident medically certified at the intermediate level.

c. NRTP/Rehabilitation 5.5; NRTP/Complex 4.5.

d. TDC 4.5.

e. Skilled ID 4.0.

4. Intermediate Care I. *Intermediate Care I* is defined as follows:

a. This is a medium level of care provided to Medicaid recipients residing in nursing facilities. The conditions requiring this level of care are characterized by a need for monitoring of moderate intensity. Care shall be provided by qualified facility staff or by ancillary health care providers under the supervision of a registered nurse or licensed practical nurse in accordance with physician's orders. This care shall be available to residents on a 24 hour a day basis.

b. Intermediate Care I services is determined by the following:

i. The resident shall need services in order to attain and maintain a maximum level of wellness.

ii. Care usually considered IC II can become IC I if there are complicating circumstances.

iii. A resident may have multiple conditions, any one of which could require only IC II level of care, but the sum total of which would indicate the need for IC I level of care.

NOTE: Examples of IC I Services (not all inclusive):

- Administration of oral medications and eye drops;
- Special appliance: Urethral catheter care;
- Colostomy care;
- Surgical dressings;
- Care of decubitus ulcers which are not extensive;
- Dependence on staff for a majority of personal care needs;
- Bed or chair bound;
- Frequent periods of agitation requiring physical or chemical restraints;

- Combined sensory defects (e.g. blindness, deafness, significant speech impairment);
- Care of limbs in cast, splints, and other appliances;
- Post surgical convalescence;
- Incontinence of bladder and/or bowel;
- Recent history of seizures;
- Need for protective restraints;
- Use of oxygen occasionally;
- Frequent monitoring and recording of vital signs;
- Need for physical therapy; and
- Uncommunicative or aphasic and unable to express needs adequately.

5. Intermediate Care II. Intermediate Care II is defined as follows:

a. This is a level of care provided to Medicaid recipients residing in nursing facilities characterized by the need for monitoring of less intensity than Skilled Nursing or Intermediate Care I. This care shall be such that it can be given by facility staff (trained aides and orderlies) who are monitored by and under the supervision of licensed nurses in accordance with physician's orders. These residents require care by licensed personnel for 12 hours a day during daylight hours.

NOTE: Examples of IC II Services (not all inclusive):

- Supervision or assistance with personal care needs;
- Assistance in eating;
- Administration of medication, eye drops, topical applications which can be given in a 12 hour period;
- Injections given less frequently than daily or for which a rigid time schedule is not important;
- Prophylactic skin care or treatment of minor skin problems in ambulatory residents;
- Protection from hazards;
- Mild confusion or withdrawal;
- Medications for stable conditions or those requiring monitoring only once a day; and
- Stable blood pressure requiring daily monitoring.

6. Skilled Nursing Facility Within a NF (Distinct Part SNF Unit). Skilled nursing facilities must provide 24 hour nursing services. Except where waived, the services of a registered nurse is required at least eight consecutive hours a day, seven days a week. The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. Nursing services are not included under "shared services." The distinct part SNF must demonstrate the capacity to provide the services, facilities, and supervision required by SNF requirements of participation.

H. Skilled Nursing Care

1. This is the classification of care provided to Medicaid recipients residing in nursing facilities. The conditions requiring this classification of care are characterized by a need for intensive, frequent, and comprehensive monitoring by professional staff.

2. This care shall be such that it can only be given by a registered nurse or licensed practical nurse or under the supervision and observation of such persons in accordance with physician's orders.

3. This care shall be available to residents only on a 24 hour a day basis.

4. An individual shall be determined to meet the requirements for the SNF classification of care in a nursing facility when the following criteria based on current needs are met. These criteria are meant to be objective, self-explanatory, and universally applicable.

a. The individual requires nursing, psychosocial, or rehabilitation services, i.e., services that must be performed by or under the supervision of the professional health personnel; e.g., registered nurse, licensed practical nurse, physical therapist, occupational therapist, speech pathologist or audiologist, or a combination thereof.

b. The individual requires such services on a regular basis (seven days per week). Rehabilitation services must be at least five days per week.

I. Services Requiring Supervision of Professional Personnel. The following services are those which are considered to require the supervision of professional personnel (including but not limited to):

1. intravenous, intramuscular, or subcutaneous injections;

2. levine tube and gastrostomy feedings;

3. insertion, sterile irrigation and replacement of catheters as adjunct to active treatment of a urinary tract disease;

4. application of dressings involving prescription medications and sterile techniques;

5. nasopharyngeal or tracheostomy aspiration;

6. treatment of decubitus ulcers, of a severity Grade three or worse, or multiple lesions of a lesser severity;

7. heat treatments (moist) specifically ordered by a physician as part of active treatment done by physical therapist;

8. initial phases of a regimen involving administration of medical gases such as bronchodilator therapy;

9. rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, i.e. bowel and bladder training;

10. care of a colostomy during the immediate postoperative period in the presence of associated complications;

11. observation, assessment, and judgement of professional personnel in presence of an unstable or complex medical condition and to assure safety of the resident and/or other residents in cases of active suicidal or assaultive behavior; and

12. therapy (at least five times per week):

a. physical therapy;

b. speech therapy; and

c. occupational therapy (in conjunction with another therapy.

i. Documentation must support that skilled services were actually needed and that these services were actually provided on a daily basis.

J. Skilled Id Nursing Care For AIDS. These residents have a clinical diagnosis of Human Immunodeficiency Virus (HIV) infection and related conditions which require 24 hour a day skilled nursing care.

1. Facility Responsibilities. The facility shall:

a. aggressively meet the medical needs of a predominantly young population who have a terminal illness;

b. provide comprehensive skilled nursing care and related services for residents who require constant nursing intervention and monitoring. The staff shall have specialized training and skills in the care of persons with HIV;

c. develop policy to govern the comprehensive skilled nursing care and related medical or other services provided. This includes a physician, registered nurse, and any other staff responsible for the execution of such policies;

d. have an established plan to insure that the health care of every resident is under the supervision of a licensed physician interested and experienced in the primary care of persons with HIV;

e. make provision to have a licensed physician available to make frequent visits and to furnish necessary medical care in cases of an emergency;

f. make provisions to have 24 hour access to services in an acute care hospital;

g. maintain clinical records on all residents and maintain the confidentiality of such records to the highest extent possible;

h. provide 24 hour nursing service sufficient to meet the complex nursing needs with registered nurse coverage 24 hours per day, seven days per week as the plan of care indicates;

i. provide appropriate methods and procedures for dispensing and administering medications and biologicals which shall also include a protocol for experimental pharmaceutical use;

j. provide policy, procedure, and ongoing education for enhanced universal precautions, be responsible for keeping policy update on current trends for universal precautions related to infectious diseases as outlined by the Center for Disease Control (CDC), and develop specific policies (Practices and Precautions) for preventing transmission of infection in the work-place including employee health issues;

k. provide social services sufficient to meet the mental, psychosocial, behavioral, and emotional needs of the resident. These services shall be provided by a social worker with at least a master level degree from an accredited school

of social work and who is licensed as applicable by the state of Louisiana, who shall provide a minimum of two hours per week of services per resident;

l. provide dietary services to meet the complex and comprehensive nutritional needs of the resident. These services shall be provided by registered dietician who shall provide at least one hour per week per resident, but in no case less than four hours per month;

m. provide a dynamic activity program congruent with the needs and ages of the resident which includes an exercise program when indicated to promote and maintain the residents tolerance level to daily activity levels;

n. provide and/or arrange transportation services to meet the medical needs of the resident;

o. provide for the resident the opportunity to participate in the coordination and facilitation in the service delivery and personal treatment plan;

p. provide care plan meetings and updates as often as necessary as necessary by the residents changing condition;

q. provide for appropriate consultation and services to meet the needs of the resident including but not limited to: oncology, infectious diseases, hematology, neurology, dermatology, gastro-enterology, thoracic, gynecology, pediatrics, mental health and/or any other specialized services as indicated;

r. develop respiratory therapy protocols. The respiratory therapist shall work with other medical staff to assure compliance. These services shall be provided as often as necessary by a respiratory therapist either contractually or full-time employment for no less than eight hours per month;

s. provide physical therapy and other rehabilitative services as necessary to meet the special needs of the resident with sensory perception deficit (touch, hearing, sight, etc.);

t. provide and/or arrange through community resources for legal and/or pastoral services as needed by the resident;

u. provide a component of care related to personality changes and communication problems brought on as the illness progresses;

v. provide for access to volunteers and community resources;

w. provide for access to "significant others" to participate in the emotional support and personal care services;

x. Provide a minimum daily average of 4.0 actual nursing hours per resident.

2. Determination of Skilled Nursing Services for Aids. An individual shall be determined to meet the requirements for SN-ID HIV classification of care in a Long Term Care facility when the following criteria, based on current needs

are met. These criteria are meant to be objective, self-explanatory, and universally applicable.

3. Payment or reimbursement is not made just because of a diagnosis of AIDS or being HIV+. The payment is intended to be reimbursement for the additional expenses of administering IV therapy and the additional RN hours required to provide this type of therapy in the nursing facility.

a. Enhanced level of universal precautions based on resident needs (blood and body fluid precautions)

b. Continuous ongoing education regarding disease process, infection control, medication, side effects, etc.

4. These services are in conjunction with the following:

a. intermittent or continuous IV therapy, respiratory therapy, nutritional therapy, or other intervention;

b. administration of highly toxic pharmaceutical and experimental drugs which include monitoring of side effects;

c. continuous changes in treatment plan for symptom control;

d. daily medical/nursing assessment for residents changing condition;

e. continuous monitoring for:

i. tolerance level;

ii. skin integrity;

iii. bleeding;

iv. persistent diarrhea;

v. pain intensity;

vi. mental status;

vii. nutritional status; and

viii. tuberculosis (monthly sputum for AFB).

5. The following related conditions may also require SNF ID LOC for HIV:

a. opportunist infections;

i. pneumocystis carinii pneumonia (PCP);

ii. mycobacterium avium-intracellular complex (MAC);

iii. cytomegalovirus;

iv. cytopccus neoformans;

v. strongylcides stercoralis

b. non-opportunistic infections:

i. mycobacterium tuberculosis;

ii. pyogenic bacteria (staphylococcus, Streptococcus, etc.); and

- iii. histoplasmosis;
- c. Malignancies—Kaposi's Sarcoma;
- d. opportunistic gastrointestinal infections:
 - i. *Cyptosporidium*;
 - ii. *Isospora Belli*; and
 - iii. Malabsorption Syndrome with progressive malnutrition;
- e. neurological complications:
 - i. progressive multi-focal leukoencephalopathy;
 - ii. brain abscesses;
 - iii. acute encephalitis;
 - iv. vascular accident;
 - v. toxoplasmosis; and
 - vi. retinopathy.

K. Infectious Disease For Methicillin-Resistant *Staphylococcus Aureus* (MRSA)—Determination of Skilled Nursing Services for MRSA

1. The following resident criteria for reimbursement of services under the Infectious Disease (MRSA) rate must be met to establish the need for care at this designation. These criteria are meant to be objective, self-explanatory, and applicable to those residents seeking care at this designation. The resident shall:

- a. have a positive MRSA culture (symptomatic). Symptoms may be manifested locally or systemically and include but not limited to: Erthema, edema, cellulitis, abscessed furuncles, carbuncles, septicemia, osteomyelitis, purulent drainage, elevated white count, elevated temperature, wound infections or urinary infections;
- b. require IV antibiotic therapy given in the nursing facility or a hospital;
- c. require comprehensive skilled nursing;
- d. require that isolation procedures be initiated and maintained as the plan of care dictates.

2. Facility responsibilities to residents at this level of care designation shall:

- a. meet the medical nursing needs of residents having MRSA and maintain documentation of such care;
- b. have laboratory confirmation of a diagnosis of MRSA done by a laboratory certified by national standards;
- c. collect specimens for culture utilizing acceptable techniques or arrange for this to be done by a laboratory. This shall be done as soon as the facility becomes aware of infection and includes but is not limited to drainage from skin lesions, blood, sputum, urine, and aspirations;
- d. institute isolation procedures immediately when a resident with indications of MRSA is admitted to the facility or there is an infection identified in-house using the Center

for Disease Control (CDC) guidelines. These procedures shall be initiated even if the physician has not seen the resident or been contacted. These procedures shall be fully documented;

e. have physician orders for each resident that are specific for each resident's situation. Standing orders shall not be used without the physicians approval for each individual resident;

f. be expected to insure that IV vancomycin will be initiated under physician order when MRSA has been identified in an active infection with tissue invasion. This therapy can be given within the hospital or in the nursing facility. Exceptions to vancomycin treatment may be made for debilitated and very aged resident(s), a history of sensitivity to this agent, and end state renal disease. Any reason for exception to IV vancomycin therapy must be described in detail the resident's chart and a copy of this documentation provided to Health Standards. There is no assurance that an exception will be granted;

NOTE: The intent for the insertion of the "exception" portion of the Declaration of Emergency document was to remove the appearance of mandating that physicians must treat MRSA residents with IV antibiotics (Vancomycin) under all conditions and circumstances, fully realizing that there would be conditions and circumstances in which Vancomycin could not or would not be given. Payment or reimbursement shall not be made in any case where the resident did not receive the I.V. medication for whatever the reason. Each case requesting an exception will be reviewed on an individual basis. The payment is intended to be reimbursement for the additional expenses of administering IV antibiotics and 24-hour RN coverage. It is not paid just because of the diagnosis of MRSA. Isolation in itself is not a reason for payment for SN-ID, as other diseases require isolation procedures and are not reimbursed as SN-ID.

g. provide IV therapy in the nursing facility only with RN coverage 24 hours a day under a registered nurse employed by the facility and with appropriate laboratory monitoring;

h. provide continuous nursing assessment of any change in the resident's status or therapy;

i. provide aggressive wound care and other indicated nursing care. This must be administered by nurses skilled in these procedures and documentation maintained;

j. provide social services by a masters level social worker and a registered dietician as dictated by the plan of care;

k. provide equipment, supplies, and teaching necessary for significant others to visit the residents;

l. evaluate an individual who is an asymptomatic carrier of MRSA with a complicating problem (example: tracheostomy, gastrostomy, colostomy) for need for IV vancomycin therapy;

m. have policy, procedures, and ongoing education for enhanced universal quality assurance infection control;

n. be responsible for maintaining facility policies updated with current trends in infection control as outlined by the Center for Disease Control;

o. develop specific policies, practices, and precautions for preventing transmission of infection in the facility for protection of residents and employees;

p. have training based on CDC guidelines for MRSA for facility staff responsible for infection control.

3. Requirements for Participation. The facility shall:

a. be currently enrolled to provide nursing services for the treatment of methicillin-resistant staphylococcus aureus; and

b. sign the addendum to the Provider Agreement for participation in the NF-Infectious Disease (MRSA) level of care designation.

4. Certification Requirements. The following medical certification requirements must be met in addition to the Forms 90-L and 148.

a. The facility data submission shall follow the guidelines published for the levels of care.

b. The following additional information requirements must be met:

i. date of onset of MRSA infection;

ii. physicians' orders (specific to each resident's care relating to MRSA infection);

iii. request for a change in level of care to provide treatment for MRSA;

iv. laboratory reports verifying the diagnosis of MRSA;

v. detailed description including measurements of the lesions on tissue involvement; and

vi. documentation that appropriate isolation procedures were carried out (description) from date of the level of care request.

5. Reimbursement Requirements

a. The level of care change request must be approved.

b. Request for changes in the resident's level of care from MRSA level to the former level of care must be completed promptly.

c. The infectious disease reimbursement rate will be paid during the hospital stay.

L. Skilled Infectious Disease; Tuberculosis Multiple Drug Resistant Tuberculosis. This is a Medicaid program (Title XIX) which was developed in conjunction with the TB Control Section of the Department of Public Health. The purpose of the program is to meet the needs of Louisiana citizens who require specialized care for the treatment of tuberculosis of the respiratory tract who are sputum positive for the Tuberculosis germ and who cannot be treated on an out-resident basis for whatever reason.

1. Determination of SN-ID; Tuberculosis. The resident shall:

a. be referred to the nursing facility only by the Tuberculosis Section of the Louisiana Department of Public Health;

b. have a diagnosis of active tuberculosis of the respiratory tract;

c. have an infection caused by the Mycobacterium tuberculosis or Mycobacterium bovis, but not by other mycobacterial species (atypical Tuberculosis);

d. require 24 hour specialized skilled nursing care;

e. be treated under the umbrella of guidelines from the Tuberculosis Section of the Department of Public Health and monitored by the regional tuberculosis clinician;

f. require that immediate isolation procedures be initiated and that the resident not be released from isolation until three sputum smears collected on consecutive days have been negative for acid-fast bacilli. Thereafter, sputum will be monitored at least biweekly or whenever symptoms recur or worsen. If the sputum smear again becomes positive for acid-fast bacilli, isolation will be immediately re-instituted;

g. be admitted and discharged by the public health officer;

h. have 24 hour security guard when needed.

2. Facility Responsibilities

a. The nursing facility shall be approved by the Tuberculosis Section of the Public Health Department to care for SN-ID Tuberculosis residents.

b. The approval shall include as having appropriate "Source-Control Methods" ventilation systems to prevent Tuberculosis bacilli transmission in accordance with federal, state, and local regulations for environmental discharges.

c. Shall monitor at appropriate intervals the ventilation system to maintain effective control of possible transmission of the Tuberculosis bacilli.

d. Initiate, update, and maintain vigorous infection control policy and procedures to manage the infectious/contagious disease process according to current trends established by the Centers for Disease Control and Prevention.

e. Shall employ or contract with an engineer or other professional with expertise in ventilation or other industrial hygiene. This person shall work closely with the Infection Control Committee in the control of airborne infections.

f. Achieve, maintain, and document compliance with all requirements outlined in the Minimum Standards for Nursing Facilities and the enhanced requirements for SN-ID.

g. Shall inform the Regional Tuberculosis Clinician if the resident becomes intolerant of Tuberculosis medications or refuses Tuberculosis medications.

3. Facility Requirements for Participation

a. The facility shall be enrolled as a provider of the Nursing Facility/Infectious Disease (SN-ID) program with appropriate Provider Agreements to participate.

b. The facility shall be currently enrolled to provide nursing facility services to the level of care designation for the treatment of tuberculosis.

c. The facility has been designated by Tuberculosis Control of the Public Health Department to provide SN-ID Tuberculosis care to those residents referred by them.

M. The following medical certification requirements shall be met in addition to the Forms 148, 90-1 and PASARR.

1. The facility data submission shall follow the guidelines established for the level of care.

2. The following additional information requirements must be met:

a. outside information consisting of summary of drug therapy prior to admission, past, and present history of non-tubercular illness such as diabetes, previous drug reactions, laboratory test results, and any previous eye or VII cranial nerve tests (auditory and equilibrium);

b. physician orders specific to Infection Control for tuberculosis and other infectious diseases including but not limited to HIV and Staphylococcus Aureus/Methicillin resistant staph Aureus infections;

c. documentation to support that appropriate isolation procedures were implemented on admission.

3. Reimbursement Requirements

a. The 90-L, level of care, and PASARR must be approved by the Department of Health and Hospitals, Health Standards Section.

b. Request for change in level of care when the resident is discharged from the SN-ID Tuberculosis level shall be submitted within five working days.

c. The SN-ID TB reimbursement rate is not applicable to residents who have a non-pulmonary/respiratory diagnosis or who have atypical mycobacteriosis or who have a conversion of skin test without positive sputum.

d. The SN-ID tuberculosis reimbursement rate will be paid during a hospital stay up to the customary ten day bed hold policy.

N. Rehabilitation and Complex Levels of Care

1. These levels of care were developed to provide services and care to residents who have sustained severe neurological injury or who have conditions which have caused significant impairment in their ability to independently carry out activities of daily living. Residents shall have, based upon a physicians assessment, the potential for regaining a level of functioning which is feasible. Significant practical improvement must be expected in a prescribed or predetermined period of time. An expectation

of complete independence in the activities of daily living is not necessary, but there must be a reasonable expectation of improvement that will be of practical value to the resident measured against his/her condition at the start of care.

2. Rehabilitation services are designed to reduce the resident's rehabilitation and medical needs while restoring the person to an optimal level of physical, cognitive, and behavioral function within the content of the person, family, and community.

3. Complex care services are designed to provide care for residents who have a variety of medical/surgical concerns requiring a high skill level of nursing, medical and/or rehabilitation interventions to maintain medical/functional stability.

O. Rehabilitation and Complex Levels of Care

1. These levels of care were developed to provide services and care to residents who have sustained severe neurological injury or who have conditions which have caused significant impairment in their ability to independently carry out activities of daily living. Residents shall have, based upon a physician's assessment, the potential for regaining a level of functioning which is feasible. Significant practical improvement must be expected in a prescribed or predetermined period of time. An expectation of complete independence in the activities of daily living is not necessary, but there must be a reasonable expectation of improvement that will be of practical value to the resident measured against his/her condition at the start of care.

2. The health conditions of the individuals who qualify for either of these levels of care are too medically complex or demanding for a typical skilled nursing facility, but no longer warrant care in an acute setting. Reimbursement is available under the Title XIX program for a period not to exceed 90 days if medical eligibility criteria established by the department have been met. Extensions may be requested in 30-day increments up to a maximum of three extensions based on documentation contained in progress reports. Level of care certification cannot exceed a total of six months. The Health Standards Section shall review the documentation submitted by the facility and determine if the applicant meets the criteria for admission certification and continued stay at these levels of care.

3. The rehabilitation and complex levels of care shall utilize the *Consumer Price Index for All Urban Consumers* Southern Region, All Items Economic Adjustment Factors, as published by the United States Department of Labor to give yearly inflation adjustments. This economic adjustment factor is computed by dividing the value of All Items index for December of the year preceding the rate year (July 1 through June 30) by the value of the All Items index one year earlier (December of the second preceding year). This factor, All Items, will be applied to the total base which excludes fixed cost. Rebasings and interim adjustments to rates shall be calculated in the same manner as for regular nursing facilities.

4. Annual financial and compliance audits are required from the providers of these services. Additional cost reporting documents as requested by the department may also be required. Providers are required to segregate these costs from all other nursing facility costs and submit a separate annual cost report for each level of care (rehabilitation and complex care services). Medicare cost principles found in the Provider Reimbursement Manual (HIM-15) shall be used to determine allowable costs.

P. Criteria for Certification of SN Rehabilitation and SN-Complex Level of Care, and Provision of Services

1. Medical Eligibility Criteria for Certification of SN-Rehabilitation Level of Care. Residents seeking skilled services at the SN Rehabilitation level of care shall meet all of the following criteria:

a. require an intense, individualized rehabilitation program designed to address severe neurological deficits (not due to a psychiatric disorder) caused from an injury or neurological condition which shall have occurred within six months from the date of admission;

b. have a severe loss of function (not secondary to behavioral deficits) in activities of daily living, mobility, and communication with the potential for significant practical improvement as measured against his/her condition prior to rehabilitation;

c. shall be capable of participating in a minimum of two hours of active (not passive) rehabilitation (OT, PT, ST) per day;

d. require a minimum of 5.5 hours of nursing care per day. Monitoring of behaviors by attendants cannot be considered as meeting the required nursing hours;

e. require aggressive medical support and a coordinated program of care delivered through a multidisciplinary team approach;

f. demonstrate documented, measurable progress toward the reduction of physical, cognitive and/or behavioral deficits to qualify for continued funding at this level of care.

2. Exclusionary Criteria for SN-Rehabilitation Services. Residents meeting any one of the following criteria do not qualify for this level of care:

a. the resident has already participated in a comprehensive rehabilitation effort on an inpatient basis either in an acute care setting or other type of rehabilitation facility;

b. the resident has a neurological condition which is considered to be progressive in nature and where no practical improvement can be expected (e.g., Huntington's Chorea);

c. the resident requires medication adjustment or attention to psychological problems related to a neurological condition or injury but has the ability to carry out the basic activities of daily living;

d. the resident lives out of state and has access to rehabilitation services in his/her state of residence;

e. the resident does not have sufficient mental alertness to actively participate in the program;

f. the resident has a major psychiatric disorder (schizophrenia, manic-depression, etc.) which precludes active participation;

g. the resident with an uncomplicated CVA whose needs can be met at the skilled level of care.

3. Medical Eligibility Criteria for Certification of SN-Complex Level of Care. Residents seeking skilled services at the complex level of care shall meet all of the following criteria:

a. have a neurological injury/condition resulting in severe functional, cognitive and/or physical deficits which shall have occurred within six months from the date of admission;

b. require a level of care and services which are not able to be provided in a typical skilled nursing facility or on an outpatient basis. Facility documentation must specify why an alternative setting is inappropriate or inadequate to meet the needs of the resident;

c. require a minimum of 4.5 hours of nursing care per day;

d. shall be capable of participating in a minimum of two hours of active (not passive) rehabilitation per day.

4. Provision of Therapy Services for SN Rehabilitation and Complex Level of Care. Therapy services must be rendered on a per resident basis by a licensed therapist. Skilled therapy services must meet all of the following conditions:

a. the services must be directly and specifically related to an active written treatment plan designed by the physician after any needed consultation with a multidisciplinary team including a licensed therapist(s);

b. therapies shall be available and provided at least five days per week. If the resident is unable to participate or refuses to participate, the facility shall document the reason for nonparticipation and shall promptly notify the Health Standards Section;

c. the services must be of a level of complexity and sophistication, or the condition of the resident must be of a nature that requires the judgment, knowledge, and skills of a licensed therapist(s);

d. the services must be provided with the expectation, based on the assessment made by the physician of the resident's restoration potential, that the condition of the resident will improve materially in a reasonable and generally predictable period of time, not to exceed 90 days, or the services must be necessary for the establishment of a safe and effective maintenance program which can be continued after discharge;

e. the services must be considered under accepted standards of medical practice to be specific and effective treatment for the resident's condition;

f. the services must be reasonable and necessary for the treatment of the resident's condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable and not able to be provided in a less restrictive setting such as outpatient. Documentation by the facility must support that rehabilitation services are actually needed on an inpatient basis. When the resident has behavior or physical limitations that cannot be modified any further, the level of care shall be discontinued. There must be significant practical improvement as measured against the condition or injury prior to the episode which resulted in admission—significant improvement being the ability to self-perform activities of daily living;

g. therapy cannot be provided at the skilled level of care. The medical record shall document why the therapy cannot be provided at a lower level of care;

h. recreational therapies shall not be included when determining compliance with the required number of hours of therapy a day.

5. Criteria for Discharge from the Rehabilitation and Complex Levels of Care

a. there is evidence in the medical record that the resident has achieved stated goals;

b. medical complications preclude an intensive rehabilitation effort. Any regression or deterioration in the resident's medical condition shall immediately be reported to the Health Standards Section;

c. multidisciplinary therapy is no longer needed;

d. no additional practical improvement in function is anticipated;

e. the resident's functional status has remained unchanged for 14 days;

f. the resident has received services for 90 days;

g. if the resident exhibits inability or refuses to participate in therapy, this shall constitute termination of rehabilitation services and/or recertification for level of care. Discharge shall be initiated when the resident fails to participate in five consecutive therapy sessions during a two-week period;

h. the resident has an established behavior management plan.

Q. Documentation Requirements for Vendor Payment

1. Documentation Requirements for the Determination of Medical Eligibility for Vendor Payment. The following documentation requirements shall be submitted to the Health Standards Section for consideration of medical certification at either the rehabilitation or complex levels of care:

a. Form 148 (Notification of Admission/Change);

b. Form 90-L (Request for Level of Care Determination);

c. Level I PAS/RAS (Pre-admission Screening/ Re-admission Screening);

d. history of current condition;

e. presenting problems and current needs;

f. if transferring from an acute care hospital, all therapy evaluations, therapy progress reports, physician's orders and physician progress notes;

g. assessments done by facility field evaluators;

h. evaluations done by all facility therapists participating in the individual treatment plan;

i. preliminary plan of care including services to be rendered; plan should specify frequency, responsible discipline, and projected time frame for completion of each goal.

2. Documentation of Progress. The facility shall document, in detail, progress in meeting goals.

a. Progress reports shall be submitted to the Health Standards office every 30 days. Progress reports shall address the resident's ability to self-perform activities of daily living. If there is no progress in this area, it shall be so stated.

b. Active discharge planning shall be addressed in all progress reports. If the established goal is to return home, involvement by family members or significant others shall be noted in progress reports.

c. It is not necessary that progress reports recapitulate events resulting in admission.

d. It is the responsibility of the facility to promptly notify the Health Standards Section when goals have been achieved or the resident is not making progress toward meeting established goals, regardless of the amount of time in the program.

R. Facility Responsibilities for Participation. The facility seeking to provide services under the rehabilitation and complex level of care must meet all of the following requirements:

1. be licensed to provide nursing facility services and shall admit and maintain residents requiring any nursing facility level of care designation;

2. have a valid Medicaid Program provider agreement for provision of nursing facility services;

3. have entered into a contractual agreement with the Bureau of Health Services Financing to provide rehabilitation and complex care services;

4. be accredited by the Joint Commission on Accreditation on Health Care Organizations (JCAHO) and by the Commission on Accreditation of Rehabilitation Facilities (CARF);

5. have appropriate rehabilitation services to manage the complex functional and psychosocial needs of the residents and appropriate medical services to evaluate and treat the pathophysiologic process. The staff shall have intensive specialized training and skills in rehabilitation;

6. provide an interdisciplinary team of professionals to direct the clinical course of treatment. This team shall include, but is not limited to a physician, registered nurse, physical therapist, occupational therapist, speech/language therapist, respiratory therapist, psychologist, social worker, recreational therapist, and case manager;

7. ensure that the health and rehabilitation needs of every resident in certified for rehabilitation/complex level of care shall be under the supervision of a licensed physiatrist, board-certified or board-eligible in physical medicine and rehabilitation;

8. have policies and procedures to ensure that a licensed physician visits and assesses each resident's care frequently but no less than weekly;

9. have formalized policies and procedures to furnish necessary medical care in cases of emergency and provide 24-hour-a-day access to services in an acute care hospital;

10. have established policies to screen residents who are not appropriate for the program according to the Medicaid medical eligibility criteria or whose needs the facility cannot meet;

11. have each resident assigned to a facility case manager to monitor, measure, and document goal attainment and functional improvement. The case manager shall be responsible for cost containment and appropriate utilization of services. Coverage should stop when further progress toward the established rehabilitation goals are unlikely or can be achieved in a less intensive setting;

12. assure that discharge planning is an integral part of the rehabilitation program and should begin upon the resident's admittance to the facility. Plans of care must be individualized and aggressive with regard to the projected time frame for discharge. When progress notes show that the resident has not made significant, measurable progress from one review period to the next or that the condition cannot be modified any further, Medicaid will not authorize further reimbursement for rehabilitation. Significant progress should be the ability to self-perform or require only minimal to moderate assistance to perform activities of daily living;

13. provide private rooms for residents demonstrating extraordinary medical and/or behavioral needs. Dedicated treatment space shall be provided for all treating disciplines including the availability of distraction-free individual treatment rooms and areas;

14. provide 24-hour nursing services to meet the medical and behavioral needs with registered nurse coverage 24 hours per day, seven days a week. Management of the resident's daily activities shall be under the direct supervision of a registered nurse;

15. provide appropriate methods and procedures for dispensing and administering medications and biologicals that are in accordance with the organizations issuing the facility's accreditations;

16. have formalized policies and procedures for ongoing staff education in rehabilitation, respiratory, specialized medical services, and other related clinical and nonclinical issues. Staff education shall be provided on a regular basis;

17. provide dietary services to meet the comprehensive nutritional needs of the residents. These services shall be provided under the direction of a registered dietician who shall consult a minimum of two hours per month;

18. provide families/significant others the opportunity to participate in the coordination and facilitation of service delivery and individual treatment plan;

19. provide nonmedical and nonemergency medical transportation services and arrange for medical transportation services to meet the medical/social needs of the residents;

20. provide initial and ongoing integrated, interdisciplinary assessments to develop treatment plans which should address medical/neurological issues such as sensorimotor, cognitive and perceptual deficits, communicative capacity, affect/mood, interpersonal and social skills, behaviors, ADLs, recreation/leisure skills, education/vocational capacities, sexuality, family, legal competency, adjustment to disability, post-discharge services environmental modifications, and all other areas deemed relevant for the individual;

21. assure that the interdisciplinary team meets in conference at least every 14 days to update the individual treatment plan but as often as necessary to address the changing needs of the client;

22. provide appropriate consultation services to meet the needs of clients, including, but not limited to, audiology, orthotics, prosthetics, or any other specialized services;

23. establish a protocol for ongoing contact with professionals in vocational rehabilitation education, mental health, developmental disabilities, Social Security, medical assistance, head injury advocacy groups and any other relevant community agencies;

24. establish protocols to provide for a close working relationship with acute care hospitals capable of caring for persons with brain and upper spinal cord injuries to provide post discharge follow-up, in-service education and on-going training of treatment protocols to meet the needs of residents;

25. establish written policies and procedures to address referrals coming from out of state. The facility must provide written explanation as to what steps were taken to obtain services within the state of residence and why the services were not available or inadequate to meet the needs of the resident. The facility shall seek reimbursement for all level

of care services from the state of residence or referral prior to making application for Louisiana Medicaid.

S. Change in Level of Care Within a NF. The facility shall be responsible for submitting current medical information to the HSS Regional Office for approval of level of care change when recommended by the attending physician. Form 149-B shall be completed when making the request for change. This procedure shall be followed whether the change is within the facility or requires a move to another facility. The facility shall have five working days to submit Form 149-B to the Health Standards Section for both upgrade and downgrade in level of care. The effective date of medical certification will be the date the physician signs the Form 149-B. If the facility fails to submit the request timely, the certification will be the date the Form 149-B is received in the HSS Regional Office. A statement from the physician in lieu of Form 149-B is not acceptable when requesting level of care change. If applicable, notice is also required when a resident transfers to Medicare skilled level. The state will pay co-insurance beginning on the twenty-first day.

1.-2.t. Reserved.

u. require staff to attend specialized training on ventilator assisted care if the facility provides SN-TDC services to Medicaid recipients from birth through age 25. The training will be conducted by a contractor designated by the department. The facility shall also cooperate with ongoing monitoring conducted by the contractor. Training content includes:

- i. the special health needs of, and risks to ventilator-dependent recipients;
- ii. the proper use and maintenance of equipment in use or new to the facility;
- iii. current, new, or unusual health procedures and medications;
- iv. diagnoses and treatments specific to pediatrics and in the development and nutritional needs of recipients;
- v. emergency intervention;
- vi. accessing school services for ventilator-assisted recipients; and
- vii. discharge planning where families express interest in a recipient returning home.

2.v. - 3.e. Reserved.

T. Change in Level of Care Within a NF. The facility shall be responsible for submitting current medical information to the HSS Regional Office for approval when the attending physician recommends a change in the level of care. Form 149-B shall be completed when making the request for a level of care change. This procedure shall be followed whether the change is within the facility or whether the change requires a transfer to another facility. A statement from the physician, in lieu of Form 149-B, is not acceptable.

1. The facility shall have 20 working days to submit Form 149-B to the Health Standards Section for both upgrades and downgrades in level of care. If submitted within the 20 working day time frame, the effective date of change in medical certification will be the date the physician signs the Form 149-B.

2. If the facility fails to timely submit the request, the effective date of the medical certification will be the date the Form 149-B is received in the HSS Regional Office.

3. The completion of the Form 149-B is also required when a resident transfers to Medicare skilled level.

4. The Medicaid Program will pay co-insurance beginning on the twenty-first day.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996), LR 23:970 (August 1997), 24:457 (March 1998), LR 29:911 (June 2003).

§10156. Level of Care Pathways

A. Several potential avenues of functional and medical eligibility shall be investigated by OAAS. These avenues are called pathways. The pathways are utilized to ensure consistency, uniformity, and reliability in making nursing facility level of care determinations. In order to meet the nursing facility level of care, an individual must meet eligibility requirements in only one pathway.

B. When specific eligibility criteria are met within a pathway, that pathway is said to have triggered. The Medicaid program defines nursing facility level of care for Medicaid eligible individuals as the care required by individuals who meet or trigger any one of the established level of care pathways described in this Subchapter. The pathways of eligibility focus on information used to determine if an individual has met or triggered a level of care pathway. When a pathway is triggered, that individual may be approved for a limited stay/length of service as deemed appropriate by OAAS.

C. The level of care pathways elicit specific information, within a specified time period, regarding the individual's:

1. functional capabilities;
2. receipt of assistance with activities of daily living (ADL);
3. current medical treatments and conditions; and
4. other aspects of an individual's life.

D. Activities of Daily Living Pathway

1. The intent of this pathway is to determine the individual's self-care performance in activities of daily living during a specified look-back period (e.g., the last seven days, last three days, etc. from the date the LOC assessment was completed), as specified in prescribed screening and assessment tools.

2. The ADL Pathway identifies those individuals with a significant loss of independent function measured by the amount of assistance received from another person in the period just prior to the day the LOC assessment was completed.

3. The ADLs for which the LOC assessment elicits information include but are not limited to:

- a. locomotion—how the individual moved around in his or her home;
- b. dressing—how the individual dressed/undressed;
- c. eating—how the individual ate or consumed food (this does not include meal preparation);
- d. bed mobility—how the individual moved around while in bed;
- e. transferring—how the individual moved from one surface to another (this excludes getting on and off of the toilet and getting in and out of the tub/shower);
- f. toileting—how the individual got on and off the toilet (toilet transfer), wiped, arranged clothes, etc.;
- g. personal hygiene—how the individual managed personal hygiene (this excludes baths/showers); and
- h. bathing—how the individual took a full-body bath or shower (this excludes washing of hair and back).

4. Since an individual can vary in ADL performance from day to day, OAAS trained assessors shall capture the total picture of ADL performance over the specified time period.

5. In order for an individual to be approved under the ADL Pathway, the individual must score at the:

- a. limited assistance level or greater on toileting, transferring, or bed mobility; or
- b. extensive assistance level or greater on eating.

E. Cognitive Performance Pathway.

1. This pathway identifies individuals with the following cognitive difficulties:

- a. short-term memory which determines the individual's functional capacity to remember recent events;
- b. cognitive skills for daily decision making which determines the individual's actual performance in making everyday decisions about tasks or activities of daily living such as:
 - i. planning how to spend their day;
 - ii. choosing what to wear;
 - iii. knowing when to eat;
 - iv. knowing and using space in home appropriately;
 - v. using awareness of one's own strengths and limitations to ask for help when needed;

- vi. using environmental cues to organize and plan the day;
- vii. making prudent decisions regarding how and when to go places; and

viii. using canes/walkers or other assistive devices/equipment reliably.

c. making self understood which determines the individual's ability to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these (includes use of word board or keyboard).

2. In order for an individual to be approved under the cognitive performance pathway, the individual must have any one of the conditions noted below:

- a. severely impaired or greater impairment in daily decision making (e.g., never or rarely makes decisions);
- b. have a short-term memory problem and moderately impaired in daily decision making(e.g., the individual's decisions are consistently poor or unsafe, and cues or supervision are required at all times);
- c. have a short-term memory problem and the individual is sometimes understood (e.g., the individual's ability is limited to making concrete requests) or is rarely or never understood;
- d. moderately impaired in daily decision making and the individual is often understood (e.g., the individual has difficulty finding words or finishing thoughts, and prompting is usually required);

e. moderately impaired in daily decision making and the individual is sometimes understood (e.g., the individual's ability is limited to making concrete requests) or is rarely or never understood; or

f. minimally impaired in daily decision making (e.g., his/her decisions are poor or unsafe in specific situations, and cues or supervision are needed) and the individual is sometimes understood, (e.g., the individual's ability is limited to making concrete requests) or is rarely or never understood;

F. Physician Involvement Pathway

1. The intent of this pathway is to identify individuals with unstable medical conditions that may be affecting his/her ability to care for himself/herself.

2. The following are investigated for this pathway:

- a. physician visits occurring during the 14-day look-back period (excluding emergency room exams); and
- b. physician orders issued during the 14-day look-back period (excluding order renewals without change and hospital inpatient visits).

3. In order for an individual to be approved under the physician involvement pathway, the individual must have:

a. one day of doctor visits and at least 4 new order changes within the 14-day look-back period; or

b. at least 2 days of doctor visits and at least 2 new order changes during the 14-day look-back period.

4. Supporting documentation is required and must include:

a. a copy of the physician's orders; or

b. the home health care plans, or other medical provider documentation documenting the diagnosis, treatments, and conditions within the designated time frames; or

c. the appropriate form designated by OAAS to document the individual's medical status and condition.

G. Treatments and Conditions Pathway

1. The intent of this pathway is to identify individuals with unstable medical conditions that may be affecting a person's ability to care for himself/herself.

2. The following are investigated for this pathway:

a. stage 3-4 pressure sores during the 14-day look-back period;

b. intravenous feedings during the 7-day look-back period;

c. intravenous medications during the 14-day look-back period;

d. daily tracheostomy care and ventilator/respiratory suctioning during the 14-day look-back period;

e. pneumonia during the 14-day look-back period and the individual had associated need for assistance with IADLs, ADLs, or restorative nursing care;

f. daily respiratory therapy provided by a qualified professional during the 14-day look-back period;

g. daily insulin injections with two or more order changes during the 14-day look-back period; or

h. peritoneal or hemodialysis during the 14-day look-back period.

3. In order for an individual to be approved under the treatments and conditions pathway, the individual must have:

a. any one of the conditions listed in G.2.a-h above; and

b. supporting documentation for the specific condition(s) identified. Acceptable documentation must include:

i. a copy of the physician's orders; or

ii. the home health care plans, or other medical provider documentation documenting the diagnosis, treatments and conditions within the designated time frames; or

iii. the appropriate form designated by OAAS to document the individual's medical status and condition.

H. Skilled Rehabilitation Therapies Pathway

1. The intent of this pathway is to identify individuals who have received, or are scheduled to receive physical therapy, occupational therapy or speech therapy.

2. In order for an individual to be approved under this pathway, the individual must:

a. have received at least 45 minutes of active physical therapy, occupational therapy, and/or speech therapy during the seven-day look-back period; or

b. be scheduled to receive at least 45 minutes of active physical therapy, occupational therapy, and/or speech therapy scheduled during the seven-day look-forward period.

3. Supporting documentation of the therapy received/scheduled during the look-back/look-forward period is required and must include:

a. a copy of the physician's orders for the received/scheduled therapy;

b. the home health care plan, or other medical provider documentation notes indicating the received/scheduled therapy;

c. progress notes indicating the physical, occupational, and/or speech therapy received;

d. nursing facility or hospital discharge plans indicating the therapy received/scheduled; or

e. the appropriate form designated by OAAS to document the individual's medical status and condition.

I. Behavior Pathway

1. Effective upon promulgation of this Rule, the behavior pathway will be eliminated as a pathway for meeting nursing facility level of care.

2. Individuals receiving services who met the nursing facility level of care only by triggering the behavior pathway prior to promulgation of this Rule shall continue to remain eligible for services requiring nursing facility level of care until:

a. the individual is discharged from long term care services; or

b. the individual has been found eligible for services in another program or setting more appropriate to their needs.

J. Service Dependency Pathway

1. The intent of this pathway is to identify individuals who are currently in a nursing facility or receiving services through the Adult Day Health Care Waiver, the Community Choices Waiver, Program of All Inclusive Care for the Elderly (PACE) or receiving long-term personal care services.

2. In order for individuals to be approved under this pathway, the afore-mentioned services must have been approved prior to December 1, 2006 and ongoing services are required in order for the individual to maintain current functional status.

3. There must have been no break in services during this time period.

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 Aging and Adult Services, LR 37:342 (January 2011), amended LR 39:1471 (June 2013), LR 41:1289 (July 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 43:2187 (November 2017), LR 44:1019 (June 2018), LR 48:2130 (August 2022).

Subchapter H. Reserved

Subchapter I. Resident Rights

§10161. General Provisions

A. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident.

B. Exercise of Rights

1. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

2. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.

3. In the case of a resident adjudged incompetent under the laws of a state by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under state law to act on the resident's behalf.

C. Civil Rights Act Of 1964 (Title VI)

1. Title VI of the Civil Rights Act of 1964 states No person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or subjected to discrimination under any program or activity receiving federal financial assistance.

2. Nursing facilities shall meet the following criteria in regard to the above-mentioned Act.

a. **Compliance.** Facilities shall be in compliance with Title VI of the Civil Rights Act of 1964 and shall not discriminate, separate, or make any distinction in housing, services, or activities based on race, color, or national origin.

b. **Written Policies.** Facilities shall has written policies and procedures that notify the community that admission to the facility, resident care services, and other

activities are provided without regard to race, color, or national origin.

c. **Community Notification.** Facilities shall notify the community that admission to the facility, resident care services, and other activities are provided without regard to race, color, or national origin. Notice to the community may be given by letters to and meeting with physicians, local health and welfare agencies, paramedical personnel, and public and private organizations having interest in equal opportunity. Notices published in newspapers and signs posted in the facility may also be used to inform the public.

D. **Section 504 Of The Rehabilitation Act Of 1973.** Facilities shall comply with Section 504 of the Rehabilitation Act of 1973 which states the following: No qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from federal financial assistance.

E. **Age Discrimination Act of 1975.** This Act prohibits discrimination on the basis of age in programs or activities receiving federal financial assistance. All facilities must be in compliance with this Act.

F. **Notice Of Rights and Services.** All residents or legal representative shall sign a statement that they have been fully informed verbally and in writing in a language that the resident understands of the following information prior to or at the time of admission and when changes occur during their stay in the facility:

1. the facility's rules and regulations;
2. their rights;
3. their responsibilities to obey all reasonable rules and regulations and respect the personal rights and private property of other residents;
4. rules for conduct at the time of their admission and subsequent changes during their stay in the facility;
 - a. changes in resident rights policies shall be conveyed both verbally and in writing to each resident at the time of or prior to the change, and acknowledged in writing.
 - b. the resident or his/her legal representative has the right:
 - i. upon an oral or written request to access all records pertaining to himself or herself including clinical records within 24 hours; and
 - ii. after receipt of his/her records for inspection to purchase, at a cost as set forth in LA R.S. 40:1299.96, photocopies of the records or any portions of them upon request and two working days advance notice to the facility;
5. the resident has the right to be fully informed in a language that he/she can understand of his/her total health status including but not limited to his/her medical condition;
6. the resident has the right to:

a. refuse medication and medical treatment including a physician visit, other than to discover and prevent the spread of infection of contagious disease to protect environmental health and hygiene or otherwise indicated by the attending physician and to be informed of the consequences of such actions; and

b. refuse to participate in experimental research;

c. refuse to formulate an advance directive;

7. exercise of this resident's right does not include the refusal to perform reasonable hygiene measures (i.e., bathing, shampooing, oral care);

a. the facility must:

i. inform each resident who is entitled to Medicaid benefits in writing at the time of admission to the nursing facility of when the resident becomes eligible for Medicaid; of

(a). the items and services that are included in nursing facility services under the State Plan and for which the resident may not be charged by providing a copy of the Department of Health and Hospitals Blue Book;

(b). those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services;

ii. inform each resident when changes are made to these items and services;

iii. inform each resident before or at the time of admission and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/Medicaid or by the facility's per diem rate;

iv. furnish a written description of legal rights which includes:

(a). a description of the manner of protecting personal funds as outlined in this document on pages 216 through 220;

(b). a description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his/her process of spending down to Medicaid eligibility levels;

(c). a posting of names, addresses, and telephone numbers of all pertinent state client advocacy groups such as the Bureau of Health Services Financing-Health Standards Section, the State Ombudsman Program, the Protection and Advocacy Network, and the Medicaid Fraud Control Unit;

(d). a statement that the resident may file a complaint with the Bureau of Health Services Financing-Health Standards Section concerning resident abuse, neglect, and misappropriation of resident property in the facility;

v. inform each resident of the name, specialty, and way of contacting the physician responsible for his/her care;

vi. prominently display in the facility written information and provide to residents and applicants on admission oral and written information about how to apply for and use Medicare and Medicaid benefits and how to receive refunds for previous payments covered by such benefits.

G. Notification of Changes. A facility must inform or make a reasonable attempt to notify the resident's legal representative or interested family member when there is:

1. an accident involving the resident which results in injury and has the potential for requiring physician intervention;

2. a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

3. a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment);

4. a decision to transfer or discharge the resident from the facility;

5. documentation of the notification or attempts in notification shall be entered in the medical record.

a. The facility must also notify the resident and the resident's legal representative or sponsor when there is:

i. a change in room or roommate assignment. Notification must be given at least 24 hours before the change and a reason for the move shall be given to all parties. Documentation of this shall be entered in the medical record;

ii. a change in resident rights under state law or regulations.

H. Involuntary Admittance. Residents shall not be forced to enter or remain in a nursing facility against their will unless they have been judicially interdicted.

I. Delegation Of Rights

1. Resident rights and responsibilities are passed on to a guardian, next of kin, sponsor, responsible party, or sponsoring agency in the following instances:

a. when a competent individual chooses to allow another to act for him/her. (Example: Power of Attorney);

b. when the resident is adjudicated incompetent in accordance with state law.

2. The physician and the facility must be aware of, address, and document specific information concerning the incapability of the resident to understand and exercise their rights even if the resident has been adjudicated incompetent.

3. The following documentation is required:

PUBLIC HEALTH—MEDICAL ASSISTANCE

- a. administrative documentation;
 - i. the relation of the resident to the person assuming his rights and responsibilities;
 - ii. that the responsible person can act for the resident; and
 - iii. the extent of a guardianship or Durable Power of Attorney;
- b. physician documentation;
 - i. a statement that the resident is not capable of understanding and exercising his rights;
 - ii. specific causative and/or contributing medical diagnosis(es); and
 - iii. medical observations and tests which support the diagnosis(es).

EXAMPLES: Alzheimer's Disease and/or Organic Brain Syndrome

J. Management Of Resident Finances. Residents shall have the right to the following options regarding their personal financial affairs.

1. They shall be allowed to manage their personal financial affairs or to designate someone to assume this responsibility for them. They shall be permitted to spend their personal funds as they desire unless interdicted and/or under a curatorship. There shall be no limitations on the use of personal funds so long as the funds are not used to pay for anything covered by the Medicaid program.

2. There is no obligation for a resident to deposit funds with the facility. However, the facility is obliged to hold, safeguard, and account for personal funds upon written request by the resident or his or her representative. This delegation may be only to the extent of the funds held in trust by the facility. The facility does not have the option of refusing to hold, safeguard, or manage resident funds. The facility must comply with the wishes of the resident once written authorization is received.

3. The resident, his or her legal representative shall have access through quarterly statements and on request financial records if the facility has been delegated the responsibility for handling their financial affairs. Upon request the facility shall provide a list or statement regarding personal funds to the parish/regional office of Bureau of Health Services Financing with the resident's written consent. A copy shall be retained in the resident's record.

a. The nursing facility may not require the resident to deposit his/her personal funds with the facility.

b. Once the facility receives the written authorization from the resident, it must safeguard and account for such personal funds under a system established and maintained by the facility. The facility shall have written policies and procedures to protect resident funds. Current facility records shall reflect if residents handle their own funds or the names of parties designated to handle their personal funds.

c. The facility may make arrangements with a federal or state insured banking institution to provide banking services, but the responsibility for the disbursements, quality, and accuracy of required records remains with the facility.

NOTE: Any charge for this service is included in the facility's basic rate.

d. Upon receipt of written authorization of a resident, the facility must manage and account for the personal funds of the resident deposited with the facility as follows.

i. Deposit. The facility must deposit any amount of personal funds in excess of \$50 with respect to a resident in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts and credit all interest earned on such separate account to such account. The facility may maintain resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest bearing account, or petty cash fund.

ii. Accounting and Records. The facility shall assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a resident deposited with the facility and afford the resident (or legal representative of the resident) reasonable access to such record.

iii. Notice of Certain Balances. The facility must notify each resident receiving medical assistance under Medicaid Program State Plan when the amount in the resident's account reaches \$200 less than the dollar amount of resources allowed under SSI policy and the fact that if the amount in the account (in addition to the value of the resident's other non-exempt resources) exceeds the SSI resource limit the resident may lose eligibility for such medical assistance or for benefits under Title XVI (SSI) and Medicaid.

K. Collective Bank Account(s). Collective bank account(s) shall:

- 1. be for the resident's money;
- 2. be separate and distinct from all nursing facility accounts;
- 3. consist of resident's money and shall not be commingled with the facility's operating account; and
- 4. be regular checking account(s) or interest-bearing account(s). Interest shall be computed to each resident on the basis of actual earnings or end-of-quarter balance.

a. There shall be a monthly reconciliation between the collective or individual bank accounts and the individual resident account(s).

b. The individual financial record must be available through quarterly statements and on request to the resident or his/her legal representative.

L. Resident Fund Accounting System. The facility shall maintain current written individual records of all financial

transactions involving the personal funds which the facility is holding, safeguarding, and accounting. The facility shall keep these records in accordance with requirements of law for a trustee in a fiduciary relationship which exists for these financial transactions. The facility shall ensure the soundness and accuracy of the resident fund account system.

1. The facility shall develop the following procedures to ensure a sound and workable fund accounting system.

2. A file shall exist for each participating resident.

Each file or record shall contain all transactions pertinent to the account, including the following information:

a. money received:

i. source;

ii. amount; and

iii. date;

b. money expended:

i. purpose;

ii. amount; and

iii. date of all disbursements to or in behalf of the resident.

3. All monies, either spent on behalf of the resident or withdrawn by the resident or shall be supported by a receipt and cancelled check or signed voucher on file.

NOTE: It is recommended that the functions of actual cash receipt disbursements and recording of cash disbursements be separate.

4. Receipt for disbursements shall include the following information:

a. the date of the disbursement;

b. the amount of the disbursement;

c. the signature of the resident or responsible party; and

d. purpose and payee of disbursement.

NOTE: A running list of disbursements and receipts may be kept for posting on ledger sheets or individual vouchers. The resident's individual ledger sheet shall constitute the necessary receipt in situations where no check has been drawn if the ledger sheet is dated, shows the amount, resident's signature, and has the person's signature responsible for the resident's funds. Cancelled checks are sufficient receipt for disbursements if coupled with information regarding the purpose of the expenditure. When a resident is unable to sign the ledger, it should be signed by the custodian of the fund and two witnesses.

5. The file shall be available to the resident or his or her legal representative upon request during the normal administrative work day.

6. Cash on Hand. The facility shall have a minimum of cash on hand to meet residents' spending needs. Cash on hand shall be maintained on the imprest petty cash system.

7. Ownership of Accounts. The account shall be in a form which clearly indicates that a facility does not have an ownership interest in the funds.

8. Insured Accounts. The account shall be insured under federal and state law.

9. Distribution of Interest. The interest earned in any pooled interest-bearing account shall be distributed in one of the following manners:

a. prorated to each resident on an actual interest-earned basis;

b. prorated to each resident on the basis of his end-of-quarter balance.

10. Surety Bond. The facility shall purchase a surety bond or otherwise provide assurance satisfactory to the Secretary to assure the security of all personal funds of residents deposited with the facility.

11. Closing a Discharged Resident's Fund Account. Nursing facilities shall refund the balance of the resident's personal funds when a resident is discharged. The amount shall be refunded by the end of the month following the month of discharge. Date, check number, and "to close account" should be noted on the ledger sheet.

12. Conveyance Upon Death. Legally the funds should be turned over to the executor of the estate. Within three months the legal representative or sponsor should notify the facility as to whom the executor is. The executor must then open succession. The facility must convey within 30 days the balance of the resident's personal funds account and the unused portion of any advance room and board payment, and a final accounting of those funds to the individual or person administering the resident's estate. In lieu of a lengthy legal process, a facility can obtain an "Affidavit of Small Succession" from the Unclaimed Property Section at the Louisiana Department of Revenue and Taxation for estates involving less than \$50,000 and where no real estate is involved. This will allow for transfer of assets to the heirs without a waiting period.

a. The following shall apply in regard to a deceased resident's unclaimed personal funds.

i. If the facility fails to receive notification of the appointment or other designation of a responsible party (legal guardian, administrator or the estate, or person placed in possession by court judgement) within three months after the date of death, the facility shall retain the funds and notify the Public Administrator or Curator of Vacant Successions in the parish where the facility is located. The notice shall provide detailed information about the decedent, his next of kin, and the amount of funds.

ii. The facility shall continue to retain the funds until a court order specifies that the funds are to be turned over to the Public Administrator or Curator of Vacant Successions.

iii. If neither order nor judgement is forthcoming, the facility shall retain the funds for five years after date of death.

iv. Thereafter, the facility is responsible for delivering the unclaimed funds to the Secretary of Revenue and Taxation.

v. A termination date of the account and the reason for termination shall be recorded on the resident's participation file. A notation shall read, "to close account". The endorsed cancelled check with check number noted on the ledger sheet shall serve as sufficient receipt and documentation.

b. Nursing Facility Residents' Burial Insurance Policy. "With the resident's permission, the nursing facility administrator or designee may assist the resident in acquiring a burial policy, provided that the administrator, designee, or affiliated persons derive no financial or other benefit from the resident's acquisition of the policy."

M. Specific Rights

1. Free Choice. The resident has the right to:

- a. choose a personal attending physician;
- b. obtain pharmaceutical supplies and services from a pharmacy of choice at their own expense or through Medicaid, provided the drugs are delivered timely to the facility and packaged compatibly with a facility's medication administration system;
- c. be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being;
- d. unless adjudged incompetent or otherwise found to be incapacitated under the laws of the state participate in planning care and treatment or changes in care and treatment; and
- e. withhold payment for a physician's visit if the physician did not perform an examination;
- f. to be returned to the nursing facility upon discharge from an acute hospital bed.

2. Privacy and Confidentiality

- a. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.
- b. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. This does not require the facility to provide a private room for each resident.
 - i. Privacy shall include:
 - (a). having closed room doors;
 - (b). having facility personnel knock on a closed door before entering their room except in an emergency situation or unless medically contraindicated;

(c). having privacy during toileting, bathing, and other activities of personal hygiene except as needed for safety reasons or assistance; and

(d). having privacy screens or curtains in use during treatment, bathing, toileting, or other activities of personal hygiene.

c. Except as provided in the next paragraph, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

d. The resident's right to refuse release of personal and clinical records does not apply when:

- i. the resident is transferred to another health care institution;
- ii. record release is required by law; and
- iii. requested by staff from the Department of Health and Hospitals.

e. Grievances. A resident has the right to:

- i. voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished;
- ii. prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

f. Examination of Survey Results. A resident has the right to:

- i. examine the results of the most recent survey of the facility conducted by federal or state surveyors and any plan of correction in effect with respect to the facility. The results must be made available for examination by the facility in a place readily accessible;
- ii. receive information from agencies acting as recipient advocates and be afforded the opportunity to contact these agencies.

g. Work. The resident has the right to:

- i. refuse to perform services for the facility; and
- ii. perform services for the facility if he/she chooses when:
 - (a). the facility has documented the need or desire for work in the plan of care;
 - (b). the plan specifies the nature of the services performed and whether the services are voluntary or paid;
 - (c). compensation for paid services is at or above the prevailing rates; and
 - (d). the resident agrees to the work arrangement described in the plan of care.

h. Mail. The resident has the right to privacy in written communications including the right to:

i. send and promptly receive mail that is unopened; and

ii. have access to stationary, postage, and writing implements at the resident's own expense.

i. Access and Visitation Rights. The resident has the right and the facility must provide immediate access by any resident to the following:

i. any representative of the Secretary of HHS;

ii. any representative of the state;

iii. the resident's individual physician;

iv. the State Long Term Care Ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965);

v. the agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act);

vi. the agency responsible for the protection and advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally Ill Individuals Act);

vii. subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident;

viii. subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident; and

ix. visiting overnight outside the facility with family and friends in accordance with the facility policies, physician's orders, and Title XVIII (Medicare) and Title XIX (Medicaid) regulations without the loss of their bed. Home visit policies and procedures for arranging home visits shall be fully explained.

(a). The facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident subject to the resident's right to deny or withdraw consent at any time.

(b). The facility must allow trained compensated representatives of the State Ombudsman to examine a resident's clinical records with the permission of the resident or the resident's legal representative and consistent with state law.

(c). Visiting hours shall be flexible taking into consideration special circumstances such as out-of-town visitors and working relatives and friends. Additionally, the facility shall arrange for critically ill residents to receive visitors other than during normal business hours.

j. Telephone. The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.

k. Personal Property. The resident has the right to retain and use personal possessions including some furnishings and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

l. Married Couples. The resident has the right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.

m. Self-Administration of Drugs. An individual resident may self-administer drugs if the interdisciplinary team has determined that this practice is safe.

n. Choice of Roommate. Residents shall have the right to have their wish respected regarding choice(s) of roommate(s), insofar as possible and/or reasonable.

o. Smoking. Residents shall have the right to use tobacco at their own expense under the facility's safety rules and the state's applicable laws and rules unless the use of tobacco is medically contraindicated as documented in the medical record by the attending physician.

p. Alcoholic Beverages. Residents shall have the right to consume a reasonable amount of alcoholic beverages at their own expense unless the following conditions are present.

i. It is medically contraindicated as documented in the medical record by the attending physician.

ii. It is expressly prohibited by published rules and regulations of a facility owned and operated by a religious denomination which has abstinence from the consumption of alcoholic beverages as part of its religious beliefs.

iii. There is no disruption to other facility residents or staff.

q. Retiring and Rising. Residents shall have the right to retire and rise in accordance with reasonable requests if the following conditions are met:

i. they do not disturb others.

ii. they do not disrupt the posted meal schedule;

iii. upon the facility's request, they remain in a supervised area; and

iv. retiring and rising in accordance with their request is not medically contraindicated as documented in the medical record by the attending physician.

r. Participation in Resident and Family Groups

i. A resident has the right to organize and participate in resident groups in the facility.

ii. A resident's family has the right to meet in the facility with the families of other residents in the facility.

iii. The facility must provide a resident or family group, if one exists, with private space.

iv. Staff or visitors may attend meetings at the group's invitation.

v. The facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings.

vi. When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and lift in the facility.

s. Representative Payee

i. Residents receiving Social Security benefits shall have the right to make an application with the Social Security Administration to designate a representative payee.

ii. If residents receiving Social Security benefits are incapable of managing their personal funds and have no legal representative, the facility may notify the Social Security Administration and request that a representative payee be appointed.

N. Violation of Rights. Any person who submits or reports a complaint concerning a suspected violation of residents' rights or concerning services or conditions in a facility or who testifies in any administrative or judicial proceeding arising from such complaint, shall have immunity from any criminal or civil liability therefor unless that person has acted in bad faith with malicious purpose or if the court finds that there was an absence of a justifiable issue of either law or fact raised by the complaining party.

O. Bill of Rights. Resident Bill of Rights shall be prominently displayed in accessible areas at a proper height and in a size print which is appropriate to elderly individuals having impaired vision. The Bill of Rights shall include the following assurances in addition to the above mentioned rights. All facilities shall adopt and make public a statement of the rights and responsibilities of residents residing in the facility and shall treat all individuals in accordance with the provisions of the statement.

1. Each nursing facility shall provide a copy of the statement required by R.S. 40:2010 8(A) to each resident, sponsor, and/or the resident's legal representative upon or before admission to the facility and to each staff member. The statement shall also advise the resident, sponsor, and/or responsible party that the nursing facility is not responsible for the actions or inactions of other persons or entities not employed by the facility, such as the treating physician, pharmacist, sitter, or other such persons or entities employed or selected by the resident, sponsor, and/or responsible party. Each facility shall prepare a written plan and provide appropriate staff training to implement the provisions of R.S. 40:2010.6 et seq., but not limited to explanation of the following:

a. the resident rights and the staff's responsibilities in the implementation of those rights;

b. the staff's obligation to provide all residents who have similar needs with comparable services as required by state licensure standards.

2. Any violation of the residents' rights in R.S. 40:2010.6 et seq. shall constitute grounds for appropriate action by the Department of Health and Hospitals. Residents shall have a private right of action to enforce these rights as set forth in T.S. 40:2010.9. The state courts shall have jurisdiction to enjoin a violation of residents' rights and assess fines for violations not to exceed \$100 per individual violation.

P. Civil and Religious Liberties. Residents shall have the right to civil and religious liberties including but not limited to the following:

1. knowledge of available choices;
2. the right to independent personal decisions;
3. the right to encouragement and assistance from facility staff in exercising these rights to the fullest extent possible;
4. the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility; and
5. the resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

Q. Freedom from Restraints and Abuse. Residents shall have the right to be free from verbal, sexual, physical or mental abuse, corporal punishment, involuntary seclusion, and any physical and chemical restraints imposed for the purpose of discipline or convenience and not required to treat the resident's medical symptoms. Bed-rails used during sleeping hours at the request of the resident's legal representative or responsible party are not restraints. Restraints may only be imposed:

1. to insure the physical safety of the resident;
2. only upon written order of a physician that specifies the duration, type of restraint, and circumstances under which the restraints are to be used except in emergency circumstances;
3. in case of an emergency, physical restraint may only be applied by a qualified licensed nurse who shall document in the medical record the circumstances requiring the necessity for use of the restraint;
4. in case of emergency, a chemical restraint may be used by a qualified licensed nurse if authorized by the attending physician. The necessity for the use of the chemical restraint shall be documented in the medical record as well a monitoring of vital signs after the drug has been administered. In this case, the attending physician shall be consulted immediately thereafter;

a. as needed or PRN antipsychotic drugs should only be used when the resident has a "specific condition" for

which antipsychotic drugs are indicated and one of the following circumstances exists:

i. the as needed or PRN does is being used to titrate the resident's total daily dose up or down or is being used to manage unexpected harmful behaviors that cannot be managed without antipsychotic drugs. Under this circumstance, a PRN antipsychotic drug may be used no more than twice in any 7 days period without an assessment or the cause for the resident's behavioral symptoms and the development of a plan of care designed to attempt to reduce or eliminate the cause(s) for the harmful behavior;

5. psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the written Plan of Care) designed to eliminate or modify the symptoms for which the drugs are prescribed (Applicable only to Medicaid residents.);

6. bedrails and geri-chairs, if used for the purpose of restricting free movement, are considered restraints. Before using such methods, the facility should first attempt to use less restrictive alternatives. If these alternatives are found to be ineffective in the context of treating the resident's medical symptoms, the facility may apply them within the context of individualized care planning. The facility should also monitor in a way that promotes the highest practicable physical, mental and psychosocial well-being of the resident. If the use is associated with a decline in the resident's functional ability, such as increased agitation, the interdisciplinary team should reassess the resident's needs;

7. if the restraint is used to enable the resident to attain or maintain his or her highest practicable level of functioning, a facility must have evidence of consultation with appropriate health professionals, such as occupational or physical therapists. The consultation should consider the use of less restrictive therapeutic intervention prior to using restraints for such purposes.

R. Housing

1. All residents shall be housed without regard to race, color, or national origin. Bi-racial occupancy of rooms and wards on a non-discriminatory basis shall be required.

2. Residents shall not be asked if they are willing to share a room with a person of another race, color, or national origin.

3. Resident transfers shall not be used to evade compliance with Title VI of the Civil Rights Act of 1964.

a. *Open Admission Policy.* An open admission policy and desegregation of facilities shall be required, particularly when the facility previously excluded or primarily served residents of a particular race, color, or national origin. Facilities which exclusively serve residents of one race have the responsibility for taking corrective action, unless documentation is provided that this pattern has not resulted from discriminatory practices.

b. *Restricted Occupancy.* A facility owned or operated by a private organization may restrict occupancy to members of the organization without violating Civil Rights

compliance, provided membership in the organization and admission to the facility is not denied on the basis of race, color, or national origin.

S. *Resident Services.* All residents shall be provided medical, non-medical, and volunteer services without regard to race, color, or national origin. All administrative, medical, and non-medical services are covered by this requirement.

T. Facility Personnel

1. Attending physicians shall be permitted to provide resident services without regard to race, color, or national origin.

2. Other medical, paramedical, or non-medical persons, whether engaged in contractual or consultative capacities, shall be selected and employed in a non-discriminatory manner. Opportunity shall not be denied to qualified persons on the basis of race, color, or national origin.

3. Dismissal from employment shall not be based upon race, color, or national origin.

U. Advance Directives. Each resident shall be:

a. afforded the opportunity to participate in the planning of his medical treatment;

b. encouraged and assisted throughout his/her period of stay to exercise his/her rights as a patient and as a citizen; and

c. treated with consideration, respect, and full recognition of his/her dignity and individuality.

2. Nursing facilities must:

a. provide all adult individuals with written information about their rights under state law to make health care decisions including the right to accept or refuse treatment and the right to execute advance directives;

b. document in the resident's medical record whether or not he/she has signed an advance directive;

c. not discriminate against an individual based on whether he/she has executed an advanced directive; and

d. provide facility and community with education on advance directives.

NOTE: If an advance directive has been executed, a copy shall be kept in the medical record.

3. Definitions

a. *Attending Physician*—the physician who has primary responsibility for the treatment and care of the resident.

b. *Declaration*—a witnessed document, statement, or expression voluntarily made by the declarant, authorizing the withholding or withdrawal of life-sustaining procedures, in accordance with requirements of Louisiana Law. A declaration may be made in writing, orally, or by other means of nonverbal communication.

c. *Life-sustaining Procedure*—any medical procedure or intervention which within reasonable medical judgement, would serve only to prolong the dying process for a person diagnosed as having a terminal and irreversible condition. A "life-sustaining procedure" shall not include any measure deemed necessary to provide comfort care.

d. *Physician*—a physician or surgeon licensed by the Louisiana State Board of Medical Examiners.

e. *Qualified Resident*—a resident diagnosed and certified in writing as having a terminal and irreversible condition by two physicians, one of whom shall be the attending physician, who have personally examined the resident.

f. *Terminal and Irreversible Condition*—a condition caused by injury, disease, or illness which within reasonable medical judgement, would produce death and for which the application of life-sustaining procedures would serve only to postpone the moment of death.

4. Written Policy

a. All facilities shall have an appropriate written policy and procedure regarding the decision to have life-sustaining procedures withheld or withdrawn in instances where such residents are diagnosed as having a terminal and irreversible condition.

b. If the policies of a nursing facility preclude compliance with the declaration of a resident or preclude compliance with provisions pertaining to a representative acting on behalf of a qualified resident, the nursing facility shall take all reasonable steps to effect the transfer of the resident to a facility in which the provisions of his/her declaration can be carried out.

5. Facility Responsibility

a. Physician orders shall:

i. be based on the medical examination of the resident's immediate and long-term needs;

ii. document that the condition is terminal and irreversible;

NOTE: Two physicians must document that the resident has a terminal and irreversible condition ("Qualified Resident");

iii. prescribe a planned regimen of total care for the resident which shall include special exceptions to the treatment regimen.

b. Plan of care shall:

i. Include a statement indicating that a valid declaration has been made; and

ii. Include measures to ensure the comfort care of the resident during the dying process.

e. Nursing Notes. Charting shall be done as often as necessary but at least every eight hours during the time that life-sustaining procedures are withheld or withdrawn.

6. Declaration. The declaration may be executed at any time by the individual or legal representative. The declaration is not activated until two physicians determine that the resident has a terminal or irreversible condition. For purposes of clarity in the event the document must be executed, the resident should be advised that it should be specific as to what measures the resident does and does not want.

7. Do Not Resuscitate—DNR Order. If the responsible physician finds that resuscitation would be medically inappropriate, a Do Not Resuscitate (DNR) order becomes effective only upon the informed choice of a competent resident or by agreement of the family members as a class if the resident is incompetent. A signed DNR order must be witnessed by two persons not related by blood or marriage and who would not be entitled to any portion of the estate.

The DNR is not a decision that can be made by a physician or facility committee acting alone.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

Subchapter J. Transfer and Discharge Procedures

§10163. General Provisions

A. Health facilities must permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless:

1. the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

2. the transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the facility;

3. the safety of individuals in the facility is endangered;

4. the health of individuals in the facility would otherwise be endangered;

5. the resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility; and

6. the facility ceases to operate.

B. When the facility proposes to transfer or discharge a resident under any of the circumstances specified in number one through number five above, the resident's clinical records must be documented. The documentation must be made by the following:

1. the resident's physician when transfer or discharge is necessary as specified in number one or number two as listed above;

2. any physician when transfer or discharge is necessary as specified in number four as listed above.

C. Before an interfacility transfer or discharge occurs the facility must, on a form prescribed by the Louisiana Department of Health and Hospitals, do the following:

1. Notify the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident's clinical record and transmit a copy to the following:

- a. the resident;
- b. a family member of the resident, if known;
- c. the resident's legal representative and legal guardian, if known;
- d. the local long term care ombudsman program (for involuntary relocations or discharges only);
- e. the person or agency responsible for the resident's placement, maintenance, and care in the facility;
- f. in situations where the resident is developmentally disabled, the Regional Office of the Division of Mental Health who may assist with placement decisions; and
- g. the resident's physician when the transfer or discharge is necessary under situations as described in number three through six in §10163.A. of this Subchapter;

2. record the reasons in the resident's clinical record;

3. Include in the notice the items as described in number one through eight in §10163.E. of this Subchapter.

D. Except when specified in number one below, the notice of transfer or discharge required in §10163.D of this Subchapter must be made by the facility at least 30 days before the resident is transferred or discharged.

1. Notice may be made as soon as practicable before transfer or discharge when:

- a. the safety of individuals in the facility would be endangered as described in number three §10163.A. of this Subchapter;
- b. The health of individuals in the facility would be endangered as described in number four in §10163.A. of this Subchapter;
- c. The resident's health improves sufficiently to allow a more immediate transfer or discharge as described in number two of §10163.A. of this Subchapter;
- d. an immediate transfer or discharge is required by the resident's urgent medical needs; and
- e. a resident has not resided in the facility for 30 days.

E. For health facilities the written notice as described in §10163 of this Subchapter must include the following:

1. the reason for transfer or discharge;
2. the effective date of transfer or discharge;
3. the location to which the resident is transferred or discharged;
4. a statement regarding appeal rights that reads: You have the right to appeal the health facility's decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing postmarked within ten days after you receive this notice. If you request a hearing, it will be held within 23 days after you receive this notice, and you will not be transferred from the facility earlier than 30 days after you receive this notice of transfer or discharge, unless the facility is authorized to transfer you as described in number one, §10163.D. of this Subchapter. If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Louisiana Department of Health and Hospitals at the number listed below;
5. the name of the director, and the address, telephone number, and hours of operation of the Bureau of Appeals of the Louisiana Department of Health and Hospitals;
6. a hearing request form utilized by the Louisiana Department of Health and Hospitals;
7. the name, address, and telephone number of the state long term care ombudsman;
8. for health facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection advocacy services commission.

F. Appeal of Transfer or Discharge

1. If the resident appeals the transfer or discharge, the health facility may not transfer or discharge the resident within 30 days after the resident receives the initial transfer or discharge unless an emergency exists as described in number one §10163.D.1 of this subchapter. A physician determines that an emergency exists.

2. If non-payment is the basis of a transfer or discharge, the resident shall have the right to pay the balance owed to the facility up to the date of the transfer or discharge and then is entitled to remain in the facility.

3. The Louisiana Department of Health and Hospitals shall provide a resident who wishes to appeal the transfer or discharge from a facility the opportunity to file for a hearing postmarked within ten days following the resident's receipt of the written notice or the transfer or discharge from the facility.

4. If a health facility resident requests a hearing, the Louisiana Department of Health and Hospitals shall hold a hearing at the health facility, or by telephone if agreed upon by all parties, within 30 days from the date the resident receives the notice of transfer or discharge. The Louisiana Department of Health and Hospitals shall issue a decision within 30 days from the date the resident receives

the notice. The health facility must convince the Department by a preponderance of the evidence that the transfer or discharge is authorized under Section A. If the Department determines that the transfer is appropriate, the resident must not be required to leave the health facility within 30 days after the resident's receipt of the initial transfer or discharge notice unless an emergency exists as described in number one § 10163.D.1. of this Subchapter.

G. Room to Room transfer (intra-facility). The resident or curator and responsible party shall receive at least a 24 hour notice before the room of the resident is changed. A reason for the move will be given to resident and curator/responsible party. Documentation of all of this information will be entered in the medical record. A resident has the right to receive notice when their roommate is changed.

NOTE: The resident has the right to relocate prior to the expiration of the 24 hours notice if this change is agreeable to him/her.

H. Facility Responsibilities In An Individual Involuntary Transfer or Discharge. Facility responsibilities in ensuring an orderly individual involuntary transfer shall include the following tasks:

1. The facility shall complete a final review and update the plan of care with the transfer in mind. The update shall include review of the following:

- a. the discharge plan; and
- b. the overall plan of care and current MDS.

2. A discharge plan shall be submitted to the individual or institution into whose care the resident is being discharged. It shall include the following information:

- a. nursing services required including needed medications;
- b. rehabilitative needs;
- c. appropriate level of medical care;
- d. any special medical arrangement necessary to alleviate any adverse effects of the discharge;
- e. memory and orientation as to time, place, and person; and
- f. length of residence in the facility;

g. a discharge plan containing all pertinent information regarding a resident's present condition and documentation showing lack of continued need for the level of care provided by the facility shall be submitted to the Bureau of Health Services Financing-Health Standard Section Regional Office, once the following conditions are met:

- i. A medical assessment is made as near as practicable to the date of discharge; and
- ii. The attending physician executes a written statement showing that on the basis of the resident's current

physical and mental condition, there are no medical contraindications to the discharge.

h. Written Notice of Transfer or Discharge. The written notice of transfer or discharge shall contain the following information:

- i. the proposed date of the transfer or discharge and reason(s) for same;
- ii. a date, time, and place for a conference;
- iii. the nursing home personnel available to assist in locating a new nursing facility or alternate living arrangement; and
- iv. the resident's right for personal and/or third party representation at all stages of the transfer or discharge process.

i. Transfer or Discharge Conference. The facility Administrator and/or Nursing Director and/or Social Services Director shall meet with the resident and resident's legal representative or sponsor to discuss the transfer or discharge. The discussion shall be conducted within the following time frames to ensure an orderly process:

- i. as soon as possible in advance of the transfer or discharge; but
- ii. at least within the written 30 day advance notice time period.

(a). The resident's presence at the conference may be waived with a written statement from the attending physician explaining the medical contraindications for participation in such a meeting.

(b). Discussion should include information outlined above.

j. Pre-Transfer Services. The facility shall provide all pre-transfer services required in the final update of the individual plan of care and transfer or discharge plan.

k. Resident Overstay. The facility is responsible for keeping the resident whenever medical conditions warrant such action for as long as necessary, even if beyond the proposed date of transfer or discharge, except in emergency situations and when payment has been arranged.

l. Transportation. The facility shall arrange for transportation to the new residence.

I. Voluntary Individual Transfer or Discharge. Voluntary Individual Transfer.

1. To the extent possible, facilities shall adhere to the procedures outlined above prior to the actual transfer of residents who voluntarily transfer from one facility to another. The information in the plan of care, MDS, and discharge plan should be submitted to the receiving facility at the request of the resident and/or legal representative.

2. Voluntary Individual Discharge. To the extent possible, facilities shall adhere to the procedures outlined above prior to the actual discharge of residents who voluntarily leave the facility. The information in the care

plan, MDS, and discharge plan shall be submitted to the individual or institution into whose care the resident is being discharged at the written request of the resident and/or legal representative.

3. **Bed Hold.** Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic home leave of 24 hours duration or longer, the nursing facility shall provide written information to the resident and a family member or legal representative that specifies the following:

a. the duration of the bed-hold policy under the State Plan during which the resident is permitted to return and resume residence in the facility; and

b. the health facility's policies regarding bed-hold periods, which must be consistent with §10163.I.3.ii. of this Subchapter.

i. Except in an emergency, at the time of transfer of a resident for hospitalization or therapeutic home leave, a health facility shall provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy.

ii. Medicaid certified facilities must establish and follow a written policy under which a resident, whose hospitalization or therapeutic home leave exceeds the bed-hold period under the State Plan, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident:

(a). requires the services provided by the facility; and

(b). is eligible for Medicaid nursing facility services.

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Subchapter K. Complaint Procedures

§10165. Purpose and Scope

A. Under the provisions of Louisiana R.S. 40:2009.2 through 2009.20 and State Operations Manual as published by the Department of Health and Hospitals and Health Care Financing Administration, the following procedures are established for receiving, evaluating, investigating, and correcting grievances pertaining to resident care in licensed and certified nursing facilities. The following procedures also provide mandatory reporting of abuse and neglect in nursing facilities.

B. Applicability

1. Any person having knowledge of the alleged abuse or neglect of a resident or knowledge of a resident being denied care and treatment may submit a complaint, preferably in writing.

2. Any person may submit a complaint if he/she has knowledge that a state law, standard, rule, regulation, correction order, or certification rule issued by the Department of Health and Hospitals has been violated.

C. **Duty to Make Complaints.** Any of the following persons who have actual knowledge of a facility's abuse or neglect of a resident, shall submit a complaint within 24 hours:

1. physicians or other allied health professionals;
2. Social Services personnel;
3. facility administration;
4. psychological or psychiatric treatment personnel;
5. registered nurses;
6. licensed practical nurses; and
7. nurse's aides.

D. Penalties for Failure To Make Complaint

1. Any person who knowingly and willfully fails to report an abuse or neglect situation shall be fined not more than \$500 or imprisoned not more than six months or both. The same sanctions shall apply to an individual who knowingly and willingly files a false report.

2. Penalties for committing cruelty or negligent mistreatment to a resident of a health care facility shall be not more than \$10,000.00 or imprisoning with or without hard labor for more than ten years, or both.

E. **Where to Submit Complaint.** A complaint may be filed as follows.

1. It may be submitted in writing to the Secretary of the Department of Health and Hospitals or his designee at P.O. Box 94065, Baton Rouge, LA 70804-4065;

2. It may be relayed by calling Health Standards Section at (504) 342-0082;

3. It may be submitted to any local law enforcement agency.

F. DHH's Referral of Complaints for Investigation

1. Complaints involving residents of all ages in institutions received by the Department of Health and Hospitals shall be referred to the Health Standards Section Special Consultant.

2. If it has been determined that complaints involving alleged violations of any criminal law pertaining to a nursing facility are valid, the investigating office of DHH shall furnish copies of the complaints for further investigation to both the Medicaid Fraud Control Unit of the Louisiana Department of Justice and the local office of the District Attorney.

G. **Investigation Procedure.** The protocol to be used when investigating complaints is as follows.

PUBLIC HEALTH—MEDICAL ASSISTANCE

1. The investigator(s) must identify him/herself to the administrator or in the absence of the administrator, to the person designated to be in charge at the time.

2. At the entrance conference, the nature of the complaint will be given and anonymity of the complaint respected if requested.

3. If, during the investigation, deficiencies are found which were not cited in the complaint, these shall be written in a separate memo and addressed in a separate letter to the administrator.

4. At the conclusion of the investigation, an exit conference should be held with the administrator and any other personnel the Administrator may want present. The valid and non-valid findings should be shared with those present at the conference. Appropriate recommendations can be made at this time.

a. Prompt Investigation of Cases Determined to be Immediate Jeopardy. A complaint of abuse will be referred by DHH to the Regional Office immediately upon receipt and staff from the Regional office will investigate the complaint within five days. The facility also has a responsibility to thoroughly investigate and take measures to prevent further abuse.

i. The disposition of other complaints will be determined according to the content and urgency of the complaint. When possible, referrals will be made to other agencies or Departments which can address the complaint and respond to the complainant.

b. Investigation Tasks. If the complaint involves abuse and/or neglect, an immediate investigation shall include the following:

- i. interviewing the resident, if possible, and other persons who may have pertinent information;
- ii. determining the nature of the abuse and/or neglect;
- iii. determining the extent of the abuse and/or neglect;
- iv. determining the cause of the abuse and/or neglect, if known; and

NOTE: A copy of the investigation report shall be submitted to the District Attorney.

v. if the complaint involves dietary, housekeeping, general care, residents' rights, patient funds, etc., the investigation shall include the following (as applicable to the situation);

- (a). review of the medical record(s);
- (b). interview (observation) of the resident and other residents;
- (c). interview pertinent staff members;
- (d). interview complainant, family, visitors, doctor as necessary for the particular complaint;

- (e). perform a drug pass observation; and
- (f). perform dining and eating assistance observation.

c. Manner of Reporting

i. If the complaint is not valid, a typed report of the investigation, listing each complaint and the findings will be sent to the Special Consultant of the Bureau of Health Services Financing-Health Standards Section.

ii. If any portion of the complaint is found to be valid, a 2567 Form shall be filled out, on site if possible, identifying the ID Prefix Tag, the deficiency, and the Administrator's Plan of Correction and completion date. This form should accompany the written report of the findings of this complaint. If the administrator is not able to provide a Plan of Correction on site, the portion of Form 2567 to be filled in by the investigator should be completed and sent with the written report to the Special Consultant, who will be responsible for obtaining the Plan of Correction.

d. Notice of Investigation to the Facility. The nature of the complaint shall be given to the nursing facility no earlier than when the on-site investigation begins at the facility.

e. Confidentiality. In order to protect the confidentiality of complainants, residents shall not be identified to the nursing facility unless they consent to the disclosure.

NOTE: If disclosure becomes essential to the investigation, the complainant shall be given the opportunity to withdraw the complaint.

f. Disposition of Complaints. If, after investigation, the complaint is found to be valid, the Department of Health and Hospitals shall notify the administrator who will provide an acceptable plan of correction.

i. If it is determined that a situation presents a threat to the health and safety of the resident, the nursing facility shall be required to take immediate corrective action. The Department of Health and Hospitals will certify non-compliance and initiate termination, non-renewal, or intermediate sanctions. HCFA-462 (Adverse Action Extract) and HCFA-562 (Medicare/Medicaid Complaint Form) will be completed.

ii. In all other instances of violation, an expeditious correction, not to exceed 90 days, shall be required. If a Condition of Participation in a Skilled Nursing Facility or a Program Standard in a Nursing Facility is not met and determined that the provider has a limited capacity to provide adequate care and/or services, or provider is unable or unwilling, the Department of Health and Hospitals will certify non-compliance and initiate termination, non-renewal, or intermediate sanctions.

iii. In cases of abuse and/or neglect, referral for appropriate corrective action shall be made to the Medicaid Fraud Control Unit of the Attorney General's Office.

g. **Unsubstantiated Complaint.** If, after investigation, the complaint is determined to be unsubstantiated, DHH shall notify the complainant and the facility of this fact.

h. **Repeat Violations.** When violations continue to exist after the corrective action was taken, the Department of Health and Hospitals may take appropriate action against the nursing facility to include decertification or revocation of its license.

i. **Follow-up Activity.** Deficiencies will be scheduled for follow-up visits as soon as possible after the approved provider completion date on appropriate documents.

j. **Narrative Report Content.** The narrative report content is as follows:

- i. date of investigation;
- ii. what was done (tour, drug pass, etc.);
- iii. who was interviewed;
- iv. identify each aspect of the complaint, conclusions and state whether valid, not valid, or unable to validate.

k. **Results of Complaint Investigation.** These results will be considered in conducting annual surveys and making certification decisions. Staff will read the complaint file prior to the annual survey.

l. **Fair Hearing.** Complainants who are dissatisfied with any action taken by the Department of Health and Hospitals in response to their complaints may request a fair hearing to review the action in accordance with Subchapter §10161. A request for a fair hearing shall be submitted in writing to the Secretary, DHH, P.O. Box 629, Baton Rouge, LA 70821-0629.

m. **Retaliation by Nursing Facility.** Facilities are prohibited from taking retaliatory action against complainants. Persons aware of retaliatory action or threats in this regard should contact the Department of Health and Hospitals.

n. **Notification of the Complaint Procedure.** The Department of Health and Hospitals "Blue Book" which has the complaint procedure shall be posted in each nursing facility in a conspicuous place where residents gather. This "Blue Book", known as "Nursing Home Care in Louisiana", was developed for the public by the Department of Health and Hospitals. This booklet shall be distributed based upon availability by all licensed nursing facilities to all current residents and/or their legal representatives or sponsors and to all new residents and/or their legal representative or sponsors on the date of their admissions.

o. **Reporting of Incidents.** For each resident who is involved in an accident or incident, an incident report shall be completed including the name, date, time, details or accident or incident, circumstances under which it occurred, witnesses and action taken. Incident reports are an administrative tool to pinpoint problem areas and shall result

in corrective action, where representatives of the U.S. Department of Health and Human Services and DHH upon request and without prior notice.

i. Incidents or accidents involving residents shall be noted in the nurse's notes and these records should contain all pertinent medical information.

(a). The examples listed below are not all inclusive, but are presented to serve as a guideline to assist those facility employees responsible for reporting incident reports.

(i). **Suspicious Death.** Death of a resident or on-duty employee when there is suspicion of death other than by natural causes.

(ii). **Abuse and/or Neglect.** All incidents or allegations of abuse and/or neglect.

(iii). **Runaways.** Runaways considered to be dangerous to self or others.

(iv). **Law Enforcement Involvement.** Arrest, incarceration, or other serious involvement of residents with law enforcement authorities.

(v). **Mass Transfer.** The voluntary closing of a facility or involuntary mass transfer of residents from a facility.

(vi). **Violence.** Riot or other extreme violence.

(vii). **Disasters.** Explosions, bombings, serious fires.

(viii). **Accidents/Injuries.** Severe accidents or serious injury involving residents or on-duty employees caused by residents such as life threatening or possible permanent and/or causing lasting damage.

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Subchapter L. Sanctions and Appeal Procedures

§10167. General Provisions

A. **Authority and Scope.** Any person or entity found to be in violation of any provision of R.S. 40:2009.1 through 40:2009.11 or any other state or federal statute, regulation, or any Department of Health and Hospitals' rule adopted pursuant to the Administrative Procedure Act governing the administration of nursing facility care may be sanctioned by one or more of the following remedies:

1. plan of correction;
2. monitoring;
3. special staffing requirements;
4. civil money penalties (fines);
5. denial of payment for new admissions;

6. withholding of vendor payments;
7. temporary management;
8. termination of certification; and
9. revocation of license;

NOTE: The Secretary or his designee may impose any of the above cited sanctions separately or in combination. In addition to the foregoing administrative remedies, the Secretary may have recourse to any judicial remedies provided by law;

a. Considerations. The secretary shall impose the sanction(s) which will bring the facility into compliance in the most efficient and effective manner with the care and well-being of the residents being the paramount consideration. The secretary's decision shall be based on an assessment of some or all of the following factors:

- i. whether the violations pose an immediate threat to the health or safety of the residents;
- ii. the duration of the violations;
- iii. whether the violation (or one that is substantially similar) has previously occurred during the last three consecutive surveys;
- iv. the facility's history of compliance during the last three consecutive surveys;
- v. what sanction is most likely to cause the facility to come into compliance in the shortest amount of time;
- vi. the severity of the violation if it does not pose an immediate threat to health or safety;
- vii. the logistical feasibility of implementing the sanction;
- viii. the "good faith" exercised by the facility in attempting to stay in compliance;
- ix. the financial benefit to the facility of committing or continuing the violation; and
- x. such other factors as the secretary deems appropriate.

b. Repeated Findings of Substandard Care. Where the facility has been found to have provided substandard quality of care on three consecutive standard surveys, the secretary shall (regardless of what other remedies are provided):

- i. deny payment under the state plan with respect to any individual admitted to the nursing facility involved after notice to the public and to the facility as may be provided for by law;
- ii. monitor the facility on site, until the facility has demonstrated, to the satisfaction of the Department, that it is in compliance with all requirements and that it will remain in compliance with such requirements;

c. Immediate Jeopardy. Where the department determines that a facility no longer meets the requirements of certification and further finds that the facility's

deficiencies immediately jeopardize the health or safety of its residents, the department shall:

- i. take immediate action to remove the jeopardy and correct the deficiencies through the appointment of temporary management; or
- ii. terminate the facility's participation under the state plan and may provide, in addition, any other remedies the department deems appropriate.

d. Non-immediate Jeopardy. If the facility's deficiencies do not immediately jeopardize the health or safety of its residents, the department may:

- i. terminate the facility's participation under the state plan;
- ii. provide for one or more of the remedies described in Authority and Scope of this Subchapter §10167; or
- iii. do both.

B. Notice and Appeal Procedure

1. Unless otherwise indicated, any sanction may be administratively appealed in the manner described as long as the appeal is timely filed following notice of the department's decision.

2. The Health Standards Section will notify the Office of Elderly Affairs State Ombudsman of all adverse actions taken against nursing facilities. If adverse actions result in an appeal hearing, the representative of the Office of State Ombudsman will attend and offer testimony if knowledgeable about the situation.

3. Notice to Facility of Violation. When the Department of Health and Hospitals has reasonable cause to believe through an on-site survey, a complaint investigation, or other means that there exists or has existed a threat to the health, safety, welfare, or rights of a nursing facility resident, the department shall give notice of the violation(s) in the following manner.

a. The head of the survey team shall conduct an exit conference and give the facility administrator or his designee the preliminary finding of fact and the possible violations before leaving the facility.

b. The department shall follow the discussion with confirmed written notice given by certified mail or hand delivery to the facility administrator. The written notice of deficiencies shall be consistent with the unresolved findings delivered at the exit conference.

- c. The written notice given by the department shall:
- i. specify the violation(s);
 - ii. cite the legal authority which established such violation(s);
 - iii. cite any sanctions assessed for each violation;
 - iv. inform the administrator that the facility has ten days from receipt of notice sent by certified mail or hand

delivery within which to request a reconsideration of the proposed agency action;

v. inform the administrator of the facility that the consequences of failing to timely request an administrative appeal will be that the departmental determination is final and no further administrative or judicial review may be had; and

vi. inform the administrator of the facility if the Department has elected to regard the violation(s) as repeat violation(s) or as continuing violation(s) and the manner in which sanctions will be imposed.

d. The Department of Health and Hospitals shall have the authority to determine whether a violation is a repeat violation and shall inform the facility in its notice of that determination. Violations may be considered repeat violations by the Department of Health and Hospitals if the following conditions are found to exist.

i. Where the Department of Health and Hospitals has established the existence of a violation as of a particular date and the violation is one that may be reasonably expected to continue until corrective action is taken, the department may elect to treat said continuing violation as a repeat violation subject to appropriate fines for each day following the date on which the initial violation is established, until such time as there is evidence establishing a date by which the violation was corrected.

ii. Where the Department of Health and Hospitals has established the existence of a violation and another violation occurs within 18 months which is the same or substantially similar to the previous violation, the subsequent violation and all other violations thereafter shall be considered repeat violations subject to fines and other Sanctions appropriate for repeat violations.

iii. If the facility does not request an administrative appeal in a timely manner or does not submit satisfactory evidence to rebut the department's findings of a violation, the secretary shall have the authority to enforce sanctions, as provided in these regulations. The Department of Health and Hospitals shall forward its findings to the facility by certified mail or hand delivery, and any sanctions imposed shall commence as of the date such determination is received by the facility. The department may institute all necessary civil court action to collect fines imposed and not timely appealed. No nursing facility may claim fines as reimbursable costs, nor increase charges to residents as a result of such fines. Interest shall begin to accrue at the current judicial rate on the day following the date on which any fines become due and payable.

iv. The facility may request an administrative reconsideration of the violation(s) within ten days of receipt of notice of the proposed agency action. This reconsideration shall be conducted by a designated official of the department who did not participate in the initial decision to impose the penalty. Reconsideration shall be made solely on the basis of documents before the official and shall include the survey report and statement of violations and all documentation the

facility submits to the department at the time of its request for reconsideration.

Correction of a violation shall not be a basis for reconsideration. A hearing shall not be held. Oral presentations can be made by Department spokesperson, facility spokesperson, and Elderly Affairs Representatives familiar with the facts and circumstances of the violation. The designated official shall have authority only to affirm the decision, to revoke the decision, to affirm in part and revoke in part, or to request additional information from either the department or the facility. The secretary or a designated official shall be without authority to waive any penalty or to compromise the dollar amount of any penalty unless part of the original decision is revoked. The official shall render a decision on the reconsideration within three days from the date of receipt of the facility's request.

e. If the facility requests an administrative appeal, such request shall:

i. state which violation(s) the facility contests and the specific reasons for disagreement; and

ii. be submitted to the Department of Health and Hospitals within 30 days of receipt of the secretary's decision on the final agency action by certified mail or hand delivery.

f. The administrative hearing shall be limited to those issues specifically contested and shall not include any claim or argument that the violation(s) have been corrected. Any violations not specifically contested shall become final, and sanctions shall be enforced at the expiration of the time for appeal. All violations/sanctions not contested shall become final at the expiration of the appeal request time period.

g. Administrative Appeal Process

i. Except as hereinafter provided, when an administrative appeal is requested in a timely and proper manner, the Department of Health and Hospitals shall provide an administrative hearing in accordance with the provisions of the Louisiana Administrative Procedure Act. Any party may appear and be heard at any proceeding described herein through an attorney at law or through a designated representative. A person appearing in a representative capacity shall file a written notice of appearance on behalf of the facility identifying himself by name, address, and telephone number, and identifying the party represented, and shall have a written authorization to appear on behalf of the facility.

ii. The administrative law judge conducting the hearing may require the prevailing of any motions by either party no later than the close of business on the third working day prior to the hearing.

iii. When the violation(s) jeopardize the health, safety, rights, or welfare of the facility's residents, the requested hearing shall be held within 14 days of the receipt of the request. The administrative law judge shall review all relevant evidence and make a final written determination within six days after the administrative hearing.

iv. In all other cases, the requested hearing shall be held within 30 days of the receipt of the request. The administrative law judge shall review all relevant evidence and make a final written determination within 15 days after the administrative hearing.

v. The administrative law judge may assess attorney's fees and costs against the facility if it is determined that the facility's appeal was frivolous.

vi. Although not specifically required for an administrative hearing, the Administrative law judge may schedule a preliminary conference.

h. The purposes of the preliminary conference, if scheduled, include but are not limited to the following:

- i. clarification, formulation and simplification of issue(s);
- ii. resolution of matters in controversy;
- iii. exchange of documents and information;
- iv. stipulations of fact so as to avoid unnecessary introduction of evidence at the formal review;
- v. the identification of witnesses; and
- vi. such other matters as may aid disposition of the issues.

(a). When the administrative law judge schedules a preliminary conference, (s)he shall notify all parties in writing. The notice shall direct any parties and their attorneys to appear at a specified date, time, and place.

(b). Where the preliminary conference resolves all or some matters in controversy, a summary of the findings agreed to at the conference shall be provided by the administrative law judge. Where the preliminary conference does not resolve all matters in controversy, an administrative hearing shall be scheduled on those matters still in controversy. The hearing shall be scheduled to conform to these procedures on those matters still in controversy.

(c). When an administrative hearing is scheduled, the administrative law judge shall notify the facility and/or its attorney and the agency representative in writing of the date, time, and place of the hearing. Notice shall be mailed not less than 10 calendar days before the scheduled date of the hearing.

h. Hearing Procedures

i. The administrative appeal hearing shall be conducted by an administrative law judge from the Appeals Section.

ii. Testimony shall be taken only on oath, affirmation, or penalty of perjury.

iii. Each party shall have the right to call and examine parties and witnesses, to introduce exhibits, to question opposing witnesses and parties on any matter relevant to the issue even though the matter was not covered in the direct examination, to impeach any witness regardless

of which party first called him to testify, and to rebut the evidence against him.

iv. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs regardless of the existence of any common law or statutory rule which might make improper the admission of such evidence over objection in civil or criminal actions. Documentary evidence may be received in the form of copies or excerpts.

v. The administrative law judge may question any party or witness and may admit any relevant and material evidence.

vi. The administrative law judge shall control the taking of evidence in a manner best suited to ascertain the facts and safeguard the rights of the parties. Prior to taking evidence, the administrative law judge shall explain the issues and the order in which evidence will be received.

vii. A party has the burden of proving whatever facts it must establish to sustain its position.

viii. The burden of producing evidence as to a particular fact is on the party against whom a finding on that fact would be required in the absence of further evidence.

ix. Each party shall arrange for the presence of their witnesses at the hearing.

x. A subpoena to compel the attendance of a witness may be issued by the Administrative law judge upon written request by a party and showing of the need therefore. A subpoena may be issued by the administrative law judge on his own motion.

xi. An application for subpoena duces tecum for the production by a witness of books, papers, correspondence, memoranda, or other records shall be made in writing to the administrative law judge, giving the name and address of the person or entity upon whom the subpoena is to be served. The application shall precisely describe the material that is desired to be produced and shall state the materiality thereof to the issue involved in the proceeding. It shall also include a statement, that to the best of the applicant's knowledge, the witness has such items in his possession or under his control.

xii. The administrative law judge may continue the matter when such continuance will not jeopardize the health, safety, rights, or welfare of the facility's residents.

xiii. The administrative law judge may continue a hearing to another time or place, or order a further hearing on his own motion or upon showing of good cause, at the request of any party, provided that the time limits by the Administrative Appeal Process in this subchapter §10167 are met.

xiv. Where the administrative law judge determines that additional evidence is necessary for the proper determination of the case, he may at his discretion:

(a). continue the hearing to a later date and order the party to produce additional evidence; or

(b). close the hearing and hold the record open in order to permit the introduction of additional documentary evidence. Any evidence so submitted shall be made available to both parties and each party shall have the opportunity for rebuttal.

xv. Written notice of the time and place of a continued or further hearing shall be given except that when a continuance of further hearing is ordered during a hearing, oral notice of the time and place of the hearing may be given to each party present at the hearing.

xvi. A sound recording of the hearing shall be made. A transcript will be prepared and reproduced at the request of a party to the hearing provided he bears the cost of the copy of the transcript.

xvii. At the conclusion of the hearing, the administrative law judge shall take the matter under submission. The administrative law judge shall prepare a written proposed decision to the Secretary of the Department of Health and Hospitals which will contain findings of fact, a determination of the issues presented, a citation of applicable policy and regulations, and an order.

xviii. The administrative law judge shall make specific written findings as to each violation that was contested by the facility. The administrative law judge shall have authority to affirm, reverse, or modify the findings or penalties of the department. The administrative law judge shall transmit such findings by certified mail or hand delivery to the facility at the last known address within time periods stated above in Administrative Appeal Process and by regular mail or hand delivery to the Department and other affected parties. Any civil fines assessed shall commence as of the date findings are received by the facility. Interest on the amount of the fines assessed shall begin accruing on the eleventh day following commencement of the fines at the then current rate of judicial interest.

xix. If a facility representative fails to appear at a hearing, a decision may be issued by the administrative law judge dismissing the appeal hearing and making the departmental findings final. A copy of the decision shall be mailed to each party.

x. Any dismissal may be rescinded upon order of the administrative law judge if the facility's representative makes written application within 10 calendar days after mailing of the dismissal, provides evidence of good cause for his failure to appear at the hearing, and no delay beyond the time limits as indicated in this Subchapter, §10167 under Administrative Appeal Process results.

i. Judicial Review

i. If the results of the administrative hearings are adverse to the facility, the facility may request a judicial review of such matters to the Nineteenth Judicial District Court within 15 days of receipt of such findings. Such appeal shall be suspensive.

ii. The facility shall furnish with the appeal, a bond in the minimum amount of one and one-half times the amount of the fine imposed by the Department of Health and Hospitals. The bond furnished shall provide in substance that it is furnished as security that the facility will prosecute its appeal, that any judgment against it including court costs, will be paid or satisfied from the amount furnished, or that otherwise the surety is liable for the amount assessed against the facility.

iii. The appeal shall be heard in a summary proceeding.

iv. At the conclusion of the judicial review, any party aggrieved by the decision may seek further appeals as authorized by law.

C. Description of Sanctions

1. Monitoring On-Site. In the case of a nursing facility which, on three consecutive standard surveys conducted, has been found to have provided substandard quality of care, the state shall (regardless of what other remedies are provided):

a. impose the denial of payment for new admissions; and

b. monitor the facility until the facility has demonstrated to the satisfaction of the state, that it is in compliance with the requirements and that it will remain in compliance with such requirements. The department shall monitor, on-site, on a regular, as needed basis, a nursing facility's compliance with the requirements if:

i. the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

ii. the facility was previously found not to be in compliance with such requirements, has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

iii. the state has reason to question the compliance of the facility with such requirements.

c. The department may monitor conditions while improvements are being made or while the facility is being closed. Monitoring can include:

i. periodic unannounced site visits by a surveyor during the period of the day where care is most compromised (e.g. during the medication administration or during the meal service); or

ii. on-site full time monitoring by surveyors on shifts on 8-12 hours to observe all phases of operation of the facility.

d. The state may maintain and utilize a specialized team (including an attorney, an auditor, and appropriate health care professionals) for the purpose of identifying, surveying, gathering and preserving evidence, and carrying out appropriate enforcement actions against chronically substandard nursing facilities.

NOTE: The notice and appeal procedures previously described in this Subchapter, §10167 apply.

2. **Specific Staffing Requirements.** When there is a breakdown in the care and services at a facility and the efforts of the facility have not been successful in correcting these deficiencies, the department may require special staffing on the part of the facility paid for by the facility. This could include (though it is not limited to) a consultant on resident assessments or care planning, an additional licensed nurse to provide treatments, a consultant dietician, a consultant pharmacist, or medical records practitioner. Any special staffing shall be in addition to the staff already hired. The special staffing shall be time limited and shall be clearly outlined in a letter from the secretary or the designee.

a. The notice and appeal procedures described previously in this Subchapter, §10167 shall apply.

3. **Civil Money Penalties (Fines).** The following listed civil fines pertaining to classified violations may be assessed by the secretary against nursing facilities. In the case of Class A violations, the following civil fines shall be assessed. In the cases of Class B, C, D, or E violations, the Secretary, in his discretion, may elect to assess the following civil fines or may allow a specified period of time for correction of said violation. For Class D and E violations, the facility will be given notice of the fine at the time of the first violation and may be given an opportunity to demonstrate compliance before the fine becomes final. If compliance is demonstrated on the follow-up visit, payment of fine may be waived. In all instances the violation is counted and recorded. If compliance is not demonstrated at the next visit, the penalty for a repeat violation will be assessed. No facility shall be penalized because of a physician's or consultant's non-performance beyond the facility's control or if the violation is beyond the facility's control, if the situation and the efforts to correct it are clearly documented. It is not the intent that every violation found on a survey, inspection, or related visit should be accompanied by an administrative penalty.

a. **Class A Violations.** Class A violations are subject to a civil fine which shall not exceed \$2,500.00 for the first violation. A second Class A violation occurring within an 18 month period from the first violation shall not exceed \$5,000.00 per day. The third Class A violation shall result in proceedings being commenced for termination of the facility's Medicaid agreement and may result in proceedings being commenced for revocation of licensure of the facility.

b. **Class B Violations.** Class B violations are subject to a civil fine which shall not exceed \$1,500.00 for the first violation. A second Class B violation occurring within an 18 month period from the first violation shall not exceed \$3,000.00 per day. The third Class B violation shall result in proceedings being commenced for termination of the facility's Medicaid agreement and may result in proceedings being commenced for revocation of licensure of the facility.

c. **Class C Violations.** Class C violations are subject to a civil fine which shall not exceed \$1,000.00 for the first violation. A second Class C violation occurring within an 18

month period from the first violation shall not exceed \$2,000.00 per day. The third Class C violation shall result in proceedings being commenced for termination of the facility's Medicaid agreement and may result in proceedings being commenced for revocation of licensure of the facility.

d. **Class D Violations.** Class D violations are subject to a civil fine which shall not exceed \$100 for the first violation. Each subsequent Class D violation within an 18 month period from the first violation shall not exceed \$250 per day.

e. **Class E Violations.** Class E violations are subject to a civil fine which shall not exceed \$500 for the first violation. Each subsequent Class E violation occurring within an 18 month period from the first violation shall not exceed \$100 per day.

i. The total amount of fines assessed for violations determined in any one month shall not exceed \$5,000.00, except that the aggregate fines assessed for Class A or B violations shall not exceed \$10,000.00 in any one month.

f. **Factors in Assessment of Civil Fines.** In determining whether a civil fine is to be assessed and in affixing the amount of the fine to be imposed, the secretary shall consider:

i. the gravity of the violation including the probability that death or serious physical harm to a resident will result or has resulted;

ii. the severity and scope of the actual or potential harm;

iii. the extent to which the provisions of the applicable statutes or regulations were violated;

iv. the "good faith" exercised by the licensee. Indications of good faith include, but are not limited to:

(a) prior accomplishments manifesting the licensee's desire to comply with requirements;

(b) efforts to correct; and

(c) any other mitigating factors in favor of the licensee;

v. any relevant previous violations committed by the licensee.

vi. the financial benefit to the licensee of committing of continuing the violation;

vii. approved waivers.

g. **Right to Assess Civil Fines Not Merged In Other Remedies.** Assessment of a civil fine provided by this section shall not affect the right of the Department of Health and Hospitals to take such other action as may be authorized by law or regulation.

D. Classes of Violations Defined

1. **Class A Violations.** Those violations which create a condition or occurrence relating to the operation and

maintenance of a nursing facility which result in death or serious harm to a resident.

2. The following examples of Class A violations are provided for illustrative purposes only and are subject to the conditions outlined in Subchapter L, Sanctions.

a. Death of a Resident. Any condition or occurrence relating to the operation of a nursing facility in which the conduct, act, or omission of a person or actor purposely, knowingly, or negligently results in the death of a resident shall be a Class A violation.

b. Serious Physical Harm to a Resident. Any condition or occurrence relating to the operation of a nursing facility in which the conduct, act, or omission of a person or actor purposely, knowingly, or negligently results in serious physical harm to a resident shall be a Class A violation.

NOTE: The above examples of Class A violations are provided for illustrative purposes only.

3. Class B Violations. Those violations which create a condition or occurrence relating to the operation and maintenance of a nursing facility which create a substantial probability that death or serious physical harm to a resident will result from the violation.

4. The following examples of Class B violations are provided for illustrative purposes only and are subject to the conditions outlined in Subchapter L, Sanctions.

5. The following conduct, acts, or omissions, which do not result in death or serious physical harm but which create a substantial probability that death or serious physical harm to a resident will result therefrom, are conditions or occurrences relating to the operation of a nursing facility and are Class B violations:

a. Nursing Techniques. A Class B violation shall exist when good nursing practice is not exercised and this results in the following occurrences:

i. medications or treatments are improperly administered or withheld by nursing personnel;

ii. there is a failure to adequately and appropriately feed residents who are unable to feed themselves or there is use of specialized feeding equipment or substances which are outdated, not protected from contamination, or incorrectly used;

iii. there is a failure to change or irrigate catheters as ordered by a physician or there is use of irrigation sets or solutions which are outdated or not protected from contamination;

iv. there is a failure to obtain physician orders for the use, type, and duration of restraints or physical restraints are improperly applied or facility personnel fail to check and release restraint as specified in regulations;

v. staff knowingly fails to answer call lights;

vi. there is a failure to turn or reposition as ordered by a physician or as specified in regulations;

vii. there is a failure to provide rehabilitative nursing as ordered by a physician or as specified in regulations.

b. Poisonous Substances. A Class B violation shall exist when a facility fails to provide proper storage of poisonous substances.

c. Falls by Residents. A Class B violation shall exist when a facility fails to maintain required direct care staffing, follow physician's orders, provide a safe environment, or address a history of falls on a resident's care plan, and this failure directly causes a fall by a resident. (Examples: Equipment not properly maintained or a fall due to personnel not responding to a resident's request for assistance.)

d. Assaults. A Class B violation shall exist when a facility fails to maintain required direct care staffing, adequately trained staff, or take appropriate measures when it is known that a resident is combative or assaultive with other residents, and this failure causes an assault upon a resident of the facility by another resident. A Class B violation shall also exist when a facility fails to perform adequate screening of personnel and this failure causes an assault upon a resident by an employee of the facility.

e. Permanent Injury to a Resident. A Class B violation shall exist when facility personnel improperly apply physical restraints as directed by physician's orders or regulations and this failure causes permanent injury to a resident.

f. Nosocomial Infection. A Class B violation shall exist when a facility does not follow or meet nosocomial infection control standards as outlined by regulations or as ordered by the physician.

g. Medical Services. A Class B violation shall exist when a facility fails to secure proper medical assistance or orders from a physician and this creates the probability of death or serious harm of a resident.

h. Decubitus Ulcers. A Class B violation shall exist when a facility does not take decubitus ulcer measures as ordered by the physician or facility personnel fail to notify the physician of the existence or change in the condition of such ulcers and such failure creates a probability of death or serious physical harm of a resident.

i. Treatments. A Class B violation shall exist when facility personnel performs treatment(s) contrary to a physician's order or fail to perform such treatments and such treatment creates the probability of death or serious physical harm of a resident.

j. Medications. A Class B violation shall exist when facility personnel knowingly withhold medication from a resident as ordered by a physician and such withholding of medication(s) creates the probability of death or serious injury of a resident, or facility personnel fails to order and/or stock medication(s) prescribed by the physician and the failure to order and/or stock medication(s) creates a probability of death or serious harm of a resident.

k. **Elopement.** A Class B violation shall exist when a facility does not provide reasonable supervision of residents to prevent a resident from wandering away from the facility and such failure creates the probability of death or serious harm to a resident, or a facility does not provide adequate measures to ensure that residents with an elopement history do not wander away from the facility. (Examples of preventive measures include but are not limited to documentation that an elopement history has been discussed with the family or other caretaker of the resident, alarms have been placed on exit doors, personnel have been trained to make additional effort to watch the resident with such history, and the physician of such resident has been made aware of such history.)

l. **Failure to Provide Heating or Air Conditioning.** A Class B violation shall exist when a facility fails to reasonably maintain its heating and air conditioning system as required by regulation. Isolated incidents of breakdown or power failure shall not be considered Class B violations under this section.

m. **Natural Disaster/Fire.** A Class B violation shall exist when a facility does not train staff in fire/disaster procedures as required by regulations or when staffing requirements are not met.

n. **Life Safety Code System.** A Class B violation shall exist when a facility fails to maintain the required life safety code system. Isolated incidents of breakdown shall not be considered a Class B violation if the facility has immediately notified the Health Standards Section upon discovery of the problem and has taken all necessary measures to correct the problem.

o. **Nursing Equipment/Supplies.** A Class B violation shall exist if equipment and supplies to care for a resident as ordered by a physician are not provided, or if the facility does not have sufficient equipment and supplies for residents as specified by regulation and these conditions create a probability of death or serious harm to a resident.

p. **Call System.** A Class B violation shall exist when a facility fails to maintain a resident call system or the call system is not functioning for a period of more than 24 hours. If call system cords are not kept within reach of residents then it will be determined that the facility has failed to maintain a resident call system and this failure creates a probability of death or serious physical harm to a resident.

NOTE: The above examples of Class B violations are provided for illustrative purposes only.

6. **Class C Violations -** The following conduct, acts, or omissions which do not result in death or serious physical harm to a resident or the substantial probability thereof but create a condition or occurrence relating to the operation and maintenance of a nursing home facility that create a potential for harm by directly threatening the health, safety, rights or welfare of a resident are Class C violations.

NOTE: The following examples of Class C violations are provided for illustrative purposes only and are subject to the conditions outlined in Subchapter L.

a. **Nursing Techniques.** A Class C violation shall exist when good nursing practice is not exercised and this results in the following occurrences:

i. medications or treatments are improperly administered or withheld by nursing personnel;

ii. there is a failure to adequately and appropriately feed residents who are unable to feed themselves or there is use of specialized feeding equipment and substances which are outdated, not protected from contamination or incorrectly used;

iii. there is a failure to change or irrigate catheters as ordered by a physician or there is use of irrigation sets and solutions which are outdated or not protected from contamination;

iv. there is a failure to obtain physician orders for the use, type, and duration of restraints, or physical restraints are improperly applied, or facility personnel fail to check and release the restraint as specified in regulations;

v. staff knowingly fails to answer call lights;

vi. there is a failure to turn or reposition residents as ordered by a physician or as specified in regulations; and

vii. there is a failure to provide rehabilitative nursing as ordered by a physician or as specified in regulations.

b. **Poisonous Substances.** A Class C violation shall exist when a facility fails to provide proper storage of poisonous substances and this failure threatens the health, safety, rights or welfare of a resident.

c. **Falls by Residents.** A Class C violation shall exist when it is determined that falls may occur in a facility as a result of the facility's failure to maintain required direct care staffing or a safe environment (including adequate training of staff) as set forth in regulation and this failure threatens the health, safety, rights, or welfare of a resident.

d. **Assaults.** A Class C violation shall exist when a facility fails to maintain required direct care staffing or measures are not taken when it is known that a resident is combative and assaultive with other residents and this lack threatens the health, welfare, rights, or safety of a resident.

e. **Improper Use of Restraints.** A Class C violation shall exist when facility personnel apply physical restraints contrary to published regulations or fail to check and release such restraints as directed by physician's order or regulations and such failure threatens the health, safety, rights, or welfare of a resident.

f. **Medical Services.** A Class C violation shall exist when a facility fails to secure proper medical assistance or orders from a physician and this failure threatens the health, safety, rights or welfare of a resident.

g. **Decubitus Ulcers.** A Class C violation shall exist when a facility does not take decubitus ulcer measures as ordered by the physician and this failure threatens the health, safety, rights or welfare of a resident, or facility personnel

fail to notify the physician of such ulcers or change in a resident's condition with regard to decubitus ulcers and this failure threatens the health, safety, rights or welfare of a resident.

h. Treatments. A Class C violation shall exist when facility personnel perform treatments contrary to physician's order or fail to perform such treatments and such treatment threatens the health, safety, rights, or welfare of a resident.

i. Medications. A Class C violation shall exist when facility personnel withhold physician ordered medication(s) from a resident and such withholding threatens the health, safety, rights, or welfare of a resident, or facility personnel fail to order or stock medication(s) prescribed by the physician and this failure threatens the health, safety, rights, or welfare of a resident.

j. Elopement. A Class C violation shall exist when a facility does not provide reasonable supervision of residents to prevent a resident from wandering away from the facility and such failure threatens the health, safety, rights, or welfare of a resident, or a facility does not provide adequate measures to ensure that residents with a history of elopement do not wander away from the facility and such failure threatens the health, safety, rights, or welfare of a resident.

k. Food on Hand. A Class C violation shall exist when there is an insufficient amount of food on hand in the facility to meet the menus for the next three-day period and this failure threatens the health, safety, rights, or welfare of a resident.

l. Nursing Equipment/Supplies. A Class C violation shall exist if equipment and supplies to care for a resident as ordered by a physician are not provided, or if the facility does not have sufficient equipment and supplies for residents as specified by regulation and these conditions threaten the health, safety, rights, or welfare of a resident.

m. Call System. A Class C violation shall exist when a facility fails to maintain a resident call system or the call system is not functioning for a period of 24 hours. If call system cords are not kept within reach of residents then it will be determined that the facility has failed to maintain a resident call system and this failure threatens the health, safety, rights, or welfare of a resident.

n. Heating and Air Conditioning. A Class C violation shall exist when a facility fails to maintain its heating and air conditioning systems as required by regulation and such failure threatens the health, safety, rights, or welfare of a resident. Isolated incidents of breakdown or power failure shall not be considered a Class C violation under this Section.

o. Natural Disaster/Fire. A Class C violation shall exist when a facility does not train staff in fire/disaster procedures as required by regulations or when staffing requirements are not met and this failure threatens the health, safety, rights, or welfare of a resident.

p. Life Safety Code System. A Class C violation shall exist when a facility fails to maintain the required life safety systems and this threatens the health, safety, rights or welfare of a resident. Isolated incidents of breakdown shall not be considered a Class C violation if the facility has immediately notified the Health Standards Section upon discovery of the problem and has taken all necessary measures to correct the problem.

r. Dietary Allowance. A Class C violation shall exist when it is determined that the minimum dietary needs of a resident are not being met as ordered by the physician.

s. Resident Rights. A Class C violation shall exist when facility personnel fails to inform a resident of his Resident Rights as outlined in regulation, or facility personnel fail to allow a resident to honor or exercise any of his rights as outlined in regulation or statute.

t. Sanitation. A Class C violation shall exist when it is determined that regulations relating to sanitation are not met.

u. Administrator. A Class C violation shall exist when it is determined that a facility does not have a licensed administrator for 30 or more consecutive days as required by regulation.

v. Director of Nurses. A Class C violation shall exist when it is determined that a facility does not have a director of nurses (DON) as required by regulation for 30 or more consecutive days unless a waiver has been granted by the department.

w. Notice of Staff Vacancy. A Class C violation shall exist when it is determined that a facility does not have a licensed administrator or a Director of Nurses and has not notified the bureau within ten days as required by regulation.

NOTE: The examples above of Class C violations are provided for illustrative purposes only.

7. Class D Violations. Those violations which are related to administrative and reporting requirements that do not directly threaten the health, safety, rights, or welfare of a resident.

NOTE: The following examples of Class D violations are provided for illustrative purposes only and are subject to the conditions outlined in subchapter L.

a. Overbedding. A Class D violation shall exist when a facility is found to exceed its licensed bed capacity.

b. False Reporting. A Class D violation shall exist when it has been determined that a report, physician's orders, nurses' notes, patient account records, staffing records, or other documents or records which the facility is required to maintain have been intentionally falsified.

c. Resident Trust Funds. A Class D violation shall exist when it is determined that the facility's records reflect that resident trust funds have been misappropriated by facility personnel or if a resident has been charged for items which the facility must provide at no cost to the resident.

d. Denial of Access of Facility. A Class D violation shall exist when it is determined that personnel from the Louisiana Department of Health and Hospitals, the United States Department of Health and Human Services, or personnel of any other agency authorized to have access to any nursing facility have been denied access to the facility or to any facility document record.

e. Reporting of Unusual Occurrences/ Accidents .A Class D violation shall exist when it has been determined that a facility did not report any unusual occurrences or accidents in a timely manner as mandated by regulation.

f. Residents' Council. A Class D violation shall exist when a facility fails to allow a resident access to an established Residents' Council if one exists.

NOTE: The examples above of Class D violations are provided for illustrative purposes only.

8. Class E Violations. Class E violations are defined as the failure of any nursing facility to submit a statistical or financial report in a timely manner as required by regulations. The failure to timely submit a statistical or financial report shall be considered a separate Class E violation during any month or part thereof in non-compliance.

NOTE: In addition to any civil fine which may be imposed, the director is authorized after the first month of a Class E violation to withhold any further reimbursement to the facility until the statistical or financial report is received by the Bureau of Health Services Financing.

E. Collection of Civil Fines Assessed. Civil fines assessed shall be final if:

1. no timely or proper appeal was requested;
2. the facility admits the violations and agrees to pay; and
3. the administrative hearing is concluded with findings of violations and time for seeking judicial review has expired.
 - a. When civil fines become final, they shall be paid in full within ten days of their commencement unless the department allows a payment schedule in light of a documented financial hardship. Such documentation shall be submitted within the ten-day period.
 - b. If payment of assessed civil fines is not received or security not posted within ten days after they are deemed final, the Department of Health and Hospitals shall deduct the full amount plus interest from money otherwise due to the facility as Medicaid reimbursement in its next (quarterly or monthly) payment.
 - c. No nursing facility may claim imposed fines as reimbursable costs, nor increase charges to residents as a result of such fines. Any audits performed by the Department of Health and Hospitals shall monitor this prohibition.

F. Denial of Medicaid Payments For All New Admissions

1. Mandatory Denial. In the case of a nursing facility which no longer meets the requirements, the state shall, regardless of what other remedies are provided:

- a. impose the denial of payment; and
- b. monitor the facility;

i. denial of payment applies to any individual admitted to the nursing facility involved after such notice to the public and to the facility as may be provided for by the state.

2. Agency Procedures. Before denying payments for new admissions, the agency must comply with the following requirements:

a. Provide the facility up to 60 days to correct the cited deficiencies and comply with the requirements (for SNFs and NFs);

b. If at the end of the specified period, the facility has not achieved compliance, give the facility notice of intent to deny payment for new admissions, and opportunity for an informal hearing.

NOTE: If the facility requests a hearing, see §10167, Notice and Appeal Procedure, of this Chapter.

3. Effect of Sanction on Status of Residents

a. The resident's status at the effective date of the denial of payment is the controlling factor in determining whether or not residents are subject to the denial of payment, if readmitted.

b. Residents admitted and discharged before the effective date of the denial of payment are considered new admissions, if readmitted, and are subject to the denial of payment.

c. Residents admitted on or after and discharged after the effective date of the denial of payment are considered new admissions if readmitted, and are subject to the denial of payment.

d. Residents admitted before and discharged on or after the effective date of the denial of payment are not considered new admissions if readmitted, and are not subject to the denial of payment.

e. Residents admitted before the effective date of the denial of payment and taking temporary leave, before, on, or after the effective date of the denial of payment are not considered new admissions upon return and thereafter, are not subject to the denial of payment.

f. Residents admitted on or after the effective date of the denial of payment and taking temporary leave, are not considered new admissions, but continue to be subject to the denial of payment.

4. Duration

a. The denial shall remain in effect until the Department determines the NF is in substantial compliance with requirements.

b. Notification to the provider and the appeal procedure is described in this chapter under Notice and Appeal Procedure.

c. Notification to the public shall be in the newspaper of widest circulation in the area.

G. Withholding of Vendor Payments. The Department of Health and Hospitals may withhold Medicaid vendor payments in whole or in part in the following situations, which are not all inclusive.

1. Incorrect/Inappropriate Charges. When the Department of Health and Hospitals determines that a Nursing Facility has incorrectly or inappropriately charged residents or responsible parties or there has been misapplication of resident funds, a sum not to exceed the inappropriate charges or misapplied funds may be withheld until the provider does the following:

- a. makes restitution; and
- b. submits documentation of such restitution to the Department of Health and Hospitals.

2. Inadequate Review/Revision of Plan of Care. When a Nursing Facility repeatedly fails to ensure that an adequate plan of care for a resident is reviewed and revised at least at required intervals, the vendor payment may be withheld or recouped until such time as compliance is achieved.

3. Corrective Action on Complaints. When a facility fails to submit an adequate corrective plan in response to a complaint within seven days after receiving the complaint report, vendor payments may be withheld until an adequate corrective plan is received unless the time limit is extended by the Bureau of Health Services Financing or an administrative reconsideration or appeal is timely filed.

4. Unapproved Staffing Shortage. When a survey report indicates an unapproved staffing shortage, vendor payments may be withheld until such time as staffing is brought into compliance.

5. Corrective Action for Audit Findings. When a facility fails to submit corrective action in response to financial and compliance audit findings within 15 days after receiving the notification letter, vendor payments may be withheld until such time as compliance is achieved.

6. Request for Information. When a facility fails to respond satisfactorily to requests for information within 15 days after receiving the department's letter, vendor payments may be withheld until such time the information is received by the department.

7. Unauditable Records. When the department's auditors determine that a facility's records are unauditable, vendor payment shall be withheld as determined by the department.

8. Full Scope Audits. When the department's limited scope audit of the Residents' Personal Funds Account indicates a material number of transactions were not sufficiently supported, the department shall initiate a full

scope audit of the account and the costs of the audit shall be withheld from the facility's monthly vendor payment.

NOTE: The Notice and Appeal procedures in this Subchapter apply.

H. Temporary Management

1. Regulatory Citation. Section 1919(h)(2)(A)(iii) of the Social Security Act requires the appointment of temporary management to oversee the operation of the facility and to assure the health and safety of the facility's residents.

2. Application. Immediately effective temporary management is appropriate while:

a. the facility is operating without a current Louisiana license;

b. the licensee has abandoned the facility;

c. the nursing facility is closing within 30 calendar days and the Department of Health and Hospitals has reasonable cause to believe that inadequate arrangements designed to minimize the adverse effects of transfer have been made to relocate its residents;

d. a condition or practice in a facility poses a serious and imminent threat to the health, safety, or welfare of the residents or presents a substantial probability that death or serious physical harm would result therefrom. In such instance the facility owner may request approval from the secretary to be put on 23-day fast track in lieu of temporary management. However, such request may only be granted when the Secretary determines that an adequate plan to protect the health, safety, and welfare of residents has been devised by the facility to prevent an imminent threat of harm to the facility's residents and when the secretary has provided satisfactory means for the department to monitor subsequent implementation of such corrective measures by the facility.

i. Appointment of a temporary manager based on one or more of the following grounds shall become effective only upon the later of the expiration of the period for seeking appeal or upon the entry of a final administrative determination by the Department of Health and Hospitals or a hearing officer.

(a). The nursing facility exhibits a consistent pattern of violating residents' rights established pursuant to Louisiana or federal laws or regulations.

(b). The nursing facility is experiencing financial difficulties that present a substantial probability the facility will be compelled to terminate operation.

3. Notice of Appointment of Temporary Manager. When the Secretary of the Department of Health and Hospitals determines that a nursing facility is in need of a temporary manager, he shall provide written notice which shall include:

a. the date the appointment shall take effect;

b. a statement setting forth grounds for the appointment;

c. The name of the person within the Department of Health and Hospitals who has the responsibility for responding to inquiries about the appointment;

d. The name of the person appointed temporary manager, if such designation has been made;

e. A statement explaining the procedure for requesting a hearing.

NOTE: Notice shall be delivered by hand or by certified mail to the owner and administrator of a nursing facility.

4. Powers and Duties of Temporary Manager. The licensee and administrator shall be divested of administration of the nursing facility in favor of the temporary manager from the effective date of appointment.

a. The temporary manager shall have the following powers and duties:

i. exercise those powers and perform those duties set out by the Department of Health and Hospitals in accordance with these and any other applicable provisions;

ii. operate the nursing facility in such a manner as to assure safety and adequate health care for the residents;

iii. take such action as is reasonably necessary to protect or conserve the assets or property of the facility for which the temporary manager is appointed, or the proceeds from any transfer thereof, and use them only in the performance of authorized powers and duties;

iv. use the building, fixtures, furnishings, and any accompanying consumable goods in the provision of care and services to residents and to any other persons receiving services from the nursing facility;

v. Collect payments for all goods and services provided to residents or others during the period of the temporary management at the same rate of payment charged by the owners at the time the temporary manager was appointed or at a fair and reasonable rate as otherwise approved by the Department of Health and Hospitals;

vi. correct or eliminate any deficiency in the structure or furnishings of the nursing facility which endanger the safety, health, or welfare of residents, provided the total cost of correction does not exceed \$5,000. The Department of Health and Hospitals may order expenditures for this purpose in excess of \$5,000 on application from the temporary manager after notice to the owner and an opportunity for informal hearing by the secretary or his designee to determine the reasonableness of the expenditures;

vii. let contracts and hire employees at rates reasonable in the community to carry out the powers and duties of the temporary management;

viii. honor all leases, mortgages, and secured transactions governing the building in which the nursing facility is located and all goods and fixtures in the building

of which the temporary manager has taken possession, but only to the extent of payments which, in the case of a rental agreement, are for the use of the property during the period of temporary management, or which, in the case of a purchase agreement, become due during that same period;

ix. have full power to direct, manage, and discipline employees of the nursing facility, subject to any contract rights they have. The temporary manager shall not discharge employees without authorization from the Department of Health and Hospitals and notice to the owner. Temporary management shall not relieve the owner of any obligation to employees made prior to the appointment of a temporary manager and not carried out by the temporary manager;

x. preserve all property or assets of residents which are in the possession of a nursing facility or its owner; preserve all property or assets and all resident records of which the temporary manager takes possession; and provide for the prompt transfer of the property, assets, and records to the new placement of any transferred resident. An inventory list certified by the owner and temporary manager shall be made at the time the temporary manager takes possession of the nursing facility.

5. Procedure for Payments to Temporary Manager of Debts Owed to the Facility

a. As soon as possible after the effective date of appointment of the temporary manager but in no event later than ten days thereafter, the owner and administrator shall inform the temporary manager of the names and addresses of all persons owing money to the facility and of the amounts owed.

b. The temporary manager shall be the proper recipient of all funds due and owing to the facility from and after the effective date of appointment regardless of whether such funds are for goods or services rendered before or after the effective date of appointment, and the owner and administrator shall immediately transfer to the temporary manager any such funds received by either of them after the effective date of appointment.

c. The temporary manager shall notify persons making payments to the facility of the appointment of a temporary manager.

d. A person who is notified of the Department of Health and Hospital's appointment of a temporary manager and of the temporary manager's name and address shall be liable to pay the temporary manager for any goods or services provided by the temporary manager after the date of the appointment, if the person would have been liable for the goods and services as supplied by the owner.

e. The temporary manager shall give a receipt for each payment and shall keep a copy of each receipt on file.

f. The temporary manager shall deposit amounts received in a separate account and may make disbursements from such account. The temporary manager may bring an

action to enforce liabilities created by the foregoing provisions.

g. A payment to the temporary manager of any sum owing to the nursing facility or to its owner shall discharge any obligation to the nursing facility to the extent of the payment.

6. Qualifications and Compensation of a Temporary Manager

a. The Department of Health and Hospitals shall appoint to serve as a temporary manager any person qualified by education and the requisite experience in nursing home administration and who is licensed in accordance with Louisiana law.

b. A temporary manager shall have no financial or fiduciary interest in the facility or any affiliated entities. No temporary manager shall be appointed who is affiliated with a management firm under an order of decertification in Louisiana or another state.

c. The Department of Health and Hospitals shall set the necessary expense of the temporary management. Said compensation shall be in line with the prevailing wage in the nursing home field and shall be charged as an expense to the facility for which the manager is appointed. The department may seek reimbursement for such expenses by deducting the appropriate amount from funds due or payable to the facility.

7. Personal Liability of the Temporary Manager

a. A temporary manager may be held liable in a personal capacity for the temporary manager's gross negligence, intentional acts, or breach of fiduciary duty, but otherwise, the acts and omissions of such temporary manager will be defended and discharged by the department.

b. The Department of Health and Hospitals shall secure a bond to cover any acts of negligence or mismanagement committed by the temporary manager when not covered by the facility's insurance.

8. Termination of Temporary Management. Temporary management shall be terminated when it is determined that:

a. the conditions which gave rise to the temporary management no longer exist; or

b. all of the Title XVIII (Medicare) and XIX (Medicaid) residents in the nursing facility have been transferred or discharged and the facility is no longer certified as a provider in the Medicare or Medicaid programs; or

c. the temporary manager has concluded all financial and patient care responsibilities, and

d. determination has been made that the party assuming responsibility for continued operation of the facility is capable of competently managing the facility in compliance with all requirements.

9. Notice of Appeal. Procedures described in the Notice and Appeal Procedure of this Subchapter §10167 shall apply.

I. Revocation of License

a. The Secretary of the Department of Health and Hospitals may deny an application for a license or refuse to renew a license or may revoke an outstanding license when an investigation reveals that the applicant or licensee is in non-conformance with or in violation of the provisions of R.S. 40:2009:6; provided that in all such cases, the Secretary shall furnish the applicant or licensee 30 calendar days written notice specifying reasons for the action.

b. The secretary, in a written notice of denial, non-renewal, or revocation of a license shall notify the applicant or licensee of his right to file a suspensive appeal with the Office of the Secretary within 30 calendar days from the date the notice, as described in this Subchapter §10167 in Notice and Appeal Procedure, is received by him. This appeal or request for a hearing shall specify in detail reasons why the appeal is lodged and why the appellant feels aggrieved by the action of the secretary.

c. When any appeal as described in the Notice and Appeal Procedure of this Subchapter is received by the secretary, if timely filed, he shall appoint an impartial three member board to conduct a hearing on the appeal at such time and place as such members deem proper, and after such hearing to render a written opinion on the issues presented at the hearing. The written decision or opinion of a majority of the members conducting the hearing shall constitute final administrative action on the appeal.

d. Any member of said board or the Secretary shall have power to administer oaths and to subpoena witnesses on behalf of the board or any party in interest and compel the production of books and papers pertinent to any investigation or hearing authorized by this subchapter, provided that in all cases witness fees and transportation and similar hearing costs shall be paid by the appellant or by the Department of Health and Hospitals if the appellant is found innocent of charges. Any person having been served with a subpoena who shall fail to appear in response to the subpoena or fail or refuse to answer any question or fail to produce any books or papers pertinent to any investigation or hearing or who shall knowingly give false testimony therein shall be guilty of a misdemeanor and shall upon conviction be punished by a fine of not less than one hundred dollars nor more than five hundred dollars or by imprisonment of not less than one month nor more than six months, or by both such fine and imprisonment.

J. Penalty for Falsification of Resident Assessment

1. An individual who willfully and knowingly certifies a material and false statement in a residents assessment is subject to a civil money penalty of not more than \$1,000.00 with respect to each assessment.

2. An individual who willfully and knowingly causes another individual to certify a material and false statement in

a resident assessment is subject to a civil penalty of not more than \$5,000.00 with respect to each assessment.

3. The notice and appeal procedures described previously apply.

K. Residents' Trust Fund

1. The Residents' Trust Fund, hereinafter referred to as the "trust fund" is hereby established in the Department of Health and Hospitals to receive monies collected from civil fines levied against nursing homes found to have been in violation of regulations of the department. Monies deposited in the trust fund shall be used to support social welfare programs for the aid and support of the needy residents of nursing homes, and to achieve that purpose the department is hereby authorized to enter into cooperative endeavor agreements with public and private entities. The monies deposited shall be segregated from other funds of the State or the department and shall be designated exclusively for the uses and purposes of this section. All monies of the Trust Fund shall be deposited in an interest bearing account under the supervision of the State Treasurer. Interest on these monies shall be retained in the trust fund.

2. The monies in the trust fund may be used for the following purposes:

- a. to protect the health or property of residents of nursing homes which the department finds deficient;
- b. to pay for the cost of relocation of residents to other facilities;
- c. to maintain operation of a facility pending correction of deficiencies or closure; and
- d. to reimburse residents for personal funds lost.

3. Monies from the trust fund shall be utilized only to the extent that private or public funds, including funds available under Title XVIII (Medicare) and Title XIX (Medicaid) of the Social Security Act, are not available or are not sufficient to meet the expenses of the facility. The Secretary of the Department shall conserve the resources of the Trust Fund and shall only authorize expenditures that are consistent with usual and customary charges.

4. Disbursements may be approved for charges in excess of usual and customary charges if the secretary provides adequate written explanation of the need for such disbursement to the House and Senate Health and Welfare Committees within five days of authorizing such disbursement.

5. The existence of the trust fund shall not make the department responsible for the maintenance of residents of a nursing home facility or maintenance of the facility itself.

6. The trust fund shall be administered by the secretary of the department or his designee. Requests for monies from the trust fund may be made by a nursing home administrator or owner, a resident of the facility, or a resident's relative, conservator, guardian, or representative. The applicant must submit a completed fund request form to the secretary of the department. Forms may be obtained

from the department, which shall maintain an adequate supply of such forms in all state and parish offices. A decision shall be provided within seven days of the request.

7. If an emergency exists, the applicant may request immediate consideration by notifying the secretary of the department by telephone, indicating the seriousness and immediate nature of the request. The secretary may orally authorize immediate disbursement but proper documentation or reasons for the disbursement and all completed forms must be filed in the office of the secretary within five days thereafter.

8. The department shall make an annual accounting to the Division of Administration of all monies received in the Trust Fund and all disbursements of those monies.

9. The terms of repayment, if any, of monies disbursed from the trust fund shall be determined by the secretary of the department and may, where appropriate, be set forth in a contract signed by the secretary and the applicant or other party responsible for repayment.

10. Failure to repay the funds according to the established schedule may, at the discretion of the Secretary, prevent future disbursements to the applicant from the trust fund until all monies are repaid. Monies due and owing to reimburse the trust fund shall accrue interest at a rate of two percent above the prime lending rate, unless a different rate is specified in the repayment agreement. The secretary may authorize funds owed by the department to a nursing home facility to be transferred into the trust fund in order to reimburse amounts owed by the facility to the Trust Fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

Subpart 5. Reimbursement

Editor's Note: This Subpart has been moved from LAC 50:VII.Chapter 13 and renumbered.

Chapter 200. Reimbursement Methodology

§20001. General Provisions

A. Definitions

Active Assessment—a resident MDS assessment is considered active when it has been accepted by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). The assessment will remain active until a subsequent minimum data set (MDS) assessment for the same resident has been accepted by CMS, the maximum number of days (121) for the assessment has been reached, or the resident has been discharged.

Administrative and Operating Cost Component—the portion of the Medicaid daily rate that is attributable to the general administration and operation of a nursing facility.

Assessment Reference Date—the date on the minimum data set (MDS) used to determine the due date and delinquency of assessments.

Base Resident-Weighted Median Costs and Prices—the resident-weighted median costs and prices calculated in accordance with §20005 of this rule during rebase years.

Calendar Quarter—a three-month period beginning January 1, April 1, July 1, or October 1.

Capital Cost Component—the portion of the Medicaid daily rate that is:

- a. attributable to depreciation;
- b. capital related interest;
- c. rent; and/or
- d. lease and amortization expenses.

Care Related Cost Component—the portion of the Medicaid daily rate that is attributable to those costs indirectly related to providing clinical resident care services to Medicaid recipients.

Case Mix—a measure of the intensity of care and services used by similar residents in a facility.

Case-Mix Documentation Review (CMDR)—a review of original legal medical record documentation and other documentation as designated by the department in the MDS supportive documentation requirements, supplied by a nursing facility provider to support certain reported values that resulted in a specific RUG classification on a randomly selected MDS assessment sample. The review of the documentation provided by the nursing facility will result in the RUG classification being supported or unsupported.

Case-Mix Index (CMI)—a numerical value that describes the resident's relative resource use within the groups under the resource utilization group (RUG-III) classification system, or its successor, prescribed by the department based on the resident's MDS assessments. CMIs will be determined for each nursing facility on a quarterly basis using all residents.

Case-Mix MDS Documentation Review (CMDR)—a review of original legal medical record documentation on a randomly selected MDS assessment sample. The original legal medical record documentation supplied by the nursing facility is to support certain reported values that resulted in a specific RUG classification. The review of the documentation provided by the nursing facility will result in the RUG classification being supported or unsupported.

Cost Neutralization—refers to the process of removing cost variations associated with different levels of resident case mix. Neutralized cost is determined by dividing a facility's per diem direct care costs by the facility cost report period case-mix index.

Delinquent MDS Resident Assessment—an MDS assessment that is more than 121 days old, as measured by the assessment reference date (ARD) field on the MDS.

Department—the Louisiana Department of Health (LDH), or its successor, and the associated work product of its designated contractors and agents.

Direct Care Cost Component—the portion of the Medicaid daily rate that is attributable to:

- a. registered nurse (RN), licensed practical nurse (LPN) and nurse aide salaries and wages;
- b. a proportionate allocation of allowable employee benefits; and
- c. the direct allowable cost of acquiring RN, LPN and nurse aide staff from outside staffing companies.

Final Case-Mix Index Report (FCIR)—the final report that reflects the acuity of the residents in the nursing facility.

a. Prior to the January 1, 2017 rate setting, resident acuity is measured utilizing the point-in-time acuity measurement system.

b. Effective with the January 1, 2017 rate setting, resident acuity will be measured utilizing the time-weighted acuity measurement system.

Index Factor—based on the *Skilled Nursing Home without Capital Market Basket Index* published by IHS Global Insight (IHS Economics), or a comparable index if this index ceases to be published.

MDS Supportive Documentation Requirements—the department's publication of the minimum documentation and review standard requirements for the MDS items associated with the RUG-III or its successor classification system. These requirements shall be maintained by the department and updated and published as necessary.

Minimum Data Set (MDS)—a core set of screening and assessment data, including common definitions and coding categories that form the foundation of the comprehensive assessment for all residents of long-term care nursing facility providers certified to participate in the Medicaid Program. The items in the MDS standardize communication about resident problems, strengths, and conditions within nursing facility providers, between nursing facility providers, and between nursing facility providers and outside agencies. The Louisiana system will employ the current required MDS assessment as approved by the Centers for Medicare and Medicaid Services (CMS), or as mandated by the Department of Health through the use of the optional state assessment (OSA).

Nursing Facility Cost Report Period Case Mix Index—the average of quarterly nursing facility-wide average case mix indices, carried to four decimal places. The quarters used in this average will be the quarters that most closely coincide with the nursing facility provider's cost reporting period that is used to determine the medians. This average includes any revisions made due to an on-site CMDR.

a. For the cost reporting periods utilized in the next rebase of rates on or after July 1, 2017, the calendar quarter case mix index averages will be calculated using the time-weighted acuity measurement system, and be inclusive of

MDS assessments available as of the date of the applicable quarterly FCIRs. This average includes any revisions made due to an on-site CMDR.

EXAMPLE: A January 1, 2015-December 31, 2015 cost report period would use the time-weighted facility-wide average case mix indices calculated for the four quarters ending March 31, 2015, June 30, 2015, September 30, 2015 and December 31, 2015.

Nursing Facility-Wide Average Case Mix Index—the simple average, carried to four decimal places, of all resident case mix indices.

a. Prior to the January 1, 2017, rate setting resident case mix indices will be calculated utilizing the point-in-time acuity measurement system. If a nursing facility provider does not have any residents as of the last day of a calendar quarter or the average resident case mix indices appear invalid due to temporary closure or other circumstances, as determined by the department, a statewide average case mix index using occupied and valid statewide nursing facility case mix indices may be used.

i. Effective as of the January 1, 2017 rate setting, resident case mix indices will be calculated utilizing the time-weighted acuity measurement. If a nursing facility provider does not have any residents during the course of a calendar quarter, or the average resident case mix indices appear invalid due to temporary closure or other circumstances, as determined by the department, a statewide average case mix index using occupied and valid statewide nursing facility provider case mix indices may be used.

Optional State Assessment (OSA)—assessment required by Louisiana Medicaid to report on Medicaid-covered stays. Allows nursing facility providers using RUG-III or RUG-IV models as the basis for Medicaid payment to do so until the legacy payment model (RUG-III) ends.

Pass-Through Cost Component—includes the cost of property taxes and property insurance. It also includes the provider fee as established by the Department of Health.

Patient Driven Payment Model (PDPM)—the proposed new Medicare payment rule for skilled nursing facilities. The PDPM identifies and adjusts different case-mix components for the varied needs and characteristics of a resident's care and then combines these with a non-case-mix component to determine the full skilled nursing facilities (SNF) prospective payment system (PPS) per diem rate for that resident.

Point-In-Time Acuity Measurement System (PIT)—the case mix index calculation methodology that is compiled utilizing the active resident MDS assessments as of the last day of the calendar quarter, referred to as the point-in-time.

Preliminary Case-Mix Index Report (PCIR)—the preliminary report that reflects the acuity of the residents in the nursing facility.

a. Prior to the January 1, 2017 rate setting, resident acuity is measured utilizing the point-in-time acuity measurement system.

b. Effective as of the January 1, 2017 rate setting, resident acuity will be measured utilizing the time-weighted acuity measurement system.

RUG-III Resident Classification System—the resource utilization group used to classify residents. When a resident classifies into more than one RUG-III, or its successor's group, the RUG-III or its successor's group with the greatest CMI will be utilized to calculate the nursing facility provider's total residents average CMI and Medicaid residents average CMI.

Rate Year—a one-year period from July 1 through June 30 of the next calendar year during which a particular set of rates are in effect. It corresponds to a state fiscal year.

Resident-Day-Weighted Median Cost—a numerical value determined by arraying the per diem costs and total actual resident days of each nursing facility from low to high and identifying the point in the array at which the cumulative total of all resident days first equals or exceeds half the number of the total resident days for all nursing facilities. The per diem cost at this point is the resident-day-weighted median cost.

Summary Review Results Letter—a letter sent to the nursing facility that reports the final results of the case-mix documentation review and concludes the review.

a. The summary review results letter will be sent to the nursing facility provider within 10 business days after the final exit conference date.

Supervised Automatic Sprinkler System—a system that operates in accordance with the latest adopted edition of the National Fire Protection Association's *Life Safety Code*. It is referred to hereafter as a *fire sprinkler system*.

Time-Weighted Acuity Measurement System (TW)—the case mix index calculation methodology that is compiled from the collection of all resident MDS assessments transmitted and accepted by CMS that are considered active within a given calendar quarter. The resident MDS assessments will be weighted based on the number of calendar days that the assessment is considered an active assessment within a given calendar quarter.

Two-Hour Rated Wall—a wall that meets American Society for Testing and Materials International (ASTM) E119 standards for installation and uses two-hour rated sheetrock.

Unsupported MDS Resident Assessment—an assessment where one or more data items that are used to classify a resident pursuant to the RUG-III, 34-group, or its successor's resident classification system is not supported according to the MDS supportive documentation requirements and a different RUG-III, or its successor, classification would result; therefore, the MDS assessment would be considered "unsupported."

B. Effective for the rate period of July 1, 2015 through June 30, 2016, the department shall suspend the provisions of LAC 50:II.Chapter 200 governing the reimbursement methodology for nursing facilities and impose the following

provisions governing reimbursements for nursing facility services.

1. During this time period, no inflation factor will be applied to the base resident day weighted medians and prices calculated as of July 1, 2014.

2. All costs and cost components that are required by rule to be trended forward will only be trended forward to the midpoint of the 2015 state fiscal year (December 31, 2014).

3. The base capital per square foot value, land value per square foot, and per licensed bed equipment value utilized in the calculation of the fair rental value (FRV) component will be set equal to the value of these items as of July 1, 2014.

4. Base capital values for the Bed Buy-Back program (§20012) purposes will be set equal to the value of these items as of July 1, 2014.

5. Nursing facility providers will not have their weighted age totals for the FRV component calculation purposes increased by one year as of July 1, 2015.

6. As of the July 1, 2016 rate setting, nursing facility provider weighted age totals for the FRV component calculation purposes will be increased by two years to account for the suspended year of aging occurring as of the July 1, 2015 rating period.

7. No other provisions of LAC 50:II.Chapter 200 shall be suspended for this time period.

C. Effective for the rate period of July 1, 2017 through June 30, 2018, the department shall suspend the provisions of LAC 50:II.Chapter 200 governing the reimbursement methodology for nursing facilities and impose the following provisions governing reimbursements for nursing facility services.

1. During this time period, no inflation factor will be applied to the base resident day weighted medians and prices calculated as of July 1, 2016.

2. All costs and cost components that are required by rule to be trended forward will only be trended forward to the midpoint of the 2017 state fiscal year (December 31, 2016).

3. The base capital per square foot value, land value per square foot, and per licensed bed equipment value utilized in the calculation of the fair rental value (FRV) component will be set equal to the value of these items as of July 1, 2016.

4. Base capital values for the Bed Buy-Back Program (LAC 50:II.20012) purposes will be set equal to the value of these items as of July 1, 2016.

5. Nursing facility providers will not have their weighted age totals for the FRV component calculation purposes increased by one year as of July 1, 2017.

6. As of the July 1, 2018 rate setting, nursing facility provider weighted age totals for the FRV component

calculation purposes will be increased by two years to account for the suspended year of aging occurring as of the July 1, 2017 rate period.

7. No other provisions of LAC 50:II.Chapter 200 shall be suspended for this time period.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 46:2742, 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 28:1473 (June 2002), repromulgated LR 28:1790 (August 2002), amended LR 28:2537 (December 2002), LR 32:2262 (December 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:825 (March 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1522 (September 2016), LR 43:525 (March 2017), LR 43:2187 (November 2017), LR 46:695 (May 2020), LR 46:1684 (December 2020), LR 50:219 (February 2024).

§20003. Cost Reports

[Formerly LAC 50:VII.1303]

A. Nursing facility providers under Title XIX are required to file annual cost reports as follows.

1. Providers of nursing facility level of care are required to report all reasonable and allowable cost on a regular nursing facility cost report. Effective for periods ending on or after June 30, 2002, the regular nursing facility cost report will be the skilled nursing facility cost report adopted by the Medicare program, hereafter referred to as the Medicare cost report. This cost report is frequently referred to as the Health Care Financing Administration (HCFA) 2540. The cost reporting period begin date shall be the later of the first day of the facility's fiscal period or the facility's certification date. The cost reporting end date shall be the earlier of the last day of the facility's fiscal period or the final day of operation as a nursing facility.

2. In addition to filing the Medicare cost report, nursing facility providers must also file supplemental schedules designated by the bureau. Facilities shall submit their Medicare cost report and their state Medicaid supplemental cost report in accordance with procedures established by the department.

3. Separate cost reports must be submitted by central/home offices when costs of the central/home office are reported in the facility's cost report.

B. Cost reports must be prepared in accordance with the cost reporting instructions adopted by the Medicare Program using the definition of allowable and non-allowable cost contained in the CMS Publication 15-1, Provider Reimbursement Manuals, with the following exceptions.

1. Cost reports must be submitted annually. The due date for filing annual cost reports is the last day of the fifth month following the facility's fiscal year end.

2. There shall be no automatic extension of the due date for the filing of cost reports. If a provider experiences unavoidable difficulties in preparing its cost report by the prescribed due date, one 30-day extension may be permitted,

upon written request submitted to the department prior to the due date. The request must explain in detail why the extension is necessary. Extensions beyond 30 days may be approved for situations beyond the facility's control. An extension will not be granted when the provider agreement is terminated or a change in ownership occurs.

3. **Amended Cost Reports.** The department will accept amended cost reports in electronic format for a period of 12 months following the end of the cost reporting period. Cost reports may not be amended after an audit or desk review has been initiated; however, the department maintains the right, at their discretion, to supersede this requirement and allow a cost report to be amended after the desk review or audit has been initiated. When an amended cost report is received by the department, it will notify the submitting facility if a desk review or audit covering the submitted cost report period has been initiated and that the amended cost report cannot be accepted. Amended cost reports should include a letter explaining the reason for the amendment, an amended certification statement with original signature, and the electronic format completed amended cost reports. Each amended cost report submitted should be clearly marked with "Amended" in the file name.

4. **Rate Warning.** While the Medicare regulations may allow more than one option for classifying costs, Medicaid will only recognize costs in a rate and floor component based on the case mix cross-walk shown on the case mix cross-walk tab of the Medicaid Excel cost report template. If a facility chooses to classify cost on their Medicare cost report in a manner that excludes that cost from their direct care or care-related rate component and floor, then the cost will forever be excluded from the direct care and care-related rate and floor, unless adjusted at audit or desk review.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 46:2742, 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 28:1473 (June 2002), repromulgated LR 28:1790 (August 2002), amended LR 28:2537 (December 2002), LR 32:2263 (December 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:541 (March 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:526 (March 2017), LR 48:303 (February 2022).

§20005. Rate Determination

[Formerly LAC 50:VII.1305]

A. For dates of service on or after July 1, 2002, each nursing facility's rate for skilled nursing (SN), intermediate care I (IC-I) and intermediate care II (IC-II) services shall be the daily rates for these services in effect on June 30, 2002 as adjusted by legislative appropriations for state fiscal year 2003.

B. For dates of service on or after January 1, 2003, the Medicaid daily rates shall be based on a case-mix price-based reimbursement system. Rates shall be calculated from cost report and other statistical data.

1. Effective July 3, 2009, and at a minimum, every second year thereafter, the base resident-day-weighted

median costs and prices shall be rebased using the most recent four month or greater unqualified audited or desk reviewed cost reports that are available as of the April 1, prior to the July 1, rate setting or the department may apply a historic audit adjustment factor to the most recently filed cost reports. The department, at its discretion, may rebase at an earlier time.

a. For rate periods between rebasing, an index factor shall be applied to the base resident-day weighted medians and prices.

C. Each facility's Medicaid daily rate is calculated as:

1. the sum of the facility's direct care and care related price;
2. the statewide administrative and operating price;
3. each facility's capital rate component;
4. each facility's pass-through rate component;
5. adjustments to the rate; and
6. the statewide durable medical equipment price.

D. Determination of Rate Components

1. **Facility Specific Direct Care and Care Related Component.** This portion of a facility's rate shall be determined as follows.

a. The per diem direct care cost for each nursing facility is determined by dividing the facility's direct care cost during the base year cost reporting period by the facility's actual total resident days during the cost reporting period. These costs shall be trended forward from the midpoint of the facility's base year cost report period to the midpoint of the rate year using the index factor. The per diem neutralized direct care cost is calculated by dividing each facility's direct care per diem cost by the facility cost report period case-mix index.

b. The per diem care related cost for each nursing facility is determined by dividing the facility's care related cost during the base year cost reporting period by the facility's actual total resident days during the base year cost reporting period. These costs shall be trended forward from the midpoint of the facility's base year cost report period to the midpoint of the rate year using the index factor.

c. The per diem neutralized direct care cost and the per diem care related cost is summed for each nursing facility. Each facility's per diem result is arrayed from low to high and the resident-day-weighted median cost is determined. Also for each facility, the percentage that each of these components represents of the total is determined.

d. Effective July 1, 2011, the statewide direct care and care related price is established at 112.40 percent of the direct care and care related resident-day-weighted median cost.

e. The statewide direct care and care related floor is established at 94 percent of the direct care and care related resident-day-weighted median cost. For periods prior to

January 1, 2007 the statewide direct care and care related floor shall be reduced to 90 percent of the direct care and care related resident-day-weighted median cost in the event that the nursing wage and staffing enhancement add-on is removed. Effective January 1, 2007 the statewide direct care and care related floor shall be reduced by one percentage point for each 30 cent reduction in the average Medicaid rate due to a budget reduction implemented by the department. The floor cannot be reduced below 90 percent of the direct care and care related resident-day-weighted median cost.

f. For each nursing facility, the statewide direct care and care related price shall be apportioned between the per diem direct care component and the per diem care related component using the facility-specific percentages determined in §1305.D.1.c. On a quarterly basis, each facility's specific direct care component of the statewide price shall be multiplied by each nursing facility's average case-mix index for the prior quarter. The direct care component of the statewide price will be adjusted quarterly to account for changes in the facility-wide average case-mix index. Each facility's specific direct care and care related price is the sum of each facility's case mix adjusted direct care component of the statewide price plus each facility's specific care related component of the statewide price.

g. For each nursing facility, the statewide direct care and care related floor shall be apportioned between the per diem direct care component and the per diem care related component using the facility-specific percentages determined in §1305.D.1.c. On a quarterly basis, each facility's specific direct care component of the statewide floor shall be multiplied by each facility's average case-mix index for the prior quarter. The direct care component of the statewide floor will be adjusted quarterly to account for changes in the facility-wide average case-mix index. Each facility's specific direct care and care related floor is the sum of each facility's case mix adjusted direct care component of the statewide floor plus each facility's specific care related component of the statewide floor.

i. Effective for rate periods January 1, 2017 through June 30, 2017 each nursing facility providers direct care and care related floor will be calculated as follows.

(a). For each nursing facility, the statewide direct care and care related floor shall be apportioned between the per diem direct care component and the per diem care related component using the facility-specific percentages determined in Subparagraph c of this Paragraph. On a quarterly basis, each facility's specific direct care component of the statewide floor shall be multiplied by each nursing facility provider's most advantageous average case mix index for the prior quarter. The most advantageous case mix index will be determined by utilizing the nursing facility providers' calculated point-in-time or time-weighted measurement system case mix index value that results in the lowest direct care and care related floor amount for the associated rate quarter. The direct care component of the statewide floor will be adjusted quarterly to account for changes in the nursing facility-wide average case mix index. Each facility's specific direct care and care related floor is

the sum of each facility's case mix adjusted direct care component of the statewide floor plus each facility's specific care related component of the statewide floor.

h. Effective with cost reporting periods beginning on or after January 1, 2003, a comparison will be made between each facility's direct care and care related per diem cost and the direct care and care related cost report period per diem floor. If the total direct care and care related per diem cost the facility incurred is less than the cost report period per diem floor, the facility shall remit to the bureau the difference between these two amounts times the number of Medicaid days paid during the cost reporting period. The cost report period per diem floor shall be calculated using the calendar day-weighted average of the quarterly per diem floor calculations for the facility's cost reporting period.

EXAMPLE: A May 1, 2003-April 30, 2004 cost report period would use the average of the per diem floor calculations for April 1, 2003 (weighted using 61 days), July 1, 2003 (weighted using 92 days), October 1, 2003 (weighted using 92 days), January 1, 2004 (weighted using 91 days) and April 1, 2004 (weighted using 30 days).

i. For dates of service on or after July 3, 2009, the facility-specific direct care rate will be adjusted in order to reduce the wage enhancement from \$4.70 to a \$1.30 wage enhancement prior to the case-mix adjustment for direct care staff. The \$1.30 wage enhancement will be included in the direct care component of the floor calculations. It is the intent that this wage enhancement be paid to the direct care staff.

i. Effective with the next rebase, on or after July 1, 2010, the wage enhancement will be eliminated.

2. The administrative and operating component of the rate shall be determined as follows.

a. The per diem administrative and operating cost for each nursing facility is determined by dividing the facility's administrative and operating cost during the base year cost reporting period by the facility's actual total resident days during the base year cost reporting period. These costs shall be trended forward from the midpoint of the facility's base year cost report period to the midpoint of the rate year using the index factor.

b. Each facility's per diem administrative and operating cost is arrayed from low to high and the resident-day-weighted median cost is determined.

c. The statewide administrative and operating price is established at 107.5 percent of the administrative and operating resident-day-weighted median cost.

3. The capital component of the rate for each facility shall be determined as follows.

a. The capital cost component rate shall be based on a fair rental value (FRV) reimbursement system. Under a FRV system, a facility is reimbursed on the basis of the estimated current value, also referred to as the current construction costs, of its capital assets in lieu of direct reimbursement for depreciation, amortization, interest and rent/lease expenses. The FRV system shall establish a

nursing facility's bed value based on the age of the facility and its total square footage.

b. Effective January 1, 2003, the new value per square foot shall be \$97.47. This value per square foot shall be increased by \$9.75 for land plus an additional \$4,000 per licensed bed for equipment. This amount shall be trended forward annually to the midpoint of the rate year using the change in the unit cost listed in the three-fourths column of the R.S. means building construction data publication or a comparable publication if this publication ceases to be published, adjusted by the weighted average total city cost index for New Orleans, LA. The cost index for the midpoint of the rate year shall be estimated using a two-year moving average of the two most recent indices as provided in this Subparagraph. A nursing facility's fair rental value per diem is calculated as follows.

i. Each nursing facility's actual square footage per bed is multiplied by the January 1, 2003 new value per square foot, plus \$9.75 for land. The square footage used shall not be less than 300 square feet or more than 450 square feet per licensed bed. If 15 percent or more of the nursing facility's licensed beds are private rooms compared to the total licensed beds of the nursing facility, then the maximum square footage used shall not be more than 550 square feet per licensed bed. To this value add the product of total licensed beds times \$4,000 for equipment, sum this amount and trend it forward using the capital index. This trended value shall be depreciated, except for the portion related to land, at 1.25 percent per year according to the weighted age of the facility. Bed additions, replacements and renovations shall lower the weighted age of the facility. The maximum age of a nursing facility shall be 30 years. Therefore, nursing facilities shall not be depreciated to an amount less than 62.5 percent or [100 percent minus (1.25 percent*30)] of the new bed value. There shall be no recapture of depreciation.

ii. A nursing facility's annual fair rental value (FRV) is calculated by multiplying the facility's current value times a rental factor. The rental factor shall be the 20-year treasury bond rate as published in the *Federal Reserve Bulletin* using the average for the calendar year preceding the rate year plus a risk factor of 2.5 percent with an imposed floor of 9.25 percent and a ceiling of 10.75 percent.

iii. Effective July 1, 2011, the nursing facility's annual fair rental value shall be divided by the greater of the facility's annualized actual resident days during the cost reporting period or 85 percent of the annualized licensed capacity of the facility to determine the FRV per diem or capital component of the rate. Annualized total patient days will be adjusted to reflect any increase or decrease in the number of licensed beds as of the date of rebase by applying to the increase or decrease the greater of the facility's actual occupancy rate during the base year cost report period or 85 percent of the annualized licensed capacity of the facility.

iv. The initial age of each nursing facility used in the FRV calculation shall be determined as of January 1, 2003, using each facility's year of construction. This age will

be reduced for replacements, renovations and/or additions that have occurred since the facility was built provided there is sufficient documentation to support the historical changes. The age of each facility will be further adjusted each July 1 to make the facility one year older, up to the maximum age of 30 years. Beginning January 1, 2007 and the first day of every calendar quarter thereafter, the age of each facility will be reduced for those facilities that have completed and placed into service major renovation or bed additions. This age of a facility will be reduced to reflect the completion of major renovations and/or additions of new beds. If a facility adds new beds, these new beds will be averaged in with the age of the original beds and the weighted average age for all beds will be used as the facility's age. Changes in licensed beds are only recognized, for rate purposes, at July 1 of a rebase year unless the change in licensed beds is related to a change in square footage. The occupancy rate applied to a facility's licensed beds will be based on the base year occupancy.

v. If a facility performed a major renovation/improvement project (defined as a project with capitalized cost equal to or greater than \$500 per bed), the cost of the renovation project will be used to determine the equivalent number of new beds that the project represents. The equivalent number of new beds from a renovation/improvement project will be determined by dividing the cost of the renovation/improvement project by the accumulated depreciation per bed of the facility's existing beds immediately before the renovation/improvement project. The equivalent number of new beds will be used to determine the weighted average age of all beds for this facility.

(a). Major renovation/improvement costs must be documented through cost reports, depreciation schedules, construction receipts or other auditable records. Costs must be capitalized in compliance with the Medicare provider reimbursement manual in order to be considered in a major renovation/improvement project. The cost of the project shall only include the cost of items placed into service during a time period not to exceed the previous 24 months prior to a re-aging. Entities that also provide non-nursing facility services or conduct other non-nursing facility business activities must allocate their renovation cost between the nursing facility and non-nursing facility business activities. Documentation must be provided to the department or its designee to substantiate the accuracy of the allocation of cost. If sufficient documentation is not provided, the renovation/improvement project will not be used to re-age the nursing facility.

(b). Weighted average age changes as a result of replacements/improvements and/or new bed additions must be requested by written notification to the department prior to the rate effective date of the change and separate from the annual cost report. The written notification must include sufficient documentation as determined by the department. All valid requests will become part of the quarterly case-mix FRV rate calculation beginning January 1, 2007.

4. Pass-Through Component of the Rate. The pass-through component of the rate is calculated as follows.

a. The nursing facility's per diem property tax and property insurance cost is determined by dividing the facility's property tax and property insurance cost during the base year cost reporting period by the facility's actual total resident days. These costs shall be trended forward from the midpoint of the facility's base year cost report period to the midpoint of the rate year using the index factor. The pass-through rate is the sum of the facility's per diem property tax and property insurance cost trended forward plus the provider fee determined by the Department of Health and Hospitals.

b. Effective August 1, 2005, the pass-through rate will include a flat statewide fee for the cost of durable medical equipment and supplies required to comply with the plan or care for Medicaid recipients residing in nursing facilities. The flat statewide fee shall remain in place until the cost of the durable medical equipment is included in rebase cost reports, as determined under §1305.B, at which time the department may develop a methodology to incorporate the durable medical equipment cost in to the case-mix rate.

c. Effective September 1, 2016, the pass through rate shall be increased as a result of the provider fee increase on nursing facility days from \$10.00 per day up to \$12.08 per day per occupied bed.

d. Effective for rate periods beginning January 1, 2017 through June 30, 2017, each applicable nursing facility provider will receive an additional pass-through rate adjustment to allow for a phase-in of the time-weighted acuity measurement system. The nursing facility provider pass-through rate adjustment will be calculated and applied as follows.

i. The nursing facility provider's rate period reimbursement rate will be calculated in accordance with §20005.B using the point-in-time acuity measurement system for determining the nursing facility-wide average case mix index values. The reimbursement rate will be determined after considering all other rate period changes to the reimbursement rates.

ii. The nursing facility provider's rate period reimbursement rate will be calculated in accordance with §20005.B using the time-weighted acuity measurement system for determining the nursing facility-wide average case mix index values. The reimbursement rate will be determined after considering all other rate period changes to the reimbursement rate.

iii. The reimbursement rate differential will be determined by subtracting the reimbursement rate calculated using the point-in-time acuity measurement system from the reimbursement rate calculated using the time-weighted acuity measurement system.

iv. If the calculated reimbursement rate differential exceeds a positive or negative \$2, then a pass-through rate adjustment will be applied to the nursing

facility provider's reimbursement rate in an amount equal to the difference between the rate differential total and the \$2 threshold, in order to ensure the nursing facility provider's reimbursement rate is not increased or decreased more than \$2 as a result of the change of the time-weighted acuity measurement system.

(a). Should the nursing facility provider, for the aforementioned rate periods, receive an adjusted nursing facility-wide average case mix index value due to a CMDR change or other factors, the facility will have their rate differential recalculated using the revised case mix index values. The \$2 reimbursement rate change threshold will apply to the recalculated differential and associated case mix index values, not the original differential calculation.

v. If a nursing facility provider's calculated rate differential does not exceed the \$2 rate change threshold, then no pass-through rate adjustment will be applied for the applicable rate period.

5. Adjustment to the Rate. Adjustments to the Medicaid daily rate may be made when changes occur that will eventually be recognized in updated cost report data (such as a change in the minimum wage, a change in FICA or a utility rate change). These adjustments would be effective until the next rebasing of cost report data or until such time as the cost reports fully reflect the change.

6. Budget Shortfall. In the event the department is required to implement reductions in the nursing facility program as a result of a budget shortfall, a budget reduction category shall be created. Without changing the parameters established in these provisions, this category shall reduce the statewide average Medicaid rate by reducing the reimbursement rate paid to each nursing facility using an equal amount per patient day.

E. All capitalized costs related to the installation or extension of supervised automatic fire sprinkler systems or two-hour walls placed in service on or after July 1, 2006 will be excluded from the renovation/improvement costs used to calculate the FRV to the extent the nursing home is reimbursed for said costs in accordance with §1317.

F. Effective for dates of service on or after January 22, 2010, the reimbursement paid to non-state nursing facilities shall be reduced by 1.5 percent of the per diem rate on file as of January 21, 2010 (\$1.95 per day).

G. Effective for dates of service on or after July 1, 2010, the per diem rate paid to non-state nursing facilities shall be reduced by an amount equal to 4.8 percent of the non-state owned nursing facilities statewide average daily rate on file as of July 1, 2010 until such time as the rate is rebased.

H. Effective for dates of service on or after July 1, 2011, the per diem rate paid to non-state nursing facilities, excluding the provider fee, shall be reduced by \$26.98 of the rate in effect on June 30, 2011 until such time that the rate is rebased.

I. Effective for dates of service on or after July 1, 2012, the per diem rate paid to non-state nursing facilities,

excluding the provider fee, shall be reduced by \$32.37 of the rate in effect on June 30, 2012 until such time that the rate is rebased.

J. Effective for dates of service on or after July 1, 2012, the average daily rates for non-state nursing facilities shall be reduced by \$4.11 per day of the average daily rate on file as of June 30, 2012 after the sunset of the state fiscal year 2012 rebase and before the state fiscal year 2013 rebase.

K. Effective for dates of service on or after July 1, 2012, the average daily rates for non-state nursing facilities shall be reduced by \$1.15 per day of the average daily rate on file as of June 30, 2012 after the sunset of the state fiscal year 2012 rebase and after the state fiscal year 2013 rebase.

L. Effective for dates of service on or after July 20, 2012, the average daily rates for non-state nursing facilities shall be reduced by 1.15 percent per day of the average daily rate on file as of July 19, 2012 after the sunset of the state fiscal year 2012 rebase and after the state fiscal year 2013 rebase.

M. Effective for dates of service on or after September 1, 2012, the average daily rates for non-state nursing facilities shall be reduced by \$13.69 per day of the average daily rate on file as of August 31, 2012 before the state fiscal year 2013 rebase which will occur on September 1, 2012.

N. Effective for dates of service on or after September 1, 2012, the average daily rates for non-state nursing facilities shall be reduced by \$1.91 per day of the average daily rate on file as of August 31, 2012 after the state fiscal year 2013 rebase which will occur on September 1, 2012.

O. Effective for dates of service on or after July 1, 2013, the per diem rate paid to non-state nursing facilities, excluding the provider fee, shall be reduced by \$53.05 of the rate in effect on June 30, 2013 until such time that the rate is rebased.

P. Effective for dates of service on or after July 1, 2013, the per diem rate paid to non-state nursing facilities, excluding the provider fee, shall be reduced by \$18.90 of the rate in effect on June 30, 2013 until such time that the rate is rebased.

Q. Effective for dates of service on or after July 1, 2014, the per diem rate paid to non-state nursing facilities shall be reduced by \$90.26 of the rate in effect on June 30, 2014 until such time that the rate is rebased.

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 28:1791 (August 2002), amended LR 31:1596 (July 2005), LR 32:2263 (December 2006), LR 33:2203 (October 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:325 (February 2010), repromulgated LR 36:520 (March 2010), amended LR 36:1556 (July 2010), LR 36:1782 (August 2010), LR 36:2566 (November 2010), LR 37:902 (March 2011), LR 37:1174 (April 2011), LR 37:2631 (September 2011), LR 38:1241 (May 2012), LR 39:1286 (May 2013), LR 39:3097, 3097 (November 2013), LR 41:707 (April 2015), LR 41:949 (May 2015), amended

by the Department of Health, Bureau of Health Services Financing, LR 43:82 (January 2017), LR 43:526 (March 2017), LR 46:1684 (December 2020).

§20006. Reimbursement Adjustment
[Formerly LAC 50:VII.1306]

A. Effective for dates of service on or after January 1, 2004, for state fiscal year 2003-2004 only, each private nursing facility's per diem case mix adjusted rate shall be reduced by \$0.67.

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 30:804 (April 2004).

§20007. Case-Mix Index Calculation
[Formerly LAC 50:VII.1307]

A. The Resource Utilization Groups-III (RUG-III) Version 5.20, 34-group, or its successor, index maximizer model shall be used as the resident classification system to determine all case-mix indices, using data from the minimum data set (MDS) submitted by each facility. Standard Version 5.20, or its successor, case-mix indices developed by CMS shall be the basis for calculating average case-mix indices to be used to adjust the direct care cost component. Resident assessments that cannot be classified to a RUG-III group, or its successor, will be excluded from the average case-mix index calculation.

B. Each resident in the nursing facility, with a completed and submitted assessment, shall be assigned a RUG-III, 34-group, or its successor based on the following criteria.

1. Prior to the January 1, 2017 rate setting, the RUG-III group, or its successor, is calculated based on the resident's most current assessment, available on the last day of each calendar quarter, and shall be translated to the appropriate case mix index. From the individual resident case mix indices, two average case mix indices for each Medicaid nursing facility provider shall be determined four times per year based on the last day of each calendar quarter.

2. Effective as of the January 1, 2017 rate setting, the RUG-III group, or its successor, will be calculated using each resident MDS assessment transmitted and accepted by CMS that is considered active within a given calendar quarter. These assessments are then translated to the appropriate case mix index. The individual resident case mix indices are then weighted based on the number of calendar days each assessment is active within a given calendar quarter. Using the individual resident case mix indices, the calendar day weighted average nursing facility-wide case mix index is calculated using all residents regardless of payer type. The calendar day weighted nursing facility-wide average case mix index for each Medicaid nursing facility shall be determined four times per year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 46:2742, 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 28:1475 (June 2002), repromulgated LR

28:1792 (August 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:826 (March 2012), LR 43:527 (March 2017).

§20009. Non-State, Government Owned or Operated Facilities and State-Owned or Operated Facilities

A. Non-state, government-owned or operated nursing facilities will be paid a case-mix reimbursement rate in accordance with §1305.

B. State-owned or operated nursing facilities will be paid a prospective per diem rate. The per diem payment rate for each of these facilities will be calculated annually on July 1, using the nursing facility's allowable cost from the most recently filed Medicaid cost report trended forward from the midpoint of the cost report year to the midpoint of the rate year using the index factor.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 46:2742, 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 28:1793 (August 2002), amended LR 30:53 (January 2004), LR 31:1596 (July 2005), LR 32:2265 (December 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:325 (February 2010), LR 36:520 (March 2010).

§20010. Additional Payments and Square Footage Adjustments for Private Room Conversion [Formerly LAC 50:VII.1310]

A. Effective for dates of service on or after September 1, 2007, Medicaid participating nursing facilities that convert a semi-private room to a Medicaid-occupied private room are eligible to receive an additional \$5 per diem payment. Facilities that participate will have their fair rental value per diem revised based on the change in licensed beds.

B. Qualifying Facilities

1. In order for a nursing facility's beds to qualify for an additional \$5 per diem payment, a revised fair rental value (FRV), a revised property tax pass-through, and revised property insurance pass-through, all of the following conditions must be met.

a. The nursing facility must convert one or more semi-private rooms to private rooms on or after September 1, 2007.

b. The converted private room(s) must be occupied by a Medicaid resident(s) to receive the \$5 per diem payment.

c. The nursing facility must surrender their bed licenses equal to the number of converted private rooms.

d. The nursing facility must submit the following information to the department within 30 days of the private room conversion:

i. the number of rooms converted from semi-private to private;

ii. the revised bed license;

iii. a resident listing by payer type for the converted private rooms; and

iv. the date of the conversions.

C. The additional \$5 per diem payment determination will be as follows.

1. An additional \$5 will be added to the nursing facility's case-mix rate for each Medicaid resident day in a converted private room.

2. The payment will begin the first day of the following calendar quarter, after the facility meets all of the qualifying criteria in §1310.B.1.

3. A change in ownership, major renovation, or replacement facility will not impact the \$5 additional per diem payment provided that all other provisions of this Section have been met.

D. The revised fair rental value per diem will be calculated as follows.

1. After a qualifying conversion of semi-private rooms to private rooms, the nursing facility's square footage will be divided by the remaining licensed nursing facility beds to calculate a revised square footage per bed.

2. After a qualifying private room conversion, the allowable square footage per bed used in §1305.D.3.b. will be determined as follows.

a. No Change in Total Square Footage. The total allowable square footage after a qualifying private room conversion will be equal to the total allowable square footage immediately prior to the conversion, provided no other facility renovations or alterations changing total square footage occur concurrently or subsequently to the private room conversion.

b. Square Footage Changes to Existing Buildings. If a change in total nursing square footage occurs in a building existing on the effective date of this rule and that change is concurrent or subsequent to a private room conversion, the allowable square footage will be determined in accordance with §1305.D.3.b.i as if the private room conversion did not occur.

c. Square Footage Changes Due to New Buildings. Replacement buildings constructed or first occupied after the effective date of this rule will have their allowable square footage calculated in accordance with §1305.D.3.b.i.

3. Resident days used in the fair rental value per diem calculation will be the greater of the annualized actual resident days from the base year cost report or 85 percent of the revised annual bed days available after the change in licensed beds.

4. A revised fair rental value per diem will be calculated under §1305.D.3.b. using the allowable square footage according to §1310.D.2, remaining licensed beds, and the revised minimum occupancy calculation.

5. The revised fair rental value per diem will be effective the first of the following calendar quarter, after the facility meets all qualifying criteria in paragraph §1310.B.1.

E. Reporting

1. To remain eligible for the conversion payments and the allowable square footage calculations, facilities must report Medicaid-occupied private rooms with every annual cost report.

2. The department may also require an alternate billing procedure for providers to receive the additional \$5 private room rate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 46:2742, 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 33:1646 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:794 (April 2014).

§20011. New Facilities, Changes of Ownership of Existing Facilities and Existing Facilities with Disclaimer or Non-Filer Status [Formerly LAC 50:VII.1311]

A. New facilities are those entities whose beds have not previously been certified to participate, or otherwise participated, in the Medicaid program. New facilities will be reimbursed in accordance with this rule using the statewide average case mix index to adjust the statewide direct care component of the statewide price and the statewide direct care component of the floor. The statewide direct care and care related price shall be apportioned between the per diem direct care component and the per diem care related component using the statewide average of the facility-specific percentages determined in §1305.D.1.c. After the second full calendar quarter of operation, the statewide direct care and care related price and the statewide direct care and care related floor shall be adjusted by the facility's case mix index calculated in accordance with §1305.D.1.f-g and §1307 of this rule. The capital rate paid to a new facility will be based upon the age and square footage of the new facility. An interim capital rate shall be paid to a new facility at the statewide average capital rate for all facilities until the start of a calendar quarter two months or more after the facility has submitted sufficient age and square footage documentation to the department. Following receipt of the age and square footage documentation, the new facility's capital rate will be calculated using the facility's actual age and square footage and the statewide occupancy from the most recent base year and will be effective at the start of the first calendar quarter two months or more after receipt. New facilities will receive the statewide average property tax and property insurance rate until the facility has a cost report included in a base year rate setting. New facilities will also receive a provider fee that has been determined by the department.

B. A change of ownership exists if the beds of the new owner have previously been certified to participate, or otherwise participated, in the Medicaid program under the

previous owner's provider agreement. Rates paid to facilities that have undergone a change in ownership will be based upon the acuity, costs, capital data and pass-through of the prior owner. Thereafter, the new owner's data will be used to determine the facility's rate following the procedures specified in this rule.

C. Existing facilities with disclaimer status includes any facility that receives a qualified audit opinion or disclaimer on the cost report used for rebase under §1305.B. Facilities with a disclaimed cost report status may have adjustments made to their rates based on an evaluation by the secretary of the department.

D. Existing facilities with non-filer status includes any facility that fails to file a complete cost report in accordance with §1303. These facilities will have their case-mix rates adjusted as follows.

1. The statewide direct care and care related price shall be apportioned between the per diem direct care component and the per diem care related component using percentages that result in the lowest overall rate.

2. No property tax and insurance pass-through reimbursement shall be included in the case-mix rate.

3. The fair rental value rate calculated shall be based on 100 percent occupancy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 46:2742, 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 28:1793 (August 2002), amended LR 32:2265 (December 2006).

§20012. Fair Rental Value, Property Tax and Property Insurance Incentive Payments to Buyers of Nursing Facilities [Formerly LAC 50:VII.1312]

A. On or after July 20, 2007, a Louisiana Medicaid participating nursing facility [buyer(s)] that purchases and closes an existing Louisiana Medicaid participating nursing facility (seller) will be eligible to receive fair rental value, property tax and property insurance incentive payments for five years after the legal transfer of ownership and closure of the seller's nursing facility.

B. Qualifying Buyer(s). In order for the buying facility to qualify for the incentive payments described in this Section, the following conditions must be met.

1. Buyer(s) must purchase and close a Medicaid-certified nursing facility within 90 days after the legal transfer of ownership from the seller to buyer(s).

2. After closing the facility, all buyer(s) must permanently surrender their interest in the seller's bed license and the Facility Need Review bed approvals to the state.

3. The buyer(s) must be a Medicaid-certified nursing facility operator(s) at the time of purchase and continue their Medicaid participation throughout the entire five year

payment period. A change in ownership of a buyer facility will not be considered a break in Medicaid participation provided the new owner of the nursing facility continues participation in the Medicaid Program as a Medicaid-certified nursing facility.

4. The buyer(s) must provide the following documentation to the secretary of the department, in writing, within 30 days after the legal transfer of ownership:

- a. a list of all buyer(s);
- b. a list of all seller(s);
- c. the date of the legal transfer of ownership;
- d. each buyer's percentage share of the purchased facility; and
- e. each buyer's current nursing facility resident listing and total occupancy calculations as of the date of the legal transfer of ownership.

5. The buyer(s) must provide the following documentation to the secretary of the department, in writing, within 110 days after the legal transfer of ownership:

- a. a list of the nursing facility residents that transferred from the seller facility and were residents of the buyer facility as of 90 days after the legal transfer of ownership date. The nursing facility resident list must include the payer source for each resident;
- b. the date that the seller's facility was officially closed and no longer operating as a nursing facility.

C. Incentive Calculation. The total annual Medicaid incentive payment for each transaction will be based on the number of beds surrendered from the closed facility and the cumulative percentage increase in occupancy for all buyers involved in the purchase.

1. Beds surrendered will be based on the licensed beds surrendered for the closed facility. The number of beds surrendered will determine the base capital amount used in the incentive payment calculation as follows.

- a. Under 115 beds surrendered will result in a base capital amount of \$303,216.
- b. 115 through 144 beds surrendered will result in a base capital amount of \$424,473.
- c. 145 beds or more surrendered will result in a base capital amount of \$597,591.

2. The cumulative increase in total nursing facility occupancy for all buyers involved in the transaction will be calculated based on the total occupancy reported for all buyers at the purchase date as required by §1312.B.4.e and the reported increase in total residents received from the seller as required by §1312.B.5.a.

a. Cumulative occupancy increases for all buyers will determine the percentage of the base capital amount used in the incentive payment calculation as follows:

- i. less than 5.00 percent will result in 67 percent of the base capital amount;
- ii. 5.00 percent through 9.99 percent will result in 78 percent of the base capital amount;
- iii. 10.00 percent through 14.99 percent will result in 89 percent of the base capital amount;
- iv. 15.00 percent and up will result in 100 percent of the base capital amount.

3. Annual Medicaid Incentive Payment Calculation. The payment amount that corresponds to the cumulative occupancy increase for all buyers and the number of beds surrendered will be multiplied by each buyer's percentage share in the transaction as reported in accordance with §1312.B.4.d. The result will be each buyer's total annual Medicaid incentive payment for five years.

4. Base Capital Amount Updates. On July 1 of each year, the base capital amounts (as defined in Paragraph 1 of this Subsection) will be trended forward annually to the midpoint of the rate year using the change in the per diem unit cost listed in the three-fourths column of the R.S. Means Building Construction Data Publication, or its successor, adjusted by the weighted average total city cost index for New Orleans, LA. The cost index for the midpoint of the rate year shall be estimated using a two-year moving average of the two most recent indices as provided in this Paragraph. Adjustments to the base capital amount will only be applied to purchase and closure transactions occurring after the adjustment date.

D. Re-Base of Buyers' Fair Rental Value, Property Tax, and Property Insurance per Diems. All buyers will have their fair rental value, property tax, and property insurance per diems re-based using the number of residents reported by each buyer as required by §1312.B.5.a. The re-base will be retroactive to the date of closure of the purchased facility. The calculation will be as follows.

1. Prior to application of the minimum occupancy calculation, the actual number of total resident days used in the calculation of each buyer's current fair rental value per diem as described in §1305.D.3.b.iii will be increased by the number of residents the buyer reported under §1312.B.5.a multiplied by the total number of current rate year days.

2. The number of total resident days used in the calculation of each buyer's current pass through property tax and insurance per diem as described under §1305.D.4.a will be increased by the number of residents the buyer reported under §1312.B.5.a multiplied by the number of calendar days included in the buyer's most recent base-year cost report.

3. The resident day adjustment to each buyer's fair rental value, property tax, and property insurance per diem will continue until the buyer's base-year cost report, as defined under §1305.B, includes a full 12 months of resident day data following the closure of the acquired facility (seller). If a buyer's base year cost report overlaps the closure date of the acquired facility, a proportional

adjustment to that buyer's resident days will be made for use in the fair rental value, property tax, and property insurance per diem calculations.

E. Payments

1. The fair rental value, property tax and property insurance incentive payment will be paid to the buyer(s) as part of their Medicaid per diem for current services billed over five years (20 quarters), effective the beginning of the calendar quarter following the closure of the seller's facility and the surrender of the seller's licensed beds to the department. The per diem will be calculated as the buyer's annual Medicaid incentive payment as defined under §1312.C.3 divided by annual Medicaid days. Annual Medicaid days will be equal to Medicaid residents transferred from the seller facility, as determined under §1312.B.5.a, multiplied by total current rate year days plus the buyer's annualized Medicaid days from the most recent base year cost report. If the most recent base year cost report includes or overlaps the period of the transfer, an adjustment will be made to avoid including the transferred days twice.

2. The revised fair rental value per diem and revised property tax and insurance per diem for the buyer(s) will be effective the first day of the month following the closure of the acquired facility (seller).

3. The incentive per diems, the revised fair rental value per diem, and revised property tax and insurance per diem will be updated at every case-mix rebase effective date.

4. The incentive payments when combined with all other Medicaid nursing facility payments shall not exceed the Medicare upper payment limit.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 46:2742, 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 33:1349 (July 2007), amended LR 34:1033 (June 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 43:528 (March 2017).

§20013. Case-Mix Documentation Reviews and Case-Mix Index Reports **[Formerly LAC 50:VII.1313]**

A. The department shall provide each nursing facility provider with the preliminary case-mix index report (PCIR) by approximately the fifteenth day of the second month following the beginning of a calendar quarter. The PCIR will serve as notice of the MDS assessments transmitted and provide an opportunity for the nursing facility provider to correct and transmit any missing MDS assessments or tracking records or apply the CMS correction request process where applicable. The department shall provide each nursing facility provider with a final case-mix index report (FCIR) utilizing MDS assessments after allowing the nursing facility providers a reasonable amount of time to process their corrections (approximately two weeks).

1. If the department determines that a nursing facility provider has delinquent MDS resident assessments, for purposes of determining both average CMIs, such

assessments shall be assigned the case-mix index associated with the RUG-III group "BC1-delinquent" or its successor. A delinquent MDS shall be assigned a CMI value equal to the lowest CMI in the RUG-III, or its successor, classification system.

B. The department shall periodically review the MDS supporting documentation maintained by nursing facility providers for all residents, regardless of payer type. Such reviews shall be conducted as frequently as deemed necessary by the department. The department shall notify nursing facility providers of the scheduled case-mix documentation reviews (CMDR) not less than two business days prior to the start of the review date and a fax, electronic mail or other form of communication will be provided to the administrator or other nursing facility provider designee on the same date identifying possible documentation that will be required to be available at the start of the on-site CMDR.

1. The department shall review a sample of MDS resident assessments equal to the greater of 20 percent of the occupied bed size of the nursing facility or 10 assessments and shall include those transmitted assessments posted on the most current FCIR. The CMDR will determine the percentage of assessments in the sample that are unsupported MDS resident assessments. The department may review additional or alternative MDS assessments, if it is deemed necessary.

2. When conducting the CMDR, the department shall consider all MDS supporting documentation that is provided by the nursing facility provider and is available to the RN reviewers prior to the start of the exit conference. MDS supporting documentation that is provided by the nursing facility provider after the start of the exit conference shall not be considered for the CMDR.

3. Upon request by the department, the nursing facility provider shall be required to produce a computer-generated copy of the MDS assessment which shall be the basis for the CMDR.

4. After the close of the CMDR, the department will submit its findings in a summary review results (SRR) letter to the nursing facility within 10 business days following the final exit conference date.

5. The following corrective action will apply to those nursing facility providers with unsupported MDS resident assessments identified during an on-site CMDR.

a. If the percentage of unsupported assessments in the initial on-site CMDR sample is greater than 20 percent, the sample shall be expanded, and shall include the greater of 20 percent of the remaining resident assessments or 10 assessments.

b. If the percentage of unsupported MDS assessments in the total sample is equal to or less than the threshold percentage as shown in column (B) of the table in Subparagraph e below, no corrective action will be applied.

c. If the percentage of unsupported MDS assessments in the total sample is greater than the threshold

percentage as shown in column (B) of the table in Subparagraph e below, the RUG-III, or its successor, classification shall be recalculated for the unsupported MDS assessments based upon the available documentation obtained during the CMDR process. The nursing facility provider's CMI and resulting Medicaid rate shall be recalculated for the quarter in which the FCIR was used to determine the Medicaid rate. A follow-up CMDR process described in Subparagraphs d and e may be utilized at the discretion of the department.

d. Those nursing facility providers exceeding the thresholds (see column (B) of the table in Subparagraph e) during the initial on-site CMDR will be given 90 days to correct their assessing and documentation processes. A follow-up CMDR may be performed at the discretion of the department at least 30 days after the nursing facility provider's 90-day correction period. The department or its contractor shall notify the nursing facility provider not less than two business days prior to the start of the CMDR date. A fax, electronic mail, or other form of communication will be provided to the administrator or other nursing facility provider designee on the same date identifying documentation that must be available at the start of the on-site CMDR.

e. After the follow-up CMDR, if the percentage of unsupported MDS assessments in the total sample is greater than the threshold percentage as shown in column (B) of the following table, the RUG-III, or its successor, classification shall be recalculated for the unsupported MDS assessments based upon the available documentation obtained during the CMDR process. The nursing facility provider's CMI and resulting Medicaid rate shall be recalculated for the quarter in which the FCIR was used to determine the Medicaid rate. In addition, facilities found to have unsupported MDS resident assessments in excess of the threshold in column (B) of the table below may be required to enter into a documentation improvement plan with the department. Additional follow-up CMDR may be conducted at the discretion of the department.

Effective Date (A)	Threshold Percent (B)
January 1, 2003	Educational
January 1, 2004	40%
January 1, 2005	35%
January 1, 2006	25%
February 20, 2019 and beyond	20%

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 28:2537 (December 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:826 (March 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:528 (March 2017), LR 45:274 (February 2019).

§20015. Appeal Process
[Formerly LAC 50:VII.1315]

A. If the facility disagrees with the CMDR findings, a written request for an informal reconsideration must be

submitted to the department within 15 business days of the facility's receipt of the CMDR findings in the SRR letter. Otherwise, the results of the CMDR findings are considered final and not subject to appeal. The department will review the facility's informal reconsideration request within 10 business days of receipt of the request and will send written notification of the final results of the reconsideration to the facility. No appeal of findings will be accepted until after communication of final results of the informal reconsideration process.

B. The provider has the right to request an appeal within 30 days of the written notice of the results of the informal reconsideration. Such request must be in writing to the Appeals Section. The request must contain a statement and be accompanied by supporting documents setting forth with particularity those asserted discrepancies which the provider contends are in compliance with the agency's regulations and the reasons for such contentions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 46:2742, 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 28:2538 (December 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:827 (March 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:529 (March 2017).

§20017. Reimbursement for Fire Sprinkler Systems and Two-Hour Rated Wall Installations
[Formerly LAC 50:VII.1317]

A. All nursing facilities are required to be protected throughout by a fire sprinkler system by January 1, 2008. Where means of egress passes through building areas outside of a nursing facility, those areas shall be separated from the nursing facility by a two-hour rated wall or shall be protected by a fire sprinkler system.

B. Nursing Facility Procedure and Documentation Requirements

1. A completed fire sprinkler system plan or two-hour rated wall plan, or both, must be submitted to the department for review and approval by December 31, 2006.

2. Upon approval of the plans and after installation is completed, nursing facilities must submit auditable depreciation schedules and invoices to support the installation cost of all fire sprinkler systems and two-hour rated walls. The documentation must be submitted to the department or its designee.

a. All supporting documentation, including depreciation schedules and invoices, must indicate if the cost was previously included in a fair rental value re-age request.

C. Medicaid participating nursing facilities that install or extend fire sprinkler systems or two-hour rated walls, or both, after August 1, 2001, and in accordance with this section, may receive Medicaid reimbursement for the cost of installation over a five year period beginning the later of

July 1, 2007 or the date of installation. The Medicaid reimbursement shall be determined as follows.

1. The annual total reimbursable cost is equal to a nursing facility's total installation cost of all qualified fire sprinkler systems and two-hour rated walls divided by five.

2. The per diem cost is calculated as the annual total reimbursable cost divided by total nursing facility resident days as determined by the nursing facility's most recently audited or desk reviewed Medicaid cost report as of April 30, 2007. If a cost report is not available, current nursing facility resident day census records may be used at the department's approval.

3. The per diem cost is reduced by any fair rental value per diem increase previously recognized as a result of the costs being reimbursed under this section. This adjusted per diem cost shall be paid to each qualifying nursing facility as and additional component of their Medicaid daily rate for five years.

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 32:2266 (December 2006).

**§20019. Evacuation and Temporary Sheltering Costs
[Formerly LAC 50:VII.1319]**

A. Nursing facilities required to participate in an evacuation, as directed by the appropriate parish or state official, or which act as a host shelter site may be entitled to reimbursement of its documented and allowable evacuation and temporary sheltering costs.

1. The expense incurred must be in excess of any existing or anticipated reimbursement from any other sources, including the Federal Emergency Management Agency (FEMA) or its successor.

2. Nursing facilities must first apply for evacuation or sheltering reimbursement from all other sources and request that the department apply for FEMA assistance on their behalf.

3. Nursing facilities must submit expense and reimbursement documentation directly related to the evacuation or temporary sheltering of Medicaid nursing home residents to the department.

B. Eligible Expenses. Expenses eligible for reimbursement must occur as a result of an evacuation and be reasonable, necessary, and proper. Eligible expenses are subject to audit at the department's discretion and may include the following.

1. Evacuation Expenses. Evacuation expenses include expenses from the date of evacuation to the date of arrival at a temporary shelter or another nursing facility. Evacuation expenses include:

a. resident transportation and lodging expenses during travel;

b. nursing staff expenses when accompanying residents, including:

i. transportation;

ii. lodging; and

iii. additional direct care expenses, when a direct care expense increase of 10 percent or more is documented:

(a) the direct care expense increase must be based on a comparison to the average of the previous two pay periods or other period comparisons determined acceptable by the department;

c. any additional allowable costs as defined in the CMS Publication 15-1-21, last modified 9/28/2012, that are directly related to the evacuation and that would normally be allowed under the nursing facility case-mix rate.

2. Non-Nursing Facility Temporary Sheltering Expenses. Non-nursing facility temporary sheltering expenses include expenses from the date the Medicaid residents arrive at a non-nursing facility temporary shelter to the date all Medicaid residents leave the shelter. A non-nursing facility temporary shelter includes shelters that are not part of a licensed nursing facility and are not billing for the residents under the Medicaid case-mix reimbursement system or any other Medicaid reimbursement system. Non-nursing facility temporary sheltering expenses may include:

a. additional nursing staff expenses including:

i. lodging; and

ii. additional direct care expenses, when a direct care expense increase of 10 percent or more is documented:

(a) the direct care expense increase must be based on a comparison to the average of the previous two pay periods or other period comparisons determined acceptable by the department;

b. care-related expenses as defined in LAC 50:II.20005 and incurred in excess of care-related expenses prior to the evacuation;

c. additional medically necessary equipment such as beds and portable ventilators that are not available from the evacuating nursing facility and are rented or purchased specifically for the temporary sheltered residents, and:

i. these expenses will be capped at a daily rental fee not to exceed the total purchase price of the item;

ii. the allowable daily rental fee will be determined by the department;

d. any additional allowable costs as defined in the CMS Publication 15-1-21, last modified 9/28/2012, that are directly related to the temporary sheltering and that would normally be allowed under the nursing facility case-mix rate.

3. Host Nursing Facility Temporary Sheltering Expenses. Host nursing facility temporary sheltering expenses include expenses from the date the Medicaid residents are admitted to a licensed nursing facility to the date all temporary sheltered Medicaid residents are

discharged from the nursing facility, not to exceed a six-month period.

a. The host nursing facility shall bill for the residents under Medicaid's case-mix reimbursement system.

b. Additional direct care expenses may be submitted when a direct care expense increase of 10 percent or more is documented.

i. The direct care expense increase must be based on a comparison to the average of the previous two pay periods or other period comparisons determined acceptable by the department.

C. Payment of Eligible Expenses

1. For payment purposes, total eligible Medicaid expenses will be the sum of nonresident-specific eligible expenses multiplied by the facility's Medicaid occupancy percentage plus Medicaid resident-specific expenses.

a. If Medicaid occupancy is not easily verified using the evacuation resident listing, the Medicaid occupancy from the most recently filed cost report will be used.

2. Payments shall be made as quarterly lump-sum payments until all eligible expenses have been submitted and paid. Eligible expense documentation must be submitted to the department by the end of each calendar quarter.

3. All eligible expenses documented and allowed under §20019 will be removed from allowable expenses when the nursing facility's Medicaid cost report is filed. These expenses will not be included in the allowable cost used to set case-mix reimbursement rates in future years.

a. Equipment purchases that are reimbursed on a rental rate under §20019.B.2.c may have their remaining basis included as allowable cost on future costs reports provided that the equipment is in the nursing facility and being used. If the remaining basis requires capitalization under CMS Publication 15-1-21 guidelines, last modified 9/28/2012, then depreciation will be recognized.

4. Payments shall remain under the upper payment limit cap for nursing facilities.

D. When a nursing facility (NF) resident is evacuated to a temporary shelter site (an unlicensed sheltering site or a licensed NF) for less than 24 hours, the Medicaid vendor payment to the evacuating facility will not be interrupted.

E. When an NF resident is evacuated to a temporary shelter site (an unlicensed sheltering site or a licensed NF) for greater than 24 hours, the evacuating nursing facility may submit the claim for Medicaid vendor payment for a maximum of five days, provided that the evacuating nursing facility provides sufficient staff and resources to ensure the delivery of essential care and services to the resident at the temporary shelter site.

F. When an NF resident is evacuated to a temporary shelter site, which is an unlicensed sheltering site, for greater than five days, the evacuating nursing facility may submit

the claim for Medicaid vendor payment for up to an additional 15 days, provided that the evacuating nursing facility:

1. has received an extension to stay at the unlicensed shelter site; and

2. provides sufficient staff and resources to ensure the delivery of essential care and services to the resident, and to ensure the needs of the resident are met.

G. When an NF resident is evacuated to a temporary shelter site, which is a licensed nursing home, for greater than five days, the evacuating nursing facility may submit the claim for Medicaid vendor payment for an additional period, not to exceed 55 days, provided that:

1. the host/receiving nursing home has sufficient licensed and certified bed capacity for the resident, or the host/receiving nursing home has received departmental and/or CMS approval to exceed the licensed and certified bed capacity for a specified period; and

2. the evacuating nursing facility provides sufficient staff and resources to ensure the delivery of essential care and services to the resident, and to ensure the needs of the resident are met.

H. If an NF resident is evacuated to a temporary shelter site which is a licensed NF, the receiving/host nursing home may submit claims for Medicaid vendor payment under the following conditions:

1. beginning day two and continuing during the "sheltering period" and any extension period, if the evacuating nursing home does not provide sufficient staff and resources to ensure the delivery of essential care and services to the resident and to ensure the needs of the residents are met;

2. upon admission of the evacuated residents to the host/receiving nursing facility; or

3. upon obtaining approval of a temporary hardship exception from the department, if the evacuating NF is not submitting claims for Medicaid vendor payment.

I. Only one nursing facility may submit the claims and be reimbursed by the Medicaid Program for each Medicaid resident for the same date of service.

J. A nursing facility may not submit claims for Medicaid vendor payment for non-admitted residents beyond the expiration of its extension to exceed licensed (and/or certified) bed capacity or expiration of its temporary hardship exception.

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 34:879 (May 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 43:328 (February 2017).

§20021. Leave of Absence Days
[Formerly LAC 50:VII.1321]

A. For each Medicaid recipient, nursing facilities shall be reimbursed for up to seven hospital leave of absence days per occurrence and 15 home leave of absence days per year.

B. The reimbursement for hospital leave of absence days is 75 percent of the applicable per diem rate.

C. Nursing facilities with occupancy rates less than 90 percent. Effective for dates of service on or after February 20, 2009, reimbursement for hospital and home leave of absence days will be reduced to 10 percent of the applicable per diem rate in addition to the nursing facility provider fee.

D. Nursing facilities with occupancy rates equal to or greater than 90 percent. Effective for dates of service on or after February 20, 2009, the reimbursement paid for home leave of absence days will be reduced to 90 percent of the applicable per diem rate, which includes the nursing facility provider fee.

1. Effective for dates of service on or after March 1, 2009, the reimbursement for hospital leave of absence days for nursing facilities with occupancy rates equal to or greater than 90 percent shall be 90 percent of the applicable per diem rate, which includes the nursing facility provider fee.

E. Occupancy percentages will be determined from the average annual occupancy rate as reflected in the Louisiana Inventory of Nursing Home Bed Utilization Report published from the period six months prior to the beginning of the current rate quarter. Occupancy percentages will be updated quarterly when new rates are loaded and shall be in effect for the entire quarter.

F. Effective for dates of service on or after July 1, 2013, the reimbursement paid for leave of absence days shall be 10 percent of the applicable per diem rate in addition to the provider fee amount.

1. The provider fee amount shall be excluded from the calculations when determining the leave of absence days payment amount.

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 35:1899 (September 2009), amended LR 41:133 (January 2015).

§20023. Transition of State-Owned or Operated Nursing Facility to a Private Facility

A. A state owned or operated nursing facility that changes ownership (CHOW) in order to transition to a private nursing facility will be exempt from the case-mix direct care and care-related spending floor for a period of 12 months following the effective date of the CHOW under the following conditions:

1. the state-owned or operated facility is located in the DHH administrative region 1; and

2. the change of ownership is the result of a leasing arrangement.

B. Cost Reports

1. The previous owner of the nursing facility must file a closing cost report within 60 days of the CHOW for the time period that spans from the beginning of the facility's cost report period to the date of the CHOW.

2. The initial cost report period following the CHOW will be determined based on the elected fiscal year end of the new facility.

3. The closing and initial cost reports must be filed in accordance with the provisions of §20003, including the filing of all Medicaid supplemental schedules.

C. A capital data survey must be filed with the department within 60 days of the effective date of the CHOW. The capital data survey must include the nursing facility's date of construction, current square footage, and all renovations made since the facility's opening.

D. Rate Determination

1. During the transition period (12 months following the effective date of the change of ownership), the Medicaid reimbursement rate for the transitioned nursing facility shall be the per diem rate on file as of March 19, 2010 for the state-owned or operated facility.

2. The transitioned nursing facility will be transferred to the case-mix reimbursement system at the end of the 12 month transition period.

3. The Medicaid reimbursement rate and direct care/care-related floor shall be calculated in accordance with the provisions of §20005.

a. The direct care/care-related floor will be effective on the date of transition to the case mix reimbursement system.

b. For purposes of this initial floor calculation, direct care and care-related spending will be determined by apportioning cost report period costs based on calendar days.

4. Under the case mix reimbursement methodology, the facility will file cost reports in accordance with the provisions of §20003, including all Medicaid supplemental schedules.

a. If the nursing facility's cost report period overlaps the date of transition to the case mix reimbursement methodology, the case mix direct care and care-related floor will only be applied to the portion of the cost report period that occurs after the date of transition to case mix.

5. Until the nursing facility has an audited or desk reviewed cost report that is available for use in a case mix rebase in accordance with the provisions of §20005.B, the case mix reimbursement rate components will be based on the following criteria except as noted in Subsection D.6 of this Section.

a. The facility's acuity as determined from its specific case mix index report for the quarter prior to the effective date of the rate.

b. The direct care and care-related statewide median prices in effect for that period.

i. The statewide direct care and care related price shall be apportioned between the per diem direct care component and the per diem care related component using the nursing facility's most recent non-disclaimed audited or desk reviewed cost report.

ii. The facility-specific percentages will be determined using the methodology described in §20005.D.1.c.

c. The administrative and operating statewide median prices in effect for that period.

d. The capital data for the fair rental value rate component will be calculated from the facility-submitted capital data survey and the occupancy percentage from the most recent non-disclaimed audited or desk reviewed cost report as of the effective date of the rate.

e. The facility's property insurance cost will be calculated from the most recent non-disclaimed audited or desk reviewed cost report as of the rate effective date.

f. The property tax cost will be collected in the form of an interim property tax report specified by the department.

i. The interim property tax report must be filed within 30 days after the beginning of the nursing facility's cost reporting period.

ii. Failure to provide the interim property tax report within the specified time frame will result in a \$0 reimbursement rate for the property tax rate component.

iii. The facility must continue to file an interim property tax report until the facility is able to produce a non-disclaimed audited or desk reviewed cost report that contains property tax cost.

g. Provider fee and budget adjustments in effect for all other case mix facilities will be applicable.

6. A disclaimed cost report that would otherwise be used in a rebase will result in a rate calculated in accordance with the provisions of §20011 and the provisions contained in Subsection D.3.a-b and D.4.a of this Section will no longer be applicable.

7. If additional data is needed, the department may request that the facility submit Medicaid supplemental cost report schedules for those cost report period year ends for which the facility has not previously submitted Medicaid supplemental schedules.

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 37:903 (March 2011), amended by the Department of Health, Bureau of Health Services Financing, LR 45:275 (February 2019).

§20024. Transition of Private Nursing Facility to a State-Owned or Operated Nursing Facility through a Change of Ownership

A. Any private nursing facility that undergoes a change of ownership (CHOW) to a state-owned or operated nursing facility will be exempt from the prospective reimbursement system for public nursing facilities during the transitional period.

1. The transitional period will be effective from the date of the CHOW until the July 1 rate setting period following when the state-owned or operated nursing facility has an audited or reviewed 12 month or greater cost reporting period available for use in rate setting.

2. After the transitional period, the nursing facility will be reimbursed pursuant to the requirements of the prospective reimbursement system for public nursing facilities.

B. Effective for dates of service on or after July 5, 2018, the reimbursement amount paid to a public nursing facility during the transitional period shall be as follows:

1. Public nursing facilities transitioning from private ownership shall receive a monthly interim payment based on occupancy, which shall be a per diem rate of \$365.68.

2. For each cost reporting period ending during the transitional period a cost settlement process shall be performed. The cost settlement process shall ensure that Medicaid reimbursement for each public nursing facility transitioning from private ownership is equal to 100 percent of the nursing facility's Medicaid allowable cost for the applicable cost reporting period.

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 45:275 (February 2019).

§20025. Low Income and Needy Care Collaboration

A. Effective for dates of service on or after November 1, 2011, quarterly supplemental payments shall be issued to qualifying nursing facilities for services rendered during the quarter. Maximum aggregate payments to all qualifying nursing facilities shall not exceed the available upper payment limit per state fiscal year.

B. **Qualifying Criteria.** In order to qualify for the supplemental payment, the nursing facility must be affiliated with a state or local governmental entity through a low income and needy care nursing facility collaboration agreement.

1. A nursing facility is defined as a currently licensed and certified nursing facility which is owned or operated by a private entity or non-state governmental entity.

2. A low income and needy care nursing facility collaboration agreement is defined as an agreement between a nursing facility and a state or local governmental entity to

collaborate for purposes of providing healthcare services to low income and needy patients.

C. Each qualifying nursing facility shall receive quarterly supplemental payments for nursing facility services. Quarterly payment distribution shall be limited to one-fourth of the aggregated difference between each qualifying nursing facility's Medicare rate and Medicaid payments the nursing facility receives for covered services provided to Medicaid recipients during a 12 consecutive month period. Medicare rates in effect for the dates of service included in the supplemental payment period will be used to establish the upper payment limit. Medicaid payments will be used for the same time period.

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 40:793 (April 2014).

§20026. Geriatric Training Nursing Facility Reimbursement Rate

Note: The provisions of this Section shall be subject to approval by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) of a State Plan amendment authorizing such payment.

A. Effective for dates of service on or after July 1, 2019, LDH shall provide a private nursing facility reimbursement rate of \$365.68 per resident per day to an entity that meets the following criteria:

1. the entity has a cooperative endeavor agreement (CEA) with Louisiana State University (LSU) to operate the current John J. Hainkel, Jr. Home and Rehabilitation Center or any future location used to operate John J. Hainkel, Jr. Home and Rehabilitation Center which has been approved by the parties and the department, as a geriatric training nursing facility.

B. The private nursing facility reimbursement rate established in Subsection A above is all-inclusive.

1. Add-ons, including, but not limited to, technology dependent care (TDC), nursing facility rehabilitation services and nursing facility complex care services add-ons shall not be permitted under this reimbursement rate.

C. Any nursing facility that meets the criteria set forth in Subsection A above shall file an annual cost report with LDH within five months following the end of the facility's fiscal year.

D. The provisions of this Rule shall be subject to approval by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) of a State Plan amendment authorizing such payment.

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 45:756 (June 2019), repromulgated LR 45:909 (July 2019).

§20027. Specialized Care Reimbursement

A. A specialized care reimbursement rate shall consist of a nursing facility's Medicaid case-mix reimbursement rate plus an add-on amount. These rates can be established by the department for a specialized care unit.

B. Nursing Facility Specialized Care Unit Reimbursement

1. Effective with the January 1, 2014 rate period, infectious disease (ID) specialized care costs will no longer be reimbursed through a separate per diem add-on payment. ID costs and days will be included in the calculation of the case-mix nursing facility reimbursement rates and the direct care and care-related floor calculation as described under §20005 of this Chapter.

2. Effective with the January 1, 2014 rate period, technologically dependent care (TDC) costs and days will be included in the calculation of the case-mix nursing facility reimbursement rates and the direct care and care-related floor calculation as described under §20005 of this Chapter. TDC services will continue to be reimbursed through a separate per diem add-on payment. The department will be solely responsible for determining adjustments to the TDC per diem add-on payment.

3. Effective with the January 1, 2014 rate period, Neurological Rehabilitation Treatment Program (NRTP) costs and days for both rehabilitative and complex services will be included in the calculation of the case-mix nursing facility reimbursement rates and the direct care and care-related floor calculation as described under §20005 of this Chapter. NRTP services will be reimbursed through a separate per diem add-on payment. The department will be solely responsible for determining adjustments to the NRTP per diem add-on payment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 46:2742, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:541 (March 2014).

§20029. Supplemental Payments

A. Non-State Governmental Organization Nursing Facilities

1. Effective for dates of service on or after January 20, 2016, any nursing facility that is owned or operated by a non-state governmental organization (NSGO), and that has entered into an agreement with the department to participate, shall qualify for a Medicaid supplemental payment adjustment, in addition to the uniform Medicaid rates paid to nursing facilities. The only qualifying nursing facilities are:

- a. Gueydan Memorial Guest Home;
- b. LaSalle Nursing Home;
- c. Natchitoches Parish Hospital LTC Unit; and
- d. St. Helena Parish Nursing Home.

2. The supplemental Medicaid payment to a non-state, government-owned or operated nursing facility shall not exceed the facility's upper payment limit (UPL) pursuant to 42 CFR 447.272.

3. Payment Calculations. The Medicaid supplemental payment for each state fiscal year (SFY) shall be calculated immediately following the July quarterly Medicaid rate setting process. The total Medicaid supplemental payment for each individual NSGO will be established as the individual nursing facility differential between the estimated Medicare payments for Medicaid nursing facility residents, and the adjusted Medicaid payments for those same nursing facility residents. A more detailed description of the Medicaid supplemental payment process is described below.

a. The calculation of the total annual Medicaid supplemental payment for nursing facilities involves the following four components:

i. calculate Medicare payments for Louisiana Medicaid nursing facility residents using Medicare payment principles;

ii. determining Medicaid payments for Louisiana Medicaid nursing facility residents;

iii. adjust payments for coverage difference between Medicare payment principles and Louisiana Medicaid payment principles; and

iv. calculating the differential between the calculated Medicare payments for Medicaid nursing facility residents, and Medicaid payments for those same residents.

b. Calculating Medicaid Rates Using Medicare Payment Principles. With Medicare moving to the prospective payment system (PPS), Medicare rates will be calculated based on Medicaid acuity data. The following is a summary of the steps involved.

i. Using each resident's minimum data set assessment, the applicable RUG-III grouper code for Medicaid residents was identified. A frequency distribution of Medicaid residents in each of the Medicare RUG classification categories is then generated.

(a). The resident minimum data set assessments will be from the most recently available minimum data set assessments utilized in Medicaid rate setting processes as of the development of the Medicaid supplemental payment calculation demonstration.

ii. After the Medicaid resident frequency distribution was developed, rural and urban rate differentials and wage index adjustments will be used to adjust the Medicare rate tables. Medicare rate tables will be applicable to SFY periods.

(a). Medicare rate tables will be established using information published in 42 CFR part 483 where available. Should the finalized Medicare rate tables for any portion of the applicable SFY period be unavailable, the most recent preliminary Medicare rate adjustment percentage published in the *Federal Register* available as of

the development of the Medicaid supplemental payment calculation demonstration will be utilized as the basis of the Medicare rate for that portion of the SFY period.

(b). The resulting Medicare rates are multiplied by the number of Medicaid residents in each RUG category, summed and then averaged. The Medicare rate tables applicable to each period of the SFY will be multiplied by an estimate of Medicaid paid claims days for the specified period. Medicaid paid claims days will be compiled from the state's Medicaid Management Information System's (MMIS) most recent 12 months, as of the development of the Medicaid supplemental payment calculation demonstration.

c. Determining Medicaid Payments for Louisiana Medicaid Nursing Facility Residents. The most current Medicaid nursing facility reimbursement rates as of the development of Medicaid supplemental payment calculation demonstration will be utilized. These reimbursement rates will be multiplied by Medicaid paid claims compiled from the state's MMIS system from the most recent 12 months, as of the development of the Medicaid supplemental payment calculation demonstration, to establish total Medicaid per diem payments. Total calculated Medicaid payments made outside of the standard nursing facility per diem are summed with total Medicaid reimbursement from the per diem payments to establish total Medicaid payments. Payments made outside of the standard nursing facility per diem are reimbursement for the following services.

i. Specialized Care Services Payments. Specialized care services reimbursement is paid outside of the standard per diem rate as an add-on payment to the current facility per diem rate. The established specialized care add-on per diems will be multiplied by Medicaid paid claims for specialized care days compiled from the state's MMIS system from the most recent 12 months, as of the development of the Medicaid supplemental payment calculation demonstration, to establish projected specialized care services payments for the applicable SFY.

ii. Home/Hospital Leave Day (Bed Hold) Payments. Allowable Medicaid leave days were established using Medicaid paid claims days compiled from the state's MMIS system from the most recent 12 months, as of the development of the Medicaid supplemental payment calculation demonstration. Allowable Medicaid Leave days will be multiplied by the most recent Medicaid leave day quarterly reimbursement rates as of the of the Medicaid supplemental payment calculation demonstration to established projected Medicaid Leave day payments for the SFY.

iii. Private Room Conversion Payments. Private room conversion (PRC) Medicaid days will be established utilizing the most recently reviewed or audited Medicaid supplemental cost reports as of the development of the Medicaid supplemental payment calculation demonstration. The applicable cost reporting period information will be annualized to account for short year cost reporting periods. Allowable PRC Medicaid days will be multiplied by the PRC incentive payment amount of \$5 per allowable day to

establish the total projected Medicaid PRC payments for the SFY.

d. Adjusting for Differences between Medicare Principles and Louisiana Medicaid Nursing Facility Residents. An adjustment to the calculation of the Medicaid supplemental payment limit will be performed to account for the differences in coverage between the Medicare PPS rate and what Louisiana Medicaid covers within the daily rate provided above. To accomplish this, an estimate will be calculated for pharmacy, laboratory, and radiology claims that were paid on behalf of nursing facility residents for other than their routine daily care. These estimates will then be added to the total calculated Medicaid payments.

e. Calculating the Differential Between the Calculated Medicare Payments for Medicaid Nursing Facility Residents, and Medicaid Payments for Those Same Residents. The total annual Medicaid supplemental payment will be equal to the individual NSGO nursing facility's differential between their calculated Medicare payments and the calculated adjusted Medicaid payments for the applicable SFY, as detailed in the sections above.

4. Frequency of Payments and Calculations. The Medicaid supplemental payments will be reimbursed through a calendar quarter based lump sum payment. The amount of the calendar quarter lump sum payment will be equal to the SFY total annual Medicaid supplemental payment divided by four. The total annual Medicaid supplemental payment calculation will be performed for each SFY immediately following the July quarterly Medicaid rate setting process.

5. No payment under this section is dependent on any agreement or arrangement for provider or related entities to donate money or services to a governmental entity.

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 42:63 (January 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 43:529 (March 2017), LR 47:476 (April 2021).

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE

Part III. Eligibility

Subpart 1. General Administration

Chapter 1. General Provisions

§101. Fair Hearings

A. Every applicant for, and enrollee of, Medicaid Program benefits has the right to appeal an agency action or decision, and has the right to request a fair hearing in the presence of an impartial hearing officer.

1. *Action*—a termination, suspension or reduction of Medicaid eligibility or covered services. This includes terminations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a state (Medicaid Program) with regard to the preadmission screening and annual resident review requirements of §1917(e)(7) of the Social Security Act.

2. *Exception*. Enrollees are not entitled to a fair hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all Medicaid recipients.

3. Applicants and enrollees shall be informed in writing of the right to request a fair hearing and of the procedure to do so.

B. The Medicaid Program may delegate the responsibility for conducting fair hearings to another state agency. Any agency with delegated authority to conduct fair hearings on behalf of the Medicaid Program shall comply with the federal notice and fair hearing requirements pursuant to 42 CFR 431, subpart E, and all other Medicaid Program and state regulations governing fair hearings.

C. Applicants and enrollees must request a fair hearing within 30 days of the date of the adequate and/or timely decision notice issued by the Medicaid Program or its designee.

D. *Maintenance of Services Pending a Fair Hearing Request*

1. If the Medicaid Program sends a notice to the recipient as required under 42 CFR 431.211 or §431.214, and the recipient requests a hearing before the date of action, the recipient's services will not be terminated or reduced by the Medicaid Program until a decision is rendered after the hearing unless:

a. it is determined at the hearing that the sole issue is one of federal or state law or policy; and

b. the recipient is promptly informed by Medicaid, in writing, that the services are to be terminated or reduced pending the hearing decision.

2. If the Medicaid Program's action is sustained by the hearing decision, recovery procedures may be instituted against the applicant/recipient to recoup the cost of any services furnished, to the extent they were furnished solely by reason of this §101.D.

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 42:901 (June 2016).

Chapter 3. Asset Verification Program

§301. General Provisions

A. Pursuant to §7001(d) of the Supplemental Appropriations Act of 2008 (P.L. 110-252) and §1940 of the Social Security Act, the department hereby establishes provisions to implement an Asset Verification Program (AVP) for Louisiana Medicaid.

B. The department will provide for the verification of assets for the purposes of determining or redetermining (renewing) Medicaid eligibility for aged, blind and disabled Medicaid applicants and recipients of Medicaid using an asset verification system (AVS) which meets the following requirements.

1. The request and response system will be an electronic system and meet the following criteria.

a. Verification inquiries will be sent electronically via the internet or similar means from Medicaid to the financial institution (FI).

b. The system will not be based on mailing paper-based requests.

c. The system will have the capability to accept responses electronically.

C. The system will be secure, based on a recognized industry standard of security.

D. The system will establish and maintain a database of the FIs that will participate in the department's AVS as mandated by federal requirements.

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 42:901 (June 2016).

Chapter 5. Application Processing

§501. Filing Application

A. The bureau requires an applicant to complete and sign a written application in order to initiate the eligibility determination process for Medicaid benefits. The applicant's signature on the application affirms that all of the information contained on the form is true and correct or the applicant could be subject to a penalty for perjury. In order to facilitate the application process, the Bureau authorizes the electronic filing of Medicaid applications. Applications may be signed by the following means:

1. the applicant's signature on a paper application;
2. a personal identification number (PIN); or a digital signature as issued by DHH (in the Louisiana Medicaid Manual).

B. The application may be filed by the applicant or one of the following individuals:

1. a parent;
2. the legal guardian, which is a person legally responsible for the care and management of the person or property of one considered by law to be incompetent to manage his own affairs;
3. a curator, which is any person acting under legal authority for an applicant/recipient who is determined by a court of law to be incompetent to take care of his own person or to administer his estate (an interdict); or

4. someone acting responsibly for the applicant.

C. Assistance with Application

1. The applicant may choose an individual to accompany, assist, and/or represent him/her in the application or renewal process.

2. The bureau must provide assistance if the applicant is unable to participate and has no responsible representation in the application process.

D. Grounds for Accepting/Rejecting Application. The applicant must cooperate in the process of determining eligibility by completing an application form and providing required information. The application may be rejected for non-cooperation only if the applicant, curator, parent or legal guardian is physically and mentally able to make application and provide information and either:

1. does not provide information after being notified; or
2. after being advised of the consequences, has failed to cooperate.

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 30:1483 (July 2004).

§503. Application Date

A. The application date shall be the date the signed Medicaid application is received in the local Medicaid office or in an agency representative's office.

B. The date of receipt shall be protected as the certified date of application, as determined by Subsection A above.

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 30:1025 (May 2004).

§505. Federally-Facilitated Marketplace Determinations

A. Effective April 20, 2016, Louisiana Medicaid will delegate its Medicaid eligibility determination authority to the federally-facilitated marketplace (FFM) in order to begin accepting eligibility determinations made by the FFM for only those individuals who apply for healthcare coverage through the FFM. This action will result in the state becoming a determination state.

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 41:1489 (August 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1091 (July 2016).

Chapter 9. Financial Eligibility

Subchapters A.-C. Reserved.

Subchapter D. Incurred Medical

§939. Medically Needy

A. The following criteria apply to all incurred medical expenses for medically needy.

1. Bills for necessary medical and remedial services furnished more than three months before the Medicaid application is filed will be excluded as an incurred expense. Current payments on excluded expenses will be allowed as an incurred expense.

2. The first budget period for the Medically Needy will begin the first month in the three-month period prior to the date of application in which the applicant received covered services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:1702 (August 2004).

§941. Incurred Medical and Remedial Care Expenses

A. In accordance with 42 C.F.R. Part 435 Subparts H and I, certain medical and remedial care expenses incurred by institutionalized individuals and individuals receiving home and community-based services furnished under a waiver, subject to the reasonable limits specified herein, are

deducted from the individual's income in the calculation of patient liability.

B. Reasonable limits imposed are:

1. For medically necessary care, services, and items not paid under the Medicaid State Plan or, if covered under the Medicaid State Plan, denied due to service limitations.

a. The medical or remedial care must be:

- i. recognized under state law;
- ii. medically necessary as verified by an independent licensed physician or medical director; and
- iii. incurred no earlier than three months preceding the month in which it is reported to the state; and

b. The medical or remedial care cannot be:

- i. for cosmetic or elective purposes, except when medically necessary as verified by an independent licensed physician or medical director; and/or
- ii. for payment of a medical or dental service plan that has not been approved by the Department of Insurance in accordance with the Louisiana Insurance Code, Title 22 of the Louisiana Revised Statutes.

2. The deduction for medical and remedial care expenses that were incurred as a result of imposition of transfer of assets penalty period is limited to \$0.

3. The deduction for medical and remedial care expenses that were incurred as a result of the individual's equity interest in the home exceeding the limit established under 42 U.S.C. §1396p(f) is limited to \$0.

4. The deduction for medical or remedial care expenses that were incurred during a period when the individual is not subject to patient liability is limited to \$0.

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 50:216 (February 2024).

Chapter 11. Express Lane Eligibility

§1101. General Provisions

A. The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, Public Law No. 111-3, established provisions which allowed states to rely on a finding from an Express Lane agency to more effectively reach out and enroll eligible but uninsured children in the Medicaid Program or the Children's Health Insurance Program (CHIP).

B. Express Lane eligibility is an administrative streamlining option that uses data from other government agencies to identify, enroll and retain children who are eligible for Medicaid or CHIP.

C. Express Lane eligibility shall be utilized for enrollment of uninsured children under the age of 19.

D. These provisions shall not apply to eligibility determinations made after September 30, 2013.

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 36:1555 (July 2010)

§1103. Eligibility Determinations

A. The department shall rely on the findings from an Express Lane agency to satisfy one or more of the eligibility components (regardless of any differences in the income budget unit, disregards, deeming of income or other methodologies) required to make an eligibility determination.

1. An Express Lane agency is a public agency that is determined by the department to be capable of making the determinations of one or more of the eligibility requirements defined in the Medicaid State Plan. Express Lane agencies are need-based programs/agencies.

B. The department shall utilize eligibility findings from express lane agencies that administer the:

1. Food and Nutrition Act of 2008 (Supplemental Nutrition Assistance Program/SNAP, also known as the Food Stamp Program);
2. Temporary Assistance for Needy Families;
3. state program funded under title IV-D (child support enforcement services/SES); and
4. Child Care and Development Block Grant Act of 1990.

C. Verification requirements for citizenship or nationality status are applicable to Express Lane eligibility determinations.

D. If a finding from an Express Lane agency results in a determination that a child does not satisfy an eligibility requirement for Medicaid or CHIP, the department shall determine eligibility for assistance using its regular procedures.

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 36:1555 (July 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2534 (December 2017).

§1105. Automatic Enrollment

A. The department may initiate and determine Medicaid eligibility based on data from sources other than the child (or the child's family) without an application form; however, a child can only be automatically enrolled for coverage if the:

1. child or family consents to being enrolled through affirmation and signature on an Express Lane agency application; and

2. department has informed the parent, guardian or custodial relative of the:

- a. services that will be covered;
- b. appropriate methods for using such services;
- c. premium or other cost-sharing charges that apply (if applicable);
- d. medical support obligations created by enrollment (if applicable); and
- e. actions the parent, guardian or relative must take to maintain enrollment and renew coverage.

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 36:1556 (July 2010).

§1107. Disclosure of Eligibility Data

A. Notwithstanding any other provisions of law, Express Lane agencies in possession of data directly relevant to Express Lane eligibility determinations shall convey such data to the department and shall ensure that the individual (or his parent, guardian, caretaker relative, authorized representative) whose circumstances are described in the data has either provided consent to disclosure, or has not objected to disclosure.

1. Such individuals shall be provided with advance notice of disclosure and a reasonable opportunity to object to the disclosure of their information.

B. Express Lane agency sources of data shall include, but is not limited to, the following:

- 1. eligibility files;
 - 2. unemployment compensation benefits;
 - 3. wages and income information;
 - 4. Social Security Administration and Internal Revenue Service information;
 - 5. employer wage reports to a state agency;
 - 6. vital records information about births in any state;
- or
- 7. third party health insurance information.

C. Improper Disclosure Penalties

1. Civil Monetary Penalty. A private entity that publishes, discloses, or makes known in any manner or to any extent not authorized by the department any information obtained for the purposes of Express Lane eligibility may be subject to civil monetary penalties for each unauthorized publication or disclosure, pursuant to §1942 of Title XIX of the Social Security Act.

2. Criminal Penalty. A private entity that willfully publishes, discloses, or makes known in any manner or to any extent not authorized by the department any information under this section shall be fined not more than \$10,000 or

imprisoned not more than 1 year, or both, for each unauthorized publication or disclosure.

3. The limitations and requirements that apply to Express Lane eligibility data disclosure shall not be construed to prohibit the conveyance or disclosure of data or information otherwise permitted under federal law.

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 36:1556 (July 2010).

Subpart 3. Eligibility Groups and Factors

Chapter 23. Eligibility Groups and Medicaid Programs

§2303. Family Opportunity Act Medicaid Program

A. The Family Opportunity Act, signed into law by Congress as part of the Deficit Reduction Act of 2005, allows states to offer a Medicaid buy-in program to families with income up to 300 percent of the federal poverty level (FPL) for children with disabilities who are not eligible for Supplemental Security income (SSI) disability benefits due to excess income or resources. The department hereby implements a Medicaid buy-in program called the Family Opportunity Act Medicaid Program to provide Medicaid coverage to children with disabilities.

B. Eligibility Requirements. Children born on or after October 1, 1989, up to age 19, and who meet the following requirements may receive health care coverage through the Family Opportunity Act Medicaid Program.

1. The child must have a disability which meets the Social Security administration’s childhood disability criteria.

2. Gross family income must not be more than 300 percent of the federal poverty level using the income methodologies of the SSI program.

a. For the purpose of determining family income, the family unit shall consist of the following members:

- i. child(ren) with disabilities;
- ii. natural or legal parent(s); and
- iii. siblings under age 19.

b. Step-parents and step-siblings are excluded from the income determination.

3. The child may be uninsured or underinsured.

a. Parents are required to enroll in available employer-sponsored health plans when the employer contributes at least 50 percent of the annual premium costs. Participation in such employer-sponsored health plans is a condition of continuing Medicaid coverage.

C. Children determined eligible under the Family Opportunity Act Medicaid Program shall receive coverage of

medically necessary health care services provided under the Medicaid state plan.

D. Premium Payments. Families with gross income above 200 percent, but not more than 300 percent of the FPL, are required to pay premiums for Medicaid coverage. Families with gross income up to 200 percent of the FPL are not required to pay premiums for Medicaid coverage.

1. The amounts paid for premiums for Medicaid-required family coverage and other cost-sharing may not exceed 5 percent of a family's income for families with income up to 200 percent of the FPL and 7.5 percent of a family's income for families with income above 200 percent of the FPL.

2. For families with gross income above 200 percent, but not more than 300 percent of the FPL, the premium amount for Medicaid is determined by whether the natural or legal parent(s) living in the household is paying for other creditable health insurance that covers the child(ren) with disabilities.

a. Families who have other creditable health insurance that provides coverage to the child(ren) with disabilities will pay a family Medicaid premium on a sliding scale as follows:

i. \$12 per month for families with income above 200 percent and up to 250 percent of the FPL;

ii. \$15 per month for families with income above 250 percent, but not more than 300 percent of the FPL.

b. Families who do not have other creditable health insurance that provides coverage to the child(ren) with disabilities will pay a family Medicaid premium on a sliding scale as follows:

i. no premium is required for families with income from 0 percent and up to 200 percent of the FPL;

ii. \$30 per month for families with income above 200 percent and up to 250 percent of the FPL;

iii. \$35 per month for families with income above 250 percent, but not more than 300 percent of the FPL.

3. The first premium is due the month following the month that eligibility is established. Prepayment of premiums is not required. A child's eligibility for medical assistance will not terminate on the basis of failure to pay a premium until the failure to pay continues for at least 60 days from the date on which the premium was past due.

4. The premium may be waived in any case where it is determined that requiring a payment would create an undue hardship for the family. Undue hardships exist when a family:

a. is homeless or displaced due to a flood, fire, or natural disaster;

b. resides in an area where there is a presidential-declared emergency in effect;

c. presents a current notice of eviction or foreclosure; or

d. has other reasons as determined by the department.

5. Families whose eligibility has been terminated for non-payment of premiums must pay any outstanding premium balances for Medicaid-covered months before eligibility can be re-established, unless:

a. the liability has been canceled by the Bureau of Appeals or the Medicaid Recovery Unit; or

b. there has been a lapse in Medicaid coverage of at least 12 months.

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 34:1628 (August 2008), amended LR 35:69 (January 2009).

§2305. Provisional Medicaid Program

A. The Provisional Medicaid Program provides Medicaid-only coverage to individuals who:

1. are aged or have a disability; and

2. meet income and resource requirements for supplemental security income (SSI) cash assistance.

B. The Provisional Medicaid Program provides coverage to individuals with income equal to or less than the federal benefit rate (FBR), and resources that are equal to or less than the resource limits of the SSI cash assistance program.

C. A certification period for the Provisional Medicaid Program shall not exceed 12 months.

D. Retroactive coverage up to three months prior to the receipt of the Medicaid application shall be available to recipients in the Provisional Medicaid Program.

1. Any retroactive coverage period shall not be prior to the implementation date of the Provisional Medicaid Program.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1118 (June 2015).

§2307. Youth Aging Out of Foster Care

A. Pursuant to section 477 of the Foster Care Independence Act of 1999 (Public Law 106-169) and Act 352 of the 2008 Regular Session of the Louisiana Legislature, the Department of Health and Hospitals hereby implements a Medicaid eligibility group, effective March 1, 2009, to provide health care coverage to youth who are transitioning out of foster care to self-sufficiency upon reaching age 18. This eligibility group will be called youth aging out of foster care.

B. Eligibility Requirements. Youth who are aging out of foster care on or after March 1, 2009 and meet all of the

following requirements may receive Medicaid health care coverage under this new eligibility group.

1. The youth must be from age 18 up to age 21.
2. The youth must have been in foster care and in state custody, either in Louisiana or another state, upon obtaining age 18.
3. The youth must live in Louisiana.

C. Income, resources and insurance status are not considered when determining eligibility.

D. Individuals determined eligible in this group shall receive coverage of medically necessary health care services provided under the Medicaid state plan.

1. The assistance unit shall consist of the youth only.

E. Eligibility for the program will continue until the youth reaches age 21 unless the youth:

1. moves out of state;
2. requests closure of the case;
3. is incarcerated; or
4. dies.

F. Application Process. No application is required for this eligibility group. Closure of a foster care case due to the youth reaching age 18 establishes eligibility.

G. Certification Period. The certification period shall begin the month the youth reaches age 18 and will end on the last day of the month in which the youth reaches age 21.

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 35:2449 (November 2009).

§2308. Former Foster Care Children Group

A. Pursuant to the Patient Protection and Affordable Care Act of 2010 (collectively referred to as the Affordable Care Act), the Department of Health implemented a Medicaid eligibility group, effective December 31, 2013, to provide health care coverage to youth who are transitioning out of foster care to self-sufficiency upon reaching age 18 or at a higher age selected by the department. This eligibility group is called former foster care children group.

B. Eligibility Requirements

1. For youth who turned age 18 prior to January 1, 2023, the youth must meet all of the following requirements to receive Medicaid health care coverage under this eligibility group:

- a. be from age 18 to 26 years old;
- b. is not eligible or enrolled in another mandatory eligibility group described in sections 1902(a)(10)(A)(i)(I)-(VII) of the Social Security Act;
- c. was in foster care under Louisiana's custody and receiving Medicaid upon turning age 18 or upon aging out of

foster care at a higher age elected by the state in its title IV-E plan (up to age 21); and

- d. resides in Louisiana.

2. For youth who turned age 18 on or after January 1, 2023, the youth must meet all of the following requirements to receive Medicaid health care coverage under this eligibility group:

- a. be from age 18 to 26 years old;
- b. is not enrolled in another mandatory eligibility group described in sections 1902(a)(10)(A)(i)(I)-(VII) of the Social Security Act;
- c. was in foster care under the responsibility of any state and receiving Medicaid upon turning age 18 or such higher age (up to 21) as the state has elected in its title IV-E plan; and
- d. resides in Louisiana.

C. Income, resources and insurance status are not considered when determining eligibility.

D. Individuals determined eligible in this group shall receive coverage of medically necessary health care services provided under the Medicaid state plan.

1. The assistance unit shall consist of the youth only.

E. Eligibility for the program will continue until the youth reaches age 26 unless the youth:

1. moves out of state;
2. requests closure of the case; or
3. dies.

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 40:2260 (November 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1389 (July 2017), LR 49:1728 (October 2023).

§2309. Medicaid Purchase Plan [Formerly LAC 50:III.763-765]

A. Effective January 1, 2004, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing implemented the Medicaid Purchase Plan Program for workers with disabilities under title XIX of the Social Security Act. The Medicaid Purchase Plan allows persons who meet the Social Security disability criteria to seek the employment services, vocational rehabilitation services, and other support services needed to obtain, regain or maintain employment, and reduce their independence on cash benefit programs.

B. Recipient Eligibility. Effective January 1, 2014, the Medicaid purchase plan shall cover workers with disabilities who meet the following criteria:

1. are employed;
2. are age 16 through age 64;

3. meet the Social Security Administration criteria for disability;
4. have net income less than 100 percent of the federal poverty level;
5. have countable resources (assets) less than \$10,000;
 - a. all life insurance policies, medical savings accounts, and retirement accounts shall be counted towards the resource limit; and
6. are enrolled in no-cost health insurance.

C. Spousal income and resources shall be counted towards the income and resource limits.

D. Effective January 1, 2014, buy-in premiums shall be eliminated from the Medicaid Purchase Plan Program.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3299 (December 2013).

§2311. Louisiana Health Insurance Premium Payment Program

A. Section 1906 of Title XIX of the Social Security Act mandates that Medicaid recipients enroll, and maintain their enrollment, in cost-effective group health insurance plans as a condition of Medicaid eligibility if such a plan is available. In compliance with section 1906, the department hereby establishes the Louisiana Health Insurance Premium Payment (LaHIPP) Program to provide Medicaid payment of the costs associated with the enrollment of recipients in cost-effective group health insurance plans.

B. Medicaid recipients shall be enrolled in LaHIPP when cost-effective health plans are available through the recipient's employer or a responsible party's employer-based health plan if the recipient is enrolled or eligible for such a health plan.

1. The enrollment period for the LaHIPP Program shall be no less than six months.

C. When coverage for eligible family members is not possible unless ineligible family members are enrolled, the Medicaid Program will pay the premiums for the enrollment of other family members when it is cost-effective.

D. The recipient, or the individual acting on behalf of the recipient, shall cooperate to establish the availability and cost effectiveness of group health insurance.

1. Medicaid benefits of the parent may be terminated for failure to cooperate unless good cause for non-cooperation is established. Medicaid benefits for a child shall not be terminated due to the parent's or authorized representative's failure to cooperate.

E. Continued eligibility for this program is dependent upon the individual's ongoing eligibility for Medicaid.

F. LaHIPP recipients shall be entitled to coverage of the patient responsibility amounts for services covered under the

group health insurance to the extent allowed under the Medicaid State Plan and for all services that are not covered by the group health insurance but are provided for under the Medicaid State Plan and rendered by Medicaid providers.

G. The department shall be entitled to any rate refund made when the health insurance carrier determines a return of premiums to the policy holder is due because of lower than anticipated claims for any period of time in which the department paid the premiums.

H. The Medicaid Program will make the determination whether the group health insurance plan(s) available to the recipient is cost effective.

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 43:664 (April 2017).

§2313. Medically Needy Program

A. The Medically Needy Program (MNP) provides Medicaid coverage when an individual's or family's income and/or resources are sufficient to meet basic needs in a categorical assistance program, but not sufficient to meet medical needs according to the MNP standards.

1. The income standard used in the MNP is the federal medically needy income eligibility standard (MNIES).

2. Resources are not applicable to modified adjusted gross income (MAGI) related MNP cases.

3. MNP eligibility cannot be considered prior to establishing income ineligibility in a categorically related assistance group.

B. MNP Eligibility Groups

1. Regular Medically Needy

a. Prior to the implementation of the MAGI income standards, parents who met all of the parent and caretaker relative (PCR) group categorical requirements and whose income was at or below the MNIES were eligible to receive Regular MNP benefits. With the implementation of the MAGI-based methodology for determining income and household composition and the conversion of net income standards to MAGI equivalent income standards, individuals who would have been eligible for the Regular Medically Needy Program are now eligible to receive Medicaid benefits under the parent and caretaker relative eligibility group. Regular medically needy coverage is only applicable to individuals included in the MAGI-related category of assistance.

b. Individuals in the non-MAGI [formerly aged (A-), blind (B-), or disability (D-)] related assistance groups cannot receive Regular MNP.

c. The certification period for Regular MNP cannot exceed six months.

2. Spend-Down Medically Needy

a. Spend-Down MNP is considered after establishing financial ineligibility in categorically related Medicaid programs and excess income remains. Allowable medical bills/expenses incurred by the income unit, including skilled nursing facility coinsurance expenses, are used to reduce (spend-down) the income to the allowable MNP limits.

b. The following individuals may be considered for Spend-Down MNP:

- i. individuals who meet all of the parent and caretaker relative group requirements;
- ii. non-institutionalized individuals (non-MAGI related); and
- iii. institutionalized individuals or couples (non-MAGI related) with Medicare co-insurance whose income has been spent down.

c. The certification period for spend-down MNP begins no earlier than the spend-down date and shall not exceed three months.

3. Long Term Care (LTC) Spend-Down MNP

a. Individuals residing in Medicaid LTC facilities, not on Medicare-coinsurance with resources within the limits, but whose income exceeds the special income limits (three times the current federal benefit rate), are eligible for LTC Spend-Down MNP.

C. The following services are covered in the Medically Needy Program:

1. inpatient and outpatient hospital services;
2. intermediate care facilities for persons with intellectual disabilities (ICF/ID) services;
3. intermediate care and skilled nursing facility (ICF and SNF) services;
4. physician services, including medical/surgical services by a dentist;
5. nurse midwife services;
6. certified registered nurse anesthetist (CRNA) and anesthesiologist services;
7. laboratory and x-ray services;
8. prescription drugs;
9. early and periodic screening, diagnosis and treatment (EPSDT) services;
10. rural health clinic services;
11. hemodialysis clinic services;
12. ambulatory surgical center services;
13. prenatal clinic services;
14. federally qualified health center services;
15. family planning services;

16. durable medical equipment;
17. rehabilitation services (physical therapy, occupational therapy, speech therapy);
18. nurse practitioner services;
19. medical transportation services (emergency and non-emergency);
20. home health services for individuals needing skilled nursing services;
21. chiropractic services;
22. optometry services;
23. podiatry services;
24. radiation therapy; and
25. behavioral health 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, Bureau of Health Services Financing, LR 42:1888 (November 2016).

§2315. LaMOMS Program

A. Pursuant to the provisions of the Omnibus Budget Reconciliation Act of 1986, the Department of Health, Bureau of Health Services Financing shall provide health care coverage through the LaMOMS Program to Medicaid eligible pregnant women with low income under the Medicaid state plan.

B. Eligibility Requirements. Eligibility for LaMOMS coverage may begin at any time during a pregnancy, and as early as three months prior to the month of application. Eligibility cannot begin before the first month of pregnancy. The pregnant woman must be pregnant for each month of eligibility, except for the 12-month postpartum period.

C. Financial Eligibility. Effective January 1, 2014, the LaMOMS Program shall provide Medicaid coverage to pregnant women with family income up to 133 percent of the federal poverty level. For applicants with income above 133 percent of the federal poverty level, 5 percent of the federal poverty level shall be disregarded from their income.

1. Changes in income shall be disregarded during the period of pregnancy and for the 12-month postpartum period.

D. The LaMOMS program shall provide Medicaid coverage for:

1. prenatal care;
2. delivery;
3. conditions which may complicate the pregnancy; and
4. postpartum care during the 12-month postpartum period.

E. Certification Period

1. Eligibility for the pregnant women group may begin:

- a. at any time during a pregnancy; and
- b. as early as three months prior to the month of application.

2. Eligibility cannot begin before the first month of pregnancy. The pregnant women group certification may extend through the calendar month in which the 12-month postpartum period ends.

3. An applicant/enrollee whose pregnancy terminated in the month of application or in one of the three months prior without a surviving child shall be considered a pregnant woman for the purpose of determining eligibility in the pregnant women group.

4. Certification shall be from the earliest possible month of eligibility (up to three months prior to application) through the month in which the 12-month postpartum period ends.

5. Retroactive eligibility shall be explored regardless of current eligibility status.

a. If the applicant/enrollee is eligible for any of the three prior months, she remains eligible throughout the pregnancy and 12-month postpartum period. When determining retroactive eligibility, actual income received in the month of determination shall be used.

b. If application is made after the month her pregnancy ends, the period of eligibility will be retroactive but shall not start more than three months prior to the month of application. The start date of retroactive eligibility is determined by counting back three months prior to the date of application. The start date will be the first day of that month.

6. Coverage during the 12-month postpartum period is only available to an individual who is eligible for medical assistance under the state plan while pregnant, including during a period of retroactive eligibility.

7. Eligibility may not extend past the month in which the 12-month postpartum period ends.

a. The 12-month postpartum period begins on the last day of pregnancy.

b. The 12-month postpartum period ends the last day of the month in which the 12-month postpartum period has expired.

8. The applicant/enrollee must be income eligible during the initial month of eligibility only. Changes in income after the initial month will not affect eligibility.

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 39:3299 (December 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 48:499 (March 2022).

§2317. New Adult Eligibility Group

A. Pursuant to the Patient Protection and Affordable Care Act (P.L. No. 111-148), hereafter referred to as the Affordable Care Act (ACA), and §1937 of title XIX of the Social Security Act, the department will expand Medicaid coverage to a targeted new eligibility group, hereafter referred to as the new adult group.

B. Effective July 1, 2016, the department will establish a new Medicaid eligibility category for the new adult group, as defined in §1905(y)(2)(A) of title XIX of the Social Security Act.

C. Eligibility Requirements. Coverage in the new adult group will be provided to individuals with household income up to 133 percent of the federal poverty level with a 5 percent income disregard who are:

1. from age 19 to 65 years old;
2. not pregnant;
3. not entitled to, or enrolled in Medicare Part A or Medicare Part B;
4. not otherwise eligible for and enrolled in mandatory coverage under the Medicaid State Plan;

a. parents, children or disabled persons receiving Supplemental Security Income (SSI) benefits are excluded from enrollment as a new adult; and

5. parents or other caretaker relatives living with a dependent child(ren) under age 19 who are receiving benefits under Medicaid, the Children's Health Insurance Program, or otherwise enrolled in minimum essential coverage as defined in 42 CFR 435.4.

D. Covered Services. The new adult group will be provided with a benefit package which incorporates the benefits and services covered under the Medicaid State Plan including essential health benefits as provided in §1302(b) of ACA effective July 1, 2016.

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 42:755 (May 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1889 (November 2016).

§2325. Medicare Savings Programs

A. Medical assistance furnished to qualified Medicare beneficiaries (QMB), specified low income beneficiaries (SLMB) and qualified individuals (QI) is commonly referred to as the Medicare Savings Programs (MSP). Medicaid coverage under these programs is limited to payment of Medicare premiums, and may pay deductibles and co-insurance.

1. Effective January 1, 2010, with the consent of an individual completing an application for low income subsidy (LIS) benefits, the Social Security Administration will transmit LIS data to Medicaid.

2. Medicaid shall use the data to initiate an application for the individual for benefits under the Medicare Savings Program.

3. The date that the LIS application is filed with the Social Security Administration will be used as the date of application for MSP and for determining the effective date of MSP eligibility.

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 36:2867 (December 2010).

§2327. Modified Adjusted Gross Income (MAGI) Groups

A. For eligibility determinations effective December 31, 2013 eligibility shall be determined by modified adjusted gross income (MAGI) methodology in accordance with section 1004(a)(2) of the Patient Protection and Affordable Care Act (ACA) of 2010 and section 36B(d)(2)(B) of the *Internal Revenue Code*, for the following groups:

1. parents and caretaker relatives group which includes adult individuals formerly considered for low income families with children as parents or caretaker relatives;

2. pregnant women;

3. child related groups; and

4. other adult related groups including breast and cervical cancer, tuberculosis (TB) and family planning.

B. A MAGI determination will be necessary for each individual in the home for whom coverage is being requested. The MAGI household resembles the tax household.

1. MAGI Household. The individual's relationship to the tax filer and every other household member must be established for budgeting purposes. The MAGI household is constructed based on whether an individual is a:

a. tax filer;

b. tax dependent; or

c. non-filer (neither tax filer or tax dependent).

2. For the tax filer the MAGI household includes the tax filer and all claimed tax dependents.

a. Whether claimed or not, the tax filer's spouse, who lives in the home, must be included.

b. If a child files taxes and is counted as a tax dependent on his/her parent's tax return, the child is classified as a tax dependent not a tax filer.

3. When taxes are filed for the tax dependent the MAGI household consists of the tax filer and all other tax dependents unless one of the following exceptions is met:

a. being claimed as a tax dependent by a tax filer other than a parent or spouse (for example, a grandchild, niece, or tax filer's parent);

b. children living with two parents who do not expect to file a joint tax return (including step-parents); or

c. children claimed as a tax dependent by a non-custodial parent.

4. For individuals who do not file taxes nor expect to be claimed as a tax dependent (non-filer), the MAGI household consists of the following when they all live together:

a. for an adult:

i. the individual's spouse; and

ii. the individual's natural, adopted, and step-children under age 19; and

b. for a minor:

i. the individual's natural, adoptive, or step-parents; and

ii. the individual's natural, adopted, and step-siblings under age 19.

C. Parents and Caretaker Relatives Group

1. A caretaker relative is a relative of a dependent child by blood, adoption, or marriage with whom the child is living, and who assumes primary responsibility for the child's care. A caretaker relative must be one of the following:

a. parent;

b. grandparent;

c. sibling;

d. brother-in-law;

e. sister-in-law;

f. step-parent;

g. step-sibling;

h. aunt;

i. uncle;

j. first cousin;

k. niece; or

l. nephew.

2. The spouse of such parents or caretaker relatives may be considered a caretaker relative even after the marriage is terminated by death or divorce.

3. The assistance/benefit unit consists of the parent and/or caretaker relative and the spouse of the parent and/or caretaker relative, if living together, of child(ren) under age 18, or age 18 and a full-time student in high school or vocational/technical training. Children are considered deprived if income eligibility is met for the parents and

caretaker relatives group. Children shall be certified in the appropriate children's category.

D. Pregnant Women Group

1. Eligibility for the pregnant women group may begin:

- a. at any time during a pregnancy; and
- b. as early as three months prior to the month of application.

2. Eligibility cannot begin before the first month of pregnancy. The pregnant women group certification may extend through the calendar month in which the 12-month postpartum period ends.

3. An applicant/enrollee whose pregnancy terminated in the month of application or in one of the three months prior without a surviving child shall be considered a pregnant woman for the purpose of determining eligibility in the pregnant women group.

4. Certification shall be from the earliest possible month of eligibility (up to three months prior to application) through the month in which the 12-month postpartum period ends.

5. Retroactive eligibility shall be explored regardless of current eligibility status.

a. If the applicant/enrollee is eligible for any of the three prior months, she remains eligible throughout the pregnancy and 12-month postpartum period. When determining retroactive eligibility actual income received in the month of determination shall be used.

b. If application is made after the month her pregnancy ends, the period of eligibility will be retroactive but shall not start more than three months prior to the month of application. The start date of retroactive eligibility is determined by counting back three months prior to the date of application. The start date will be the first day of that month.

6. Coverage during the 12-month postpartum period is only available to an individual who is eligible for medical assistance under the state plan while pregnant, including during a period of retroactive eligibility.

7. Eligibility may not extend past the month in which the 12-month postpartum period ends.

a. The 12-month postpartum period begins on the last day of pregnancy.

b. The 12-month postpartum period ends the last day of the month in which the 12-month postpartum period has expired.

8. The applicant/enrollee must be income eligible during the initial month of eligibility only. Changes in income after the initial month will not affect eligibility.

E. Child Related Groups

1. Children Under Age 19—CHAMP. CHAMP children are under age 19 and meet income and non-financial eligibility criteria. ACA expands mandatory coverage to all children under age 19 with household income at or below 133 percent federal poverty level (FPL). Such children are considered CHAMP children.

2. Children Under Age 19—LaCHIP. A child covered under the Louisiana State Children's Health Insurance Program (LaCHIP) shall:

- a. be under age 19;
- b. not be eligible for Medicaid under any other optional or mandatory eligibility group or eligible as medically needy (without spend-down liability);
- c. not be eligible for Medicaid under the policies in the state's Medicaid plan in effect on April 15, 1997;
- d. not have health insurance; and
- e. have MAGI-based income at or below 212 percent (217 percent FPL with 5 percent disregard) of the federal poverty level.

3. Children Under Age 19—LaCHIP Affordable Plan. A child covered under the Louisiana State Children's Health Insurance Program (LaCHIP) Affordable Plan shall:

- a. be under age 19;
- b. not be income eligible for regular LaCHIP;
- c. have MAGI-based income that does not exceed 250 percent FPL;
- d. not have other insurance or access to the State Employees Health Plan;
- e. have been determined eligible for child health assistance under the State Child Health Insurance Plan; and
- f. be a child whose custodial parent has not voluntarily dropped the child(ren) from employer sponsored insurance within the last three months without good cause. Good cause exceptions to the three month period for dropping employer sponsored insurance are:
 - i. the premium paid by the family for coverage of the child under the group health plan exceeded 5 percent of household income;
 - ii. the child's parent is determined eligible for advance payment of the premium tax credit for enrollment in a qualified health plan (QHP) through the marketplace because the employer-sponsored insurance (ESI) in which the family was enrolled is determined unaffordable in accordance with 26 CFR 1.36B-2(c)(3)(v);
 - iii. the cost of family coverage that includes the child exceeded 9.5 percent of the household income;
 - iv. the employer stopped offering coverage of dependents (or any coverage) under an employer-sponsored health insurance plan;

v. a change in employment, including involuntary separation, resulted in the child's loss of employer-sponsored insurance (other than through full payment of the premium by the parent under the Consolidated Omnibus Reconciliation Act of 1985 (COBRA));

vi. the child has special health care needs;

vii. the child lost coverage due to the death or divorce of a parent;

viii. involuntary termination of health benefits due to a long-term disability or other medical condition;

ix. the child has exhausted coverage under the COBRA continuation provision (i.e., COBRA expired); or

x. lifetime maximum has been reached.

4. Children Under Age 19-Phase IV LaCHIP (SCHIP). The State Child Health Insurance Program (SCHIP) provides prenatal care services, from conception to birth, for low income uninsured mothers who are not otherwise eligible for other Medicaid programs, including CHAMP pregnant women benefits. This program, phase IV LaCHIP, also covers non-citizen women who are not qualified for other Medicaid programs due to citizenship status only.

F. Regular and Spend Down Medically Needy MAGI. Regular and spend down medically needy shall use the MAGI determination methodology.

G. Former Foster Care Children. Former foster care children are applicants/enrollees under 26 years of age, who were in foster care under the responsibility of the state at the time of their eighteenth birthday, and are not eligible or enrolled in another mandatory coverage category.

1. Former foster care children may also be applicants/enrollees who:

a. have lost eligibility due to moving out of state, but re-established Louisiana residency prior to reaching age 26.

2. Former foster care children must:

a. be at least age 18, but under age 26;

b. currently live in Louisiana;

c. have been a child in foster care in any state's custody upon reaching age 18; and

d. not be eligible for coverage in another mandatory group.

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 41:945 (May 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 48:499 (March 2022).

§2329. Lawfully Resident Children

A. The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, Public Law No. 111-3, established provisions which allow states the option

of providing Medicaid and Children's Health Insurance Program (CHIP) coverage to children up to age 19 who are lawfully residing in the United States, including those within their first five years of having certain legal status.

B. The department shall utilize the CHIPRA Option under P.L. 111-3 provisions for the enrollment of children, up to age 19, who are lawfully residing in the United States.

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 45:44 (January 2019).

§2330. Twelve-Months Postpartum Medicaid Coverage

A. Pursuant to the provisions of the section 9812 of the American Rescue Plan Act of 2021, the Department of Health, Bureau of Health Services Financing shall provide, during a five year period beginning April 1, 2022, that an individual who, while pregnant, is eligible for and has received medical assistance under the state plan or waiver of such plan including during a period of retroactive eligibility, shall remain eligible for a 12-month postpartum period. The 12-month postpartum period begins on the last day of pregnancy and ends on the last day of the month in which the 12-month postpartum period has expired.

B. The medical assistance provided for the pregnant or postpartum individual shall:

1. include all items and services covered under the state plan (or waiver) that are not less in amount, duration, or scope to the medical assistance available for an individual described in section 1902(a)(10)(A)(i) of the Social Security Act; and

2. be provided for the individual while pregnant and during the 12-month period that begins on the last day of the individual's pregnancy and ends on the last day of the month in which such 12-month period ends.

C. Coverage Under CHIP. A targeted low-income child who while pregnant, is eligible for and has received title XXI child health assistance, shall remain eligible for a 12-month postpartum period. The 12-month postpartum period begins on the last day of pregnancy and ends on the last day of the month in which the 12-month postpartum period has expired.

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 48:500 (March 2022).

Subpart 3. Eligibility Groups and Factors

Chapter 23. Eligibility Groups and Medicaid Programs

§2331. Act 421 Children's Medicaid Option (Act 421-CMO/TEFRA)

A. Pursuant to section 1902(e)(3) of the Social Security Act the state may extend Medicaid eligibility to certain children living in the community, who require the level of care provided in an institution, and who would be eligible for Medicaid if living in an institution.

B. Effective January 1, 2022, the department implemented the Act 421 Children's Medicaid Option (Act 421-CMO) program to provide Medicaid State Plan services to children with disabilities who, despite parental or household income and resources, meet the eligibility criteria set forth in this Section.

C. Eligibility Criteria. In order to qualify for the 421-CMO program, an applicant/Act 421-CMO beneficiary must meet all of the following criteria:

1. is 18 years of age or younger (under 19 years of age);
2. is a U.S. citizen or qualified non-citizen;
3. is a Louisiana resident;
4. has countable resources that are equal to or less than the resource limits for the Supplemental Security Income (SSI) program;
5. has countable income equal to or less than the special income level for long-term care services (nursing facility, ICF/IID, and home and community-based services);
6. qualifies as a disabled individual under section 1614(a) of the Social Security Act;
7. must meet a level of care, assessed on an annual basis, provided in an intermediate care facility for individuals with intellectual disabilities (ICF/IID), a nursing facility, or a hospital; and
8. care needs are being safely met at home at a lower cost than the cost of services provided in an institutional setting.

D. Act 421 Children's Medicaid Option (Act 421-CMO/TEFRA) Levels of Care

1. The individual meets Act 421-CMO ICF/IID level of care when demonstrating both of the following:
 - a. has obtained a statement of approval from the Office for Citizens with Developmental Disabilities, or its designee, or EarlySteps eligibility (depending on age) confirming that he/she has a developmental disability as defined in R.S. 28:451.2; and

- b. meets the requirements for active treatment of a developmental disability under the supervision of a qualified developmental disability professional, as prescribed on the Request for Medical Eligibility Determination, Form 90-L.

2. The individual meets Act 421-CMO nursing facility level of care when demonstrating both of the following, assessed in accordance with the Act 421 Children's Medicaid Option assessment tool:

- a. has a diagnosis of a medical/physical condition resulting in needs requiring long term care services of at least six months; and
 - b. requires skilled nursing interventions and/or has substantial functional limitations (SFLs) requiring hands-on assistance from others throughout the day.

3. The individual meets hospital level of care when demonstrating all of the following, assessed in accordance with the Act 421 Children's Medicaid Option assessment tool:

- a. the need for frequent medical care that requires the use of equipment to prevent life-threatening situations, with skilled medical care required more than once during each 24-hour period;
 - b. the need for skilled medical interventions that are expected to persist for at least six months; and
 - c. an overall health condition that is unstable, presenting the constant potential for complications or rapid deterioration, such that he/she requires monitoring by professional nurses, parents, or other properly instructed individuals, in order to detect unstable and life-threatening conditions and respond promptly with appropriate care.

E. Cost Effectiveness

1. On an annual basis, each 421-CMO beneficiary's expenditures will be measured against the average cost of care in an institution that corresponds to his/her level of care (i.e. hospital, ICF/IID, nursing facility) to ensure that home and community-based care is more cost effective than institutional care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:977.21-977.25, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 47:1872 (December 2021), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 49:1222 (July 2023).

Chapter 25. Eligibility Factors

§2523. Citizenship

A. Qualified Non-Citizens

1. The department hereby adopts criteria for the coverage of qualified non-citizens pursuant to the provisions of §401 of the Personal and Work Opportunity Act of 1996 (P.L. 104-193) as amended by the Balanced Budget Act of 1997 (P.L. 105-33).

2. The department elects to provide regular Medicaid coverage to optional qualified non-citizens who were in the United States prior to August 22, 1996, who meet all eligibility criteria.

3. Qualified non-citizens entering the United States on or after August 22, 1996 are not eligible for Medicaid coverage for five years after entry into the United States.

a. Such qualified non-citizens are eligible for emergency services only.

b. Upon expiration of the five-year period, coverage for regular Medicaid services shall be considered if the qualified non-citizen meets all eligibility criteria.

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 45:44 (January 2019).

§2525. Twelve-Month Continuous Eligibility

A. Act 128 of the First Extraordinary Session of the 1998 Louisiana Legislature authorized the Department to adopt the guaranteed eligibility option for children, pursuant to §4731 of the Balanced Budget Act (BBA) of 1997. These provisions allow states to guarantee Medicaid eligibility for children, under age 19, for up to 12 months from the date of determination.

B. Children who are under age 19 and certified in a child-related or family-related category of assistance are entitled to 12 months of continuous Medicaid eligibility as long as eligibility does not extend beyond the child's nineteenth birthday.

C. A child's eligibility may not be terminated during a continuous eligibility period, regardless of any changes in circumstances, unless the child meets an exception set forth in 42 CFR 435.926(d) or 42 CFR 457.342.

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 34:253 (February 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 47:737 (June 2021), LR 49:1394 (August 2023).

§2529. Hospital Presumptive Eligibility

A. Effective December 31, 2013 any hospital designated by Louisiana Medicaid as a hospital presumptive eligibility qualified provider (HPEQP) may obtain information and determine hospital presumptive eligibility (HPE) for individuals who are not currently enrolled in Medicaid and who are in need of medical services covered under the state plan.

1. Coverage groups eligible to be considered for hospital presumptive eligibility include:

- a. parents and caretaker relatives;
- b. pregnant women;
- c. children under age 19;

- d. former foster care children;
- e. family planning; and
- f. certain individuals needing treatment for breast or cervical cancer.

B. Qualified Hospitals. Qualified hospitals shall be designated by the department as entities qualified to make presumptive Medicaid eligibility determinations based on preliminary, self-attested information obtained from individuals seeking medical assistance.

1. A qualified hospital shall:

a. be enrolled as a Louisiana Medicaid provider under the Medicaid state plan or a Medicaid 1115 demonstration;

b. not be suspended or excluded from participating in the Medicaid Program;

c. have submitted a statement of interest in making presumptive eligibility determinations to the department; and

d. agree to make presumptive eligibility determinations consistent with the state policies and procedures.

C. The qualified hospital shall educate the individuals on the need to complete an application for full Medicaid and shall assist individuals with:

1. completing and submitting the full Medicaid application; and

2. understanding any document requirements as part of the full Medicaid application process.

D. Eligibility Determinations

1. Household composition and countable income for HPE coverage groups are based on modified adjusted gross income (MAGI) methodology.

2. The presumptive eligibility period shall begin on the date the presumptive eligibility determination is made by the qualified provider.

3. The end of the presumptive eligibility period is the earlier of:

a. the date the eligibility determination for regular Medicaid is made, if an application for regular Medicaid is filed by the last day of the month following the month in which the determination for presumptive eligibility is made; or

b. the last day of the month following the month in which the determination of presumptive eligibility is made, if no application for regular Medicaid is filed by that date.

4. Those determined eligible for presumptive eligibility shall be limited to no more than one period of eligibility in a 12-month period, starting with the effective date of the initial presumptive eligibility period.

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 41:946 (May 2015).

Subpart 5. Financial Eligibility

Chapter 103. Income

§10305. Income Disregards

A. For recipients in the Family Opportunity Act Medicaid Program, an income disregard of \$85 will be applied to total gross (earned and unearned) family income and then half of the remaining income will be disregarded.

B. During the eligibility determination process for home and community-based services, an individual shall be considered eligible under the Medicaid State Plan as though the individual was a resident in a nursing facility or intermediate care facility for persons with developmental disabilities (ICF/DD) and an income disregard shall be applied to gross income over the special income level.

1. The special income level used to determine financial eligibility for long-term care services (nursing facility, ICF/DD, and home and community-based services) is three times the Supplemental Security Income federal benefit rate.

2. Gross income may exceed the special income level but cannot be more than the highest Medicaid facility rate (nursing or ICF/DD, as applicable) in the state at the time of application for home and community-based services.

3. Income disregarded in the initial eligibility determination process will not be disregarded in the post-eligibility process for determining contributions toward the cost of care.

4. The personal care needs amount (the amount of income protected to cover the expense of living in the community) remains capped at the special income level.

5. All income over the special income level shall be contributed towards the cost of care.

C. Effective December 31, 2013, the income of children ages 6 to 19 from 100 percent up to 142 percent of the federal poverty level shall be disregarded.

D. Effective December 31, 2013, the income of parents or siblings of pregnant unmarried minors (PUMs) or pregnant minor unmarried mothers (MUMs) will not be included when determining Medicaid eligibility for a PUM or pregnant MUM.

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 34:1629 (August 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1898 (September 2009), LR 40:2260, 2261 (November 2014).

§10307. Modified Adjusted Gross Income (MAGI) Groups

A. MAGI-based

1. Income shall be calculated in accordance with 42 CFR §435.603 and §457.315.

B. Financial eligibility for the MAGI groups shall be made using income received in the calendar month prior to the month of application or renewal as an indicator of anticipated income. The taxable gross income of each member of the MAGI household shall be used. Income eligibility of the household shall be based on anticipated income and circumstances unless it is discovered that there are factors that will affect income currently or in future months.

1. Income eligibility is determined by prospective income budgeting or actual income budgeting.

a. Prospective income budgeting involves looking at past income to determine anticipated future income. Income earned in the calendar month prior to the month of application or renewal which the applicant/enrollee earned shall be used to determine expected income in the current and future months.

b. Actual income budgeting involves looking at income actually received within a specific month to determine income eligibility for that month. Actual income shall be used for all retroactive coverage. Actual income or the best estimate of anticipated actual income shall be used if:

- i. the income terminates during the month;
- ii. the income begins during the month; or
- iii. the income is interrupted during the month.

2. The net countable income for the individual's household shall be compared to the applicable income standard for the household size to determine eligibility.

a. If the countable income is below the income standard for the applicable MAGI group, the individual is income eligible.

b. If the countable income is above the income standard for the applicable MAGI group, the individual is income ineligible.

C. Federal Poverty Income Guidelines (FPIG). Eligibility shall be based upon the following guidelines using the federal poverty income guidelines and adjusted to account for the 5 percent disregard:

1. parents/caretakers, income is less or equal to 24 percent FPIG;

2. pregnant women, income is less or equal to 138 percent FPIG;

3. CHAMP (children 0-18), income is less or equal to 147 percent FPIG;

4. LaCHIP, income is less or equal to 217 percent FPIG;

5. LaCHIP IV (unborn option), income is less or equal to 214 percent FPIG;

6. LaCHIP Affordable Plan, income is less or equal to 255 percent FPIG;

7. Adult Group, income is less than or equal to 138 percent FPIG; and

8. Take Charge Plus, income is less than or equal to 138 percent FPIG.

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 41:947 (May 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 46:29 (January 2020).

Chapter 107. Resources

§10703. General Provisions

A. Medicaid utilizes the income and asset methodologies of the Supplemental Security Income (SSI) Program to determine Medicaid eligibility for aged, blind and disabled individuals.

B. Under Section 1902(r)(2) of the Social Security Act, states are allowed to use less restrictive income and asset methodologies in determining eligibility for most Medicaid eligibility groups than are used by the cash assistance program.

C. The following individual's resources shall be considered in determining eligibility for the Qualified Disabled and Working Individual (QDWI) Program:

1. the applicant/recipient; and
2. the spouse living in the home with the applicant/recipient.

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 36:2867 (December 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:1772 (December 2019), LR 46:1392 (October 2020).

§10705. Resource Disregards

A. In compliance with the Deficit Reduction Act, individuals who are insured under a long-term care insurance policy that meets the requirements of a "qualified state long-term care insurance partnership" policy shall receive a disregard of resources equal to the amount paid under the insurance policy.

1. The Medicaid Program shall accept the certification of the Louisiana Commissioner of Insurance that the long-term care policy meets the requirements of a "qualified long-term care insurance partnership" policy.

B. The resource disregard is determined on a 1:1 ratio. For each \$1 of a qualifying long-term care insurance partnership policy benefit amount paid, \$1 of countable resources is disregarded or excluded during the eligibility determination process.

1. The disregard is permitted at the time a recipient begins receiving benefits from a qualifying long-term care insurance partnership policy.

C. All resources shall be disregarded in eligibility determinations for the Qualified Medicare Beneficiaries (QMB), Specified Low Income Beneficiaries (SLMB) and Qualifying Individuals (QI) Programs.

D. Modified Adjusted Gross Income (MAGI) Groups. Resources will be disregarded for those groups using the MAGI determinations methodology.

E. Disregard from resources unspent funds received as a class member pursuant to a class settlement in the case of *Nancy Anderson, et al. v. Bob Dean Jr., et al.*, 24th Judicial District Court, Parish of Jefferson. No. 820-839.

F. Resources accumulated from March 18, 2020 through March 31, 2023, that, but for the continuous enrollment provision at section 6008(b)(3) of the Families First/Coronavirus Response Act, would have been paid toward the cost of a beneficiary's home and community-based services waiver or institutional services based on the application of post-eligibility treatment of income, will be disregarded through the twelfth month following the first full redetermination of the beneficiary's eligibility conducted after March 31, 2023.

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 Aging and Adult Services, LR 35:1899 (September 2009), amended LR 36:2867 (December 2010), LR 41:949 (May 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 45:1772 (December 2019), LR 46:1393 (October 2020), LR 49:876 (May 2023), LR 49:1223 (July 2023), repromulgated LR 49:1394 (August 2023).

§10717. Types of SSI-Related Resources

A. The following SSI-related resources are considered in determining eligibility for Medicaid coverage.

1. Annuities

a. Any annuity purchases must adhere to the following requirements or the annuity will be considered an available countable resource.

i. The annuity must contain a statement that names the state of Louisiana as the remainder beneficiary in the first position for the total amount of Medicaid assistance paid on behalf of the annuitant unless there is a community spouse and/or a minor or disabled child.

ii. If there is a community spouse and/or a minor or disabled child, the state may be named in the next position after those individuals. If the state has been named after a community spouse and/or minor or disabled child and

any of those individuals or their representatives dispose of any of the remainder of the annuity for less than fair market value, the state may then be named in the first position.

iii. If the state is not named as a remainder beneficiary in the correct position, the purchase of the annuity will be considered a transfer for less than fair market value. The full purchase value of the annuity will be considered the amount transferred.

b. In addition to purchases of annuities, certain related transactions which occur to annuities are subject to these provisions. If any action taken by the individual changes the course of payment to be made by the annuity, then the treatment of the income or principal of the annuity is subject to these provisions. This includes additions of principal, elective withdrawals, requests to change the distribution of the annuity, elections to annuitize the contract and similar actions taken by the individual.

i. Routine changes and automatic events that do not require any action or decision after the effective date of the enactment are not considered transactions that would subject the annuity to treatment under these provisions.

c. Refusal to disclose sufficient information related to any annuity will result in denial or termination of Medicaid based on the applicant's failure to cooperate. When an unreported annuity is discovered after eligibility has been established and after payment for long-term care services has been made, appropriate steps to terminate payment for services will be taken, including appropriate notice to the individual of the adverse action.

d. Annuities purchased by or on behalf of an annuitant who has applied for medical assistance will not be treated as a transfer of assets if the annuity meets any of the following conditions:

- i. the annuity is considered to be:
 - (a). an individual retirement annuity; or
 - (b). a deemed individual retirement account (IRA) under a qualified employer plan; or
- ii. the annuity is purchased with proceeds from one of the following:
 - (a). a traditional IRA;
 - (b). certain accounts or trusts which are treated as IRAs;
 - (c). a simplified retirement account; or
 - (d). a simplified employee pension; or
- iii. the annuity:
 - (a). is irrevocable and non-assignable;
 - (b). is actuarially sound; and
 - (c). provides payments in approximately equal amounts with no deferred or balloon payments.

e. Applicants or their authorized representatives shall be responsible for providing documentation from the

financial institution verifying qualifying IRS annuities. Absent such documentation, the purchase of the annuity will be considered a transfer for less than fair market value which is subject to penalty. The full purchase value of the annuity will be considered the amount transferred.

f. If an annuity or the income stream from an annuity is transferred, except to or for the spouse's sole benefit, to their child or a trust, the transfer may be subject to penalty.

2. Continuing Care Retirement Community Entrance Fees

a. Continuing care retirement communities (CCRC's) are entities which provide a range of living arrangements from independent living through skilled nursing care. An entrance contract for admission to a continuing care retirement center or life care community must take into account the required allocation of resources or income to the community spouse before determining the amount of resources that a resident must spend on his or her own care.

b. A CCRC entrance fee shall be treated as a resource for the purposes of determining Medicaid eligibility under the following conditions if the entrance fee:

i. can be used to pay for care under the terms of the entrance contract should other resources of the individual be insufficient;

NOTE: It is not necessary for CCRC's or life care communities to provide a full, lump-sum refund of the entrance fee to the resident. If portions of the fee can be refunded or applied to pay for care as required, this condition would be met.

ii. or a remaining portion is refundable when the individual dies or terminates the contract and leaves the CCRC or life care community; and

NOTE: It is not necessary for the resident to actually receive a refund of the entrance fee for deposit. This condition is met as long as the resident could receive a refund were the contract to be terminated, or if the resident dies.

iii. does not confer an ownership interest in the community.

3. Life Estates

a. The purchase of a life estate in another individual's home is considered a countable resource and subject to examination under transfer of asset provisions unless the purchaser resides in the home for a period of at least one year after the date of purchase.

b. The life estate value will be determined using the life estate tables published by the Social Security Administration for the SSI program.

c. For transfer of assets determinations, the amount of the transfer is the entire amount used to purchase the life estate.

i. The amount shall not be reduced or prorated to reflect an individual's residency for a period of time less than one year.

d. If payment for a life estate exceeds the fair market value (FMV) of the life estate, the difference between the amount paid and the FMV will be treated as a transfer of assets.

e. If an individual makes a gift or transfer of a life estate, the value of the life estate will be treated as a transfer of assets.

f. These provisions apply only to the purchase of life estates. They do not apply in situations where an individual transfers real property but retains the life estate and the value of the remainder interest (not the life estate) is used to determine whether a transfer has occurred and to calculate the period of ineligibility.

g. For the purposes of determining eligibility for Medicaid coverage, the terms "life estate" and "usufruct" have the same meaning.

4. Loans, Mortgages, Promissory Notes and Other Property Agreements

a. Countable assets include funds used to purchase a promissory note, or funds used to make a loan or mortgage. These resources are subject to transfer of assets provisions unless the repayment terms are actuarially sound.

b. Loans, mortgages, promissory notes, property agreements or property assignments are countable resources regardless of any non-assignability, non-negotiability or non-transferability provisions contained therein.

c. Instruments containing any of the following provisions are a countable resource and shall be evaluated as a transfer of assets:

i. repayment terms that exceed the holder's life expectancy;

ii. provisions for interest only payments or principal payments that are not to be made in equal amounts during the term of the loan;

iii. deferral or balloon payments; or

iv. cancellation or forgiveness clauses that cancel the balance upon some occurrence such as death of the lender.

d. If there is evidence that there is not a good faith agreement to repay the entire principal of a note, loan or mortgage, the instrument shall not be considered bona fide and shall be evaluated as a transfer of resources.

5. Substantial Home Equity

a. Substantial home equity above the state's established limit is a countable resource which causes ineligibility for long-term care services. If an individual's equity interest in their home exceeds \$500,000, that individual is not eligible for Medicaid payment of nursing facility services or other long-term care services.

b. Home equity limitations do not apply if the individual's spouse, the individual's child under the age of 21, or the individual's blind or disabled child is residing in the home.

i. A child is considered disabled if he or she meets the definition of disability as defined by Section 1614(a)(3) of the Social Security Act.

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 34:1410 (July 2008).

Chapter 109. Transfers of Assets

§10905. Transfers

A. The Deficit Reduction Act of 2005 established new provisions governing the treatment of transfers of assets for individuals and their spouses who apply for or receive long-term care services.

B. The look-back period is lengthened to five years for potential transfers of assets.

C. For transfers of assets for less than fair market value, the period of ineligibility for an individual in a long term care facility begins the later of the first day of the month after which the asset was transferred for less than fair market value or the date on which the individual is eligible for Medicaid and is receiving institutional level of care services (based on an approved application for such services) that, but for the imposition of the penalty, would be covered by Medicaid.

1. Periods of ineligibility cannot occur during any other period of ineligibility; they must be consecutive and not concurrent.

D. For transfers of assets for less than fair market value, the period of ineligibility for an individual applying for, or receiving, home and community-based services (HCBS) waiver services begins the later of the first day of the month after which the asset was transferred for less than fair market value or the date on which it is determined that the individual meets the financial and non-financial requirements for Medicaid eligibility and all other requirements for admission to an HCBS waiver are met.

E. Partial Month Transfers. The department shall impose penalties for transfers in a month that are less than the state's average monthly cost to a private patient of nursing facility services in the state.

F. Combining Multiple Transfers Made in More Than One Month. These provisions refer to more than one transfer during the look-back period where each transfer results in less than a full month of eligibility.

1. The department shall combine multiple transfers for less than fair market value in more than one month and impose a single period of ineligibility or apply multiple penalty periods.

a. If the department imposes a single period of ineligibility, all transfers will be added together and a single continuous period of eligibility will be imposed. Otherwise, a separate period of ineligibility shall be calculated for each month and the resulting periods of eligibility shall be imposed separately.

G. Undue Hardship. The department shall provide for an undue hardship waiver when application of the transfer of assets provision would deprive the individual of medical care such that the individual's health, life or other necessities of life would be endangered.

1. Undue hardship provisions shall permit the facility in which the individual is residing to file an undue hardship waiver application on his behalf with the consent of the individual or the personal representative of the individual.

2. Bed hold payments shall not be made while an application for an undue hardship waiver is pending.

3. Terms. The penalty is a period of ineligibility for receiving long term care vendor payments as a result of a transfer of income or assets or both.

a. An undue hardship exception is when a penalty will not be imposed against the applicant/enrollee, either in whole or in part, after findings that an undue hardship exists.

b. The community spouse is not protected by the hardship exception. The exception is for the applicant/enrollee not to be deprived.

4. Undue hardship does not exist:

a. when the application of the transfer of assets provisions merely causes the individual inconvenience or when such application might restrict his or her lifestyle but would not put him/her at risk of serious deprivation; and

b. when property is transferred to one or more of the following:

- i. blood relatives to a third degree cousin;
- ii. mother-in-law;
- iii. father-in-law;
- iv. brother-in-law; or
- v. sister-in-law;

c. if the individual who transferred the assets or income, or on whose behalf the assets or income were transferred, has not exhausted all lawful means to recover the assets or income or the value of the transferred assets or income; or

d. if the applicant/enrollee's health or age indicated a need for long term care services was predictable at the time of the transfer.

5. The applicant/recipient shall be advised in writing that an undue hardship exception.

6. If an undue hardship exception is denied the applicant has the right to appeal the denial decision.

7. Determining Undue Hardship. Once a period of ineligibility has been established because of a transfer of assets or income for less than fair market value, or the equity value in the home, an applicant/enrollee may apply for an undue hardship exception.

a. An undue hardship exception request must be made within seven days from the date of notification of the penalty. Documentation supporting the request for the exception of undue hardship must be provided. The department may extend the request periods if it determines that extenuating circumstances require additional time.

b. When undue hardship requests are made for the first time, individuals challenging the penalty must raise all claims and submit all evidence permitting consideration of undue hardship. The individual has to have taken action in law and equity to get the asset back before the department can consider undue hardship.

c. Once the department determines that it has received complete documentation, it shall inform the individual within 10 business days of the undue hardship decision.

d. If no request for undue hardship is received within seven days after notification of a transfer penalty, or if the request is denied, the department shall issue an eligibility determination specifying the applicable penalty period. If the individual is a recipient, the notice shall include the date of the Medicaid long-term care termination. The notice shall also include the right to request a fair hearing and continuing benefits.

8. An undue hardship exception may be requested at any time during the penalty period if new circumstances leading to undue hardship arise during the duration of the penalty period. If granted, the undue hardship request shall be prospective from the date of the request.

9. The department shall have no obligation to pay for long-term care services during the penalty period unless it grants an undue hardship exception or the applicant/enrollee prevails in a fair hearing.

10. The individual must provide to the department sufficient documentation to support, by a preponderance of the evidence, the claim that application of the penalty will result in an undue hardship to the applicant/enrollee (not the community spouse).

11. If undue hardship is determined to exist, the transferred assets or equity value in the home shall not be considered in the eligibility process.

12. If a request for an undue hardship exception is denied, the applicant/enrollee may request a fair hearing.

13. Terminating the Undue Hardship Exception. The department shall terminate the undue hardship exception, if not earlier, at the time an individual, the spouse of the individual, or anyone with authority on behalf of the individual, makes any uncompensated transfer of income or assets after the undue hardship exception is granted.

a. The department shall deny any further requests for an undue hardship exception due to either the disqualification based on the transfer upon which the initial undue hardship determination was based or a disqualification based on the transfer, which required termination of the undue hardship exception.

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 34:1411 (July 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 46:588 (April 2020).

Subpart 9. Long-Term Care Eligibility

Chapter 161. General Provisions

§16101. Spousal Impoverishment

A. Spousal impoverishment provisions assure that the needs of an institutionalized individual's legal spouse and/or dependents that reside in the community continue to be met.

B. Spousal impoverishment resource provisions allow certain long term care applicants/recipients residing in a medical institution for a continuous period of institutionalization or home and community-based services waiver applicants/recipients to allocate resources to a legal spouse (referred to as the community spouse) who lives in a non-institutionalized living arrangement for the community spouse's own use and maintenance.

1. Exception. The spousal impoverishment provisions do not apply to individuals residing in a group home.

C. The income first rule shall apply to spousal impoverishment. Under these provisions, all of the income of the institutionalized spouse that can be made available to the community spouse will be made available to bring the spouse up to the minimum monthly needs allowance.

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 34:1409 (July 2008).

§16103. Nursing Facility Private-Pay Cost

A. The department uses a statewide average, monthly private-pay nursing facility cost amount to calculate the periods of ineligibility for long-term care services when uncompensated transfers of assets occur. The average, monthly private-pay nursing facility cost amount shall be determined by the bureau.

1. The amount will be reviewed annually to ensure that it remains aligned with private-pay costs.

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 34:1409 (July 2008).

Subpart 11. State Children's Health Insurance Program

Chapter 201. Louisiana Children's Health Insurance Program (LaCHIP)—Phases 1-3

§20101. General Provisions

A. Section 4901 of the Balanced Budget Act of 1997, Public Law 105-33, established provisions under Title XXI of the Social Security Act to provide health insurance coverage to uninsured, low-income children through an expansion of existing Medicaid Programs, creation of stand-alone programs, or a combination of both. The department implemented the provisions of Title XXI as a Medicaid expansion program called the Louisiana Children's Health Insurance Program (LaCHIP).

B. Effective October 20, 1998, the department implemented phase one of LaCHIP which provides coverage to uninsured children with family income up to 133 percent of the federal poverty level.

C. Effective October 1, 1999, the department implemented phase two of LaCHIP which provides coverage to uninsured children with family income between 133 and 150 percent of the federal poverty level.

D. Effective January 1, 2001, the department implemented phase three of LaCHIP which provides coverage to uninsured children with family income up to 200 percent of the federal poverty level.

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

HISTORICAL NOTE: Repromulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:659 (April 2008).

§20103. Eligibility Criteria

A. The LaCHIP Medicaid program provides health insurance coverage to low-income, uninsured children who meet the following criteria:

1. are under the age of 19;
2. are from families with income at or below 217 percent of the federal poverty level; and
3. do not meet the state's Medicaid eligibility criteria in effect as of March 31, 1997.

B. The following children are excluded from coverage under the LaCHIP Medicaid expansion:

1. those currently eligible for Medicaid;
2. those currently covered by other types of health insurance;
3. inmates of a public institution; and
4. patients in an institution for mental disease.

C. Children are considered uninsured, for the purpose of determining eligibility for LaCHIP, if they do not have creditable coverage for health insurance.

1. The department is adopting the definition of creditable coverage for health insurance, the definition for health insurance coverage and the exceptions to health insurance coverage as cited in Section 2110 of the Social Security Act which references 42 U.S.C. §300gg(c)(1), §300gg-91(b)(1), and §300 gg-91(c)(1).

D. Children shall not be considered uninsured if their creditable coverage is dropped within the three calendar months prior to application for LaCHIP benefits unless the reason for dropping the coverage is loss of the employment that provided access to insurance coverage.

1. For the purposes of this Rule, the term *loss of employment* shall include the following:

- a. loss of employment due to a lay-off, downsizing, resignation, firing, etc.;
- b. death of the parent whose employment provided access to dependent coverage;
- c. change of employment to an employer that does not provide an option for dependent coverage;
- d. discontinuation of health benefits for all employees of the applicant's employer;
- e. expiration of coverage periods established by the Consolidated Omnibus Reconciliation Act of 1985 (COBRA); or
- f. termination of health benefits due to a long term disability of the parent whose employment provided access to dependent coverage.

E. Effective December 31, 2013 eligibility for LaCHIP shall be determined by modified adjusted gross income (MAGI) methodology in accordance with section 1004(a)(2) of the Patient Protection and Affordable Care Act (ACA) of 2010 and section 36B(d)(2)(B) of the *Internal Revenue Code*.

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

HISTORICAL NOTE: Repromulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:659 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1292 (July 2015).

Chapter 203. LaCHIP Phase IV— Prenatal Care Services

§20301. General Provisions

A. Effective May 1, 2007, the Department of Health and Hospitals provides State Children's Health Insurance Program (SCHIP) coverage of prenatal care services to low income, non-citizen women as an expansion of coverage for children under Title XXI of the Social Security Act. SCHIP coverage of prenatal care services will be an expansion of coverage for children, from conception to birth, with income

from 0 percent through 200 percent of the federal poverty level (FPL).

B. Effective December 31, 2013, coverage of SCHIP prenatal care services shall be expanded to include any pregnant woman with income between 138 percent and 214 percent of the FPL.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XXI 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 35:72 (January 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:708 (April 2015).

§20303. Eligibility Criteria

A. An applicant must be a Louisiana resident and cannot be eligible for Medicaid benefits under the provisions of Title XIX of the Social Security Act.

B. Applicants must be uninsured at the time of application.

1. Applicants are considered to be uninsured if they do not have creditable health insurance that provides coverage of prenatal care services.

C. Recipients must have family income at or below 214 percent of the FPL.

D. Recipients cannot be covered under a group health insurance plan or have creditable health insurance coverage and cannot have access to a state employee health benefits plan.

1. A state employee health benefits plan is a plan that is offered or organized by the state government, or on behalf of state employees, or other public agency for employees within the state.

E. Recipients shall be eligible to receive SCHIP coverage of prenatal care services from the month of conception or the first month of eligibility following conception, whichever is later, through the month of birth.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XXI 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 35:72 (January 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:708 (April 2015).

§20305. Services

A. Covered Services. Recipients shall receive coverage of pregnancy-related health care services and associated medically necessary services for conditions that, if not treated, would complicate the pregnancy. Pregnancy-related health care services which may be covered include:

1. inpatient and outpatient health care services;
2. physician services;
3. surgical services;
4. clinic and other ambulatory health care services;

5. prescription and over-the-counter medications;
6. laboratory and radiological services;
7. pre-natal care and pre-pregnancy family services and supplies;
8. inpatient and outpatient mental health services other than those services relative to substance abuse treatment;
9. durable medical equipment and other medically-related or remedial devices;
10. disposable medical supplies;
11. nursing care services;
12. case management services;
13. physical therapy, occupational therapy and services for individuals with speech, hearing and language disorders;
14. medical transportation services; and
15. any other medically necessary medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative services.

B. Service Exclusion. Sterilization procedures are not a covered service in this program.

C. Service Limits and Prior Authorization. Other Medicaid-specific benefit limits, age limits and prior authorization requirements may be applicable to the services covered in this program.

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

HISTORICAL NOTE: Repromulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 35:72 (January 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:545 (March 2014).

Chapter 205. Louisiana Children's Health Insurance Program (LaCHIP)—Phase V

§20501. General Provisions

A. Effective April 1, 2008, the Department implements phase five of LaCHIP as a stand-alone program under the provisions of title XXI of the Social Security Act to provide coverage to uninsured children with family income from 200 percent up to 250 percent of the federal poverty level.

B. The department retains the oversight and management of this LaCHIP expansion with health care benefits provided through the BAYOU HEALTH Program and behavioral health services provided through the Louisiana behavioral health partnership (LBHP).

C. Phase five is a cost-sharing program. Families who are enrolled in phase five of LaCHIP will be responsible for paying premiums.

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

HISTORICAL NOTE: Repromulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:660 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1291 (July 2015).

§20503. Eligibility Criteria

A. This LaCHIP stand-alone program provides health care coverage to uninsured children who meet the following criteria:

1. are under the age of 19;
2. have family income from 200 percent up to 250 percent of the federal poverty level
3. do not have creditable health insurance coverage; and
4. are not eligible for any other Medicaid program.

B. For the purpose of determining eligibility for phase five of LaCHIP, children are considered to be uninsured if they do not have creditable health insurance at the time of application. Children shall not be considered uninsured if their creditable coverage is dropped within the 12 calendar months prior to application, unless the reason for dropping the coverage is considered to be involuntary loss of coverage. Loss of coverage for one of the following reasons shall be considered involuntary loss of coverage:

1. loss of coverage resulting from divorce or death of a parent;
2. the child reaches his maximum lifetime coverage amount;
3. expiration of coverage under a Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 continuation provision within the meaning given in 42 U.S.C. 300gg-91;
4. involuntary termination of health benefits due to;
 - a. a long-term disability or medical condition;
 - b. termination of employment, including lay-off or business closure; or
 - c. reduction in the number of hours of employment;
5. changing to a new employer who does not provide an option for dependent coverage; or
6. the family terminated health insurance coverage for the child because private insurance is not cost effective (the cost to the child's family for the coverage exceeded 10 percent of the family's income).

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

HISTORICAL NOTE: Repromulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:660 (April 2008).

§20505. Covered Services

A. Children covered in phase five of the LaCHIP expansion shall receive health care benefits through an array of covered services offered by health plans participating in the BAYOU HEALTH Program, and behavioral health services administered by the statewide management organization under the LBHP. The following services shall be included:

1. inpatient hospital services:
 - a. pre-certification is required for hospital admissions. Emergency services are covered if, upon review, presentation is determined to be life-threatening, resulting in admission to inpatient, partial hospital or intensive outpatient level of care;
2. outpatient hospital services:
 - a. the relative therapies require pre-certification;
3. physician services;
4. surgical procedures;
5. clinic services and other ambulatory health care services;
6. prescription drugs;
7. laboratory and radiological services;
8. pre-natal care and pre-pregnancy family services and supplies;
9. inpatient and outpatient behavioral health services other than those listed in any other provisions of §20503:
 - a. these services include those furnished in a state-operated mental hospital, residential facility or other 24 hour therapeutically-planned structural services. Pre-certification is required for these services. Emergency services are covered if, upon review, presentation is determined to be life-threatening, resulting in admission to inpatient, partial hospital or intensive outpatient level of care;
 - b. inpatient and outpatient visits are limited to medically necessary services not to exceed a combined 52 visits per plan year for mental health and substance abuse services;
10. durable medical equipment;
11. nursing care services;
12. dental services;
13. inpatient substance abuse treatment services, including residential substance abuse treatment services:
 - a. inpatient admissions must be pre-certified. Emergency services are covered if, upon review, presentation is determined to be life-threatening, resulting in admission to inpatient, partial hospital or intensive outpatient level of care;

b. inpatient days are limited to medically necessary services not to exceed a combined 45 visits per plan year for mental health and substance abuse services;

14. outpatient substance abuse treatment services:

a. all services must be pre-certified;

b. outpatient visits are limited to medically necessary services not to exceed a combined 52 visits per plan year for mental health and substance abuse services;

15. case management services:

16. physical therapy, occupational therapy and services for individuals with speech, hearing and language disorders:

a. physical and occupational therapy is limited to 50 visits per year and speech therapy is limited to 26 visits per year;

17. hospice care:

18. medical transportation; and

19. any other medically necessary medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative services.

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

HISTORICAL NOTE: Repromulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:660 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1292 (July 2015).

§20507. Cost Sharing

A. Phase five of LaCHIP is a cost-sharing program with premiums limited to no more than 5 percent of the family's annual income.

B. The following cost-sharing criteria shall apply.

1. Premiums. When family income is between 201 percent and 250 percent of the federal poverty level, families shall be responsible for paying a \$50 per month premium.

a. Premiums are due by the first of each month. If payment is not received by the tenth of the month, the responsible party shall be notified that coverage may be terminated if payment is not received by the twenty-first of the month.

C. Non-payment of premiums may result in disenrollment from LaCHIP. Recipients shall be allowed a 60-day grace period prior to disenrollment for non-payment.

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

HISTORICAL NOTE: Repromulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:661 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1292 (July 2015).

§20509. Dental Services Reimbursement Methodology

A. Services covered in the LaCHIP Affordable Plan Dental Program shall be reimbursed at the lower of either:

PUBLIC HEALTH—MEDICAL ASSISTANCE

1. the dentist's billed charges minus any third party coverage; or

2. the state's established schedule of fees, which is developed in consultation with the Louisiana Dental Association and the Medicaid dental consultants, minus any third party coverage.

B. Effective for dates of service on or after July 1, 2012, the reimbursement fees for LaCHIP Affordable Plan dental services shall be reduced to the following percentages of the 2009 National Dental Advisory Service comprehensive fee report 70th percentile, unless otherwise stated in this Chapter:

1. 65 percent for the following oral evaluation services:

- a. periodic oral examination;
- b. oral examination-patients under 3 years of age; and
- c. comprehensive oral examination-new patients;

2. 62 percent for the following annual and periodic diagnostic and preventive services:

- a. radiographs-periapical, first film;
- b. radiographs-periapical, each additional film;
- c. radiographs-panoramic film;
- d. diagnostic casts;
- e. prophylaxis-adult and child;

f. topical application of fluoride, adult and child (prophylaxis not included); and

g. topical fluoride varnish, therapeutic application for moderate to high caries risk patients (under 6 years of age);

3. 45 percent for the following diagnostic and adjunctive general services:

- a. oral/facial image;
- b. non-intravenous conscious sedation; and
- c. hospital call; and

4. 56 percent for the remainder of the dental services.

C. Removable prosthodontics and orthodontic services are excluded from the July 1, 2012 rate reduction.

D. Effective for dates of service on or after August 1, 2013, the reimbursement fees for LaCHIP Affordable Plan dental services shall be reduced by 1.5 percent of the rate on file July 31, 2013, unless otherwise stated in this Chapter.

1. The following services shall be excluded from the August 1, 2013 rate reduction:

- a. removable prosthodontics; and
- b. orthodontic services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:1285 (May 2013), amended LR 40:1008 (May 2014).

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part V. Hospital Services

Subpart 1. Inpatient Hospitals Services

Chapter 1. General Provisions

§107. Elective Deliveries

A. Induced deliveries and cesarean sections shall not be reimbursed when performed prior to 39 weeks gestation. This shall not apply to deliveries when there is a documented medical condition that would justify delivery prior to 39 weeks gestation.

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 40:1530 (August 2014).

§109. Healthcare-Acquired and Provider Preventable Conditions

A. Effective for dates of service on or after July 1, 2012, the Medicaid Program will not provide reimbursement for healthcare-acquired or provider preventable conditions which result in medical procedures performed in error and have a serious, adverse impact to the health of the Medicaid recipient.

B. Reimbursement shall not be provided for the following healthcare-acquired conditions (for any inpatient hospital settings participating in the Medicaid Program) including:

1. foreign object retained after surgery;
2. air embolism;
3. blood incompatibility;
4. stage III and IV pressure ulcers;
5. falls and trauma, including:
 - a. fractures;
 - b. dislocations;
 - c. intracranial injuries;
 - d. crushing injuries;
 - e. burns; or
 - f. electric shock;
6. catheter-associated urinary tract infection (UTI);
7. vascular catheter-associated infection;
8. manifestations of poor glycemic control, including:
 - a. iabetic ketoacidosis;

- b. nonketotic hyperosmolar coma;
 - c. hypoglycemic coma;
 - d. secondary diabetes with ketoacidosis; or
 - e. secondary diabetes with hyperosmolarity;
9. surgical site infection following:
- a. coronary artery bypass graft (CABG)-mediastinitis;
 - b. bariatric surgery, including:
 - i. laparoscopic gastric bypass;
 - ii. gastroenterostomy; or
 - iii. laparoscopic gastric restrictive surgery; or
 - c. orthopedic procedures, including:
 - i. spine;
 - ii. neck;
 - iii. shoulder; or
 - iv. elbow; or

10. deep vein thrombosis (DVT)/pulmonary embolism (PE) following total knee replacement or hip replacement with pediatric and obstetric exceptions.

C. Reimbursement shall not be provided for the following provider preventable conditions, (for any inpatient hospital settings participating in the Medicaid Program) including:

1. wrong surgical or other invasive procedure performed on a patient;
2. surgical or other invasive procedure performed on the wrong body part; or
3. surgical or other invasive procedure performed on the wrong patient.

D. For discharges on or after July 1, 2012, all hospitals are required to bill the appropriate present-on-admission (POA) indicator for each diagnosis code billed. All claims with a POA indicator with a health care-acquired condition code will be denied payment.

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 38:1963 (August 2012).

§111. Coverage of Donor Human Breast Milk

A. The Medicaid Program shall provide reimbursement to acute care hospitals for donor human breast milk provided to hospitalized infants.

B. Reimbursement. Hospitals shall be reimbursed for donor human breast milk when obtained from a member bank of the Human Milk Banking Association of North America. Reimbursement will be made as an add-on service in addition to the hospital payment for the inpatient hospital stay.

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 46:1088 (August 2020).

§113. Coverage of Long-Acting Reversible Contraceptives

A. The Medicaid Program shall provide reimbursement to acute care hospitals for long-acting reversible contraceptives (LARCs) provided to women immediately following childbirth and during the hospital stay.

B. Reimbursement. Hospitals shall be reimbursed for LARCs as an add-on service in addition to their daily per diem rate for the inpatient hospital stay.

1. Physicians/professional practitioners who insert the device will also be reimbursed an insertion fee in accordance with the reimbursement rates established for this service in the Professional Services Program.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1104 (June 2014).

§115. Office of Public Health Newborn Screenings

A. The Department of Health, Bureau of Health Services Financing shall provide reimbursement to the Office of Public Health (OPH) through the Medical Assistance Program for newborn screenings performed by OPH on specimens taken from children in acute care hospital settings.

B. Reimbursement

1. Effective for dates of service on or after August 5, 2017, claims submitted by OPH to the Medicaid Program for the provision of legislatively-mandated inpatient hospital newborn screenings shall be reimbursed outside of the acute hospital per diem rate for the inpatient stay.

a. The hospital shall not include any costs related to newborn screening services provided and billed by OPH in its Medicaid cost report(s).

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 44:60 (January 2018).

§117. Laboratory Testing for Coronavirus Disease 2019 (COVID-19)

A. Effective for dates of service on or after September 20, 2021, the Medicaid Program shall provide reimbursement to acute care hospitals for COVID-19 laboratory testing provided to inpatients.

B. Reimbursement. Hospitals shall be reimbursed for such testing in addition to the hospital per diem payment for the inpatient hospital stay.

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 47:1311 (September 2021).

§119. Coverage of Genetic Testing of Critically Ill Infants

A. Pursuant to Act 501 of the 2022 Regular Session of the Louisiana Legislature, effective for dates of service on or after January 1, 2023, the Medicaid Program shall provide reimbursement to inpatient hospitals for rapid whole genome sequencing testing of a Medicaid enrolled infant who meets all of the following criteria:

1. is one year of age or younger;
2. has a complex illness of unknown etiology; and
3. is receiving inpatient hospital services in an intensive care unit or in a pediatric care unit.

B. For the purposes of this Section, rapid whole genome sequencing testing includes individual sequencing, trio sequencing of the parents of the infant, and ultra-rapid sequencing.

C. Reimbursement. Reimbursement will be made as an add-on service in addition to the hospital payment for the inpatient hospital stay.

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 49:487 (March 2023).

§121. Distinct Part Psychiatric Units

A. Qualifying Criteria. Reimbursement of psychiatric services (including substance use treatment) provided by acute care general hospitals, long-term acute hospitals, children's hospitals, and rehabilitation hospitals is allowable only for psychiatric services provided in distinct part psychiatric units that meet the following criteria:

1. Medicare prospective payment system (PPS) exempt psychiatric unit criteria in 42 CFR 412.27 and other applicable Medicare guidelines;
2. licensing standards related to hospital psychiatric units/services in LAC 48:I.Chapters 93, 94, and 95; and
3. enrolled in Medicaid and assigned a separate distinct part psychiatric unit provider number.

EXCEPTION: Emergency psychiatric admissions to non-psychiatric inpatient hospitals/units shall be paid the psychiatric rate until the beneficiary can be stabilized and transferred to a psychiatric hospital or unit.

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 50:977 (July 2024).

§123. Psychiatric Hospitals

A. Qualifying Criteria. Reimbursement of inpatient psychiatric services (including substance use treatment) provided by freestanding psychiatric hospitals is allowable only if provided in psychiatric hospitals that meet the following criteria:

1. Medicare prospective payment system (PPS) exempt psychiatric hospital criteria in the 42 CFR 412.23(a), other applicable Medicare guidelines; and

2. licensing standards related to psychiatric services/hospitals in LAC 48:I.Chapters 93, 94, and 95.

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 50:977 (July 2024).

§125. Rehabilitation Hospitals

A. Qualifying Criteria. Reimbursement of inpatient rehabilitation services provided by freestanding rehabilitation hospitals is allowable only if provided in rehabilitation hospitals that meet the following criteria:

1. Medicare prospective payment system (PPS) exempt rehabilitation hospital criteria in 42 CFR 412.23(b) and other applicable Medicare guidelines; and

2. licensing standards related to rehabilitation services/hospitals in LAC 48:I.Chapters 93, 94, and 95.

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 50:978 (July 2024).

§127. Long-Term Hospitals

A. Qualifying Criteria. Reimbursement as a long-term hospital is only allowable for inpatient services provided in hospitals that meet the Medicare prospective payment system (PPS) exempt long-term hospital criteria in 42 CFR 412.23(e) and other applicable Medicare 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, LR 50:978 (July 2024).

Chapter 5. State Hospitals

Subchapter B. Reimbursement Methodology

§551. Acute Care Hospitals

A. Inpatient hospital services rendered by state-owned acute care hospitals shall be reimbursed at allowable costs and shall not be subject to per discharge or per diem limits.

B. Effective for dates of service on or after October 16, 2010, a quarterly supplemental payment up to the Medicare upper payment limits will be issued to qualifying state-owned hospitals for inpatient acute care services rendered.

C. Qualifying Criteria for Supplemental Payment. The state-owned acute care hospitals must be located in DHH Administrative Region 8 (Monroe).

D. Effective for dates of service on or after October 16, 2010, Medicaid rates paid to state-owned acute care hospitals that do not meet the qualifying criteria for the supplemental payment shall be adjusted to 60 percent of allowable Medicaid costs.

E. Effective for dates of service on or after February 1, 2012, medical education payments for inpatient services which are reimbursed by a prepaid risk-bearing managed care organization (MCO) shall be paid monthly by Medicaid as interim lump sum payments.

1. Hospitals with qualifying medical education programs shall submit a listing of inpatient claims paid each month by each MCO.

a. *Qualifying Medical Education Programs*—graduate medical education, paramedical education, and nursing schools.

2. Monthly payments shall be calculated by multiplying the number of qualifying inpatient days times the medical education costs included in each state hospital's interim per diem rate as calculated per the latest filed Medicaid cost report.

3. Final payment shall be determined based on the actual MCO covered days and allowable inpatient Medicaid medical education costs for the cost reporting period per the Medicaid cost report.

F. Effective for dates of service on or after August 1, 2012, the inpatient per diem rate paid to state-owned acute care hospitals, excluding Villa Feliciana and inpatient psychiatric services, shall be reduced by 10 percent of the per diem rate on file as of July 31, 2012.

1. The Medicaid payments to state-owned hospitals that qualify for the supplemental payments, excluding Villa Feliciana and inpatient psychiatric services, shall be reimbursed at 90 percent of allowable costs and shall not be subject to per discharge or per diem limits.

2. The Medicaid payments to state-owned hospitals that do not qualify for the supplemental payments shall be reimbursed at 54 percent of allowable costs.

G. Effective for dates of service on or after January 1, 2020, the inpatient per diem rate paid to state-owned acute care hospitals, excluding inpatient psychiatric services, shall be calculated based on allowable costs per the latest filed cost report. Final reimbursement determined based on the allowable costs per the finalized Medicare/Medicaid cost report.

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 38:1241 (May 2012), amended LR 38:2772 (November 2012), LR 40:312 (February 2014), LR 40:1941 (October 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 45:1770 (December 2019).

§553. Inpatient Psychiatric Services for State-Owned Hospitals

A. Effective for dates of service on or after January 1, 2020, the prospective per diem rate paid to state owned free-standing psychiatric hospitals, and distinct part psychiatric units within state owned acute care hospitals, shall be increased by indexing to 32 percent of the small rural hospital prospective per diem rate in effect on January 1, 2019.

1. Psychiatric hospitals and units whose per diem rates as of January 1, 2019, excluding the graduate medical education portion of the per diem, are greater than 32 percent of the January 1, 2019 small rural hospital rate shall not be increased.

B. Effective for dates of service on or after January 1, 2021, the prospective per diem rate paid to state owned free-standing psychiatric hospitals, and distinct part psychiatric units within state owned acute care hospitals, shall be increased by 3.2 percent of the per diem rate on file as of December 31, 2020.

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 45:1770 (December 2019), amended LR 46:1683 (December 2020).

Chapter 7. Prospective Reimbursement

Subchapter A. Appeals Procedure

§701. Request for Administrative Review

A. Any hospital seeking an adjustment to its rate, shall submit a written request for administrative review to the Medicaid director (hereafter referred to as director) within 30 days after receipt of the letter notifying the hospital of its rates.

1. The receipt of the letter notifying the hospital of its rates shall be deemed to be five days from the date of the letter.

2. The time period for requesting an administrative review may be extended upon written agreement between the department and the hospital.

B. The department will acknowledge receipt of the written request within 30 days after actual receipt. Additional documentation may be requested from the hospital as may be necessary for the director to render a decision. The director shall issue a written decision upon the hospital's request for a rate adjustment within 90 days after receipt of all additional documentation or information requested.

C. Any hospital seeking an adjustment to its rate, must specify all of the following:

1. the nature of the adjustment sought;
2. the amount of the adjustment sought; and
3. the reasons or factors that the hospital believes justify an adjustment.

D. Any request for an adjustment must include an analysis demonstrating the extent to which the hospital is incurring or expects to incur a qualifying loss in providing covered services to Medicaid and indigent patients.

1. For purposes of these provisions, qualifying loss shall mean that amount by which the hospital's allowable costs (excluding disproportionate share payment adjustments) exceed the Medicaid reimbursement implemented pursuant to these provisions.

2. "Cost" when used in the context of allowable shall mean a hospital's costs incurred in providing covered inpatient services to Medicaid and indigent patients, as calculated in the relevant definitions governing cost reporting.

E. The hospital will not be required to present an analysis of its qualifying loss where the basis for its appeal is limited to a claim that:

1. the rate-setting methodology or criteria for classifying hospitals or hospital claims under the state plan were incorrectly applied;
2. that incorrect or incomplete data or erroneous calculations were used in establishment of the hospital rates; or
3. the hospital had incurred additional costs because of a catastrophe that meets certain conditions.

F. Except in cases where the basis for the hospital's appeal is limited to a claim that rate-setting methodologies or principles of reimbursement established under the reimbursement plan were incorrectly applied, or that the incorrect or incomplete data or erroneous calculations were in the establishment of the hospital's rate, the department will not award additional reimbursement to a hospital, unless the hospital demonstrates that the reimbursement it receives

based on its prospective rate is 70 percent or less of the allowable costs it incurs in providing Medicaid patients care and services that conform to the applicable state and federal laws of quality and safety standards.

1. The department will not increase a provider's rate to more than 105 percent of the peer group rate.

G. In cases where the rate appeal relates to an unresolved dispute between the hospital and its Medicare fiscal intermediary as to any cost reported in the hospital's base year cost report, the director will resolve such disputes for purposes of deciding the request for administrative review.

H. The following matters will not be subject to appeal:

1. the use of peer grouped rates;
2. the use of teaching, non-teaching and bed-size as criteria for hospital peer groups;
3. the use of approved graduate medical education and intern and resident full time equivalents as criteria for major teaching status;
4. the use of fiscal year 1991 medical education costs to establish a hospital-specific medical education component of each teaching hospital's prospective rate;
5. the application of inflationary adjustments contingent on funding appropriated by the legislature;
6. the criteria used to establish the levels of neonatal intensive care;
7. the criteria used to establish the levels of pediatric intensive care;
8. the methodology used to calculate the boarder baby rates for nursery;
9. the use of hospital specific costs for transplant per diem limits;
10. the criteria used to identify specialty hospital peer groups; and
11. the criteria used to establish the level of burn care.

I. The hospital shall bear the burden of proof in establishing facts and circumstances necessary to support a rate adjustment. Any costs that the provider cites as a basis for relief under this provision must be calculable and auditable.

J. The department may award additional reimbursement to a hospital that demonstrates by clear and convincing evidence that:

1. a qualifying loss has occurred and the hospitals current prospective rate jeopardized the hospital's long-term financial viability; and
2. the Medicaid population served by the hospital has no reasonable access to other inpatient hospitals for the services that the hospital provides and that the hospital contends are under reimbursed; or

3. alternatively, demonstrates that its uninsured care hospital costs exceeds 5 percent of its total hospital costs, and a minimum of \$9,000,000 in uninsured care hospital cost in the preceding 12 month time period and the hospital's uninsured care costs has increased at least 35 percent during a consecutive six month time period during the hospital's latest cost reporting period.

a. For purposes of these provisions, an uninsured patient is defined as a patient that is not eligible for Medicare or Medicaid and does not have insurance.

b. For purposes of these provisions, uninsured care costs are defined as uninsured care charges multiplied by the cost to charge ratios by revenue code per the last filed cost report, net of payments received from uninsured patients.

i. The increase in uninsured care costs must be a direct result of a permanent or long term (no less than six months) documented change in services that occurred at a state owned and operated hospital located less than eight miles from the impacted hospital.

ii. For the purpose of this Rule, if a hospital has multiple locations of service, each location shall measure uninsured care costs separately and qualify each location as an individual hospital. Rate adjustments awarded under this provision will be determined by the secretary of the department and shall not exceed 5 percent of the applicable per diem rate.

K. In determining whether to award additional reimbursement to a hospital that has made the showing required, the director shall consider one or more of the following factors and may take any of these actions.

1. The director shall consider whether the hospital has demonstrated that its unreimbursed costs are generated by factors generally not shared by other hospitals in the hospital's peer group. Such factors may include, but are not limited to extraordinary circumstances beyond the control of the hospital and improvements required to comply with licensing or accrediting standards. Where it appears from the evidence presented that the hospital's costs are controllable through good management practices or cost containment measures or that the hospital has through advertisement to the general public promoted the use of high costs services that could be provided in a more cost effective manner, the director may deny the request for rate adjustment.

2. The director may consider, and may require the hospital to provide financial data, including but not limited to financial ratio data indicative of the hospital's performance quality in particular areas of hospital operation.

3. The director shall consider whether the hospital has taken every reasonable action to contain costs on a hospital-wide basis. In making such a determination, the director may require the hospital to provide audited cost data or other quantitative data including, but not limited to:

- a. occupancy statistics;
- b. average hourly wages paid;

- c. nursing salaries per adjusted patient day;
- d. average length of stay;
- e. cost per ancillary procedure;
- f. average cost per meal served;
- g. average cost per pound of laundry;
- h. average cost per pharmacy prescription;
- i. housekeeping costs per square foot;
- j. medical records costs per admission;
- k. full-time equivalent employees per occupied bed;
- l. age of receivables;
- m. bad debt percentage;
- n. inventory turnover rate; and
- o. information about actions that the hospital has taken to contain costs.

4. The director may also require that an onsite operational review/audit of the hospital be conducted by the department or its designee.

L. In awarding relief under this provision, the director shall:

- 1. make any necessary adjustments so as to correctly apply the rate-setting methodology, to the hospital submitting the appeal, or to correct calculations, data errors or omissions; or
- 2. increase one or more of the hospital's rates by an amount that can reasonably be expected to ensure continuing access to sufficient inpatient hospital services of adequate quality for Medicaid patients served by the hospital.

M. The following decisions by the director shall not result in any change in the peer group rates:

- 1. the decision to:
 - a. recognize omitted, additional or increased costs incurred by any hospital;
 - b. adjust the hospital rates; or
 - c. otherwise award additional reimbursement to any hospital.

N. Hospitals that qualify under this provision must document their continuing eligibility at the beginning of each subsequent state fiscal year. Rate adjustments granted under this provision shall be effective from the first day of the rate period to which the hospital's appeal relates. However, no retroactive adjustments will be made to the rate or rates that were paid during any prior rate period.

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 37:2159 (July 2011).

§703. Administrative Appeal and Judicial Review

A. If the director's decision is adverse to the hospital, the hospital may appeal the director's decision to the Bureau of Appeals or its successor. The appeal must be lodged within 30 days of receipt of the written decision of the director. The receipt of the decision of the director shall be deemed to be five days from the date of the decision. The administrative appeal shall be conducted in accordance with the Louisiana Administrative Procedure Act (APA). The Bureau of Appeals shall submit a recommended decision to the secretary of the department. The secretary will issue the final decision of the department.

B. Judicial review of the secretary's decision shall be in accordance with the APA and shall be filed in the Nineteenth Judicial District Court.

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 37:2161 (July 2011).

Chapter 9. Non-Rural, Non-State Hospitals

Subchapter A. General Provisions

§901. Definitions

Non-Rural, Non-State Hospital—a hospital which is either owned and operated by a private entity, a hospital service district or a parish and does not meet the definition of a rural hospital as set forth in R.S. 40:1300.143(3)(a).

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 34:877 (May 2008).

§907. Well Baby Care

A. A separate prospective per diem rate shall be paid to qualifying hospitals for well baby care rendered to infants who are discharged at the same time that the mother is discharged.

B. **Qualifying Criteria.** Non-state, non-rural hospitals that perform more than 1,500 Medicaid deliveries per year shall be eligible for this payment. The department will verify that qualifying hospitals meet the 1,500 Medicaid delivery threshold each state fiscal year. Well baby payments shall be discontinued should a hospital no longer qualify.

C. **Reimbursement Methodology.** The per diem rate for well baby care shall be the same prospective rate that is paid for nursery boarder baby service.

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 49:1390 (August 2023).

§909. Children's Specialty Hospitals

A. In order to receive Medicaid reimbursement for inpatient services as a children's specialty hospital, the acute care hospital must meet the following criteria:

1. be recognized by Medicare as a prospective payment system (PPS) exempt children's specialty hospital;
2. does not qualify for Medicare disproportionate share hospital payments; and
3. has a Medicaid inpatient days utilization rate greater than the mean plus two standard deviations of the Medicaid utilization rates for all hospitals in the state receiving Medicaid payments.

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 37:597 (February 2011).

§911. Children's Specialty Hospitals Psychiatric Units

A. A psychiatric sub-provider unit in a Medicare Prospective Payment System (PPS) exempt children's specialty hospital may enroll in the Medicaid Program. The hospital must submit an attestation to the department that the unit meets the PPS exempt criteria outlined in 42 CFR 412.25 [except 412.25(a)(1)(ii)]. Enrollment of the new unit will be effective upon verification of the hospital's attestation by the department.

B. Changes in the number of beds in existing units may only be made at the start of the hospital's cost reporting period. The hospital must notify the department of changes in bed size at least 90 days prior to the end of the hospital's cost reporting period. Qualifying Medicaid services provided in these approved units shall be subjected to the existing pre-admission certification requirements for children and adolescents in distinct part psychiatric/substance abuse units in acute care general hospitals.

C. Reimbursement for services will be the inpatient psychiatric prospective per diem rate.

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 34:876 (May 2008).

§915. Distinct Part Psychiatric Units

A. Changes in the Size of Distinct Part Psychiatric Units. For the purposes of Medicaid reimbursement, the number of beds and square footage of each distinct part psychiatric unit will remain the same throughout the cost reporting period. Any changes in the number of beds or square footage considered to be a part of a distinct part psychiatric unit may be made only at the start of a cost reporting period. Verification of these changes will be completed during the Medicaid agency's on-site survey at least 60 days prior, but no more than 90 days prior, to the end of the hospital's current cost reporting period with other information

necessary for determining recognition as a distinct part psychiatric unit.

B. Effective for dates of service on or after February 10, 2012, a Medicaid enrolled non-state acute care hospital that enters into a cooperative endeavor agreement (CEA) with the Department of Health and Hospitals, Office of Behavioral Health to provide inpatient psychiatric hospital services to Medicaid and uninsured patients, and which also assumes the operation and management of a state-owned and formerly state-operated hospital distinct part psychiatric unit, may make a one-time increase in its number of beds with a one-time opening of a new distinct part psychiatric unit.

1. This expansion or opening of a new unit will not be recognized, for Medicare purposes, until the beginning of the next cost reporting period. At the next cost reporting period, the hospital must meet the Medicare Prospective Payment System (PPS) exemption criteria and enroll as a Medicare PPS excluded distinct part psychiatric unit.

2. At the time of any expansion or opening of a new distinct part psychiatric unit, the provider must provide a written attestation that they meet all Medicare PPS rate exemption criteria.

3. Admissions to this expanded or new distinct part psychiatric unit may not be based on payer source.

C. Changes in the Status of Hospital Units. The status of each hospital unit is determined at the beginning of each cost reporting period and is effective for the entire cost reporting period. Any changes in the status of a unit are made only at the start of a cost reporting period.

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 20:49 (January 1994), amended LR 34:1913 (September 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:94 (January 2013).

Subchapter B. Reimbursement Methodology

§953. Acute Care Hospitals

A. For dates of service on or after September 1, 2007, the prospective per diem rate paid to non-rural, non-state acute care hospitals for inpatient services shall be increased by 4.75 percent of the rate on file for August 31, 2007.

B. Effective for dates of services on or after October 1, 2007, a quarterly supplemental payment will be issued to non-rural, non-state acute care hospitals that qualify as a high Medicaid hospital.

1. Qualifying Criteria. A hospital is considered to be a "high Medicaid hospital" if it has a Medicaid inpatient utilization percentage greater than 30 percent based on the 12 month cost report period ending in SFY 2006. For the purposes of calculating the Medicaid inpatient utilization percentage, Medicaid days shall include nursery and distinct

part psychiatric unit days, but shall not include Medicare crossover days.

2. Each eligible hospital will receive a quarterly supplemental payment which shall be calculated based on the pro rata share of each qualifying hospital's paid Medicaid days (including covered nursery and distinct part psychiatric unit days) for dates of service in SFY 2007 to the total Medicaid days of all eligible hospitals multiplied by \$5,000,000 which is the amount appropriated for these supplemental payments.

3. Rehabilitation hospitals, long term acute care hospitals and free-standing psychiatric hospitals are not eligible for this supplemental payment.

C. Effective for dates of service on or after February 20, 2009, the prospective per diem rate paid to acute care hospitals shall be reduced by 3.5 percent of the per diem rate on file as of February 19, 2009.

1. Payments to the following hospitals and/or specialty units for inpatient hospital services shall be exempted from these reductions:

a. small rural hospitals, as defined in R.S. 40:1300.143; and

b. high Medicaid hospitals, level III regional neonatal intensive care units and level I pediatric intensive care units as defined in R.S. 46:979.

2. For the purposes of qualifying for the exemption to the reimbursement reduction as a high Medicaid hospital, the following conditions must be met.

a. The inpatient Medicaid days utilization rate for high Medicaid hospitals shall be calculated based on the cost report filed for the period ending in state fiscal year 2007 and received by the department prior to April 20, 2008.

b. Only Medicaid covered days for inpatient hospital services, which include newborn and distinct part psychiatric unit days, are included in this calculation.

c. Inpatient stays covered by Medicare Part A cannot be included in the determination of the Medicaid inpatient utilization days rate.

D. Effective for dates of service on or after February 20, 2009, the amount appropriated for quarterly supplemental payments to non-rural, non-state acute care hospitals that qualify as a high Medicaid hospital shall be reduced to \$4,925,000. Each qualifying hospital's quarterly supplemental payment shall be calculated based on the pro rata share of the reduced appropriation.

E. Major Teaching Hospitals. Effective for dates of service on or after October 1, 2009, qualifying major teaching hospitals with current per diem rates that are less than 80 percent of the current peer group rate shall have their per diem rates adjusted to equal 80 percent of the current peer group rate.

F. Minor Teaching Hospitals. Effective for dates of service on or after October 1, 2009, qualifying minor

teaching hospitals shall have their per diem rates adjusted to equal 103 percent of the current peer group rate.

G. Non-Teaching Hospitals

1. Effective for dates of service on or after October 1, 2009, qualifying non-teaching hospitals with less than 58 beds shall have their per diem rates adjusted to equal 103 percent of the current peer group rate.

2. Effective for dates of service on or after October 1, 2009, qualifying non-teaching hospitals with 58 through 138 beds shall have their per diem rates adjusted to equal 122 percent of the current peer group rate.

3. Effective for dates of service on or after October 1, 2009, qualifying non-teaching hospitals with more than 138 beds shall have their per diem rates adjusted to equal 103 percent of the current peer group rate.

H. Neonatal Intensive Care Units (NICU)

1. Effective for dates of service on or after October 1, 2009, qualifying NICU level III services with current per diem rates that are less than the NICU level III specialty peer group rate shall have their per diem rates adjusted to equal 100 percent of the specialty group rate.

2. Effective for dates of service on or after October 1, 2009, qualifying NICU level III regional services with current per diem rates that are less than 85 percent of the NICU level III regional specialty group rate shall have their per diem rates adjusted to equal 85 percent of the specialty peer group rate.

3. Effective for dates of service on or after March 1, 2011, the per diem rates for Medicaid inpatient services rendered by NICU level III and NICU level III regional units, recognized by the department as such on December 31, 2010, shall be adjusted to include an increase that varies based on the following five tiers:

a. tier 1—if the qualifying hospital's average percentage exceeds 10 percent, the additional per diem increase shall be \$601.98;

b. tier 2—if the qualifying hospital's average percentage is less than or equal to 10 percent, but exceeds 5 percent, the additional per diem increase shall be \$624.66;

c. tier 3—if the qualifying hospital's average percentage is less than or equal to 5 percent, but exceeds 1.5 percent, the additional per diem increase shall be \$419.83;

d. tier 4—if the qualifying hospital's average percentage is less than or equal to 1.5 percent, but greater than 0 percent, and the hospital received greater than .25 percent of the outlier payments for dates of service in state fiscal year (SFY) 2008 and SFY 2009 and calendar year 2010, the additional per diem increase shall be \$263.33; or

e. tier 5—if the qualifying hospital received less than .25 percent, but greater than 0 percent of the outlier payments for dates of service in SFY 2008 and SFY 2009 and calendar year 2010, the additional per diem increase shall be \$35.

4. A qualifying hospital's placement into a tier will be determined by the average of its percentage of paid NICU Medicaid days for SFY 2010 dates of service to the total of all qualifying hospitals' paid NICU days for the same time period, and its percentage of NICU patient outlier payments made as of December 31, 2010 for dates of service in SFY 2008 and SFY 2009 and calendar year 2010 to the total NICU outlier payments made to all qualifying hospitals for these same time periods.

a. This average shall be weighted to provide that each hospital's percentage of paid NICU days will comprise 25 percent of this average, while the percentage of outlier payments will comprise 75 percent. In order to qualify for tiers 1-4, a hospital must have received at least .25 percent of outlier payments in SFY 2008, SFY 2009, and calendar year 2010.

b. SFY 2010 is used as the base period to determine the allocation of NICU and PICU outlier payments for hospitals having both NICU and PICU units.

c. If the daily paid outlier amount per paid NICU day for any hospital is greater than the mean plus one standard deviation of the same calculation for all NICU level III and NICU level III regional hospitals, then the basis for calculating the hospital's percentage of NICU patient outlier payments shall be to substitute a payment amount equal to the highest daily paid outlier amount of any hospital not exceeding this limit, multiplied by the exceeding hospital's paid NICU days for SFY 2010, to take the place of the hospital's actual paid outlier amount.

NOTE: Children's specialty hospitals are not eligible for the per diem adjustments established in §953.H.3.

5. The department shall evaluate all rates and tiers two years after implementation.

I. Pediatric Intensive Care Unit (PICU)

1. Effective for dates of service on or after October 1, 2009, qualifying PICU level I services with current per diem rates that are less than 77 percent of the PICU level I specialty group rate shall have their per diem rates adjusted to equal 77 percent of the specialty peer group rate.

2. Effective for dates of service on or after October 1, 2009, qualifying PICU Level II services with current per diem rates that are less than the PICU Level II specialty group rate shall have their per diem rates adjusted to equal 100 percent of the specialty peer group rate.

3. Effective for dates of service on or after March 1, 2011, the per diem rates for Medicaid inpatient services rendered by PICU level I and PICU level II units, recognized by the department as such on December 31, 2010, shall be adjusted to include an increase that varies based on the following four tiers:

a. tier 1—if the qualifying hospital's average percentage exceeds 20 percent, the additional per diem increase shall be \$418.34;

b. tier 2—if the qualifying hospital's average percentage is less than or equal to 20 percent, but exceeds 10 percent, the additional per diem increase shall be \$278.63;

c. tier 3—if the qualifying hospital's average percentage is less than or equal to 10 percent, but exceeds 0 percent and the hospital received greater than .25 percent of the outlier payments for dates of service in SFY 2008 and SFY 2009 and calendar year 2010, the additional per diem increase shall be \$178.27; or

d. tier 4—if the qualifying hospital received less than .25 percent, but greater than 0 percent of the outlier payments for dates of service in SFY 2008, SFY 2009 and calendar year 2010, the additional per diem increase shall be \$35.

4. A qualifying hospital's placement into a tier will be determined by the average of its percentage of paid PICU Medicaid days for SFY 2010 dates of service to the total of all qualifying hospitals' paid PICU days for the same time period, and its percentage of PICU patient outlier payments made as of December 31, 2010 for dates of service in SFY 2008 and SFY 2009 and calendar year 2010 to the total PICU outlier payments made to all qualifying hospitals for these same time periods.

a. This average shall be weighted to provide that each hospital's percentage of paid PICU days will comprise 25 percent of this average, while the percentage of outlier payments will comprise 75 percent. In order to qualify for Tiers 1 through 3, a hospital must have received at least .25 percent of outlier payments in SFY 2008, SFY 2009, and calendar year 2010.

b. SFY 2010 is used as the base period to determine the allocation of NICU and PICU outlier payments for hospitals having both NICU and PICU units.

c. If the daily paid outlier amount per paid PICU day for any hospital is greater than the mean plus one standard deviation of the same calculation for all PICU Level I and PICU Level II hospitals, then the basis for calculating the hospital's percentage of PICU patient outlier payments shall be to substitute a payment amount equal to the highest daily paid outlier amount of any hospital not exceeding this limit, multiplied by the exceeding hospital's paid PICU days for SFY 2010, to take the place of the hospital's actual paid outlier amount.

NOTE: Children's specialty hospitals are not eligible for the per diem adjustments established in §953.I.3.

5. The department shall evaluate all rates and tiers two years after implementation.

J. Effective for dates of service on or after August 4, 2009, the prospective per diem rate paid to acute care hospitals shall be reduced by 6.3 percent of the per diem rate on file as of August 3, 2009.

1. Payments to small rural hospitals as defined in R.S. 40:1189.3 shall be exempt from this reduction.

K. Low Income and Needy Care Collaboration. Effective for dates of service on or after January 1, 2010, quarterly supplemental payments will be issued to qualifying non-rural, non-state acute care hospitals for inpatient services rendered during the quarter. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal year.

1. Qualifying Criteria. In order to qualify for the supplemental payment, the non-rural, non-state hospital must be affiliated with a state or local governmental entity through a low income and needy care collaboration agreement.

a. A non-state hospital is defined as a hospital which is owned or operated by a private entity.

b. A low-income and needy care collaboration agreement is defined as an agreement between a hospital and a state or local governmental entity to collaborate for purposes of providing healthcare services to low income and needy patients.

2. Each qualifying hospital shall receive quarterly supplemental payments for the inpatient services rendered during the quarter. Quarterly payment distribution shall be limited to one-fourth of the lesser of:

a. the difference between each qualifying hospital's inpatient Medicaid billed charges and Medicaid payments the hospital receives for covered inpatient services provided to Medicaid recipients. Medicaid billed charges and payments will be based on a 12 consecutive month period for claims data selected by the department; or

b. for hospitals participating in the Medicaid Disproportionate Share Hospital (DSH) Program, the difference between the hospital's specific DSH limit and the hospital's DSH payments for the applicable payment period.

3. Effective for dates of service on or after January 1, 2011, all parties that participate in supplemental payments under this Section, either as a qualifying hospital by receipt of supplemental payments or as a state or local governmental entity funding supplemental payments, must meet the following conditions during the period of their participation.

a. Each participant must comply with the prospective conditions of participation in the Louisiana Private Hospital Upper Payment Limit Supplemental Reimbursement Program.

b. A participating hospital may not make a cash or in-kind transfer to their affiliated governmental entity that has a direct or indirect relationship to Medicaid payments and would violate federal law.

c. A participating governmental entity may not condition the amount it funds the Medicaid Program on a specified or required minimum amount of low income and needy care.

d. A participating governmental entity may not assign any of its contractual or statutory obligations to an affiliated hospital.

e. A participating governmental entity may not recoup funds from an affiliated hospital that has not adequately performed under the low income and needy care collaboration agreement.

f. A participating hospital may not return any of the supplemental payments it receives under this Section to the governmental entity that provides the non-federal share of the supplemental payments.

g. A participating governmental entity may not receive any portion of the supplemental payments made to a participating hospital under this Section.

4. Each participant must certify that it complies with the requirements of §953.K.3 by executing the appropriate certification form designated by the department for this purpose. The completed form must be submitted to the Department of Health, Bureau of Health Services Financing.

5. Each qualifying hospital must submit a copy of its low income and needy care collaboration agreement to the department.

6. The supplemental payments authorized in this Section shall not be considered as interim Medicaid inpatient payments in the determination of cost settlement amounts for inpatient hospital services rendered by children's specialty hospitals.

L. Effective for dates of service on or after February 3, 2010, the inpatient per diem rate paid to acute care hospitals shall be reduced by 5 percent of the per diem rate on file as of February 2, 2010.

1. Payments to small rural hospitals as defined in R.S. 40:1189.3 shall be exempt from this reduction.

M. Effective for dates of service on or after August 1, 2010, the inpatient per diem rate paid to acute care hospitals shall be reduced by 4.6 percent of the per diem rate on file as of July 31, 2010.

1. Payments to small rural hospitals as defined in R.S. 40:1189.3 shall be exempt from this reduction.

N. Effective for dates of service on or after January 1, 2011, the inpatient per diem rate paid to acute care hospitals shall be reduced by 2 percent of the per diem rate on file as of December 31, 2010.

1. Payments to small rural hospitals as defined in R.S. 40:1189.3 shall be exempt from this reduction.

O. Effective for dates of service on or after August 1, 2012, the inpatient per diem rate paid to acute care hospitals shall be reduced by 3.7 percent of the per diem rate on file as of July 31, 2012.

P. Effective for dates of service on or after February 1, 2013, the inpatient per diem rate paid to acute care hospitals shall be reduced by 1 percent of the per diem rate on file as of July 31, 2013.

Q. Effective for dates of service on or after March 1, 2017, supplemental payments to non-rural, non-state acute care hospitals that qualify as a high Medicaid hospital shall be annual. The amount appropriated for annual supplemental payments shall be reduced to \$1,000. Each qualifying hospital's annual supplemental payment shall be calculated based on the pro rata share of the reduced appropriation.

R. Effective for dates of service on or after January 1, 2017, the inpatient per diem rate paid to acute care hospitals shall be increased by 7.03 percent of the per diem rate on file as of December 31, 2016.

1. Small rural hospitals as defined in R.S. 40:1189.3 and public-private partnership hospitals as defined in LAC 50:V.1701-1703 shall be exempt from this rate increase.

S. Effective for dates of service on or after January 1, 2018, the inpatient per diem rate paid to acute care hospitals shall be increased by indexing to 56 percent of the small rural hospital prospective per diem rate in effect on January 1, 2017.

1. Acute care hospitals whose per diem rates as of January 1, 2017, excluding the graduate medical education portion of the per diem, are greater than 56 percent of the January 1, 2017 small rural hospital rate shall not be increased.

2. Carve-out specialty units, nursery boarder, and well baby services are excluded from these rate increases.

T. Effective for dates of service on or after January 1, 2020, the inpatient per diem rate paid to acute care hospitals shall be increased by 3.2 percent of the per diem rate on file as of December 31, 2019.

1. Small rural hospitals as defined in R.S. 40:1189.3 and public-private partnership hospitals as defined in LAC 50:V.1701-1703 shall be exempt from this rate increase.

2. Carve-out specialty units, nursery boarder, and well baby services are included in these rate increases.

U. Effective for dates of service on or after January 1, 2021, the inpatient per diem rate paid to acute care hospitals shall be increased by 3.2 percent of the per diem rate on file as of December 31, 2020.

1. Small rural hospitals as defined in R.S. 40:1189.3 and public-private partnership hospitals as defined in LAC 50:V.1701-1703 shall be exempt from this rate increase.

2. Carve-out specialty units, nursery boarder, and well baby services are included in these rate increases.

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

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repromulgated LR 40:1939, 1940 (October 2014), LR 41:133 (January 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:963 (May 2017), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1389 (July 2017), repromulgated LR 43:1757 (September 2017), amended LR 43:2533 (December 2017), repromulgated LR 44:1445 (August 2018), amended LR 45:1770 (December 2019), LR:46:1683 (December 2020), LR 49:1390 (August 2023).

§954. Outlier Payments

A. Pursuant to §1902(s)(1) of title XIX of the Social Security Act, additional payments called outlier payments shall be made to hospitals for catastrophic costs associated with inpatient services provided to:

1. children less than six years of age who receive services in a disproportionate share hospital setting; and
2. infants less than one year of age who receive services in any acute care hospital setting.

B. The marginal cost factor for outlier payments is considered to be 100 percent of costs after the costs for the case exceed the sum of the hospital's prospective payment and any other payment made on behalf of the patient for that stay by any other payee.

C. To qualify as a payable outlier claim, a deadline of not later than six months subsequent to the date that the final claim is paid shall be established for receipt of the written request for outlier payments.

1. Effective March 1, 2011, in addition to the 6 month timely filing deadline, outlier claims for dates of service on or before February 28, 2011 must be received by the department on or before May 31, 2011 in order to qualify for payment. Claims for this time period received by the department after May 31, 2011 shall not qualify for payment.

D. Effective for dates of service on or after March 1, 2011, a catastrophic outlier pool shall be established with annual payments limited to \$10,000,000. In order to qualify for payments from this pool, the following conditions must be met:

1. the claims must be for cases for:
 - a. children less than six years of age who received inpatient services in a disproportionate share hospital setting; or
 - b. infants less than one year of age who receive inpatient services in any acute care hospital setting; and
2. the costs of the case must exceed \$150,000.

a. The hospital specific cost to charge ratio utilized to calculate the claim costs shall be calculated using the Medicaid NICU or PICU costs and charge data from the most current cost report.

E. The initial outlier pool will cover eligible claims with admission dates from the period beginning March 1, 2011-June 30, 2011.

1. Payment for the initial partial year pool will be \$3,333,333 and shall be the costs of each hospital's qualifying claims net of claim payments divided by the sum of all qualifying claims costs in excess of payments, multiplied by \$3,333,333.

2. Cases with admission dates on or before February 28, 2011 that continue beyond the March 1, 2011 effective date, and that exceed the \$150,000 cost threshold, shall be eligible for payment in the initial catastrophic outlier pool.

3. Only the costs of the cases applicable to dates of service on or after March 1, 2011 shall be allowable for determination of payment from the pool.

F. Beginning with SFY 2012, the outlier pool will cover eligible claims with admission dates during the state fiscal year (July 1-June 30) and shall not exceed \$10,000,000 annually. Payment shall be the costs of each hospital's eligible claims less the prospective payment, divided by the sum of all eligible claims costs in excess of payments, multiplied by \$10,000,000.

G. The claim must be submitted no later than six months subsequent to the date that the final claim is paid and no later than September 15 of each year.

H. Qualifying cases for which payments are not finalized by September 1 shall be eligible for inclusion for payment in the subsequent state fiscal year outlier pool.

I. Outliers are not payable for:

1. transplant procedures; or
2. services provided to patients with Medicaid coverage that is secondary to other payer sources.

J. Effective on or after July 1, 2019, the outlier pool for admissions during SFY 2019 and subsequent state fiscal years shall cover eligible claims and shall not exceed \$21,092,179 annually. Payment shall be the costs of each hospital's eligible claims less the prospective payment, divided by the sum of all eligible claims costs in excess of payments, multiplied by \$21,092,179.

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§955. Long-Term Hospitals

A. For dates of service on or after September 1, 2007, the prospective per diem rate paid to long term hospitals for inpatient services shall be increased by 4.75 percent of the rate on file for August 31, 2007.

B. For dates of service on or after February 20, 2009, the prospective per diem rate paid to long term hospitals for inpatient services shall be reduced by 3.5 percent of the rate on file as of February 19, 2009.

1. Payments for inpatient hospital services to high Medicaid hospitals classified as long term hospitals shall be exempted from these reductions.

2. For the purposes of qualifying for the exemption to the reimbursement reduction as a high Medicaid hospital, the following conditions must be met.

a. The inpatient Medicaid days utilization rate for high Medicaid hospitals shall be calculated based on the cost report filed for the period ending in state fiscal year 2007 and received by the department prior to April 20, 2008.

b. Only Medicaid covered days for inpatient hospital services, which include newborn and distinct part psychiatric unit days, are included in this calculation.

c. Inpatient stays covered by Medicare Part A cannot be included in the determination of the Medicaid inpatient utilization days rate.

C. Effective for dates of service on or after October 1, 2009, the prospective peer group per diem rate paid to qualifying long term acute care hospitals for inpatient services other than psychiatric treatment shall be increased by 3 percent of the rate on file.

D. Effective for dates of service on or after August 4, 2009, the prospective per diem rate paid to long term hospitals for inpatient services shall be reduced by 6.3 percent of the per diem rate on file as of August 3, 2009.

E. Effective for dates of service on or after February 3, 2010, the inpatient per diem rate paid to long term hospitals shall be reduced by 5 percent of the per diem rate on file as of February 2, 2010.

F. Effective for dates of service on or after August 1, 2010, the inpatient per diem rate paid to long term hospitals shall be reduced by 4.6 percent of the per diem rate on file as of July 31, 2010.

G. Effective for dates of service on or after January 1, 2011, the inpatient per diem rate paid to long term hospitals shall be reduced by 2 percent of the per diem rate on file as of December 31, 2010.

H. Effective for dates of service on or after August 1, 2012, the inpatient per diem rate paid to long term hospitals shall be reduced by 3.7 percent of the per diem rate on file as of July 31, 2012.

I. Effective for dates of service on or after February 1, 2013, the inpatient per diem rate paid to long term hospitals shall be reduced by 1 percent of the per diem rate on file as of January 31, 2013.

J. Effective for dates of service on or after January 1, 2017, the inpatient per diem rate paid to long term hospitals shall be increased by 7.03 percent of the per diem rate on file as of December 31, 2016.

K. Effective for dates of service on or after January 1, 2018, the inpatient per diem rate paid to long term hospitals shall be increased by indexing to 42 percent of the small rural hospital prospective per diem rate in effect on January

1, 2017. Long term hospitals whose per diem rates as of January 1, 2017, excluding the graduate medical education portion of the per diem, are greater than 42 percent of the January 1, 2017 small rural hospital rate shall not be increased.

L. Effective for dates of service on or after January 1, 2020, the inpatient per diem rate paid to long term acute hospitals shall be increased by indexing to 45 percent of the small rural hospital prospective per diem rate in effect on January 1, 2019. Long term hospitals whose per diem rates as of January 1, 2019, excluding the graduate medical education portion of the per diem, are greater than 45 percent of the January 1, 2019 small rural hospital rate shall not be increased.

M. Effective for dates of service on or after January 1, 2021, the inpatient per diem rate paid to long term acute hospitals shall be increased by 3.2 percent of the per diem rate on file as of December 31, 2020.

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

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§959. Inpatient Psychiatric Hospital Services

A. For dates of service on or after September 1, 2007, the prospective per diem rate paid to private free-standing psychiatric hospitals and distinct part psychiatric units shall be increased by 4.75 percent of the rate on file for August 31, 2007.

B. Effective for dates of service on or after February 20, 2009, the prospective per diem rate paid to non-rural, non-state free-standing psychiatric hospitals and distinct part psychiatric units shall be reduced by 3.5 percent of the rate on file as of February 19, 2009.

1. Distinct part psychiatric units that operate within an acute care hospital that qualifies as a high Medicaid hospital, as defined in §953.C.2, are exempt from the rate reduction.

C. Effective for dates of service on or after October 1, 2009, the prospective per diem rate paid to private free-standing psychiatric hospitals and distinct part psychiatric units shall be increased by 3 percent of the rate on file.

D. Effective for dates of service on or after August 4, 2009, the prospective per diem rate paid to non-rural, non-state free-standing psychiatric hospitals shall be reduced by 5.8 percent of the rate on file as of August 3, 2009.

E. Effective for dates of service on or after August 4, 2009, the prospective per diem rate paid to non-rural, non-

state distinct part psychiatric units shall be reduced by 6.3 percent of the rate on file as of August 3, 2009.

F. Effective for dates of service on or after February 3, 2010, the prospective per diem rate paid to non-rural, non-state free-standing psychiatric hospitals and distinct part psychiatric units within non-rural, non-state acute care hospitals shall be reduced by 5 percent of the per diem rate on file as of February 2, 2010.

G. Effective for dates of service on or after August 1, 2010, the prospective per diem rate paid to non-rural, non-state free-standing psychiatric hospitals and distinct part psychiatric units within non-rural, non-state acute care hospitals shall be reduced by 4.6 percent of the per diem rate on file as of July 31, 2010.

H. Effective for dates of service on or after January 1, 2011, the prospective per diem rate paid to non-rural, non-state free-standing psychiatric hospitals and distinct part psychiatric units within non-rural, non-state acute care hospitals shall be reduced by 2 percent of the per diem rate on file as of December 31, 2010.

I. Low Income and Needy Care Collaboration. Effective for dates of service on or after January 1, 2012, quarterly supplemental payments shall be issued to qualifying non-rural, non-state free-standing psychiatric hospitals for inpatient services rendered during the quarter. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal year.

1. Qualifying Criteria. In order to qualify for the supplemental payment, the non-state free-standing psychiatric hospital must be affiliated with a state or local governmental entity through a low income and needy care collaboration agreement.

a. A non-state free-standing psychiatric hospital is defined as a free-standing psychiatric hospital which is owned or operated by a private entity.

b. A low income and needy care collaboration agreement is defined as an agreement between a hospital and a state or local governmental entity to collaborate for the purposes of providing healthcare services to low income and needy patients.

2. Each qualifying hospital shall receive quarterly supplemental payments for the inpatient services rendered during the quarter. Quarterly payment distribution shall be limited to one-fourth of the lesser of:

a. the difference between each qualifying hospital's inpatient Medicaid billed charges and Medicaid payments the hospital receives for covered inpatient psychiatric services provided to Medicaid recipients. Medicaid billed charges and payments will be based on a 12 consecutive month period for claims data selected by the department; or

b. for hospitals participating in the Medicaid Disproportionate Share Hospital (DSH) program, the difference between the hospital's specific DSH limit and the hospital's DSH payment for the applicable payment period.

J. Effective for dates of service on or after February 10, 2012, a Medicaid-enrolled non-state acute care hospital that enters into a cooperative endeavor agreement (CEA) with the Department of Health, Office of Behavioral Health to provide inpatient psychiatric services to Medicaid and uninsured patients, and which also assumes the operation and management of formerly state-owned and operated psychiatric hospitals/visits, shall be paid a per diem rate of \$581.11 per day.

K. Effective for dates of service on or after January 1, 2017, the prospective per diem rate paid to non-rural, non-state free-standing psychiatric hospitals, and distinct part psychiatric units within non-rural, non-state acute care hospitals, shall be increased by 2 percent of the per diem rate on file as of December 31, 2016.

1. Inpatient hospital psychiatric services provided under a public-private partnership as defined in §959.J of this Chapter, LAC 50:V.1701 and LAC 50:V.2901 shall be exempt from this rate increase.

L. Effective for dates of service on or after January 1, 2018, the prospective per diem rate paid to non-rural, non-state free-standing psychiatric hospitals, and distinct part psychiatric units within non-rural, non-state acute care hospitals, shall be increased by indexing to 31 percent of the small rural hospital prospective per diem rate in effect on January 1, 2017.

1. Psychiatric hospitals and units whose per diem rates as of January 1, 2017, excluding the graduate medical education portion of the per diem, are greater than 31 percent of the January 1, 2017 small rural hospital rate shall not be increased.

2. Inpatient hospital psychiatric services provided under a public-private partnership as defined in §959.J of this Chapter, LAC 50:V.1701 and LAC 50:V.2901 shall be exempt from this rate increase.

M. Effective for dates of service on or after January 1, 2020, the prospective per diem rate paid to non-rural, non-state free-standing psychiatric hospitals, and distinct part psychiatric units within non-rural, non-state acute care hospitals, shall be increased by 32 percent of the small rural hospital prospective per diem rate in effect on January 1, 2019.

1. Psychiatric hospitals and units whose per diem rates as of January 1, 2019, excluding the graduate medical education portion of the per diem, are greater than 32 percent of the January 1, 2019 small rural hospital rate shall not be increased.

2. Inpatient hospital psychiatric services provided under a public-private partnership as defined in §959.J of this Chapter, LAC 50:V.1701 and LAC 50:V.2901 shall be exempt from this rate increase.

N. Effective for dates of service on or after January 1, 2021, the inpatient per diem rate paid to non-rural, non-state free-standing psychiatric hospitals, and distinct part psychiatric units within non-rural, non-state acute care

hospitals, shall be increased by 3.2 percent of the per diem rate in on file as of December 31, 2020.

1. Inpatient hospital psychiatric services provided under a public-private partnership as defined in §959.J of this Chapter, LAC 50:V.1701 and LAC 50:V.2901 shall be exempt from this rate increase.

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

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§961. Inpatient Rehabilitation Hospital Services

A. Definitions

Free-Standing Rehabilitation Hospital—a non-rural, non-state hospital that is designated as a rehabilitation specialty hospital by Medicare.

B. Reimbursement Methodology

1. Effective for dates of service on or after January 1, 2018, the prospective per diem rate paid to non-rural, non-state free-standing rehabilitation hospitals shall be indexed to 36 percent of the small rural hospital prospective per diem rate in effect on January 1, 2017.

2. Rehabilitation hospitals whose per diem rates as of January 1, 2017, excluding the graduate medical education portion of the per diem, are greater than 36 percent of the January 1, 2017 small rural hospital rate shall not be increased.

3. Effective for dates of service on or after January 1, 2020, the prospective per diem rate paid to non-rural, non-state free-standing rehabilitation hospitals shall be indexed to 37 percent of the small rural hospital prospective per diem rate in effect on January 1, 2019.

4. Rehabilitation hospitals whose per diem rates as of January 1, 2019, excluding the graduate medical education portion of the per diem, are greater than 37 percent of the January 1, 2019 small rural hospital rate shall not be increased.

5. Effective for dates of service on or after January 1, 2021, the inpatient per diem rate paid to non-rural, non-state free-standing rehabilitation hospitals shall be increased by 3.2 percent of the per diem rate on file as of December 31, 2020.

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§963. Public Hospitals

A. Effective for dates of service on or after May 15, 2011, non-rural, non-state public hospitals shall be reimbursed up to the Medicare inpatient upper payment limits as determined in accordance with 42 CFR §447.272.

B. Effective for dates of service on or after August 1, 2012, quarterly supplemental payments will be issued to qualifying non-rural, non-state public hospitals for inpatient services rendered during the quarter. Payment amounts shall be reimbursed up to the Medicare inpatient upper payment limits as determined in accordance with 42 CFR §447.272.

1. Qualifying Criteria. In order to qualify for the quarterly supplemental payment, the non-rural, non-state public acute care hospital must:

a. be designated as a major teaching hospital by the department as of July 1, 2015 and have at least 300 licensed acute hospital beds; or

b. effective for dates of service on or after August 1, 2012, be located in a city with a population of over 300,000 as of the 2010 U.S. Census.

C. Each qualifying hospital shall receive quarterly supplemental payments for the inpatient services rendered during the quarter. Quarterly payments shall be the difference between each qualifying hospital's inpatient Medicaid billed charges and Medicaid payments the hospital receives for covered inpatient services provided to Medicaid recipients. Medicaid billed charges and payments will be based on a 12 consecutive month period for claims data selected by the department.

D. With respect to qualifying hospitals that are enrolled in Medicaid after December 1, 2013, projected Medicaid utilization and claims data submitted by the hospital and confirmed by the department as reasonable will be used as the basis for making quarterly supplemental payments during the hospital's start-up period.

1. For purposes of these provisions, the start-up period shall be defined as the first three years of operation.

2. During the start-up period, the department shall verify that supplemental payments do not exceed the inpatient charge differential based on each state fiscal year's claims data and shall recoup amounts determined to have been overpaid.

E. In the event that there is allowable non-state public upper payment limit that is not utilized, additional non-state public hospitals as defined by the department may be qualified for this payment.

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§965. Hemophilia Blood Products

A. Effective for dates of service on or after July 1, 2015, the Department of Health and Hospitals shall provide additional reimbursements to certain non-rural, non-state acute care hospitals for the extraordinary costs incurred in purchasing blood products for certain Medicaid recipients diagnosed with, and receiving inpatient treatment for hemophilia.

B. Hospital Qualifications. To qualify for the additional reimbursement, the hospital must:

1. be classified as a major teaching hospital and contractually affiliated with a university located in Louisiana that is recognized by the Centers for Disease Control and Prevention and the Health Resource and Services Administration, Maternal and Child Health Bureau as maintaining a comprehensive hemophilia care center;

2. have provided clotting factors to a Medicaid recipient who:

a. has been diagnosed with hemophilia or other rare bleeding disorders for which the use of one or more clotting factors is Food and Drug Administration (FDA) approved; and

b. has been hospitalized at the qualifying hospital for a period exceeding six days; and

3. have actual cost exceeding \$50,000 for acquiring the blood products used in the provision of clotting factors during the hospitalization;

a. actual cost is the hospital's cost of acquiring blood products for the approved inpatient hospital dates of service as contained on the hospital's original invoices, less all discount and rebate programs applicable to the invoiced products.

C. Reimbursement. Hospitals who meet the qualifications in §965.B may receive reimbursement for their actual costs that exceed \$50,000 if the hospital submits a request for reimbursement to the Medicaid Program within 180 days of the patient's discharge from the hospital.

1. The request for reimbursement shall be submitted in a format specified by the department.

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 34:2176 (October 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:674 (April 2009), LR 42:406 (March 2016).

§967. Children's Specialty Hospitals

A. Routine Pediatric Inpatient Services. For dates of service on or after October 4, 2014, payment shall be made per a prospective per diem rate that is 81.1 percent of the routine pediatric inpatient cost per day as calculated per the "as filed" fiscal year end cost report ending during SFY 2014. The "as filed" cost report will be reviewed by the

department for accuracy prior to determination of the final per diem rate.

B. Inpatient Psychiatric Services. For dates of service on or after October 4, 2014, payment shall be a prospective per diem rate that is 100 percent of the distinct part psychiatric cost per day as calculated per the as filed fiscal year end cost report ending during SFY 2014. The as filed cost report will be reviewed by the department for accuracy prior to determination of the final per diem rate.

1. Costs and per discharge/per diem limitation comparisons shall be calculated and applied separately for acute, psychiatric and each specialty service.

C. Carve-Out Specialty Services. These services are rendered by neonatal intensive care units, pediatric intensive care units, burn units and include transplants.

1. Transplants. Payment shall be the lesser of costs or the per diem limitation for each type of transplant. The base period per diem limitation amounts shall be calculated using the allowable inpatient cost per day for each type of transplant per the cost reporting period which ended in SFY 2009. The target rate shall be inflated using the update factors published by the Centers for Medicare and Medicaid (CMS) beginning with the cost reporting periods starting on or after January 1, 2010.

a. For dates of service on or after September 1, 2009, payment shall be the lesser of the allowable inpatient costs as determined by the cost report or the Medicaid days for the period for each type of transplant multiplied times the per diem limitation for the period.

2. Neonatal Intensive Care Units, Pediatric Intensive Care Units, and Burn Units. For dates of service on or after October 4, 2014, payment for neonatal intensive care units, pediatric intensive care units, and burn units shall be made per prospective per diem rates that are 84.5 percent of the cost per day for each service as calculated per the “as filed” fiscal year end cost report ending during SFY 2014. The “as filed” cost report will be reviewed by the department for accuracy prior to determination of the final per diem rate.

D. Children’s specialty hospitals shall be eligible for outlier payments for dates of service on or after October 4, 2014.

E. These provisions shall not preclude children’s specialty hospitals from participation in the Medicaid Program under the high Medicaid or graduate medical education supplemental payment provisions.

F. Effective for dates of service on or after February 3, 2010, the per diem rates as calculated per §967.C.1 above shall be reduced by 5 percent. Effective for dates of service on or after January 1, 2011, final payment shall be the lesser of allowable inpatient acute care costs as determined by the cost report or the Medicaid days as specified per §967.C.1 for the period, multiplied by 95 percent of the target rate per diem limitation as specified per §967.C.1 for the period.

G. Effective for dates of service on or after August 1, 2010, the per diem rates as calculated per §967.C.1 above

shall be reduced by 4.6 percent. Effective for dates of service on or after January 1, 2011, final payment shall be the lesser of allowable inpatient acute care costs as determined by the cost report or the Medicaid days as specified per §967.C.1 for the period, multiplied by 90.63 percent of the target rate per diem limitation as specified per §967.C.1 for the period.

H. Effective for dates of service on or after January 1, 2011, the per diem rates as calculated per §967.C.1 above shall be reduced by 2 percent. Final payment shall be the lesser of allowable inpatient acute care costs as determined by the cost report or the Medicaid days as specified per §967.C.1 for the period, multiplied by 88.82 percent of the target rate per diem limitation as specified per §967.C.1 for the period.

I. Effective for dates of service on or after February 1, 2012, medical education payments for inpatient services which are reimbursed by a prepaid risk-bearing managed care organization (MCO) shall be paid by Medicaid monthly as interim lump sum payments.

1. Hospitals with qualifying medical education programs shall submit a listing of inpatient claims paid each month by each MCO.

a. *Qualifying Medical Education Programs*—graduate medical education, paramedical education, and nursing schools.

2. Monthly payments shall be calculated by multiplying the number of qualifying inpatient days times the medical education costs included in each children’s specialty hospital’s interim per diem rate as calculated per the latest filed Medicaid cost report.

3. Final payment shall be determined based on the actual MCO covered days and medical education costs for the cost reporting period per the Medicaid cost report. Reimbursement shall be at the same percentage that is reimbursed for fee-for-service covered Medicaid costs after application of reimbursement caps as specified in §967.A-C and reductions specified in §967.F-H.

J. Effective for dates of service on or after August 1, 2012, the per diem rates as calculated per §967.C.1 above shall be reduced by 3.7 percent. Final payment shall be the lesser of allowable inpatient acute care costs as determined by the cost report or the Medicaid days as specified per §967.C.1 for the period, multiplied by 85.53 percent of the target rate per diem limitation as specified per §967.C.1 for the period.

K. Effective for dates of service on or after February 1, 2013, the per diem rates as calculated per §967.C.1 above shall be reduced by 1 percent. Final payment shall be the lesser of allowable inpatient acute care costs as determined by the cost report or the Medicaid days as specified per §967.C.1 for the period, multiplied by 84.67 percent of the target rate per diem limitation as specified per §967.C.1 for the period.

L. Effective for dates of service on or after January 1, 2017, the inpatient per diem rates paid to children’s specialty

hospitals for acute, neonatal intensive care units, pediatric intensive care units and burn units' services shall be increased by 7.03 percent of the per diem rate on file as of December 31, 2016.

M. Effective for dates of service on or after January 1, 2017, the prospective per diem rate paid to distinct part psychiatric units within children's specialty hospitals shall be increased by 2 percent of the per diem rate on file as of December 31, 2016.

N. Effective for dates of service on or after January 1, 2020, the inpatient per diem rates paid to children's specialty hospitals for acute, neonatal intensive care units, pediatric intensive care units and burn units' services shall be increased by 3.2 percent of the per diem rate on file as of December 31, 2019.

O. Effective for dates of service on or after January 1, 2020, the prospective per diem rate paid to distinct part psychiatric units within children's specialty hospitals shall be increased by indexing to 32 percent of the small rural hospital prospective per diem rate in effect on January 1, 2019.

P. Effective for dates of service on or after January 1, 2021, the inpatient per diem rates paid to children's specialty hospitals for acute, neonatal intensive care units, pediatric intensive care units and burn units' services shall be increased by 3.2 percent of the per diem rate on file as of December 31, 2020.

Q. Effective for dates of service on or after January 1, 2021, the inpatient per diem rates paid to distinct part psychiatric units within children's specialty hospitals shall be increased by 3.2 percent of the per diem rate on file as of December 31, 2020.

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§969. Transplant Services

A. **Qualifying Criteria.** The hospital must be a Medicare approved transplant center for each type of organ transplant to qualify for reimbursement of Medicaid transplant services. Bone marrow transplant, stem cell transplant, and certain autologous immunotherapies (such as CAR T-cell therapy) services shall only be allowable for payment to hospitals that are accredited by the Foundation for the Accreditation of Cellular Therapy (FACT).

B. **Reimbursement Methodology.** Reimbursement shall be limited to the lesser of allowable cost, net of capital and medical education cost, or the hospital-specific per diem limitation calculated for each type of transplant.

1. Allowable cost is defined as the ratio of cost to charges from the annual filed cost report multiplied by the covered charges, net of capital and medical education cost, for the specific transplant type.

2. The per diem limitation is calculated by deriving the hospital's per diem for the transplant type from the hospital's base period trended forward using the annual Medicare target rate inflation percentage for prospective payment system (PPS)-exempt hospitals.

3. The base period is the cost report period for the hospital's fiscal year ending September 30, 1983 through August 31, 1984. The base period for types of transplants that were not performed in the base period shall be the first cost report filed subsequently that includes costs for that type of transplant.

4. Reasonable capital and medical education costs as calculated per the annual filed cost report shall be paid as a pass through cost and included in cost report settlement amounts.

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 49:1393 (August 2023).

Chapter 11. Rural, Non-State Hospitals

Subchapter A. General Provisions (Reserved)

Subchapter B. Reimbursement Methodology

§1125. Small Rural Hospitals

A. Effective for dates of service on or after July 1, 2008, the prospective per diem rate paid to small rural hospitals for inpatient acute care services shall be the median cost amount plus 10 percent.

1. The per diem rate calculation shall be based on each hospital's year-end cost report period ending in calendar year 2006. If the cost reporting period is not a full period (12 months), the latest filed full period cost report shall be used.

B. The Medicaid cost per inpatient day for each small rural hospital shall be inflated from their applicable cost reporting period to the midpoint of the implementation year (December 31, 2008) by the Medicare market basket inflation factor for PPS hospitals, then arrayed from high to low to determine the median inpatient acute cost per day for all small rural hospitals.

C. The median cost and rates shall be rebased at least every other year using the latest filed full period cost reports as filed in accordance with Medicare timely filing guidelines.

D. Effective for dates of service on or after August 1, 2010, the reimbursement for inpatient acute care services rendered by small rural hospitals shall be up to the Medicare upper payment limits for inpatient hospital services.

E. Low Income and Needy Care Collaboration. Effective for dates of service on or after October 20, 2011, quarterly supplemental payments shall be issued to qualifying non-state acute care hospitals for inpatient services rendered during the quarter. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal year.

1. Qualifying Criteria. In order to qualify for the supplemental payment, the non-state hospital must be affiliated with a state or local governmental entity through a low income and needy care collaboration agreement.

a. A non-state hospital is defined as a hospital which is owned or operated by a private entity.

b. A *low income and needy care collaboration agreement* is defined as an agreement between a hospital and a state or local governmental entity to collaborate for purposes of providing healthcare services to low income and needy patients.

2. Each qualifying hospital shall receive quarterly supplemental payments for the inpatient services rendered during the quarter. Quarterly payment distribution shall be limited to one-fourth of the lesser of:

a. the difference between each qualifying hospital's inpatient Medicaid billed charges and Medicaid payments the hospital receives for covered inpatient services provided to Medicaid recipients. Medicaid billed charges and payments will be based on a 12 consecutive month period for claims data selected by the department; or

b. for hospitals participating in the Medicaid Disproportionate Share Hospital (DSH) Program, the difference between the hospital's specific DSH limit and the hospital's DSH payments for the applicable payment period.

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 35:955 (May 2009), amended LR 38:1240 (May 2012), LR 40:541 (March 2014).

§1127. Inpatient Psychiatric Hospital Services

A. Effective for dates of service on or after July 1, 2008, the prospective per diem rate paid to small rural hospitals for psychiatric services rendered in distinct part psychiatric units shall be the median cost amount per inpatient day plus 10 percent.

1. The per diem rate calculation shall be based on each hospital's year-end cost report period ending in calendar year 2006. If the cost reporting period is not a full period (12 months), the latest filed full period cost report shall be used.

B. The Medicaid cost per inpatient psychiatric day for each small rural hospital shall be inflated from their applicable cost reporting period to the midpoint of the implementation year (December 31, 2008) by the Medicare market basket inflation factor for PPS hospitals, then arrayed from high to low to determine the median inpatient acute cost per day for all small rural hospitals.

C. The median cost and rates shall be rebased at least every other year using the latest filed full period cost reports as filed in accordance with Medicare timely filing guidelines.

D. Effective for dates of service on or after August 1, 2010, the reimbursement paid for psychiatric services rendered by distinct part psychiatric units in small rural hospitals shall be up to the Medicare inpatient upper payment limits.

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 35:955 (May 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1240 (May 2012).

Chapter 13. Teaching Hospitals

Subchapter A. General Provisions

§1301. Major Teaching Hospitals

A. The Louisiana Medical Assistance Program's recognition of a major teaching hospital is limited to facilities having a documented affiliation agreement for the purpose of providing graduate medical education training with a Louisiana medical school accredited by the Liaison Committee on Medical Education (LCME) or by the Commission on Osteopathic College Accreditation (COCA). A major teaching hospital shall meet one of the following criteria:

1. be a major participant in at least four approved medical residency programs and maintain at least 15 intern and resident un-weighted full-time equivalent positions. For purposes of this Rule, full-time equivalent positions will be calculated as defined in 42 CFR 413.78. At least two of the programs must be in medicine, surgery, obstetrics/gynecology, pediatrics, family practice, emergency medicine or psychiatry; or

2. maintain at least 20 intern and resident un-weighted full-time equivalent positions, with an approved medical residency program in family practice located more than 150 miles from the medical school accredited by the LCME or the COCA. For purposes of this Rule, full-time equivalent positions will be calculated as defined in 42 CFR 413.78.

B. For the purposes of recognition as a major teaching hospital, a facility shall be considered a "major participant" in a graduate medical education program if it meets the following criteria. The facility must participate in residency programs that:

1. require residents to rotate for a required experience; and

2. require explicit approval by the appropriate residency review committee (RRC) of the medical school with which the facility is affiliated prior to utilization of the facility; or

3. provide residency rotations of more than one sixth of the program length or more than a total of six months at the facility and are listed as part of an accredited program in the graduate medical education directory of the Accreditation Council for Graduate Medical Education (ACGME).

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 39:324 (February 2013), amended LR 40:1697 (September 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 49:70 (January 2023), LR 50:384 (March 2024).

§1303. Minor Teaching Hospitals

A. The Louisiana Medical Assistance Program's recognition of a minor teaching hospital is limited to facilities having a documented affiliation agreement for the purposes of providing graduate medical education training with a Louisiana medical school accredited by the LCME or by the COCA. A minor teaching hospital shall meet the following criteria:

1. must participate significantly in at least one approved medical residency program in either medicine, surgery, obstetrics/gynecology, pediatrics, family practice, emergency medicine or psychiatry; and

2. maintain at least six intern and resident un-weighted full-time equivalent positions. For purposes of this Rule, full-time equivalent positions will be calculated as defined in 42 CFR 413.78.

B. For the purposes of recognition as a minor teaching hospital, a facility is considered to "participate significantly" in a graduate medical education program if it meets the following criteria. The facility must participate in residency programs that:

1. require residents to rotate for a required experience; and

2. require explicit approval by the appropriate residency review committee of the medical school with which the facility is affiliated prior to utilization of the facility; or

3. provide residency rotations of more than one sixth of the program length or more than a total of six months at the facility and are listed as part of an accredited program in the graduate medical education directory of the Accreditation Council for Graduate Medical Education.

a. If not listed, the sponsoring institution must have notified the ACGME, in writing, that the residents rotate through the facility and spend more than one sixth of the

program length or more than a total of six months at the facility.

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 39:324 (February 2013), amended LR 40:1698 (September 2014), amended LR 40:1698 (September 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 49:70 (January 2023), LR 50:385 (March 2024).

§1305. Approved Medical Residency Program

A. An approved medical residency program is one that meets one of the following criteria:

1. is approved by one of the national organizations listed in 42 CFR 415.152;

2. may count towards certification of the participant in a specialty or subspecialty listed in the current edition of either of the following publications:

a. *The Directory of Graduate Medical Education Programs* published by the American Medical Association, and available from American Medical Association, Department of Directories and Publications; or

b. *The Annual Report and Reference Handbook* published by the American Board of Medical Specialties, and available from American Board of Medical Specialties;

3. is approved by the Accreditation Council for Graduate Medical Education (ACGME) as a fellowship program in geriatric medicine; or

4. is a program that would be accredited except for the accrediting agency's reliance upon an accreditation standard that requires an entity to perform an induced abortion or require, provide, or refer for training in the performance of induced abortions, or make arrangements for such training, regardless of whether the standard provides exceptions or exemptions.

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 39:324 (February 2013), amended LR 40:1698 (September 2014).

§1309. Requirements for Reimbursement

A. Qualification for teaching hospital status shall be re-established at the beginning of each fiscal year.

B. To be reimbursed as a teaching hospital, a facility shall submit a signed "certification for teaching hospital recognition" form to the Bureau of Health Services, Rate Setting and Audit Section at least 30 days prior to the beginning of each state fiscal year or at least 30 days prior to the effective date of the conversion of a state owned and operated teaching hospital to private ownership in accordance with a public/private partnership cooperative endeavor agreement that was instituted to preserve graduate medical education training and access to healthcare services for indigent patients.

C. Each hospital which is reimbursed as a teaching hospital shall submit the following documentation with their Medicaid cost report filing:

1. a copy of the intern and resident information system report that is submitted annually to the Medicare intermediary; and

2. a copy of any notice given to the ACGME that residents rotate through a facility for more than one sixth of the program length or more than a total of six months.

D. Copies of all affiliation agreements, contracts, payroll records and time allocations related to graduate medical education must be maintained by the hospital and available for review by the state and federal agencies or their agents upon request.

E. If it is subsequently discovered that a hospital has been reimbursed as a major or minor teaching hospital and did not qualify for that peer group for any reimbursement period, retroactive adjustment shall be made to reflect the correct peer group to which the facility should have been assigned. The resulting overpayment will be recovered through either immediate repayment by the hospital or recoupment from any funds due to the hospital from the department.

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 39:325 (February 2013), amended LR 40:1698 (September 2014).

Subchapter B. Reimbursement Methodology

§1331. Acute Care Hospitals

A. Effective for dates of service on or after February 1, 2012, medical education payments for inpatient services which are reimbursed by a prepaid risk-bearing managed care organization (MCO) shall be paid monthly by Medicaid as interim lump sum payments.

1. Hospitals with qualifying medical education programs shall submit a listing of inpatient claims paid each month by each MCO.

a. Qualifying medical education programs are defined as graduate medical education, paramedical education, and nursing schools.

2. Qualifying hospitals must have a direct medical education add-on component included in their prospective Medicaid per diem rates as of January 31, 2012 which was carved-out of the per diem rate reported to the MCOs.

3. Monthly payments shall be calculated by multiplying the number of qualifying inpatient days submitted by the medical education costs component included in each hospital's fee-for-service prospective per diem rate. Monthly payment amounts shall be verified by the department semi-annually using reports of MCO covered days generated from encounter data. Payment adjustments or

recoupments shall be made as necessary based on the MCO encounter data reported to the department.

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 34:877 (May 2008), amended LR 38:2773 (November 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1388 (July 2017).

Chapter 17. Public-Private Partnerships

§1701. Baton Rouge Area Hospitals

A. Qualifying Criteria. Effective for dates of service on or after April 15, 2013, the department shall provide supplemental Medicaid payments for inpatient hospital services rendered by non-state privately owned hospitals in the Baton Rouge Area that meet the following conditions.

1. The hospital must be a non-state privately owned and operated hospital that enters into a cooperative endeavor agreement with the Department of Health and Hospitals to increase its provision of inpatient Medicaid and uninsured hospital services by:

a. assuming the management and operation of services at a facility where such services were previously provided by a state owned and operated facility; or

b. providing services that were previously delivered and terminated or reduced by a state owned and operated facility.

B. Reimbursement Methodology

1. Payments shall be made quarterly based on the annual upper payment limit calculation per state fiscal year.

2. Payments shall not exceed the allowable Medicaid charge differential. The Medicaid inpatient charge differential is the Medicaid inpatient charges less the Medicaid inpatient payments (which includes both the base payments and supplemental payments).

a. The payments will be made in four equal quarterly payments based on 100 percent of the estimated charge differential for the state fiscal year.

3. The qualifying hospital will provide quarterly reports to the department that will demonstrate that, upon implementation, the annual Medicaid inpatient payments do not exceed the annual Medicaid inpatient charges per 42 CFR 447.271. The department will verify the Medicaid claims data of these interim reports using the state's MMIS system. When the department receives the annual cost report as filed, the supplemental calculations will be reconciled to the cost report.

4. If there is additional cap room, an adjustment payment will be made to assure that supplemental payments are the actual charge differential. The supplemental payments will also be reconciled to the final cost report.

5. The annual supplemental payments will not exceed the allowable Medicaid inpatient charge differential per 42 CFR 447.271, and the maximum inpatient Medicaid payments shall not exceed the upper limit per 42 CFR 447.272.

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 42:407 (March 2016).

§1703. Reimbursement Methodology

A. Reserved.

B. Effective for dates of service on or after April 15, 2013, a major teaching hospital that enters into a cooperative endeavor agreement with the Department of Health and Hospitals to provide acute care hospital services to Medicaid and uninsured patients and which assumes providing services that were previously delivered and terminated or reduced by a state-owned and operated facility shall be reimbursed as follows.

1. The inpatient reimbursement shall be reimbursed at 95 percent of allowable Medicaid costs. The interim per diem reimbursement may be adjusted not to exceed the final reimbursement of 95 percent of allowable Medicaid costs.

C. - E.3. Reserved.

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 42:573 (April 2016).

Chapter 19. Urban Metropolitan Statistical Area (MSA) Facility

§1901. Qualifying Criteria

A. In order to qualify as an urban metropolitan statistical area (MSA) facility, the hospital:

1. has a facility type code of acute and opened subsequent to the March 12, 2020 presidential declaration of a national emergency due to COVID-19 to provide availability of additional beds and services for COVID-19 patients;

2. must have been licensed and certified no later than June 30, 2020, and located in zip code 70806, east of I-110, north of I-10, and south of Business Highway 190;

3. is located in an urban metropolitan statistical area (MSA) as defined by the United States Office of Management and Budget;

4. has an operational emergency room and is located greater than five miles in distance from the closest hospital emergency room; and

5. is located on a single site.

a. The addition of any off-site campus location to the license of this hospital will invalidate the provisions of this reimbursement methodology.

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 48:2759 (November 2022).

§1903. Reimbursement Methodology

A. Effective July 1, 2022, the inpatient hospital per diem rate paid to an urban MSA facility for acute care services shall be increased by indexing annually to 95 percent of the small rural hospital acute per diem rate in effect.

B. Effective July 1, 2022, the inpatient hospital per diem rate paid to an urban MSA facility for psychiatric services shall be increased by indexing annually to 95 percent of the small rural hospital psychiatric per diem rate in effect.

C. These rates are conditional on the hospital continuing to meet all qualifying criteria included in §1901. If the hospital no longer qualifies, payments will revert back to appropriate non-rural, non-state hospital assigned rates effective on the date that the qualification(s) in §1901 are no longer met.

D. The department may review all above provisions every three years, at a minimum, to evaluate continuation of these enhanced reimbursements.

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 48:2759 (November 2022).

Chapter 21. Urban Metropolitan Statistical Area (MSA) Facility—New Orleans Area

§2101. Qualifying Criteria

A. In order to qualify as an urban metropolitan statistical area (MSA) facility—New Orleans area, effective as of October 5, 2022, the hospital must:

1. be designated a non-rural hospital service district located in LDH region 1, with a facility type code of acute, Medicaid enrolled, with an original hospital license date before July 13, 2014, but after July 1, 2014, located in zip code 70127;

2. be a hospital that is located an urban MSA as defined by United States Office of Management and Budget;

3. have an operational emergency room; and

4. not add additional locations under this license, without prior written approval of the department.

a. The addition of any off-site campus, beyond an outpatient primary care clinic, to the license of this hospital will invalidate the provisions of this reimbursement methodology.

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 49:263 (February 2023).

§2103. Reimbursement Methodology

A. The inpatient hospital per diem rate paid for acute care services to qualifying urban MSA hospitals—New Orleans area who meet all of the criteria in §2101 shall be increased by indexing annually to 95 percent of the small rural hospital acute per diem rate in effect.

B. The inpatient hospital per diem rate paid for psychiatric services to qualifying urban MSA hospitals—New Orleans area who meet all of the criteria in §2101 shall be increased by indexing annually to 95 percent of the small rural hospital psychiatric per diem rate in effect.

C. These rates are conditional on the hospital continuing to meet all qualifying criteria included in §2101. If the hospital no longer qualifies, payments will revert back to appropriate non-rural, non-state hospital assigned rates effective on the date that the qualification(s) in §2101 are no longer met.

D. The department may review all above provisions every three years, at a minimum to evaluate continuation of these enhanced reimbursements.

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 49:264 (February 2023).

Chapter 23. Medicare Part A Claims for Medicaid Eligible Beneficiaries

§2301. Reimbursement Methodology

A. To determine the amount that Medicaid will reimburse on a claim for a Medicaid beneficiary who is also eligible for Medicare Part A, the Medicare claim payment is compared to the Medicaid payment rate on file for the inpatient service multiplied by the inpatient covered days. If the Medicare payment exceeds the Medicaid rate that would have been paid, the claim is adjudicated as a paid claim with a zero payment. If the Medicaid rate that would have been paid exceeds the Medicare payment, the claim is reimbursed at the lesser of the co-insurance and deductible or up to the Medicaid maximum payment. If the Medicaid payment is reduced or eliminated as a result of the Medicare/Medicaid payment comparison, the amount of the Medicare payment plus the amount of the Medicaid payment, if any, shall be considered to be payment in full for the service.

B. Medicare Part A claims for small rural hospitals, as defined in R.S. 40:1300, are exempt from the Medicaid maximum payment limitation.

C. The beneficiary does not have any legal liability to make payment for the service.

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 49:1222 (July 2023).

Chapter 24. Out-of-State Hospitals

§2401. General Provisions

A. Effective for dates of service on or after September 20, 2023, payment will be made to out-of-state hospitals for provision of inpatient services which meet at least one of the following conditions:

1. medical services are needed because of a medical emergency;
2. medical services are needed and the beneficiaries' health would be endangered if they were required to travel to their state of residence;
3. the state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state; or
4. it is general practice for beneficiaries in a particular locality to use medical resources in another state.

B. Hospitals located in counties in Mississippi, Arkansas, and Texas that border the state of Louisiana are referred to as trade area hospitals.

C. Trade area hospitals that are unable to fully treat presenting Louisiana beneficiaries shall transfer patients to the Louisiana hospital within the closest proximity with available 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, Bureau of Health Services Financing, LR 49:1565 (September 2023).

§2403. Reimbursement Methodology

A. Effective for dates of service on or after September 20, 2023, payment for all out-of-state inpatient services, other than organ transplants, shall be made at the Louisiana in-state prospective peer group rate in effect for the corresponding type of non-teaching hospital or specialty carve out service.

1. Separate prospective per diem rates will be paid for out-of-state inpatient services provided in acute care general hospitals, psychiatric hospitals and services, rehabilitation hospitals, long term acute care hospitals, children's hospitals, nursery services, neonatal intensive care services, pediatric intensive care services, and burn unit intensive care services.

B. Effective for dates of service on or after September 20, 2023, payment for inpatient organ transplant service provided by out-of-state hospitals shall be paid as follows:

1. 40 percent of allowable covered billed charges for beneficiaries ages 21 and above; or

2. 60 percent of allowable covered billed charges for beneficiaries under age 21.

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 49:1565 (September 2023).

Subpart 3. Disproportionate Share Hospital Payments

Chapter 25. Disproportionate Share Hospital Payment Methodologies

§2501. General Provisions

A. The reimbursement methodology for inpatient hospital services incorporates a provision for an additional payment adjustment for hospitals serving a disproportionate share of low income patients.

B. The following provisions govern the disproportionate share hospital (DSH) payment methodologies for qualifying hospitals.

1. Total cumulative disproportionate share payments under any and all disproportionate share hospital payment methodologies shall not exceed the federal disproportionate share state allotment for Louisiana for each federal fiscal year or the state appropriation for disproportionate share payments for each state fiscal year. The Department shall make necessary downward adjustments to hospital's disproportionate share payments to remain within the federal disproportionate share allotment and the state disproportionate share appropriated amount.

2. Appropriate action including, but not limited to, deductions from DSH, Medicaid payments and cost report settlements shall be taken to recover any overpayments resulting from the use of erroneous data, or if it is determined upon audit that a hospital did not qualify.

3. DSH payments to a hospital determined under any of the methodologies described in this Subpart 3 shall not exceed the hospital's net uncompensated cost as defined in Chapter 27 or the disproportionate share limits as defined in Section 1923(g)(1)(A) of the Social Security Act for the state fiscal year to which the payment is applicable. Any Medicaid profit shall be used to offset the cost of treating the uninsured in determining the hospital specific DHH limits.

4. Qualification is based on the hospital's latest filed cost report and related uncompensated cost data as required by the Department. Qualification for small rural hospitals is based on the latest filed cost report. Hospitals must file cost reports in accordance with Medicare deadlines, including extensions. Hospitals that fail to timely file Medicare cost reports and related uncompensated cost data will be assumed to be ineligible for disproportionate share payments. Only hospitals that return timely disproportionate share qualification documentation will be considered for disproportionate share payments. After the final payment during the state fiscal year has been issued, no adjustment

will be given on DSH payments with the exception of public state-operated hospitals, even if subsequently submitted documentation demonstrates an increase in uncompensated care costs for the qualifying hospital. After completion of a Center for Medicare and Medicaid Services' (CMS) mandated independent audit for the state fiscal year, additional payments may occur subject to the conditions specified in §2705.D.2 and §2707.B. For hospitals with distinct part psychiatric units, qualification is based on the entire hospital's utilization.

5. Hospitals shall be notified by letter at least 60 days in advance of calculation of DSH payment to submit documentation required to establish DSH qualification. Only hospitals that timely return DSH qualification documentation will be considered for DSH payments. The required documents are:

- a. obstetrical qualification criteria;
- b. low income utilization revenue calculation;
- c. Medicaid cost report; and
- d. uncompensated cost calculation.

6. Hospitals and/or units which close or withdraw from the Medicaid Program shall become ineligible for further DSH pool payments for the remainder of the current DSH pool payment cycle and thereafter.

C. A hospital receiving DSH payments shall furnish emergency and non-emergency services to uninsured persons with family incomes less than or equal to 100 percent of the federal poverty level on an equal basis to insured patients.

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 34:654 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:65 (January 2010), LR 36:512 (March 2010), LR 40:790 (April 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:522 (March 2017).

§2503. Disproportionate Share Hospital Qualifications

A. In order to qualify as a disproportionate share hospital, a hospital must:

1. have at least two obstetricians who have staff privileges and who have agreed to provide obstetric services to individuals who are Medicaid eligible. In the case of a hospital located in a rural area (i.e., an area outside of a metropolitan statistical area), the term *obstetrician* includes any physician who has staff privileges at the hospital to perform nonemergency obstetric procedures; or

2. treat inpatients who are predominantly individuals under 18 years of age; or

3. be a hospital which did not offer nonemergency obstetric services to the general population as of December 22, 1987; and

4. have a utilization rate in excess of one or more of the following specified minimum utilization rates:

a. Medicaid utilization rate is a fraction (expressed as a percentage). The numerator is the hospital's number of Medicaid (Title XIX) inpatient days. The denominator is the total number of the hospital's inpatient days for a cost reporting period. Inpatient days include newborn and psychiatric days and exclude swing bed and skilled nursing days. Hospitals shall be deemed disproportionate share providers if their Medicaid utilization rates are in excess of the mean, plus one standard deviation of the Medicaid utilization rates for all hospitals in the state receiving payments; or

b. hospitals shall be deemed disproportionate share providers if their low-income utilization rates are in excess of 25 percent. Low-income utilization rate is the sum of:

i. the fraction (expressed as a percentage). The numerator is the sum (for the period) of the total Medicaid patient revenues plus the amount of the cash subsidies for patient services received directly from state and local governments. The denominator is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the cost reporting period from the financial statements; and

ii. the fraction (expressed as a percentage). The numerator is the total amount of the hospital's charges for inpatient services which are attributable to charity (free) care in a period, less the portion of any cash subsidies as described in §2503.A.4.b.i in the period which are reasonably attributable to inpatient hospital services. The denominator is the total amount of the hospital's charges for inpatient hospital services in the period. For public providers furnishing inpatient services free of charge or at a nominal charge, this percentage shall not be less than zero. This numerator shall not include contractual allowances and discounts (other than for indigent patients ineligible for Medicaid), i.e., reductions in charges given to other third-party payers, such as HMOs, Medicare, or BlueCross; nor charges attributable to Hill-Burton obligations. A hospital providing "free care" must submit its criteria and procedures for identifying patients who qualify for free care to the Bureau of Health Services Financing for approval. The policy for free care must be posted prominently and all patients must be advised of the availability of free care and the procedures for applying. Hospitals not in compliance with free care criteria will be subject to recoupment of DSH and Medicaid payments; or

5. effective November 3, 1997, be a *small rural hospital* as defined in §2705.A.2.a-m; or

6. effective September 15, 2006, be a non-rural community hospital as defined in §2701.A;

7. effective January 20, 2010, be a hospital participating in the low-income and needy care collaboration as defined in §2713.A;

8. effective January 1, 2013, be a public-private partnership hospital as defined in §2901.A;

9. effective May 24, 2014, be a Louisiana low-income academic hospital as defined in §3101.A-B;

10. effective June 29, 2016, be a major medical center located in the central and northern areas of the state as defined in §2715.A;

11. be a major medical center with a specialized care unit located in the southwestern area of the state as defined in §2717.A;

12. be a major medical center located in the southeastern area of the state as defined in §2719.A;

13. be a psychiatric hospital located in the northern area of the state as defined in §2721.A; and

14. effective July 1, 1994, must also have a Medicaid inpatient utilization rate of at least 1 percent.

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 34:655 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3294 (December 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 43:962 (May 2017), LR 45:1763 (December 2019), LR 50:381 (March 2024).

Chapter 27. Qualifying Hospitals

§2701. Non-Rural Community Hospitals

A. Definitions

Non-Rural Community Hospital—a non-state, non-rural hospital that may be either publicly or privately owned. Psychiatric, rehabilitation and long term hospitals may also qualify for this category.

B. DSH payments to a public, non-rural community hospital shall be calculated as follows.

1. Each qualifying public, non-rural community hospital shall certify to the Department of Health and Hospitals its uncompensated care costs. The basis of the certification shall be 100 percent of the hospital's allowable costs for these services, as determined by the most recently filed Medicare/Medicaid cost report. The certification shall be submitted in a form satisfactory to the department no later than October 1 of each fiscal year. The department will claim the federal share for these certified public expenditures. The department's subsequent reimbursement to the hospital shall be in accordance with the qualifying criteria and payment methodology for non-rural community hospitals included in Act 18 and may be more or less than the federal share so claimed. Qualifying public, non-rural community hospitals that fail to make such certifications by October 1 may not receive Title XIX claim payments or any disproportionate share payments until the department receives the required certifications.

C. Hospitals shall submit supporting patient specific data in a format specified by the department, reports on their efforts to collect reimbursement for medical services from

patients to reduce gross uninsured costs, and their most current year-end financial statements. Those hospitals that fail to provide such statements shall receive no payments and any payment previously made shall be refunded to the department. Submitted hospital charge data must agree with the hospital's monthly revenue and usage reports which reconcile to the monthly and annual financial statements. The submitted data shall be subject to verification by the department before DSH payments are made.

D. In the event that the total payments calculated for all recipient hospitals are anticipated to exceed the total amount appropriated, the department shall reduce payments on a pro rata basis in order to achieve a total cost that is not in excess of the amounts appropriated for this purpose.

E. The DSH payment shall be made as an annual lump sum payment.

F. Hospitals qualifying as non-rural community hospitals in state fiscal year 2013-14 may also qualify in the federally mandated statutory hospital category.

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 40:1935 (October 2014).

§2703. Federally Mandated Statutory Hospitals

A. Definition

Federally Mandated Statutory Hospital—a hospital that meets the federal DSH statutory utilization requirements in §2503.A.4.a-b.ii.

B. DSH payments to individual federally mandated statutory hospitals shall be based on actual paid Medicaid days for a six-month period ending on the last day of the last month of that period, but reported at least 30 days preceding the date of payment. Annualization of days for the purposes of the Medicaid days pool is not permitted. The amount will be obtained by DHH from a report of paid Medicaid days by service date.

C. Disproportionate share payments for individual hospitals in this group shall be calculated based on the product of the ratio determined by:

1. dividing each qualifying hospital's actual paid Medicaid inpatient days for a six-month period ending on the last day of the month preceding the date of payment (which will be obtained by the department from a report of paid Medicaid days by service date) by the total Medicaid inpatient days obtained from the same report of all qualified hospitals included in this group. Total Medicaid inpatient days include Medicaid nursery days but do not include skilled nursing facility or swing-bed days; then

2. multiplying by the state disproportionate share appropriated amount for this pool of hospitals.

D. A pro rata decrease necessitated by conditions specified in §2501.B.1-6 for hospitals in this group will be calculated based on the ratio determined by:

1. dividing the hospitals' Medicaid days by the Medicaid days for all qualifying hospitals in this group; then

2. multiplying by the amount of disproportionate share payments calculated in excess of the federal disproportionate share allotment or the state disproportionate share appropriated amount.

E. The federally mandated statutory hospital category may also include hospitals qualifying as non-rural community hospitals in state fiscal year 2007-2008.

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 34:656 (April 2008), amended LR 34:2402 (November 2008).

§2705. Small-Rural Hospitals

A. Definitions

Net Uncompensated Cost—the cost of furnishing inpatient and outpatient hospital services, net of Medicare costs, Medicaid payments (excluding disproportionate share payments), costs associated with patients who have insurance for services provided, private payer payments, and all other inpatient and outpatient payments received from patients. Any uncompensated costs of providing health care services in a rural health clinic licensed as part of a small rural hospital as defined below shall be considered outpatient hospital services in the calculation of uncompensated costs.

Small Rural Hospital—a hospital (excluding a long-term care hospital, rehabilitation hospital, or freestanding psychiatric hospital but including distinct part psychiatric units) that meets the following criteria:

- a. had no more than 60 hospital beds as of July 1, 1994 and is located in a parish with a population of less than 50,000 or in a municipality with a population of less than 20,000; or

- b. meets the qualifications of a sole community hospital under 42 CFR §412.92(a), or:

- i. met the qualifications of a sole community hospital as of June 30, 2005 and subsequently converts to critical access hospital status; or

- c. had no more than 60 hospital beds as of July 1, 1999 and is located in a parish with a population of less than 17,000 as measured by the 1990 census; or

- d. had no more than 60 hospital beds as of July 1, 1997 and is a publicly-owned and operated hospital that is located in either a parish with a population of less than 50,000 or a municipality with a population of less than 20,000; or

- e. had no more than 60 hospital beds as of June 30, 2000 and is located in a municipality with a population, as measured by the 1990 census, of less than 20,000; or

PUBLIC HEALTH—MEDICAL ASSISTANCE

f. had no more than 60 beds as of July 1, 1997 and is located in a parish with a population, as measured by the 1990 and 2000 census, of less than 50,000; or

g. was a hospital facility licensed by the department that had no more than 60 hospital beds as of July 1, 1994, which hospital facility:

i. has been in continuous operation since July 1, 1994;

ii. is currently operating under a license issued by the department; and

iii. is located in a parish with a population, as measured by the 1990 census, of less than 50,000; or

h. has no more than 60 hospital beds or has notified the department as of March 7, 2002 of its intent to reduce its number of hospital beds to no more than 60, and is located in a municipality with a population of less than 13,000 and in a parish with a population of less than 32,000 as measured by the 2000 census; or

i. has no more than 60 hospital beds or has notified DHH as of December 31, 2003 of its intent to reduce its number of hospital beds to no more than 60 and is located:

i. as measured by the 2000 census, in a municipality with a population of less than 7,000;

ii. as measured by the 2000 census, in a parish with a population of less than 53,000; and

iii. within 10 miles of a United States military base; or

j. has no more than 60 hospital beds as of September 26, 2002 and is located:

i. as measured by the 2000 census, in a municipality with a population of less than 10,000; and

ii. as measured by the 2000 census, in a parish with a population of less than 33,000; or

k. has no more than 60 hospital beds as of January 1, 2003 and is located:

i. as measured by the 2000 census, in a municipality with a population of less than 11,000; and

ii. as measured by the 2000 census, in a parish with a population of less than 90,000; or

l. has no more than 40 hospital beds as of January 1, 2005, and is located:

i. in a municipality with a population of less than 3,100; and

ii. in a parish with a population of less than 15,800 as measured by the 2000 census; or

m. has no more than 60 hospital beds as of November 1, 2013 and is located:

i. as measured by the 2000 census, in a municipality with a population of less than 33,000;

ii. as measured by the 2000 census, in a parish with a population of less than 68,000; and

iii. within 3 miles of Jackson Barracks.

B. Payment based on uncompensated cost for qualifying small rural hospitals shall be in accordance with the following two pools.

1. *Public (Nonstate) Small Rural Hospitals*—small rural hospitals as defined in §2705.A.2 which are owned by a local government.

2. *Private Small Rural Hospitals*—small rural hospitals as defined in §2705.A.2 that are privately owned.

C. Payment to hospitals included in §2705.B.1-2 is equal to each qualifying rural hospital's pro rata share of uncompensated cost for all hospitals meeting these criteria for the latest filed cost report multiplied by the amount set for each pool. If the cost reporting period is not a full period (12 months), actual uncompensated cost data from the previous cost reporting period may be used on a pro rata basis to equate a full year.

D. Pro Rata Decrease

1. A pro rata decrease necessitated by conditions specified in §2501.B.1-6 for rural hospitals described in this §2705 will be calculated using the ratio determined by:

a. dividing the qualifying rural hospital's uncompensated costs by the uncompensated costs for all rural hospitals in §2705; then

b. multiplying by the amount of disproportionate share payments calculated in excess of the federal DSH allotment or the state DSH appropriated amount.

2. Additional payments shall only be made after finalization of the CMS mandated DSH audit for the state fiscal year. Payments shall be limited to the aggregate amount recouped from small rural hospitals based on these reported audit results. If the small rural hospitals' aggregate amount of underpayments reported per the audit results exceeds the aggregate amount overpaid, the payment redistribution to underpaid shall be paid on a pro rata basis calculated using each hospital's amount underpaid divided by the sum of underpayments for all small rural hospitals.

E. Qualifying hospitals must meet the definition for a small rural hospital contained in §2705.A.2. Qualifying hospitals must maintain a log documenting the provision of uninsured care as directed by the department.

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 34:657 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3296 (December 2013), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:790 (April 2014).

§2707. Public State-Operated Hospitals

A. Definitions

Net Uncompensated Cost—the cost of furnishing inpatient and outpatient hospital services, net of Medicare costs, Medicaid payments (excluding disproportionate share payments), costs associated with patients who have insurance for services provided, private payer payments, and all other inpatient and outpatient payments received from patients.

Public State-Operated Hospital—a hospital that is owned or operated by the state of Louisiana.

B. DSH payments to individual public state-owned or operated hospitals shall be up to 100 percent of the hospital's net uncompensated costs. Final payment shall be made in accordance with final uncompensated care costs as calculated per the CMS mandated audit for the state fiscal year.

C. In the event that it is necessary to reduce the amount of disproportionate share payments to remain within the federal disproportionate share allotment, the department shall calculate a pro rata decrease for each public state-owned or operated hospital based on the ratio determined by:

1. dividing that hospital's uncompensated cost by the total uncompensated cost for all qualifying public state-owned or operated hospitals during the state fiscal year; then
2. multiplying by the amount of disproportionate share payments calculated in excess of the federal disproportionate allotment.

D. It is mandatory that hospitals seek all third party payments including Medicare, Medicaid and other third party carriers and payments from patients. Hospitals must certify that excluded from net uncompensated cost are any costs for the care of persons eligible for Medicaid at the time of registration. Acute hospitals must maintain a log documenting the provision of uninsured care as directed by the department. Hospitals must adjust uninsured charges to reflect retroactive Medicaid eligibility determination. Patient specific data is required after July 1, 2003. Hospitals shall annually submit:

1. an attestation that patients whose care is included in the hospitals' net uncompensated cost are not Medicaid eligible at the time of registration; and
2. supporting patient-specific demographic data that does not identify individuals, but is sufficient for audit of the hospitals' compliance with the Medicaid ineligibility requirement as required by the department, including:
 - a. patient age;
 - b. family size;
 - c. number of dependent children; and
 - d. household income.

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 34:658 (April 2008), amended by the

Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:790 (April 2014).

§2709. Distinct Part Psychiatric Units

A. Effective for dates of service on or after February 10, 2012, a Medicaid-enrolled non-state acute care hospital that enters into a cooperative endeavor agreement (CEA) with the Department of Health and Hospitals, Office of Behavioral Health to provide inpatient psychiatric hospital services to Medicaid and uninsured patients, and which also assumes the operation and management of a state-owned and formerly state-operated hospital distinct part psychiatric unit, shall be paid a per diem rate of \$581.11 per day for each uninsured inpatient.

B. Qualifying hospitals must submit costs and patient specific data in a format specified by the department.

1. Cost and lengths of stay will be reviewed for reasonableness before payments are made.

C. Payments shall be made on a quarterly basis.

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 34:1627 (August 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:505 (March 2013).

§2713. Low Income and Needy Care Collaboration

A. Definitions

Low Income and Needy Care Collaboration Agreement—an agreement between a hospital and a state or local governmental entity to collaborate for purposes of providing healthcare services to low income and needy patients.

B. In order to qualify under this DSH category in any period, a hospital must be party to a low income and needy care collaboration agreement with the Department of Health and Hospitals in that period.

C. DSH payments to low income and needy care collaborating hospitals shall be calculated as follows.

1. In each quarter, the department shall divide hospitals qualifying under this DSH category into two pools. The first pool shall include hospitals that, in addition to qualifying under this DSH category, also qualify for DSH payments under any other DSH category. Hospitals in the first pool shall be eligible to receive DSH payments under §2713.C.2 provisions. The second pool shall include all other hospitals qualifying under this DSH category. Hospitals in the second pool shall be eligible to receive DSH payments under §2713.C.3 provisions.

2. In each quarter, to the extent the department appropriates funding to this DSH category, hospitals that qualify under the provisions of §2713.C.2 shall receive 100 percent of the total amount appropriated by the department for this DSH category.

a. If the net uncompensated care costs of these hospitals exceed the amount appropriated for this pool, payment shall be made based on each hospital's pro rata share of the pool.

i. The pro rata share shall be calculated by dividing the hospital's net uncompensated care costs by the total of the net uncompensated care costs for all hospitals qualifying under §2713.C.2 and multiplying by the amount appropriated by the department.

b. If the amount appropriated for this DSH category exceeds the net uncompensated care costs of all hospitals qualifying under §2713.C.2, payment shall be made up to each hospital's net uncompensated care costs.

c. Any amount available after all distributions are made under §2713.C.2 provisions shall be distributed subject to the provisions in §2713.C.3.

3. In each quarter, to the extent distributions are available, and after all distributions are made under §2713.C.2 provisions, distributions under §2713.C.3 provisions shall be made according to the following terms.

a. If the net uncompensated care costs of all hospitals qualifying for payment under §2713.C.3 provisions exceed the amount available for this pool, payment shall be made based on each hospital's pro rata share of the pool.

i. The pro rata share shall be calculated by dividing its net uncompensated care costs by the total of the net uncompensated care costs for all hospitals qualifying under §2713.C.3.

b. If the amount available for payments under §2713.C.3 exceeds the net uncompensated care costs of all qualifying hospitals, payments shall be made up to each hospital's net uncompensated care costs and the remaining amount shall be used by the department to make disproportionate share payments under this DSH category in future quarters.

D. In the event it is necessary to reduce the amount of disproportionate share payments under this DSH category to remain within the federal disproportionate share allotment in any quarter, the department shall calculate a pro rata decrease for each hospital qualifying under the provisions of §2713.C.3.

1. The pro rata decrease shall be based on a ratio determined by:

a. dividing that hospital's DSH payments by the total DSH payments for all hospitals qualifying under §2713.C.3 in that quarter; and

b. multiplying the amount of DSH payments calculated in excess of the federal disproportionate share allotment.

2. If necessary in any quarter, the department will reduce Medicaid DSH payments under these provisions to zero for all applicable hospitals.

E. After the reduction in §2713.D has been applied, if it is necessary to further reduce the amount of DSH payments under this DSH category to remain within the federal disproportionate share allotment in any quarter, the department shall calculate a pro rata decrease for each hospital qualifying under §2713.C.2.

1. The pro rata decrease shall be based on a ratio determined by:

a. dividing that hospital's DSH payments by the total DSH payments for all hospitals qualifying under §2713.C.2 in that quarter; and

b. multiplying the amount of DSH payments calculated in excess of the federal disproportionate share allotment.

2. If necessary in any quarter, the department shall reduce Medicaid DSH payments under these provisions to zero for all applicable hospitals.

F. Qualifying hospitals must submit costs and patient specific data in a format specified by the department. Costs and lengths of stay will be reviewed for reasonableness before payments are made.

G. Payments shall be made on a quarterly basis, however, each hospital's eligibility for DSH and net uncompensated care costs shall be determined on an annual basis.

H. Payments to hospitals qualifying under this DSH category shall be made subsequent to any DSH payments for which a hospital is eligible under another DSH category.

I. Aggregate DSH payments for hospitals that receive payment from this category, and any other DSH category, shall not exceed the hospital's specific DSH limit. If payments calculated under this methodology would cause a hospital's aggregate DSH payment to exceed the limit, the payment from this category shall be capped at the hospital's specific DSH limit. The remaining payments shall be redistributed to the other hospitals in accordance with these provisions.

J. If the amount appropriated for this DSH category exceeds the specific DSH limits of all qualifying hospitals, payment will be made up to each hospital's specific DSH limit and the remaining amount shall be used by the department to make disproportionate share payments under this DSH category in future quarters.

K. Effective for dates of service on or after January 1, 2011, all parties that participate in Medicaid DSH payments under this Section, either as a qualifying hospital by receipt of Medicaid DSH payments or as a state or local governmental entity funding Medicaid DSH payments, must meet the following conditions during the period of their participation:

1. Each participant must comply with the prospective conditions of participation in the Louisiana Private Hospital Upper Payment Limit Supplemental Reimbursement Program.

2. A participating hospital may not make a cash or in-kind transfer to their affiliated governmental entity that has a direct or indirect relationship to Medicaid payments and would violate federal law.

3. A participating governmental entity may not condition the amount it funds the Medicaid Program on a specified or required minimum amount of low income and needy care.

4. A participating governmental entity may not assign any of its contractual or statutory obligations to an affiliated hospital.

5. A participating governmental entity may not recoup funds from an affiliated hospital that has not adequately performed under the low income and needy care collaboration agreement.

6. A participating hospital may not return any of the Medicaid DSH payments it receives under this Section to the governmental entity that provides the non-federal share of the Medicaid DSH payments.

7. A participating governmental entity may not receive any portion of the Medicaid DSH payments made to a participating hospital under this Section.

L. Each participant must certify that it complies with the requirements of §2713.K by executing the appropriate certification form designated by the department for this purpose. The completed form must be submitted to the Department of Health and Hospitals, Bureau of Health Services Financing.

M. Each qualifying hospital must submit a copy of its low income and needy care collaboration agreement to the department.

N. The Medicaid DSH payments authorized in LAC 50:V.Subpart 3 shall not be considered as interim Medicaid inpatient payments in the determination of cost settlement amounts for inpatient hospital services rendered by children's specialty hospitals.

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 39:3295 (December 2013).

§2715. Major Medical Centers Located in Central and Northern Areas of the State

A. Effective for dates of service on or after June 30, 2016, hospitals qualifying for payments as major medical centers located in the central and northern areas of the state shall meet the following criteria:

1. be a private, non-rural hospital located in Department of Health administrative regions 6, 7, or 8;

2. have at least 200 inpatient beds as reported on the Medicare/Medicaid cost report, Worksheet S-3, column 2, lines 1-18, for the state fiscal year ending June 30, 2015. For qualification purposes, inpatient beds shall exclude nursery and Medicare-designated distinct part psychiatric unit beds;

3. does not qualify as a Louisiana low-income academic hospital under the provisions of §3101; and

4. such qualifying hospital (or its affiliate) does have a memorandum of understanding executed on or after June 30, 2016 with Louisiana State University, School of Medicine, the purpose of which is to maintain and improve access to quality care for Medicaid patients in connection with the expansion of Medicaid in the state through the promotion, expansion, and support of graduate medical education and training.

B. Payment Methodology. Effective for dates of service on or after June 30, 2016, each qualifying hospital shall be paid a DSH adjustment payment which is the pro rata amount calculated by dividing their hospital specific allowable uncompensated care costs by the total allowable uncompensated care costs for all hospitals qualifying under this category and multiplying by the funding appropriated by the Louisiana Legislature in the applicable state fiscal year for this category of hospitals.

1. Costs, patient specific data and documentation that qualifying criteria is met shall be submitted in a format specified by the department.

2. Costs and lengths of stay shall be reviewed by the department for reasonableness before payments are made.

3. Aggregate DSH payments for hospitals that receive payment from this category, and any other DSH category, shall not exceed the hospital's specific DSH limit. If payments calculated under this methodology would cause a hospital's aggregate DSH payment to exceed the limit, the payment from this category shall be capped at the hospital's specific DSH limit.

4. A pro rata decrease, necessitated by conditions specified in §2501.B.1 above for hospitals described in this Section, will be calculated based on the ratio determined by dividing the hospital's uncompensated costs by the uncompensated costs for all of the qualifying hospitals described in this Section, then multiplying by the amount of disproportionate share payments calculated in excess of the federal DSH allotment.

a. Additional payments shall only be made after finalization of the Centers for Medicare and Medicaid Services' (CMS) mandated DSH audit for the state fiscal year. Payments shall be limited to the aggregate amount recouped from the qualifying hospitals described in this Section, based on these reported audit results. If the hospitals' aggregate amount of underpayments reported per the audit results exceeds the aggregate amount overpaid, the payment redistribution to underpaid hospitals shall be paid on a pro rata basis calculated using each hospital's amount underpaid, divided by the sum of underpayments for all of the hospitals described in this Section.

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 44:280 (February 2018).

§2717. Major Medical Centers with Specialized Burn Care Units Located in the Southwestern Area of the State

A. Effective for dates of service on or after June 30, 2018, hospitals qualifying for payments as major medical centers located in the southwestern area of the state shall meet the following criteria:

1. be a private, non-rural hospital located in Department of Health administrative region 4;
2. have at least 175 inpatient beds as reported on the Medicare/Medicaid cost report, Worksheet S-3, column 2, lines 1-18, for the state fiscal year ending June 30, 2017. For qualification purposes, inpatient beds shall exclude nursery and Medicare-designated distinct part psychiatric unit beds;
3. have a burn intensive care unit that is reported on the Medicare/Medicaid cost report, Worksheet S-3, line 10, columns 1-8, for the state fiscal year ending June 30, 2017;
4. does not qualify as a Louisiana low-income academic hospital under the provisions of §3101; and
5. does not qualify as a party to a low income and needy care collaboration agreement with the Department of Health under the provisions of §2713.

B. Payment Methodology. Effective for dates of service on or after June 30, 2018, each qualifying hospital shall be paid a DSH adjustment payment which is the pro rata amount calculated by dividing their hospital specific allowable uncompensated care costs by the total allowable uncompensated care costs for all hospitals qualifying under this category and multiplying by the funding appropriated by the Louisiana Legislature in the applicable state fiscal year for this category of hospitals.

1. Costs, patient specific data and documentation that qualifying criteria is met shall be submitted in a format specified by the department.

2. Costs and lengths of stay shall be reviewed by the department for reasonableness before payments are made.

3. Aggregate DSH payments for hospitals that receive payment from this category, and any other DSH category, shall not exceed the hospital's specific DSH limit. If payments calculated under this methodology would cause a hospital's aggregate DSH payment to exceed the limit, the payment from this category shall be capped at the hospital's specific DSH limit.

4. A pro rata decrease, necessitated by conditions specified in §2501.B.1 above for hospitals described in this Section, will be calculated based on the ratio determined by dividing the hospital's uncompensated costs by the uncompensated costs for all of the qualifying hospitals described in this Section, then multiplying by the amount of disproportionate share payments calculated in excess of the federal DSH allotment.

- a. Additional payments shall only be made after finalization of the Centers for Medicare and Medicaid

Services' (CMS) mandated DSH audit for the state fiscal year.

- b. Payments shall be limited to the aggregate amount recouped from the qualifying hospitals described in this Section, based on the reported DSH audit results.

- c. If the hospitals' aggregate amount of underpayments reported per the audit results exceeds the aggregate amount overpaid, the payment redistribution to underpaid hospitals shall be paid on a pro rata basis calculated using each hospital's amount underpaid, divided by the sum of underpayments for all of the hospitals described in this Section.

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 44:1893 (October 2018).

§2719. Major Medical Centers Located in the Southeastern Area of the State

A. Effective for dates of service on or after January 1, 2020, hospitals qualifying for payments as major medical centers located in the southeastern area of the state shall meet the following criteria:

1. be a private, non-rural hospital located in Department of Health administrative region 1;
2. have at least 175 inpatient beds as reported on the Medicare/Medicaid cost report, Worksheet S-3, column 2, lines 1-18, for the state fiscal year ending June 30, 2018. For qualification purposes, inpatient beds shall exclude nursery and Medicare-designated distinct part psychiatric unit beds;
3. is certified as an advanced comprehensive stroke center by the Joint Commission as of June 30, 2018;
4. does not qualify as a Louisiana low-income academic hospital under the provisions of §3101; and
5. does not qualify as a party to a low income and needy care collaboration agreement with the Department of Health under the provisions of §2713.

B. Payment Methodology. Effective for dates of service on or after January 1, 2020, each qualifying hospital shall be paid a DSH adjustment payment which is the pro rata amount calculated by dividing their hospital specific allowable uncompensated care costs by the total allowable uncompensated care costs for all hospitals qualifying under this category and multiplying by the funding appropriated by the Louisiana Legislature in the applicable state fiscal year for this category of hospitals.

1. Costs, patient specific data and documentation that qualifying criteria is met shall be submitted in a format specified by the department.

2. Reported uncompensated care costs shall be reviewed by the department to ensure compliance with the reasonable costs definition in the Medicare Provider Reimbursement Manual, Part 1, Chapter 21, Section 2102.1, Revision 454. Allowable uncompensated care costs must be

calculated using the Medicare/Medicaid cost report methodology.

3. Aggregate DSH payments for hospitals that receive payment from this category, and any other DSH category, shall not exceed the hospital's specific DSH limit. If payments calculated under this methodology would cause a hospital's aggregate DSH payment to exceed the limit, the payment from this category shall be capped at the hospital's specific DSH limit.

4. A pro rata decrease, necessitated by conditions specified in §2501.B.1 above for hospitals described in this Section, will be calculated based on the ratio determined by dividing the hospital's uncompensated costs by the uncompensated costs for all of the qualifying hospitals described in this Section, then multiplying by the amount of disproportionate share payments calculated in excess of the federal DSH allotment.

a. If additional payments or recoupments are required based on the results of the mandated DSH audit report, they shall may be made within one year after the final report for the state fiscal year is submitted to the Centers for Medicare and Medicaid Services (CMS).

b. Additional payments shall be limited to the aggregate amount recouped from the qualifying hospitals described in this section, based on the reported DSH audit results.

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 45:1763 (December 2019).

§2721. Psychiatric Hospitals Located in the Northern Area of the State

A. Effective for dates of service on or after February 20, 2024, hospitals qualifying for payments as psychiatric hospitals located in the northern area of the state shall meet the following criteria:

1. be a private, non-rural freestanding psychiatric hospital located in Department of Health administrative regions 7 or 8; and

2. have a current executed academic affiliation agreement for purposes of providing graduate medical education and training to at least five documented intern and resident full time equivalents (FTEs) annually.

a. the affiliation agreement must be with a medical school located in Louisiana;

b. the intern and resident FTE count must be included on the Medicare Medicaid cost report annually on worksheet S-3, column 9; and

c. the hospital must be listed as a graduate medical education program training site on the Accreditation Council for Graduate Medical Education website.

B. Payment Methodology. Effective for dates of service on or after February 20, 2024, each qualifying hospital shall

be paid a DSH adjustment payment which is the pro rata amount calculated by dividing their hospital specific allowable uncompensated care costs by the total allowable uncompensated care costs for all hospitals qualifying under this category and multiplying by the funding appropriated by the Louisiana Legislature in the applicable state fiscal year for this category of hospitals.

1. Costs, patient specific data and documentation that qualifying criteria is met shall be submitted in a format specified by the department.

2. Costs and lengths of stay shall be reviewed by the department for reasonableness before payments are made.

3. Aggregate DSH payments for hospitals that receive payment from this category, and any other DSH category, shall not exceed the hospital's specific DSH limit. If payments calculated under this methodology would cause a hospital's aggregate DSH payment to exceed the limit, the payment from this category shall be capped at the hospital's specific DSH limit.

4. A pro rata decrease, necessitated by conditions specified in §2501.B.1 above for hospitals described in this Section, will be calculated based on the ratio determined by dividing the hospital's uncompensated costs by the uncompensated costs for all of the qualifying hospitals described in this Section, then multiplying by the amount of disproportionate share payments calculated in excess of the federal DSH allotment.

a. Additional payments shall only be made after finalization of the Centers for Medicare and Medicaid Services' (CMS) mandated DSH audit for the state fiscal year. Payments shall be limited to the aggregate amount recouped from the qualifying hospitals described in this Section, based on these reported audit results. If the hospitals' aggregate amount of underpayments reported per the audit results exceeds the aggregate amount overpaid, the payment redistribution to underpaid hospitals shall be paid on a pro rata basis calculated using each hospital's amount underpaid, divided by the sum of underpayments for all of the hospitals described in this Section.

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 50:381 (March 2024).

Chapter 29. Public-Private Partnerships

§2901. Qualifying Criteria

A. Free-Standing Psychiatric Hospitals. Effective for dates of service on or after January 1, 2013, a free-standing psychiatric hospital may qualify for this category by being:

1. a Medicaid enrolled non-state privately owned and operated hospital that enters into a cooperative endeavor agreement with the Department of Health to increase its provision of inpatient Medicaid and uninsured hospital services by:

a. assuming the management and operation of services at a facility where such services were previously provided by a state owned and operated facility; or

b. providing services that were previously delivered and terminated or reduced by a state owned and operated facility; or

2. a Medicaid enrolled non-state publicly owned and operated hospital that enters into a cooperative endeavor agreement with the Department of Health to increase its provision of inpatient Medicaid and uninsured hospital services by:

a. assuming the management and operation of services at a facility where such services were previously provided by a state owned and operated facility; or

b. providing services that were previously delivered and terminated or reduced by a state owned and operated facility.

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 40:2259 (November 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 49:1931 (November 2023).

§2903. Reimbursement Methodology

A. Free-Standing Psychiatric Hospitals. Effective for dates of service on or after October 1, 2015, the per diem rate paid to free-standing psychiatric hospitals shall be reduced by 5 percent of the rate in effect on September 30, 2015. The new per diem rate shall be \$552.05 per day.

1. Cost and lengths of stay will be reviewed for reasonableness before payments are made. Payments shall be made on a monthly basis.

2. Aggregate DSH payments for hospitals that receive payment from this category, and any other DSH category, shall not exceed the hospital's specific DSH limit. If payments calculated under this methodology would cause a hospital's aggregate DSH payment to exceed the limit, the payment from this category shall be capped at the hospital's specific DSH limit.

B. Effective for dates of service on or after December 1, 2023, payment for DSH eligible services provided through a cooperative endeavor agreement with the Department of Health shall be equal to the Medicaid per diem rate on file for free-standing psychiatric hospitals.

1. Cost and lengths of stay will be reviewed for reasonableness before payments are made. Reasonableness will be determined at the sole discretion of the department. Payments shall be made on a monthly basis.

2. Payment for DSH eligible services at the Medicaid rate shall be contingent on qualifying hospitals maintaining and timely submitting all department required documentation for DSH eligible services throughout the review and audit process.

3. Payments shall be limited to \$552.05 per day if the department determines that the qualifying hospital is not maintaining or timely submitting the required documentation for DSH eligible services throughout the review and audit process.

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 40:2259 (November 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:323 (February 2017), amended by the Department of Health, Bureau of Health Services Financing, LR 43:323 (February 2017), LR 49:1931 (November 2023).

Chapter 31. Louisiana Low-Income Academic Hospitals

§3101. Qualifying Criteria

A. Hospitals Located Outside of the Baton Rouge and New Orleans Metropolitan Statistical Area

1. Effective for dates of service on or after July 1, 2016, a hospital may qualify for this category by:

a. being a private acute care general hospital that is located outside of the Baton Rouge and New Orleans metropolitan statistical area (MSA) which:

i. entered into a cooperative endeavor agreement with the State of Louisiana to increase its provision of inpatient Medicaid and uninsured services by providing services that were previously delivered and terminated or reduced by a state owned and operated facility; or

ii. is formerly a state owned and operated hospital whose ownership change to non-state privately owned and operated prior to July 1, 2014;

b. has Medicaid inpatient days utilization greater than 18.9 percent. Qualification shall be calculated by dividing the Medicaid inpatient days by the total inpatient days reported on the Medicaid as filed cost report ending during state fiscal year 2015 received by April 30, 2016, and shall include traditional, shared, and managed care Medicaid days per the worksheet S-3 part I, lines 1 through 18. Column 7 shall be used to determine allowable Medicaid days and column 8 shall be used to determine total inpatient days; and

c. has a ratio of intern and resident full time equivalents (FTEs) to total inpatient beds that is greater than .08. Qualification shall be based on the total inpatient beds and intern and resident FTEs reported on the Medicare/Medicaid cost report ending during state fiscal year 2015. The ratio of interns and resident FTEs shall be calculated by dividing the unweighted intern and resident FTEs reported on the Medicare Cost Report Worksheet E-4, line 6 by the total inpatient beds, excluding nursery and Medicare designated distinct part psychiatric unit beds, reported on worksheet S-3, column 2, lines 1 through 18.

B. Hospitals Located In the New Orleans Metropolitan Statistical Area

1. Effective for dates of service on or after July 1, 2016, a hospital may qualify for this category by:

a. being a private acute care general hospital that is located in the New Orleans MSA which:

i. entered into a cooperative endeavor agreement with the State of Louisiana to increase its provision of inpatient Medicaid and uninsured services by providing services that were previously delivered and terminated or reduced by a state owned and operated facility; or

ii. is formerly a state owned and operated hospital whose ownership changed to non-state privately owned and operated prior to July 1, 2014;

b. has Medicaid inpatient days utilization greater than 45 percent. Qualification shall be calculated by dividing the Medicaid inpatient days by the total inpatient days reported on the Medicaid as filed cost report ending during state fiscal year 2015 received by April 30, 2016, and shall include traditional, shared, and managed care Medicaid days per the worksheet S-3 part I, lines 1 through 18. Column 7 shall be used to determine allowable Medicaid days and column 8 shall be used to determine total inpatient days; and

c. has a ratio of intern and resident FTEs to total inpatient beds that is greater than 1.25. Qualification shall be based on the total inpatient beds and intern and resident FTEs reported on the Medicare/Medicaid cost report ending during state fiscal year 2015. The ratio of interns and resident FTEs shall be calculated by dividing the unweighted intern and resident FTEs reported on the Medicare Cost Report Worksheet E-4, line 6 by the total inpatient beds, excluding nursery and Medicare designated distinct part psychiatric unit beds, reported on worksheet S-3, column 2, lines 1 through 18.

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 43:522 (March 2017).

§3103. Payment Methodology

A. Each qualifying hospital shall be paid DSH adjustment payments equal to 100 percent of allowable hospital specific uncompensated care costs.

1. Costs, patient specific data and documentation that qualifying criteria is met shall be submitted in a format specified by the department.

2. The department shall review cost data, charge data, lengths of stay and Medicaid claims data per the Medicaid management and information systems for reasonableness before payments are made.

B. Effective for dates of service on or after July 1, 2017, for payment calculations, the most recent Medicaid filed cost report, along with actual Medicaid and uninsured patient charge data from the most recently filed Medicaid cost report with Medicaid and uninsured charge data from the same time period, is utilized to calculate hospital specific uncompensated care costs. Costs and patient utilization from

a more current time period may be considered in the calculation of the DSH payment if significant changes in costs, services, or utilization can be documented. This change in the time-period utilized must receive prior approval by the department.

C. Effective for dates of service on or after July 1, 2017, the first payment of each fiscal year will be made by October 30 and will be 25 percent of the annual calculated uncompensated care costs. The remainder of the payment will be made by January 30, April 30 and June 30 of each year.

1. Reconciliation of these payments to actual hospital specific uncompensated care costs will be made when the cost report(s) covering the actual dates of service from the state fiscal year are filed and reviewed.

2. Additional payments or recoupments, as needed, shall be made after the finalization of the Centers for Medicare and Medicaid Services (CMS) mandated DSH audit for the state fiscal year.

D. No payment under this Section is dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

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 43:523 (March 2017), amended LR 43:961 (May 2017).

Subpart 5. Outpatient Hospital Services

Chapter 51. General Provisions

§5109. Children's Specialty Hospitals

A. In order to receive Medicaid reimbursement for outpatient services as a children's specialty hospital, the acute care hospital must meet the following criteria:

1. be recognized by Medicare as a prospective payment system (PPS) exempt children's specialty hospital;

2. does not qualify for Medicare disproportionate share hospital payments; and

3. has a Medicaid inpatient days utilization rate greater than the mean plus two standard deviations of the Medicaid utilization rates for all hospitals in the state receiving Medicaid payments.

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 39:327 (February 2013).

§5111. Hospital Provider-Based Outpatient Services

A. In order to receive Medicaid reimbursement as a hospital provider-based outpatient facility, an off-site campus of a hospital which provides outpatient services shall meet the provider-based requirements for Medicare as established in 42 CFR 413.65, except when the provisions in §5111.B are applicable.

B. Closure of a State-Owned and/or Operated Hospital. If a state-owned and/or operated hospital ceases to do business and surrenders its license, the off-site campus of that closed hospital may be deemed to be “provider-based” for purposes of Medicaid reimbursement only when all of the following criteria are met.

1. The off-site campus shall comply with the provider-based requirements in 42 CFR 413.65 except that:

a. the off-site campus shall be deemed in compliance with 42 CFR 413.65(d)(2)(vi) if the off-site campus refers patients requiring inpatient hospital services to either its main hospital provider campus or to the nearest available inpatient services; and

b. the off-site campus shall be deemed in compliance with 42 CFR 413.65(e)(3)(i) if they are licensed as an off-site campus of another state-owned and/or operated hospital that is within 100 miles of the off-site campus.

2. The off-site campus provides outpatient hospital services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:3030 (October 2011).

§5113. Never Events

A. Effective for dates of service on or after July 1, 2012, the Medicaid Program will not provide reimbursement for outpatient hospital services for “never events” or medical procedures performed in error which are preventable and have a serious, adverse impact to the health of the Medicaid recipient. Reimbursement will not be provided when the following “never events” occur:

1. the wrong surgical procedure is performed on a patient;

2. surgical or invasive procedures are performed on the wrong body part; or

3. surgical or invasive procedures are performed on the wrong patient.

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 38:1252 (May 2012), amended 38:1963 (August 2012).

§5117. Service Limits

A. Outpatient hospital services shall be limited to the following:

1. rehabilitation services-number of visits in accordance with a rehabilitation plan prior authorized by the department or its designee;

2. clinic services-physician services provided in a clinic in an outpatient hospital setting shall be considered physician services, not outpatient services, and there shall be no limits placed on the number of physician visits payable by the Medicaid program for eligible recipients; and

3. all other outpatient services, including therapeutic and diagnostic radiology services, shall have no limit imposed other than the medical necessity for the services.

B. There shall be no limits placed on emergency room visits.

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 9:551 (August 1983), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:2261 (November 2014), LR 41:2643 (December 2015).

Chapter 53. Outpatient Surgery

Subchapter A. General Provisions

§5301. Payment for Outpatient Surgery Services

A. Payment for outpatient surgery services is a flat rate in accordance with the published fee schedule. The flat rate payment covers all services provided during the outpatient surgical admission. There shall be no cost settlement for outpatient surgery services except for the specific hospital types identified in Subchapter B of this Chapter.

1. Effective for dates of service on or after February 10, 2022, the Medicaid Program shall provide reimbursement for Coronavirus Disease 2019 laboratory testing in addition to the outpatient surgery fee schedule flat fee reimbursement amount.

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 48:1842 (July 2022).

Subchapter B. Reimbursement Methodology

§5311. Small Rural Hospitals

A. Effective for dates of service on or after July 1, 2008, the reimbursement amount paid to small rural hospitals for outpatient hospital surgery services shall be as follows.

1. Small rural hospitals shall receive an interim payment for claims which shall be the Medicaid fee schedule payment on file for each service as of July 1, 2008.

2. A quarterly interim cost settlement payment shall be made to each small rural hospital to estimate a payment of 110 percent of allowable cost for fee schedule services.

a. The interim cost settlement payment shall be calculated by subtracting the actual quarterly payments for the applicable dates of services from 110 percent of the allowable costs of the quarterly claims. The cost to charge ratio from the latest filed cost report shall be applied to quarterly charges for the outpatient claims paid by fee schedule and multiplied by 110 percent of the allowable costs as calculated through the cost report settlement process.

B. Effective for dates of service on or after August 1, 2010, small rural hospitals shall be reimbursed for outpatient hospital surgery services up to the Medicare outpatient upper payment limits.

C. Low Income and Needy Care Collaboration. Effective for dates of service on or after October 20, 2011, quarterly supplemental payments will be issued to qualifying non-state hospitals for outpatient surgery services rendered during the quarter. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal year.

1. Qualifying Criteria. In order to qualify for the supplemental payment, the non-state hospital must be affiliated with a state or local governmental entity through a low income and needy care collaboration agreement.

Non-State Hospital—a hospital which is owned or operated by a private entity.

Low Income and Needy Care Collaboration Agreement—an agreement between a hospital and a state or local governmental entity to collaborate for purposes of providing healthcare services to low income and needy patients.

2. Each qualifying hospital shall receive quarterly supplemental payments for the outpatient services rendered during the quarter. Payments shall be distributed quarterly based on Medicaid paid claims for service dates from the previous state fiscal year. Payments to hospitals participating in the Medicaid Disproportionate Share Hospital (DSH) Program shall be limited to the difference between the hospital's specific DSH limit and the hospital's DSH payments for the applicable payment period. Aggregate payments to qualifying hospitals shall not exceed the maximum allowable cap for the state fiscal year.

D. Public Non-State Small Rural Hospitals. Effective for dates of service on or after July 1, 2023, quarterly supplemental payments will be issued to qualifying small rural hospitals for outpatient hospital surgery services rendered during the quarter. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal year.

1. Qualifying Criteria. In order to qualify, as of September 30, 2022, the small hospital must:

- a. be publicly (non-state) owned and operated;
- b. be located in Department of Health administrative region 3; and
- c. provide routine and emergency inpatient and outpatient obstetrical services with separately identified nursery department statistics reported on the cost report.

2. Effective for dates of service on or after July 1, 2023, quarterly supplemental payments will be issued to qualifying small rural public hospitals for outpatient hospital surgery services rendered during the quarter. Maximum aggregate payments to all qualifying hospitals in this group

shall not exceed the available upper payment limit per state fiscal 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 35:956 (May 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1251 (May 2012), LR 40:542 (March 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 49:1741 (October 2023).

§5313. Non-Rural, Non-State Hospitals

A. Effective for dates of service on or after February 20, 2009, the reimbursement paid to non-rural, non-state hospitals for outpatient surgery shall be reduced by 3.5 percent of the fee schedule on file as of February 19, 2009.

B. Effective for dates of service on or after August 4, 2009, the reimbursement paid to non-rural, non-state hospitals for outpatient surgery shall be reduced by 5.65 percent of the fee schedule on file as of August 3, 2009.

C. Low Income and Needy Care Collaboration. Effective for dates of service on or after January 1, 2010, quarterly supplemental payments will be issued to qualifying non-rural, non-state hospitals for outpatient surgery services rendered during the quarter. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal year.

1. Qualifying Criteria. In order to qualify for the supplemental payment, the non-rural, non-state hospital must be affiliated with a state or local governmental entity through a Low Income and Needy Care Collaboration Agreement

a. A non-state hospital is defined as a hospital which is owned or operated by a private entity.

b. A Low Income and Needy Care Collaboration Agreement is defined as an agreement between a hospital and a state or local governmental entity to collaborate for purposes of providing healthcare services to low income and needy patients.

2. Each qualifying hospital shall receive quarterly supplemental payments for the outpatient services rendered during the quarter. Quarterly payment distribution shall be limited to one-fourth of the lesser of:

a. the difference between each qualifying hospital's outpatient Medicaid billed charges and Medicaid payments the hospital receives for covered outpatient services provided to Medicaid recipients. Medicaid billed charges and payments will be based on a 12 consecutive month period for claims data selected by the department; or

b. for hospitals participating in the Medicaid Disproportionate Share Hospital (DSH) Program, the difference between the hospital's specific DSH limit and the hospital's DSH payments for the applicable payment period.

D. Effective for dates of service on or after February 3, 2010, the reimbursement paid to non-rural, non-state

hospitals for outpatient surgery shall be reduced by five percent of the fee schedule on file as of February 2, 2010.

1. Small rural hospitals as defined in R.S. 40:1189.3 shall be exempted from this rate reduction.

E. Effective for dates of service on or after August 1, 2010, the reimbursement paid to non-rural, non-state hospitals for outpatient surgery shall be reduced by 4.6 percent of the fee schedule on file as of July 31, 2010.

1. Small rural hospitals as defined in R.S. 40:1189.3 shall be exempted from this rate reduction.

F. Effective for dates of service on or after January 1, 2011, the reimbursement paid to non-rural, non-state hospitals for outpatient surgery shall be reduced by 2 percent of the fee schedule on file as of December 31, 2010.

1. Small rural hospitals as defined in R.S. 40:1189.3 shall be exempted from this rate reduction.

G. Effective for dates of service on or after August 1, 2012, the reimbursement rates paid to non-rural, non-state hospitals for outpatient surgery shall be reduced by 3.7 percent of the fee schedule on file as of July 31, 2012.

H. Effective for dates of service on or after February 1, 2013, the reimbursement rates paid to non-rural, non-state hospitals for outpatient surgery shall be reduced by 1 percent of the fee schedule on file as of January 31, 2013.

I. Effective for dates of service on or after January 1, 2017, the reimbursement rates paid to non-rural, non-state hospitals for outpatient surgery shall be increased by 7.03 percent of the rates on file as of December 31, 2016.

1. Hospitals participating in public-private partnerships as defined in §6701 shall be exempted from this rate increase.

J. Effective for dates of service on or after January 1, 2018, the reimbursement rates paid to non-rural, non-state hospitals for outpatient surgery shall be increased by 4.82 percent of the rates on file as of December 31, 2017.

1. Hospitals participating in public-private partnerships as defined in §6701 shall be exempted from this rate increase.

K. Effective for dates of service on or after January 1, 2019, the reimbursement rates paid to non-rural, non-state hospitals for outpatient surgery shall be increased by 11.56 percent of the rates on file as of December 31, 2018.

1. Hospitals participating in public-private partnerships as defined in §6701 shall be exempted from this rate increase.

L. Effective for dates of service on or after January 1, 2020, the reimbursement rates paid to non-rural, non-state hospitals for outpatient surgery shall be increased by 3.2 percent of the rates on file as of December 31, 2019.

1. Hospitals participating in public-private partnerships as defined in §6701 shall be exempted from this rate increase.

M. Effective for dates of service on or after January 1, 2021, the reimbursement rates paid to non-rural, non-state hospitals for outpatient surgery shall be increased by 3.2 percent of the rates on file as of December 31, 2020.

1. Hospitals participating in public-private partnerships as defined in §6701 shall be exempted from this rate increase.

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 Service Financing, LR 35:1900 (September 2009), amended LR 36:1250 (June 2010), LR 36:2041 (September 2010), LR 37:3266 (November 2011), LR 40:313 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:964 (May 2017), LR 43:2534 (December 2017), LR 44:2166 (December 2018), LR 45:1773 (December 2019), LR 46:1685 (December 2020), LR 48:1842 (July 2022).

§5315. Non-Rural, Non-State Public Hospitals

A. Effective for dates of service on or after July 1, 2013, quarterly supplemental payments may be issued to qualifying non-rural, non-state public hospitals for outpatient surgical services rendered during the quarter. Payment amounts may be reimbursed up to the Medicare outpatient upper payment limits as determined in accordance with 42 CFR §447.321.

1. Qualifying Criteria. In order to qualify for the quarterly supplemental payment, the non-rural, non-state public acute care hospital must be designated as a non-teaching hospital by the department and must:

a. be located in a Medicare metropolitan statistical area (MSA) per 42 CFR 413.231(b)(1);

b. provide inpatient obstetrical and neonatal intensive care unit services; and

c. per the cost report period ending in SFY 2012, have a Medicaid inpatient day utilization percentage in excess of 21 percent and a Medicaid newborn day utilization percentage in excess of 65 percent as documented on the as filed cost report.

2. Each qualifying hospital may receive quarterly supplemental payments for the outpatient services rendered during the quarter. Quarterly payments may be the difference between each qualifying hospital's outpatient Medicaid billed charges and the Medicaid payments the hospital receives for covered outpatient services provided to Medicaid recipients. Medicaid billed charges and payments will be based on a 12 consecutive month period for claims data selected by the department.

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 36:2867 (December 2010), amended LR 39:1473 (June 2013), LR 40:1699 (September 2014).

§5317. Children's Specialty Hospitals

A. Effective for dates of service on or after September 1, 2009, the reimbursement amount paid to children's specialty hospitals for outpatient hospital surgery services shall be as follows.

1. Qualifying hospitals shall receive an interim payment equal to the Medicaid fee schedule amount on file for each service.

2. Final reimbursement shall be 97 percent of allowable cost as calculated through the cost report settlement process.

B. Effective for dates of service on or after February 3, 2010, the reimbursement paid to children's specialty hospitals for outpatient surgery shall be reduced by five percent of the fee schedule on file as of February 2, 2010.

1. Final reimbursement shall be 92.15 percent of allowable cost as calculated through the cost report settlement process.

C. Effective for dates of service on or after August 1, 2010, the reimbursement paid to children's specialty hospitals for outpatient surgery shall be reduced by 4.6 percent of the fee schedule on file as of July 31, 2010.

1. Final reimbursement shall be 87.91 percent of allowable cost as calculated through the cost report settlement process.

D. Effective for dates of service on or after January 1, 2011, the reimbursement paid to children's specialty hospitals for outpatient surgery shall be reduced by 2 percent of the fee schedule on file as of December 31, 2010.

1. Final reimbursement shall be 86.15 percent of allowable cost as calculated through the cost report settlement process.

E. Effective for dates of service on or after August 1, 2012, the reimbursement rates paid to children's specialty hospitals for outpatient surgery shall be reduced by 3.7 percent of the fee schedule on file as of July 31, 2012.

F. Effective for dates of service on or after February 1, 2013, the reimbursement rates paid to children's specialty hospitals for outpatient surgery shall be reduced by 1 percent of the fee schedule on file as of January 31, 2013.

G. Effective for dates of service on or after January 1, 2017, the reimbursement paid to children specialty hospitals for outpatient surgery shall be increased by 7.03 percent of the rates on file as of December 31, 2016.

1. Final reimbursement shall be 87.91 percent of allowable cost as calculated through the cost report settlement process.

H. Effective for dates of service on or after January 1, 2018, the reimbursement paid to children's specialty hospitals for outpatient surgery shall be increased by 4.82 percent of the rates on file as of December 31, 2017.

1. Final reimbursement shall be 92.15 percent of allowable cost as calculated through the cost report settlement process.

I. Effective for dates of service on or after January 1, 2019, the reimbursement rates paid to children's specialty hospitals for outpatient surgery shall be increased by 5.26 percent of the rates on file as of December 31, 2018.

1. Final reimbursement shall be 97 percent of allowable cost as calculated through the cost report settlement process.

J. Effective for dates of service on or after January 1, 2020, the reimbursement rates paid to children's specialty hospitals for outpatient surgery shall be increased by 3.2 percent of the rates on file as of December 31, 2019.

1. Final reimbursement shall be 100 percent of allowable cost as calculated through the cost report settlement process.

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 36:2042 (September 2010), amended LR 37:3266 (November 2011), LR 40:313 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:965 (May 2017), LR 43:2534 (December 2017), LR 44:2167 (December 2018), LR 45:1773 (December 2019).

§5319. State-Owned Hospitals

A. Effective for dates of service on or after February 10, 2012, medical education payments for outpatient surgery services which are reimbursed by a prepaid risk-bearing managed care organization (MCO) shall be reimbursed by Medicaid annually through the Medicaid cost report settlement process.

1. For purposes of these provisions, qualifying medical education programs are defined as graduate medical education, paramedical education, and nursing schools.

2. Final payment shall be determined based on the actual MCO covered outpatient surgery services and Medicaid medical education costs for the cost reporting period per the Medicaid cost report.

B. Effective for dates of service on or after August 1, 2012, the reimbursement rates paid to state-owned hospitals for outpatient surgery shall be reduced by 10 percent of the fee schedule on file as of July 31, 2012.

C. Effective for dates of service on or after January 1, 2020, the reimbursement rates paid to state-owned hospitals for outpatient surgery shall be increased by 14.67 percent of the fee schedule rates on file as of December 31, 2019.

D. Effective for dates of services on or after January 1, 2021, the reimbursement rates paid to state-owned hospitals for outpatient surgery shall be increased by 3.2 percent of the fee schedule rates on file as of December 31, 2020.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:2773 (November 2012), amended LR 40:314 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 45:1773 (December 2019), LR 46:1685 (December 2020).

Chapter 55. Clinic Services

Subchapter A. General Provision

§5501. Payment for Outpatient Hospital Clinic Services

A. Payment for outpatient hospital clinic services is a flat rate in accordance with the published fee schedule. There shall be no cost settlement for outpatient clinic services except for the specific hospital types identified in Subchapter B of this Chapter.

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 48:1842 (July 2022).

Subchapter B. Reimbursement Methodology

§5511. Small Rural Hospitals

A. Effective for dates of service on or after July 1, 2008, the reimbursement amount paid to small rural hospitals for outpatient hospital clinic services shall be as follows.

1. Small rural hospitals shall receive an interim payment for claims which shall be the Medicaid fee schedule payment on file for each service as of July 1, 2008.

2. A quarterly interim cost settlement payment shall be made to each small rural hospital to estimate a payment of 110 percent of allowable cost for fee schedule services.

a. The interim cost settlement payment shall be calculated by subtracting the actual quarterly payments for the applicable dates of services from 110 percent of the allowable costs of the quarterly claims. The cost to charge ratio from the latest filed cost report shall be applied to quarterly charges for the outpatient claims paid by fee schedule and multiplied by 110 percent of the allowable costs as calculated through the cost report settlement process.

B. Effective for dates of service on or after August 1, 2010, small rural hospitals shall be reimbursed for outpatient hospital clinic services up to the Medicare outpatient upper payment limits.

C. Low Income and Needy Care Collaboration. Effective for dates of service on or after October 20, 2011, quarterly supplemental payments will be issued to qualifying non-state hospitals for outpatient hospital clinic services rendered during the quarter. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal year.

1. Qualifying Criteria. In order to qualify for the supplemental payment, the non-state hospital must be

affiliated with a state or local governmental entity through a low income and needy care collaboration agreement.

Non-State Hospital—a hospital which is owned or operated by a private entity.

Low Income and Needy Care Collaboration Agreement—an agreement between a hospital and a state or local governmental entity to collaborate for purposes of providing healthcare services to low income and needy patients.

2. Each qualifying hospital shall receive quarterly supplemental payments for the outpatient services rendered during the quarter. Payments shall be distributed quarterly based on Medicaid paid claims for service dates from the previous state fiscal year. Payments to hospitals participating in the Medicaid DSH Program shall be limited to the difference between the hospital's specific DSH limit and the hospital's DSH payments for the applicable payment period. Aggregate payments to qualifying hospitals shall not exceed the maximum allowable cap for the state fiscal year.

D. Public Non-State Small Rural Hospitals. Effective for dates of service on or after July 1, 2023, quarterly supplemental payments will be issued to qualifying small rural hospitals for outpatient hospital clinic services rendered during the quarter. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal year.

1. Qualifying Criteria. In order to qualify, as of September 30, 2022, the small hospital must:

a. be publicly (non-state) owned and operated;

b. be located in Department of Health administrative region 3; and

c. provide routine and emergency inpatient and outpatient obstetrical services with separately identified nursery department statistics reported on the cost report.

2. Effective for dates of service on or after July 1, 2023, quarterly supplemental payments will be issued to qualifying small rural public hospitals for outpatient hospital clinic services rendered during the quarter. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal 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 35:956 (May 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1251 (May 2012), LR 40:542 (March 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 49:1741 (October 2023).

§5513. Non-Rural, Non-State Hospitals

A. Effective for dates of service on or after February 20, 2009, the reimbursement paid to non-rural, non-state hospitals for outpatient clinic services shall be reduced by

3.5 percent of the fee schedule on file as of February 19, 2009.

B. Effective for dates of service on or after August 4, 2009, the reimbursement paid to non-rural, non-state hospitals for outpatient clinic services shall be reduced by 5.65 percent of the fee schedule on file as of August 3, 2009.

C. Low Income and Needy Care Collaboration. Effective for dates of service on or after January 1, 2010, quarterly supplemental payments will be issued to qualifying non-rural, non-state hospitals for clinic services rendered during the quarter. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal year.

1. Qualifying Criteria. In order to qualify for the supplemental payment, the non-rural, non-state hospital must be affiliated with a state or local governmental entity through a Low Income and Needy Care Collaboration Agreement.

a. A non-state hospital is defined as a hospital which is owned or operated by a private entity.

b. A Low Income and Needy Care Collaboration Agreement is defined as an agreement between a hospital and a state or local governmental entity to collaborate for purposes of providing healthcare services to low income and needy patients.

2. Each qualifying hospital shall receive quarterly supplemental payments for the outpatient services rendered during the quarter. Quarterly payment distribution shall be limited to one-fourth of the lesser of:

a. the difference between each qualifying hospital's outpatient Medicaid billed charges and Medicaid payments the hospital receives for covered outpatient services provided to Medicaid recipients. Medicaid billed charges and payments will be based on a 12 consecutive month period for claims data selected by the department; or

b. for hospitals participating in the Medicaid Disproportionate Share Hospital (DSH) Program, the difference between the hospital's specific DSH limit and the hospital's DSH payments for the applicable payment period.

D. Effective for dates of service on or after February 3, 2010, the reimbursement paid to non-rural, non-state hospitals for outpatient clinic services shall be reduced by five percent of the fee schedule on file as of February 2, 2010.

1. Small rural hospitals as defined in R.S. 40:1189.3 shall be exempted from this rate reduction.

E. Effective for dates of service on or after August 1, 2010, the reimbursement paid to non-rural, non-state hospitals for outpatient clinic services shall be reduced by 4.6 percent of the fee schedule on file as of July 31, 2010.

1. Small rural hospitals as defined in R.S. 40:1189.3 shall be exempted from this rate reduction.

F. Effective for dates of service on or after January 1, 2011, the reimbursement paid to non-rural, non-state hospitals for outpatient clinic services shall be reduced by 2 percent of the fee schedule on file as of December 31, 2010.

1. Small rural hospitals as defined in R.S. 40:1189.3 shall be exempted from this rate reduction.

G. Effective for dates of service on or after August 1, 2012, the reimbursement rates paid to non-rural, non-state hospitals for outpatient clinic services shall be reduced by 3.7 percent of the fee schedule on file as of July 31, 2012.

H. Effective for dates of service on or after February 1, 2013, the reimbursement rates paid to non-rural, non-state hospitals for outpatient clinic services shall be reduced by 1 percent of the fee schedule on file as of January 31, 2013.

I. Effective for dates of service on or after January 1, 2017, the reimbursement rates paid to non-rural, non-state hospitals for outpatient clinic services shall be increased by 7.03 percent of the rates on file as of December 31, 2016.

1. Hospitals participating in public-private partnerships as defined in §6701 shall be exempted from this rate increase.

J. Effective for dates of service on or after January 1, 2018, the reimbursement rates paid to non-rural, non-state hospitals for outpatient clinic services shall be increased by 4.82 percent of the rates on file as of December 31, 2017.

1. Hospitals participating in public-private partnerships as defined in §6701 shall be exempted from this rate increase.

K. Effective for dates of service on or after January 1, 2019, the reimbursement rates paid to non-rural, non-state hospitals for outpatient clinic services shall be increased by 11.56 percent of the rates on file as of December 31, 2018.

1. Hospitals participating in public-private partnerships as defined in §6701 shall be exempted from this rate increase.

L. Effective for dates of service on or after January 1, 2020, the reimbursement rates paid to non-rural, non-state hospitals for outpatient clinic services shall be increased by 3.2 percent of the rates on file as of December 31, 2019.

1. Hospitals participating in public-private partnerships as defined in §6701 shall be exempted from this rate increase.

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 Service Financing, LR 35:1900 (September 2009), amended LR 36:1250 (June 2010), LR 36:2042 (September 2010), LR 37:3266 (November 2011), LR 40:313 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:965 (May 2017), LR 43:2535 (December 2017), LR 44:2167 (December 2018), LR 45:1773 (December 2019), LR 48:1842 (July 2022).

§5515. Non-Rural, Non-State Public Hospitals

A. Effective for dates of service on or after July 1, 2013, quarterly supplemental payments may be issued to qualifying non-rural, non-state public hospitals for clinic services rendered during the quarter. Payment amounts may be reimbursed up to the Medicare outpatient upper payment limits as determined in accordance with 42 CFR §447.321.

1. Qualifying Criteria. In order to qualify for the quarterly supplemental payment, the non-rural, non-state public acute care hospital must be designated as a non-teaching hospital by the department and must:

- a. be located in a MSA per 42 CFR 413.231(b)(1);
- b. provide inpatient obstetrical and neonatal intensive care unit services; and
- c. per the cost report period ending in SFY 2012, have a Medicaid inpatient day utilization percentage in excess of 21 percent and a Medicaid newborn day utilization percentage in excess of 65 percent as documented on the as filed cost report.

2. Each qualifying hospital may receive quarterly supplemental payments for the outpatient services rendered during the quarter. Quarterly payments may be the difference between each qualifying hospital's outpatient Medicaid billed charges and the Medicaid payments the hospital receives for covered outpatient services provided to Medicaid recipients. Medicaid billed charges and payments will be based on a 12 consecutive month period for claims data selected by the department.

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 36:2868 (December 2010), amended LR 39:1473 (June 2013), LR 40:1699 (September 2014).

§5517. Children's Specialty Hospitals

A. Effective for dates of service on or after September 1, 2009, the reimbursement amount paid to children's specialty hospitals for outpatient hospital clinic services shall be the Medicaid fee schedule amount on file for each service.

B. Effective for dates of service on or after February 3, 2010, the reimbursement paid to children's specialty hospitals for outpatient hospital clinic services shall be reduced by five percent of the fee schedule on file as of February 2, 2010.

C. Effective for dates of service on or after August 1, 2010, the reimbursement paid to children's specialty hospitals for outpatient hospital clinic services shall be reduced by 4.6 percent of the fee schedule on file as of July 31, 2010.

D. Effective for dates of service on or after January 1, 2011, the reimbursement paid to children's specialty hospitals for outpatient hospital clinic services shall be reduced by 2 percent of the fee schedule on file as of December 31, 2010.

E. Effective for dates of service on or after August 1, 2012, the reimbursement rates paid to children's specialty hospitals for outpatient hospital clinic services shall be reduced by 3.7 percent of the fee schedule on file as of July 31, 2012.

F. Effective for dates of service on or after February 1, 2013, the reimbursement rates paid to children's specialty hospitals for outpatient hospital clinic services shall be reduced by 1 percent of the fee schedule on file as of January 31, 2013.

G. Effective for dates of service on or after January 1, 2017, the reimbursement rates paid to children's specialty hospitals for outpatient hospital clinic services shall be increased by 7.03 percent of the rates on file as of December 31, 2016.

H. Effective for dates of service on or after January 1, 2018, the reimbursement rates paid to children's specialty hospitals for outpatient hospital clinic services shall be increased by 4.82 percent of the rates on file as of December 31, 2017.

I. Effective for dates of service on or after January 1, 2019, the reimbursement rates paid to children's specialty hospitals for outpatient hospital clinic services shall be increased by 5.26 percent of the rates on file as of December 31, 2018.

J. Effective for dates of service on or after January 1, 2020, the reimbursement rates paid to children's specialty hospitals for outpatient hospital clinic services shall be increased by 3.2 percent of the rates on file as of December 31, 2019.

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 36:2042 (September 2010), amended LR 37:3266 (November 2011), LR 40:313 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:965 (May 2017), LR 43:2535 (December 2017), LR 44:2167 (December 2018), LR 45:1773 (December 2019).

§5519. State-Owned Hospitals

A. Effective for dates of service on or after February 10, 2012, medical education payments for outpatient clinic services which are reimbursed by a prepaid risk-bearing managed care organization (MCO) shall be reimbursed by Medicaid annually through the Medicaid cost report settlement process.

1. Qualifying medical education programs are defined as graduate medical education, paramedical education, and nursing schools.

2. Final payment shall be determined based on the actual MCO covered outpatient clinic services and Medicaid medical education costs for the cost reporting period per the Medicaid cost report.

B. Effective for dates of service on or after August 1, 2012, the reimbursement rates paid to state-owned hospitals

for outpatient clinic services shall be reduced by 10 percent of the of the fee schedule on file as of July 31, 2012.

C. Effective for dates of service on or after January 1, 2020, the reimbursement rates paid to state-owned hospitals for outpatient clinic services shall be increased by 14.67 percent of the fee schedule rates on file as of December 31, 2019.

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 38:2774 (November 2012), amended LR 40:314 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 45:1773 (December 2019).

Chapter 57. Laboratory Services

Subchapter A. General Provisions

§5701. Payment for Outpatient Hospital Laboratory Services

A. Payment for outpatient hospital laboratory services is a flat rate in accordance with the published fee schedule. There shall be no cost settlement for outpatient laboratory 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, Bureau of Health Services Financing, LR 48:1843 (July 2022).

Subchapter B. Reimbursement Methodology

§5711. Small Rural Hospitals

A. Effective for dates of service on or after July 1, 2008, the reimbursement amount paid to small rural hospitals for outpatient clinical diagnostic laboratory services shall be a fee schedule amount equal to the Medicare Fee Schedule amount on file as of July 1, 2008.

B. Effective for dates of service on or after August 1, 2010, small rural hospitals shall be reimbursed for outpatient clinical diagnostic laboratory services up to the Medicare outpatient upper payment limits.

C. **Low Income and Needy Care Collaboration.** Effective for dates of service on or after October 20, 2011, quarterly supplemental payments will be issued to qualifying non-state hospitals for outpatient laboratory services rendered during the quarter. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal year.

1. **Qualifying Criteria.** In order to qualify for the supplemental payment, the non-state hospital must be affiliated with a state or local governmental entity through a low income and needy care collaboration agreement.

Non-State Hospital—a hospital which is owned or operated by a private entity.

Low Income and Needy Care Collaboration Agreement—an agreement between a hospital and a state or local governmental entity to collaborate for purposes of providing healthcare services to low income and needy patients.

2. Each qualifying hospital shall receive quarterly supplemental payments for the outpatient services rendered during the quarter. Payments shall be distributed quarterly based on the Medicaid paid claims for services rendered during the quarter. Payments to hospitals participating in the Medicaid DSH Program shall be limited to the difference between the hospital's specific DSH limit and the hospital's DSH payments for the applicable payment period. Aggregate payments to qualifying hospitals shall not exceed the maximum allowable cap for the state fiscal 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 35:956 (May 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1251 (May 2012), LR 40:543 (March 2014).

§5713. Non-Rural, Non-State Hospitals

A. Effective for dates of service on or after February 20, 2009, the reimbursement paid to non-rural, non-state hospitals for outpatient laboratory services shall be reduced by 3.5 percent of the fee schedule on file as of February 19, 2009.

B. Effective for dates of service on or after August 4, 2009, the reimbursement paid to non-rural, non-state hospitals for outpatient laboratory services shall be reduced by 5.65 percent of the fee schedule on file as of August 3, 2009.

C. **Low Income and Needy Care Collaboration.** Effective for dates of service on or after January 1, 2010, quarterly supplemental payments will be issued to qualifying non-rural, non-state hospitals for laboratory services rendered during the quarter. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal year.

1. **Qualifying Criteria.** In order to qualify for the supplemental payment, the non-rural, non-state hospital must be affiliated with a state or local governmental entity through a Low Income and needy care collaboration agreement.

a. A non-state hospital is defined as a hospital which is owned or operated by a private entity.

b. A Low Income and needy care collaboration Agreement is defined as an agreement between a hospital and a state or local governmental entity to collaborate for purposes of providing healthcare services to low income and needy patients.

2. Each qualifying hospital shall receive quarterly supplemental payments for the outpatient services rendered during the quarter. Quarterly payment distribution shall be limited to one-fourth of the lesser of:

a. the difference between each qualifying hospital's outpatient Medicaid billed charges and Medicaid payments the hospital receives for covered outpatient services provided to Medicaid recipients. Medicaid billed charges and payments will be based on a 12 consecutive month period for claims data selected by the department; or

b. for hospitals participating in the Medicaid Disproportionate Share Hospital (DSH) Program, the difference between the hospital's specific DSH limit and the hospital's DSH payments for the applicable payment period.

D. Effective for dates of service on or after February 3, 2010, the reimbursement paid to non-rural, non-state hospitals for outpatient laboratory services shall be reduced by five percent of the fee schedule on file as of February 2, 2010.

1. Small rural hospitals as defined in R.S. 40:1189.3 shall be exempted from this rate reduction.

E. Effective for dates of service on or after August 1, 2010, the reimbursement paid to non-rural, non-state hospitals for outpatient laboratory services shall be reduced by 4.6 percent of the fee schedule on file as of July 31, 2010.

1. Small rural hospitals as defined in R.S. 40:1189.3 shall be exempted from this rate reduction.

F. Effective for dates of service on or after January 1, 2011, the reimbursement paid to non-rural, non-state hospitals for outpatient laboratory services shall be reduced by 2 percent of the fee schedule on file as of December 31, 2010.

1. Small rural hospitals as defined in R.S. 40:1189.3 shall be exempted from this rate reduction.

G. Effective for dates of service on or after August 1, 2012, the reimbursement rates paid to non-rural, non-state hospitals for outpatient laboratory services shall be reduced by 3.7 percent of the fee schedule on file as of July 31, 2012.

H. Effective for dates of service on or after February 1, 2013, the reimbursement rates paid to non-rural, non-state hospitals for outpatient laboratory services shall be reduced by 1 percent of the fee schedule on file as of January 31, 2013.

I. Effective for dates of service on or after January 1, 2017, the reimbursement rates paid to non-rural, non-state hospitals for outpatient laboratory services shall be increased by 7.03 percent of the rates on file as of December 31, 2016.

1. Hospitals participating in public-private partnerships as defined in §6701 shall be exempted from this rate increase.

J. Effective for dates of service on or after January 1, 2018, the reimbursement rates paid to non-rural, non-state

hospitals for outpatient laboratory services shall be increased by 4.82 percent of the rates on file as of December 31, 2017.

1. Hospitals participating in public-private partnerships as defined in §6701 shall be exempted from this rate increase.

K. Effective for dates of service on or after January 1, 2019, the reimbursement rates paid to non-rural, non-state hospitals for outpatient laboratory services shall be increased by 11.56 percent of the rates on file as of December 31, 2018.

1. In accordance with Section 1903(i)(7) of the Social Security Act, payments for Medicaid clinical diagnostic laboratory services shall be limited to the amount that Medicare pays on a per test basis. If this or any other rate adjustment causes the Medicaid calculated rate to exceed the Medicare payment rate for a clinical laboratory test, the rate shall be adjusted to the lower Medicare payment rate.

2. Hospitals participating in public-private partnerships as defined in §6701 shall be exempted from this rate increase.

L. Effective for dates of service on or after January 1, 2020, the reimbursement rates paid to non-rural, non-state hospitals for outpatient laboratory services shall be increased by 3.2 percent of the rates on file as of December 31, 2019.

1. In accordance with Section 1903(i)(7) of the Social Security Act, payments for Medicaid clinical diagnostic laboratory services shall be limited to the amount that Medicare pays on a per test basis. If this or any other rate adjustment causes the Medicaid calculated rate to exceed the Medicare payment rate for a clinical laboratory test, the rate shall be adjusted to the lower Medicare payment rate.

2. Hospitals participating in public-private partnerships as defined in §6701 shall be exempted from this rate increase.

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 Service Financing, LR 35:1900 (September 2009), amended LR 36:1250 (June 2010), LR 36:2042 (September 2010), LR 37:3266 (November 2011), LR 40:313 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:965 (May 2017), LR 43:2535 (December 2017), LR 44:2167 (December 2018), LR 45:1773 (December 2019), LR 48:1843 (July 2022).

§5715. State-Owned Hospitals

A. For dates of service on or after July 1, 2008, state-owned hospitals shall be reimbursed for outpatient clinical laboratory services at 100 per cent of the current Medicare clinical laboratory fee schedule.

B. Effective for dates of service on or after August 1, 2012, the reimbursement rates paid to state-owned hospitals for outpatient laboratory services shall be reduced by 10 percent of the fee schedule on file as of July 31, 2012.

C. Effective for dates of service on or after January 1, 2021, the reimbursement rates paid to state-owned hospitals

for outpatient laboratory services shall be reimbursed at 100 per cent of the current Medicare clinical laboratory fee schedule.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 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 Service Financing, LR 35:956 (May 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:315 (February 2014), LR 46:1685 (December 2020).

§5717. Non-Rural, Non-State Public Hospitals

A. Effective for dates of service on or after July 1, 2013, quarterly supplemental payments may be issued to qualifying non-rural, non-state public hospitals for laboratory services rendered during the quarter. Payment amounts may be reimbursed up to the Medicare outpatient upper payment limits as determined in accordance with 42 CFR §447.321.

1. **Qualifying Criteria.** In order to qualify for the quarterly supplemental payment, the non-rural, non-state public acute care hospital must be designated as a non-teaching hospital by the department and must:

- a. be located in a MSA per 42 CFR 413.231(b)(1);
- b. provide inpatient obstetrical and neonatal intensive care unit services; and
- c. per the cost report period ending in SFY 2012, have a Medicaid inpatient day utilization percentage in excess of 21 percent and a Medicaid newborn day utilization percentage in excess of 65 percent as documented on the as filed cost report.

2. Each qualifying hospital may receive quarterly supplemental payments for the outpatient services rendered during the quarter. Quarterly payments may be the difference between each qualifying hospital's outpatient Medicaid billed charges and the Medicaid payments the hospital receives for covered outpatient services provided to Medicaid recipients. Medicaid billed charges and payments will be based on a 12 consecutive month period for claims data selected by the department.

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 36:2868 (December 2010), amended LR 39:1473 (June 2013), LR 40:1699 (September 2014).

§5719. Children's Specialty Hospitals

A. Effective for dates of service on or after September 1, 2009, the reimbursement amount paid to children's specialty hospitals for outpatient clinical diagnostic laboratory services shall be the Medicaid fee schedule amount on file for each service.

B. Effective for dates of service on or after February 3, 2010, the reimbursement paid to children's specialty hospitals for outpatient clinical diagnostic laboratory

services shall be reduced by five percent of the fee schedule on file as of February 2, 2010.

C. Effective for dates of service on or after August 1, 2010, the reimbursement paid to non-rural, non-state hospitals for outpatient clinical diagnostic laboratory services shall be reduced by 4.6 percent of the fee schedule on file as of July 31, 2010.

D. Effective for dates of service on or after January 1, 2011, the reimbursement paid to non-rural, non-state hospitals for outpatient clinical diagnostic laboratory services shall be reduced by 2 percent of the fee schedule on file as of December 31, 2010.

E. Effective for dates of service on or after August 1, 2012, the reimbursement rates paid to children's specialty hospitals for outpatient clinical diagnostic laboratory services shall be reduced by 3.7 percent of the fee schedule on file as of July 31, 2012.

F. Effective for dates of service on or after February 1, 2013, the reimbursement rates paid to children's specialty hospitals for outpatient clinical diagnostic laboratory services shall be reduced by 1 percent of the fee schedule on file as of January 31, 2013.

G. Effective for dates of service on or after January 1, 2017, the reimbursement rates paid to children's specialty hospitals for outpatient clinical diagnostic laboratory services shall be increased by 7.03 percent of the rates on file as of December 31, 2016.

H. Effective for dates of service on or after January 1, 2018, the reimbursement rates paid to children's specialty hospitals for outpatient clinical diagnostic laboratory services shall be increased by 4.82 percent of the rates on file as of December 31, 2017.

I. Effective for dates of service on or after January 1, 2019, the reimbursement rates paid to children's specialty hospitals for outpatient clinical diagnostic laboratory services shall be increased by 5.26 percent of the rates on file as of December 31, 2018.

1. In accordance with Section 1903(i)(7) of the Social Security Act, payments for Medicaid clinical diagnostic laboratory services shall be limited to the amount that Medicare pays on a per test basis. If this or any other rate adjustment causes the Medicaid calculated rate to exceed the Medicare payment rate for a clinical laboratory test, the rate shall be adjusted to the lower Medicare payment rate.

J. Effective for dates of service on or after January 1, 2020, the reimbursement rates paid to children's specialty hospitals for outpatient clinical diagnostic laboratory services shall be increased by 3.2 percent of the rates on file as of December 31, 2019.

1. In accordance with section 1903(i)(7) of the Social Security Act, payments for Medicaid clinical diagnostic laboratory services shall be limited to the amount that Medicare pays on a per test basis. If this or any other rate adjustment causes the Medicaid calculated rate to exceed the

Medicare payment rate for a clinical laboratory test, the rate shall be adjusted to the lower Medicare payment rate.

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 36:2043 (September 2010), amended LR 37:3267 (November 2011), LR 40:314 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:965 (May 2017), LR 43:2535 (December 2017), LR 44:2167 (December 2018), LR 45:1774 (December 2019).

Chapter 59. Rehabilitation Services

Subchapter A. General Provisions

§5901. Payment for Outpatient Hospital Rehabilitation Services

A. Payment for outpatient hospital rehabilitation services is a flat rate in accordance with the published fee schedule. There shall be no cost settlement for outpatient rehabilitation services except for the specific hospital types identified in Subchapter B of this Chapter.

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 48:1843 (July 2022).

Subchapter B. Reimbursement Methodology

§5911. Small Rural Hospitals

A. Effective for dates of service on or after July 1, 2008, the reimbursement amount paid to small rural hospitals for rehabilitation services shall be as follows.

1. Small rural hospitals shall receive an interim payment for claims which shall be the Medicaid fee schedule payment on file for each service as of July 1, 2008.

2. A quarterly interim cost settlement payment shall be made to each small rural hospital to estimate a payment of 110 percent of allowable cost for fee schedule services.

a. The interim cost settlement payment shall be calculated by subtracting the actual quarterly payments for the applicable dates of services from 110 percent of the allowable costs of the quarterly claims. The cost to charge ratio from the latest filed cost report shall be applied to quarterly charges for the outpatient claims paid by fee schedule and multiplied by 110 percent of the allowable costs as calculated through the cost report settlement process.

B. Effective for dates of service on or after August 1, 2010, small rural hospitals shall be reimbursed for rehabilitation services up to the Medicare outpatient upper payment limits.

C. Low Income and Needy Care Collaboration. Effective for dates of service on or after October 20, 2011, quarterly supplemental payments will be issued to qualifying non-state

hospitals for outpatient rehabilitation services rendered during the quarter. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal year.

1. **Qualifying Criteria.** In order to qualify for the supplemental payment, the non-state hospital must be affiliated with a state or local governmental entity through a low income and needy care collaboration agreement.

Non-State Hospital—a hospital which is owned or operated by a private entity.

Low Income and Needy Care Collaboration Agreement—an agreement between a hospital and a state or local governmental entity to collaborate for purposes of providing healthcare services to low income and needy patients.

2. Each qualifying hospital shall receive quarterly supplemental payments for the outpatient services rendered during the quarter. Payments shall be distributed quarterly based on Medicaid paid claims for service dates from the previous state fiscal year. Payments to hospitals participating in the Medicaid DSH Program shall be limited to the difference between the hospital's specific DSH limit and the hospital's DSH payments for the applicable payment period. Aggregate payments to qualifying hospitals shall not exceed the maximum allowable cap for the state fiscal year.

D. **Public Non-State Small Rural Hospitals.** Effective for dates of service on or after July 1, 2023, quarterly supplemental payments will be issued to qualifying small rural hospitals for outpatient hospital rehabilitation services rendered during the quarter. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal year.

1. **Qualifying Criteria.** In order to qualify, as of September 30, 2022, the small hospital must:

- a. be publicly (non-state) owned and operated;
- b. be located in Department of Health administrative region 3; and
- c. provide routine and emergency inpatient and outpatient obstetrical services with separately identified nursery department statistics reported on the cost report.

2. Effective for dates of service on or after July 1, 2023, quarterly supplemental payments will be issued to qualifying small rural public hospitals for outpatient hospital rehabilitation services rendered during the quarter. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal 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 35:956 (May 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1251 (May 2012), LR 40:543 (March 2014),

amended by the Department of Health, Bureau of Health Services Financing, LR 49:1742 (October 2023).

§5913. Non-Rural, Non-State Hospitals

A. Effective for dates of service on or after February 20, 2009, the reimbursement paid to non-rural, non-state hospitals for outpatient rehabilitation services provided to recipients over the age of three years shall be reduced by 3.5 percent of the fee schedule on file as of February 19, 2009.

B. Effective for dates of service on or after August 4, 2009, the reimbursement paid to non-rural, non-state hospitals for outpatient rehabilitation services provided to recipients over the age of three years shall be reduced by 5.65 percent of the fee schedule on file as of August 3, 2009.

C. Low Income and Needy Care Collaboration. Effective for dates of service on or after January 1, 2010, quarterly supplemental payments will be issued to qualifying non-rural, non-state hospitals for rehabilitation services rendered during the quarter. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal year.

1. Qualifying Criteria. In order to qualify for the supplemental payment, the non-rural, non-state hospital must be affiliated with a state or local governmental entity through a Low Income and needy care collaboration agreement.

a. A non-state hospital is defined as a hospital which is owned or operated by a private entity.

b. A Low Income and Needy Care Collaboration Agreement is defined as an agreement between a hospital and a state or local governmental entity to collaborate for purposes of providing healthcare services to low income and needy patients.

2. Each qualifying hospital shall receive quarterly supplemental payments for the outpatient services rendered during the quarter. Quarterly payment distribution shall be limited to one-fourth of the lesser of:

a. the difference between each qualifying hospital's outpatient Medicaid billed charges and Medicaid payments the hospital receives for covered outpatient services provided to Medicaid recipients. Medicaid billed charges and payments will be based on a 12 consecutive month period for claims data selected by the department; or

b. for hospitals participating in the Medicaid Disproportionate Share Hospital (DSH) Program, the difference between the hospital's specific DSH limit and the hospital's DSH payments for the applicable payment period.

D. Effective for dates of service on or after February 3, 2010, the reimbursement paid to non-rural, non-state hospitals for outpatient rehabilitation services provided to recipients over the age of three years shall be reduced by five percent of the fee schedule on file as of February 2, 2010.

E. Effective for dates of service on or after January 1, 2019, the reimbursement rates paid to non-rural, non-state

hospitals for outpatient rehabilitation services provided to recipients over the age of three years shall be increased by 11.56 percent of the rates on file as of December 31, 2018.

1. Hospitals participating in public-private partnerships as defined in §6701 shall be exempted from this rate increase.

F. Effective for dates of service on or after January 1, 2020, the reimbursement rates paid to non-rural, non-state hospitals for outpatient rehabilitation services shall be increased by 3.2 percent of the rates on file as of December 31, 2019.

1. Hospitals participating in public-private partnerships as defined in §6701 shall be exempted from this rate increase.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1900 (September 2009), amended LR 36:1250 (June 2010), LR 36:2043 (September 2010), LR 44:2167 (December 2018), LR 45:1774 (December 2019).

§5915. Non-Rural, Non-State Public Hospitals

A. Effective for dates of service on or after July 1, 2013, quarterly supplemental payments may be issued to qualifying non-rural, non-state public hospitals for rehabilitation services rendered during the quarter. Payment amounts may be reimbursed up to the Medicare outpatient upper payment limits as determined in accordance with 42 CFR §447.321.

1. Qualifying Criteria. In order to qualify for the quarterly supplemental payment, the non-rural, non-state public acute care hospital must be designated as a non-teaching hospital by the department and must:

a. be located in a MSA per 42 CFR 413.231(b)(1);

b. provide inpatient obstetrical and neonatal intensive care unit services; and

c. per the cost report period ending in SFY 2012, have a Medicaid inpatient day utilization percentage in excess of 21 percent and a Medicaid newborn day utilization percentage in excess of 65 percent as documented on the as filed cost report.

2. Each qualifying hospital may receive quarterly supplemental payments for the outpatient services rendered during the quarter. Quarterly payments may be the difference between each qualifying hospital's outpatient Medicaid billed charges and the Medicaid payments the hospital receives for covered outpatient services provided to Medicaid recipients. Medicaid billed charges and payments will be based on a 12 consecutive month period for claims data selected by the department.

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

36:2868 (December 2010), amended LR 39:1473 (June 2013), LR 40:1700 (September 2014).

§5917. Children's Specialty Hospitals

A. Effective for dates of service on or after September 1, 2009, the reimbursement amount paid to children's specialty hospitals for rehabilitation services shall be as follows.

1. Qualifying hospitals shall receive an interim payment equal to the Medicaid fee schedule amount on file for each service.

2. Final reimbursement shall be 97 percent of allowable cost as calculated through the cost report settlement process.

B. Effective for dates of service on or after February 3, 2010, the reimbursement paid to children's specialty hospitals for outpatient rehabilitation services provided to recipients over the age of three years shall be reduced by five percent of the fee schedule on file as of February 2, 2010.

1. Final reimbursement shall be 92.15 percent of allowable cost as calculated through the cost report settlement process.

C. Effective for dates of service on or after January 1, 2019, the reimbursement rates paid to children's specialty hospitals for outpatient rehabilitation services provided to recipients over the age of three years shall be increased by 5.26 percent of the rates on file as of December 31, 2018.

1. Final reimbursement shall be 97 percent of allowable cost as calculated through the cost report settlement process.

D. Effective for dates of service on or after January 1, 2020, the reimbursement rates paid to children's specialty hospitals for outpatient rehabilitation services shall be increased by 3.2 percent of the rates on file as of December 31, 2019.

1. Final reimbursement shall be 100 percent of allowable cost as calculated through the cost report settlement process.

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 36:2043 (September 2010), LR 44:2168 (December 2018), LR 45:1774 (December 2019).

§5919. State-Owned Hospitals

A. Effective for dates of service on or after February 10, 2012, medical education payments for outpatient rehabilitation services which are reimbursed by a prepaid risk-bearing managed care organization (MCO) shall be reimbursed by Medicaid annually through the Medicaid cost report settlement process.

1. Qualifying medical education programs are defined as graduate medical education, paramedical education, and nursing schools.

2. Final payment shall be determined based on the actual MCO covered outpatient rehabilitation services and Medicaid medical education costs for the cost reporting period per the Medicaid cost report.

B. Effective for dates of service on or after January 1, 2020, the reimbursement rates paid to state hospitals for outpatient rehabilitation services shall be increased by 3.2 percent of the rates on file as of December 31, 2019.

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 38:2774 (November 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 45:1774 (December 2019).

§5921. Rehabilitation Services for Recipients Ages 0 up to Age 3

A. The following are reimbursement rates for rehabilitation services provided to Medicaid recipients up to the age of 3, regardless of the type of provider performing the services:

1. initial speech/language evaluation—\$70;
2. initial hearing evaluation—\$70;
3. initial occupational therapy evaluation—\$70;
4. occupational therapy, 15 minutes—\$15;
5. occupational therapy, 30 minutes—\$30;
6. occupational therapy, 45 minutes—\$45;
7. occupational therapy, 60 minutes—\$60;
8. physical therapy and rehab evaluation—\$75;
9. physical therapy, one modality—\$37;
10. physical therapy, two or more modalities—\$56;
11. physical therapy, one or more procedures, and/or modalities, 15 minutes—\$18.50;
12. physical therapy with procedures, 30 minutes—\$37;
13. physical therapy with procedures, 75 minutes—\$92.50;
14. procedures and modalities, 60 minutes—\$74;
15. speech and hearing therapy, 15 minutes—\$14;
16. speech and hearing therapy, 30 minutes—\$28;
17. speech and hearing therapy, 45 minutes—\$42;
18. speech and hearing therapy, 60 minutes—\$56;
19. speech/language/hearing therapy, 60 minutes—\$56;
20. visit with procedure(s), 45 minutes—\$56;
21. visit with procedure(s), 60 minutes—\$74; and
22. visit with procedure(s), 90 minutes—\$112.

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 30:1034 (May 2004), repromulgated LR 34:1921 (September 2008).

§5923. Rehabilitation Services for Recipients Ages 3 and Above (Reserved)

Chapter 61. Other Outpatient Hospital Services

Subchapter A. General Provisions

§6101. Payment for Other Outpatient Hospital Services

A. Interim payment for outpatient hospital services other than clinical diagnostic laboratory services, outpatient surgery services, rehabilitation services, and outpatient hospital clinic services shall be at a hospital-specific cost to charge ratio. Final payment shall be a percentage of cost amount as detailed for each type of hospital in Subchapter B of this Chapter. The percentage shall be applied to cost for these services as calculated based on the finalized cost report.

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 48:1843 (July 2022).

Subchapter B. Reimbursement Methodology

§6113. Small Rural Hospitals

A. Effective for dates of service on or after July 1, 2008, the reimbursement amount paid to small rural hospitals for outpatient hospital services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services, and outpatient hospital facility fees shall be as follows.

1. Small rural hospitals shall receive an interim payment for claims which shall be 110 percent of each hospital's cost to charge ratio as calculated from the latest filed cost report.

2. Final reimbursement shall be 110 percent of allowable cost as calculated through the cost report settlement process.

B. Effective for dates of service on or after August 1, 2010, small rural hospitals shall be reimbursed for services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services, and outpatient hospital facility fees up to the Medicare outpatient upper payment limits.

C. Low Income and Needy Care Collaboration. Effective for dates of service on or after October 20, 2011, quarterly supplemental payments will be issued to qualifying non-state hospitals for services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation

services, and outpatient facility fees during the quarter. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal year.

1. Qualifying Criteria. In order to qualify for the supplemental payment, the non-state hospital must be affiliated with a state or local governmental entity through a low income and needy care collaboration agreement.

Non-State Hospital—a hospital which is owned or operated by a private entity.

Low Income and Needy Care Collaboration Agreement—an agreement between a hospital and a state or local governmental entity to collaborate for purposes of providing healthcare services to low income and needy patients.

2. Each qualifying hospital shall receive quarterly supplemental payments for the outpatient services rendered during the quarter. Payments shall be distributed quarterly based on Medicaid paid claims for service dates from the previous state fiscal year. Payments to hospitals participating in the Medicaid DSH Program shall be limited to the difference between the hospital's specific DSH limit and the hospital's DSH payments for the applicable payment period. Aggregate payments to qualifying hospitals shall not exceed the maximum allowable cap for the state fiscal year.

D. Public Non-State Small Rural Hospitals. Effective for dates of service on or after July 1, 2023, quarterly supplemental payments will be issued to qualifying small rural hospitals for outpatient hospital services other than clinical diagnostic laboratory, outpatient surgeries, rehabilitation, and outpatient facility fees clinic services rendered during the quarter. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal year.

1. Qualifying Criteria. In order to qualify, as of September 30, 2022, the small hospital must:

- a. be publicly (non-state) owned and operated;
- b. be located in Department of Health administrative region 3; and
- c. provide routine and emergency inpatient and outpatient obstetrical services with separately identified nursery department statistics reported on the cost report.

2. Effective for dates of service on or after July 1, 2023, quarterly supplemental payments will be issued to qualifying small rural public hospitals for outpatient hospital services rendered during the quarter. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal 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 35:956 (May 2009), amended by the Department of Health and Hospitals, Bureau of Health Services

Financing, LR 38:1251 (May 2012), LR 40:543 (March 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 49:1742 (October 2023).

§6115. Non-Rural, Non-State Hospitals

A. Effective for dates of service on or after February 20, 2009, the reimbursement paid to non-rural, non-state hospitals for outpatient hospital services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services and outpatient hospital facility fees shall be reduced by 3.5 percent of the rates effective as of February 19, 2009. Final reimbursement shall be at 83.18 percent of allowable cost through the cost settlement process.

B. Effective for dates of service on or after August 4, 2009, the reimbursement paid to non-rural, non-state hospitals for outpatient hospital services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services and outpatient hospital facility fees shall be reduced by 5.65 percent of the rates effective as of August 3, 2009. Final reimbursement shall be at 78.48 percent of allowable cost through the cost settlement process.

C. Low Income and Needy Care Collaboration. Effective for dates of service on or after January 1, 2010, quarterly supplemental payments will be issued to qualifying non-rural, non-state hospitals for outpatient hospital services other than clinical diagnostic laboratory services, outpatient surgeries and rehabilitation services rendered during the quarter. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal year.

1. Qualifying Criteria. In order to qualify for the supplemental payment, the non-rural, non-state hospital must be affiliated with a state or local governmental entity through a low income and needy care collaboration agreement.

a. A *non-state hospital* is defined as a hospital which is owned or operated by a private entity.

b. A *low income and needy care collaboration agreement* is defined as an agreement between a hospital and a state or local governmental entity to collaborate for purposes of providing healthcare services to low income and needy patients.

2. Each qualifying hospital shall receive quarterly supplemental payments for the outpatient services rendered during the quarter. Quarterly payment distribution shall be limited to one-fourth of the lesser of:

a. the difference between each qualifying hospital's outpatient Medicaid billed charges and Medicaid payments the hospital receives for covered outpatient services provided to Medicaid recipients. Medicaid billed charges and payments will be based on a 12 consecutive month period for claims data selected by the department; or

b. for hospitals participating in the Medicaid Disproportionate Share Hospital (DSH) Program, the

difference between the hospital's specific DSH limit and the hospital's DSH payments for the applicable payment period.

D. Effective for dates of service on or after February 3, 2010, the reimbursement paid to non-rural, non-state hospitals for outpatient hospital services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services and outpatient hospital facility fees shall be reduced by 5 percent of the rates effective as of February 2, 2010. Final reimbursement shall be at 74.56 percent of allowable cost through the cost settlement process.

1. Small rural hospitals as defined in R.S. 40:1189.3 shall be exempted from this rate reduction.

E. Effective for dates of service on or after August 1, 2010, the reimbursement paid to non-rural, non-state hospitals for outpatient hospital services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services and outpatient hospital facility fees shall be reduced by 4.6 percent of the rates effective as of July 31, 2010. Final reimbursement shall be at 71.13 percent of allowable cost through the cost settlement process.

1. Small rural hospitals as defined in R.S. 40:1189.3 shall be exempted from this rate reduction.

F. Effective for dates of service on or after January 1, 2011, the reimbursement paid to non-rural, non-state hospitals for outpatient hospital services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services and outpatient hospital facility fees shall be reduced by 2 percent of the rates effective as of December 31, 2010. Final reimbursement shall be at 69.71 percent of allowable cost through the cost settlement process.

1. Small rural hospitals as defined in R.S. 40:1189.3 shall be exempted from this rate reduction.

G. Effective for dates of service on or after August 1, 2012, the reimbursement rates paid to non-rural, non-state hospitals for outpatient hospital services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services and outpatient hospital facility fees shall be reduced by 3.7 percent of the rates in effect on July 31, 2012. Final reimbursement shall be at 67.13 percent of allowable cost through the cost settlement process.

H. Effective for dates of service on or after February 1, 2013, the reimbursement rates paid to non-rural, non-state hospitals for outpatient hospital services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services and outpatient hospital facility fees shall be reduced by 1 percent of the rates in effect on January 31, 2013. Final reimbursement shall be at 66.46 percent of allowable cost through the cost settlement process.

I. Effective for dates of service on or after January 1, 2017, the reimbursement rates paid to non-rural, non-state hospitals for outpatient hospital services, other than clinical diagnostic laboratory services, outpatient surgeries,

rehabilitation services and outpatient hospital facility fees shall be increased by 7.03 percent of the rates in effect as of December 31, 2016.

1. Final reimbursement shall be at 71.13 percent of allowable cost through the cost settlement process.

J. Effective for dates of service on or after January 1, 2018, the reimbursement rates paid to non-rural, non-state hospitals for outpatient hospital services, other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services and outpatient hospital facility fees shall be increased by 4.82 percent of the rates in effect as of December 31, 2017.

1. Final reimbursement shall be 74.56 percent of allowable cost as calculated through the cost report settlement process.

K. Effective for dates of service on or after January 1, 2019, the reimbursement rates paid to non-rural, non-state hospitals for outpatient hospital services, other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services and outpatient hospital facility fees, shall be increased by 11.56 percent of the rates in effect as of December 31, 2018.

1. Final reimbursement shall be 83.18 percent of allowable cost as calculated through the cost report settlement process.

L. Effective for dates of service on or after January 1, 2020, the reimbursement rates paid to non-rural, non-state hospitals for outpatient hospital services, other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services and outpatient hospital facility fees, shall be increased by 3.2 percent of the rates in effect as of December 31, 2019.

1. Final reimbursement shall be 85.84 percent of allowable cost as calculated through the cost report settlement process.

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 Service Financing, LR 35:1900 (September 2009), amended LR 36:1250 (June 2010), LR 36:2043 (September 2010), LR 37:3267 (November 2011), LR 40:314 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:965 (May 2017), LR 43:2535 (December 2017), LR 44:2168 (December 2018), LR 45:1774 (December 2019), LR 48: 1843 (July 2022).

§6117. Non-Rural, Non-State Public Hospitals

A. Effective for dates of service on or after July 1, 2013, quarterly supplemental payments may be issued to qualifying non-rural, non-state public hospitals for outpatient services other than clinic services, diagnostic laboratory services, outpatient surgeries and rehabilitation services rendered during the quarter. Payment amounts may be reimbursed up to the Medicare outpatient upper payment limits as determined in accordance with 42 CFR §447.321.

1. **Qualifying Criteria.** In order to qualify for the quarterly supplemental payment, the non-rural, non-state public acute care hospital must be designated as a non-teaching hospital by the department and must:

a. be located in a MSA per 42 CFR 413.231(b)(1);

b. provide inpatient obstetrical and neonatal intensive care unit services; and

c. per the cost report period ending in SFY 2012, have a Medicaid inpatient day utilization percentage in excess of 21 percent and a Medicaid newborn day utilization percentage in excess of 65 percent as documented on the as filed cost report.

2. Each qualifying hospital may receive quarterly supplemental payments for the outpatient services rendered during the quarter. Quarterly payments may be the difference between each qualifying hospital's outpatient Medicaid billed charges and the Medicaid payments the hospital receives for covered outpatient services provided to Medicaid recipients. Medicaid billed charges and payments will be based on a 12 consecutive month period for claims data selected by the department.

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 36:2868 (December 2010), amended LR 39:1473 (June 2013), LR 40:1700 (September 2014).

§6119. Children's Specialty Hospitals

A. Effective for dates of service on or after September 1, 2009, the reimbursement amount paid to children's specialty hospitals for outpatient hospital services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services, and outpatient hospital facility fees shall be as follows.

1. Qualifying hospitals shall receive an interim payment that is equal to 97 percent of the hospital's cost to charge ratio as calculated from the latest filed cost report.

2. Final reimbursement shall be 97 percent of allowable cost as calculated through the cost report settlement process.

B. Effective for dates of service on or after February 3, 2010, the reimbursement paid to children's specialty hospitals for outpatient hospital services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services, and outpatient hospital facility fees shall be reduced by five percent of the rates effective as of February 2, 2010.

1. Final reimbursement shall be 92.15 percent of allowable cost as calculated through the cost report settlement process.

C. Effective for dates of service on or after August 1, 2010, the reimbursement fees paid to children's specialty hospitals for outpatient hospital services other than rehabilitation services and outpatient hospital facility fees

shall be reduced by 4.6 percent of the rates effective as of July 31, 2010.

1. Final reimbursement shall be 87.91 percent of allowable cost as calculated through the cost report settlement process.

D. Effective for dates of service on or after January 1, 2011, the reimbursement fees paid to children's specialty hospitals for outpatient hospital services other than rehabilitation services and outpatient hospital facility fees shall be reduced by 2 percent of the rates effective as of December 31, 2010.

1. Final reimbursement shall be 86.15 percent of allowable cost as calculated through the cost report settlement process.

E. Effective for dates of service on or after August 1, 2012, the reimbursement fees paid to children's specialty hospitals for outpatient hospital services other than rehabilitation services and outpatient hospital facility fees shall be reduced by 3.7 percent of the rates in effect on July 31, 2012. Final reimbursement shall be 82.96 percent of allowable cost as calculated through the cost report settlement process.

F. Effective for dates of service on or after February 1, 2013, the reimbursement fees paid to children's specialty hospitals for outpatient hospital services other than rehabilitation services and outpatient hospital facility fees shall be reduced by 1 percent of the rates in effect on January 31, 2013. Final reimbursement shall be 82.13 percent of allowable cost as calculated through the cost report settlement process.

G. Effective for dates of service on or after January 1, 2017, the reimbursement fees paid to children's specialty hospitals for outpatient hospital services, other than rehabilitation services and outpatient hospital facility fees, shall be increased by 7.03 percent of the rates in effect as of December 31, 2016.

1. Final reimbursement shall be 87.91 percent of allowable cost as calculated through the cost report settlement process.

H. Effective for dates of service on or after January 1, 2018, the reimbursement fees paid to children's specialty hospitals for outpatient hospital services, other than rehabilitation services and outpatient hospital facility fees, shall be increased by 4.82 percent of the rates in effect as of December 31, 2017.

1. Final reimbursement shall be 92.15 percent of allowable cost as calculated through the cost report settlement process.

I. Effective for dates of service on or after January 1, 2019, the reimbursement fees paid to children's specialty hospitals for outpatient hospital services, other than rehabilitation services and outpatient hospital facility fees, shall be increased by 5.26 percent of the rates in effect as of December 31, 2018.

1. Final reimbursement shall be 97 percent of allowable cost as calculated through the cost report settlement process.

J. Effective for dates of service on or after January 1, 2020, the reimbursement fees paid to children's specialty hospitals for outpatient hospital services, other than rehabilitation services and outpatient hospital facility fees, shall be increased by 3.2 percent of the rates in effect as of December 31, 2019.

1. Final reimbursement shall be 100 percent of allowable cost as calculated through the cost report settlement process.

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 36:2044 (September 2010), amended LR 37:3267 (November 2011), LR 40:314 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:965 (May 2017), LR 43:2535 (December 2017), LR 44:2168 (December 2018), LR 45:1774 (December 2019).

§6127. State-Owned Hospitals

A. Cost Based Services. The reimbursement methodology for state-owned outpatient hospital services are determined by a hospital cost to charge ratio based on each state hospital's latest filed cost report. These cost-to-charge ratio calculations will be reviewed on an ongoing basis as cost reports are filed and will be adjusted as necessary. Final reimbursement shall be the allowable cost as determined from the Medicare/Medicaid cost report for each state hospital.

B. Effective for dates of service on or after February 10, 2012, medical education payments which are reimbursed by a prepaid risk-bearing managed care organization (MCO) shall be reimbursed by Medicaid annually through the Medicaid cost report settlement process to state-owned hospitals for outpatient hospital services other than outpatient surgery services, clinic services, laboratory services, and rehabilitation services.

1. Qualifying medical education programs are defined as graduate medical education, paramedical education, and nursing schools.

2. Final payment shall be determined based on the actual MCO covered outpatient services and Medicaid medical education costs for the cost reporting period per the Medicaid cost report.

C. Effective for dates of service on or after August 1, 2012, the reimbursement rates paid to state hospitals for outpatient hospital services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services and outpatient hospital facility fees shall be reduced by 10 percent of the rates in effect on July 31, 2012. Final reimbursement shall be at 90 percent of allowable cost through the cost settlement process.

D. Effective for dates of service on or after January 1, 2020, the reimbursement rates paid to state hospitals for

outpatient hospital services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services and outpatient hospital facility fees shall be increased by 11 percent of the rates in effect on December 31, 2019. Final reimbursement shall be at 100 percent of allowable cost through the cost settlement process.

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 35:957 (May 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:2774 (November 2012), LR 40:315 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 45:1774 (December 2019).

Chapter 63. Diabetes Education Services

Subchapter A. General Provisions

§6301. Introduction

A. Effective for dates of service on or after February 20, 2011, the department shall provide coverage of diabetes self-management training (DSMT) services rendered to Medicaid recipients diagnosed with diabetes.

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 39:2505 (September 2013).

§6303. Scope of Services

A. DSMT services shall be comprised of one hour of individual instruction and nine hours of group instruction on diabetes self-management.

B. Service Limits. Recipients shall receive up to 10 hours of services during the first 12-month period beginning with the initial training date. After the first 12-month period has ended, recipients shall only be eligible for two hours of individual instruction on diabetes self-management per 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, Bureau of Health Services Financing, LR 39:2505 (September 2013).

§6305. Provider Participation

A. In order to receive Medicaid reimbursement, outpatient hospitals must have a DSMT program that meets the quality standards of one of the following accreditation organizations:

1. the American Diabetes Association;
2. the American Association of Diabetes Educators; or
3. the Indian Health Service.

B. All DSMT programs must adhere to the national standards for diabetes self-management education.

1. Each member of the instructional team must:
 - a. be a certified diabetes educator (CDE) certified by the National Certification Board for Diabetes Educators; or
 - b. have recent didactic and experiential preparation in education and diabetes management.
2. At a minimum, the instructional team must consist of one the following professionals who is a CDE:
 - a. a registered dietician;
 - b. a registered nurse; or
 - c. a pharmacist.
3. All members of the instructional team must obtain the nationally recommended annual continuing education hours for diabetes management.

C. Members of the instructional team must be either employed by or have a contract with a Medicaid enrolled outpatient hospital that will submit the claims for reimbursement of outpatient DSMT services rendered by the team.

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 39:2505 (September 2013).

Subchapter B. Reimbursement

§6311. Reimbursement Methodology

A. Effective for dates of service on or after February 20, 2011, the Medicaid Program shall provide reimbursement for diabetes self-management training services rendered by qualified health care professionals in an outpatient hospital setting.

B. Reimbursement for DSMT services shall be a flat fee based on the appropriate Healthcare Common Procedure Coding (HCPC) code.

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 39:2505 (September 2013).

Chapter 67. Public-Private Partnerships

§6701. Baton Rouge Area Hospitals

A. Qualifying Criteria. Effective for dates of service on or after April 15, 2013, the department shall provide supplemental Medicaid payments for outpatient hospital services rendered by non-state privately owned hospitals that meet the following conditions.

1. Qualifying Criteria. The hospital must be a non-state privately owned and operated hospital that enters into a cooperative endeavor agreement with the Department of

Health and Hospitals to increase its provision of outpatient Medicaid and uninsured hospital services by:

a. assuming the management and operation of services at a facility where such services were previously provided by a state owned and operated facility; or

b. providing services that were previously delivered and terminated or reduced by a state owned and operated facility.

B. Reimbursement Methodology

1. Payments shall be made quarterly based on the annual upper payment limit calculation per state fiscal year.

2. For SFY 2013, this payment shall be \$2,109,589, and for each state fiscal year starting with SFY 2014, this payment shall be \$10,000,000, not to exceed the upper payment limits pursuant to 42 CFR 447.321.

3. Maximum payments shall not exceed the upper payment limit pursuant to 42 CFR 447.321.

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 42:407 (March 2016).

§6703. Reimbursement Methodology

A. Payments to qualifying hospitals shall be made on a quarterly basis in accordance with 42 CFR 447.321.

B. Effective for dates of service on or after April 15, 2013, a major teaching hospital that enters into a cooperative endeavor agreement with the Department of Health and Hospitals to provide acute care hospital services to Medicaid and uninsured patients, and which assumes providing services that were previously delivered and terminated or reduced by a state owned and operated facility shall be reimbursed as follows.

1. **Outpatient Surgery.** The reimbursement amount for outpatient hospital surgery services shall be an interim payment equal to the Medicaid fee schedule amount on file for each service, and a final reimbursement amount of 95 percent of allowable Medicaid cost.

2. **Clinic Services.** The reimbursement amount for outpatient clinic services shall be an interim payment equal to the Medicaid fee schedule amount on file for each service, and a final reimbursement amount of 95 percent of allowable Medicaid cost.

3. **Laboratory Services.** The reimbursement amount for outpatient clinical diagnostic laboratory services shall be the Medicaid fee schedule amount on file for each service.

4. **Rehabilitative Services.** The reimbursement amount for outpatient clinic services shall be an interim payment equal to the Medicaid fee schedule amount on file for each service, and a final reimbursement amount of 95 percent of allowable Medicaid cost.

5. **Other Outpatient Hospital Services.** The reimbursement amount for outpatient hospital services other

than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services and outpatient hospital facility fees shall be an interim payment equal to 95 percent of allowable Medicaid cost.

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 42:573 (April 2016).

Chapter 69. Out-of-State Hospitals

Subchapter A. Reserved

Subchapter B. Reimbursement

§6915. Reimbursement Methodology

A. Reimbursement for all Louisiana Medicaid recipients who receive outpatient services in an out-of-state hospital, including those recipients up to the age of 21, shall be calculated as follows:

1. Outpatient services provided in out-of-state hospitals that are subject to a fee schedule in-state shall be paid at the fee schedule amounts utilized for in-state non-rural, non-state hospitals.

2. Outpatient services provided in out-of-state hospitals that are not subject to a fee schedule in-state shall be paid at the annual average cost to charge ratio calculated from the filed Medicaid cost reports for in-state non-rural, non-state hospitals multiplied by the percent of allowable cost as specified in §6115 that is in effect for the applicable time period for in-state non-rural, non-state hospitals. This ratio shall be applied to the billed charges for covered claims submitted by out-of-state hospitals to determine payment for non-fee schedule 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, Bureau of Health Services Financing, LR 48:1843 (July 2022).

Chapter 71. Medicare Part B Claims for Medicaid Eligible Recipients

Subchapter A. Reserved

Subchapter B. Reimbursement

§7115. Reimbursement Methodology

A. To determine the amount that Medicaid will reimburse on a claim for a Medicaid recipient who is also eligible for Medicare Part B, the Medicare claim payment is compared to the Medicaid rate on file for the revenue or procedure codes on the Medicare Part B claims for outpatient hospital services. If the Medicare payment exceeds the Medicaid rate, the claim is adjudicated as a paid claim with a zero payment. If the Medicaid rate exceeds the Medicare payment, the claim is reimbursed at the lesser of the co-insurance and deductible or up to the Medicaid

maximum payment. If the Medicaid payment is reduced or eliminated as a result of the Medicare/Medicaid payment comparison, the amount of the Medicare payment plus the amount of the Medicaid payment, if any, shall be considered to be payment in full for the service.

B. The recipient does not have any legal liability to make payment for the service.

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 48:1843 (July 2022).

Chapter 73. Urban Metropolitan Statistical Area (MSA) Facility

§7301. Qualifying Criteria

A. In order to qualify as an urban metropolitan statistical area (MSA) facility, the hospital:

1. has a facility type code of acute and opened subsequent to the March 12, 2020 presidential declaration of a national emergency due to COVID-19 to provide availability of additional beds and services for COVID-19 patients;

2. must have been licensed and certified no later than June 30, 2020, and located in zip code 70806, east of I-110, north of I-10, and south of Business Highway 190;

3. is located in an urban metropolitan statistical area (MSA) as defined by the United States Office of Management and Budget;

4. has an operational emergency room and is located greater than five miles in distance from the closest hospital emergency room; and

5. is located on a single site.

a. The addition of any off-site campus location to the license of this hospital will invalidate the provisions of this reimbursement methodology.

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 48:2759 (November 2022).

§7303. Reimbursement Methodology

A. Effective for dates of service on or after July 1, 2022, payments for outpatient services to qualifying urban MSA hospitals who meet all of the criteria in §7301 shall be made as follows.

1. **Outpatient Surgery.** The reimbursement amount for outpatient hospital surgery services shall be an interim payment equal to the Medicaid fee schedule amount on file for each service, and a final reimbursement amount of 95 percent of allowable Medicaid cost as calculated through the cost report settlement process.

2. **Clinic Services.** The reimbursement amount for outpatient clinic services shall be an interim payment equal to the Medicaid fee schedule amount on file for each service, and a final reimbursement amount of 95 percent of allowable Medicaid cost as calculated through the cost report settlement process.

3. **Laboratory Services.** The reimbursement amount for outpatient clinical diagnostic laboratory services shall be the Medicaid fee schedule amount on file for each service.

4. **Rehabilitation Services.** The reimbursement amount for outpatient rehabilitation services shall be an interim payment equal to the Medicaid fee schedule amount on file for each service, and a final reimbursement amount of 95 percent of allowable Medicaid cost as calculated through the cost report settlement process.

5. **Other Outpatient Hospital Services.** The reimbursement amount for outpatient hospital services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services, and outpatient hospital facility fees shall be an interim payment equal to 95 percent of allowable Medicaid cost as calculated through the cost report settlement process.

B. The department may review all above provisions every three years, at a minimum, to evaluate continuation of these enhanced reimbursements.

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 48:2759 (November 2022).

Chapter 75. Urban Metropolitan Statistical Area (MSA) Facility—New Orleans Area

§7501. Qualifying Criteria

A. In order to qualify as an urban metropolitan statistical area (MSA) facility—New Orleans area, effective October 5, 2022, a hospital must:

1. be designated a non-rural hospital service district located in LDH region 1, with a facility type code of acute, Medicaid enrolled, with an original hospital license date before July 13, 2014, but after July 1, 2014, located in zip code 70127;

2. be a hospital that is located in an MSA as defined by United States Office of Management and Budget;

3. have an operational emergency room; and

4. not add additional locations under this license, without prior written approval of the department.

a. The addition of any off-site campus, beyond an outpatient primary care clinic, to the license of this hospital will invalidate the provisions of this reimbursement methodology.

PUBLIC HEALTH—MEDICAL ASSISTANCE

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 49:265 (February 2023).

§7503. Reimbursement Methodology

A. Payments for outpatient services to qualifying urban MSA hospitals—New Orleans area who meet all of the criteria in §7501 shall be made as follows:

1. Outpatient Surgery. The reimbursement amount for outpatient hospital surgery services shall be an interim payment equal to the Medicaid fee schedule amount on file for each service, and a final reimbursement amount of 95 percent of allowable Medicaid cost as calculated through the cost report settlement process.

2. Clinic Services. The reimbursement amount for outpatient clinic services shall be an interim payment equal to the Medicaid fee schedule amount on file for each service, and a final reimbursement amount of 95 percent of allowable Medicaid cost as calculated through the cost report settlement process.

3. Laboratory Services. The reimbursement amount for outpatient clinical diagnostic laboratory services shall be the Medicaid fee schedule amount on file for each service.

4. Rehabilitation Services. The reimbursement amount for outpatient rehabilitation services shall be an interim payment equal to the Medicaid fee schedule amount on file for each service, and a final reimbursement amount of 95 percent of allowable Medicaid cost as calculated through the cost report settlement process.

5. Other Outpatient Hospital Services. The reimbursement amount for outpatient hospital services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services, and outpatient hospital facility fees shall be an interim payment equal to 95 percent of allowable Medicaid cost as calculated through the cost report settlement process.

B. The department may review all above provisions every three years, at a minimum, to evaluate continuation of these enhanced reimbursements.

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 49:265 (February 2023).

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part VII. Long Term Care

Subpart 1. Nursing Facilities

NOTE: Subpart 1 Nursing Facilities has been recodified and moved to LAC 50:II.Chapter 200.

**Subpart 3. Intermediate Care Facilities
for Persons with Intellectual Disabilities**

Chapter 301. General Provisions

§30101. Foreword

A. The ICF/MR standards for payment specify the requirements of federal and state law and regulations governing services provided by intermediate care facilities for the mentally retarded and persons with other developmental disabilities (ICF/MR).

B. The Medicaid Program is administered by the Louisiana Department of Health and Hospitals (DHH) in cooperation with other federal and state agencies.

C. Standards are established to ensure minimum compliance under the law, equity among those served, provision of authorized services, and proper disbursement. If there is a conflict between material in these standards and the federal and state laws or policies governing the program, the state laws or policies governing the program have precedence. These standards provide the ICF/MR with information necessary to fulfill the provider enrollment contract with the agency. It is the ICF/MR facility's responsibility to keep these standards current. The standards are the basis for surveys by federal and state agencies, are part of the enrollment contract, and are necessary for the ICF/MR to remain in compliance with federal and state laws.

D. Monitoring of an ICF/MR's compliance with state and federal regulations is the responsibility of DHH's Bureau of Health Services Financing (BHFS).

E. The Bureau of Health Services Financing (BHFS) Health Standards Section (HSS) is responsible for determining an ICF/MR's compliance with state licensing requirements and compliance with specific Title XIX certification requirements which include physical plant, staffing, dietary, pharmaceuticals, active treatment, and other standards. Minimum licensure requirements for ICF/MRs are covered in the booklet entitled *Licensing Requirements for Residential Care Providers* and Subpart I of the *Code of Federal Regulations*, Chapter 42:483.400-483.480.

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

13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:676 (April 1999), repromulgated LR 31:2221 (September 2005).

§30103. Definitions and Acronyms Specific to Mental Retardation and Other Developmental Disabilities

A. Definitions regarding Mental Retardation are adopted from the American Association on Mental Deficiency *Manual on Terminology and Classification in Mental Retardation*, 1977 Edition.

B. Definitions for Developmental Disabilities are taken from the 1983 amended R.S. 28:330-444 based on Public Law 95-602.

C. All clients must meet the criteria for mental retardation and other developmental disabilities in order to qualify for Title XIX reimbursement for ICF/MR services.

AAMR—American Association of Mental Retardation (formerly the AAMD/American Association of Mental Deficiency).

Abuse—the infliction of physical or mental injury to a client or causing a client's deterioration to such an extent that his/her health, moral or emotional well-being is endangered. Examples include, but are not limited to: sexual abuse, exploitation or extortion of funds or other things of value.

Active Treatment—an aggressive and consistent program of specialized and generic training, treatment, health and related services directed toward the acquisition of behaviors necessary for the client to function with as much self determination and independence as possible and the prevention and deceleration of regression or loss of current optimal functional status.

Acuity Factor—an adjustment factor which will modify the direct care portion of the Inventory for Client and Agency Planning (ICAP) rate based on the ICAP level for each resident.

Adaptive Behavior—the effectiveness or degree with which the individual meets the standards of personal independence and social responsibility expected for his age and cultural group. Since these exceptions vary for different age groups, deficits in adaptive behavior will vary at different ages.

Administrative and Operating Costs—include:

- a. in-house and contractual salaries;
- b. benefits;

- c. taxes for administration and plant operation maintenance staff;
- d. utilities;
- e. accounting;
- f. insurances;
- g. maintenance staff;
- h. maintenance supplies;
- i. laundry and linen;
- j. housekeeping; and
- k. other administrative type expenditures.

Agency—see Medicaid Agency.

Ambulatory—an ability to walk about.

ANSI—American National Standards Institute.

Applicant—an individual whose written application for Medicaid has been submitted to the agency but whose eligibility has not yet been determined.

ART—accredited record technician.

Attending Physician—a physician currently licensed by the Louisiana State Board of Medical Examiners, designated by the client, family, agency, or responsible party as responsible for the direction of overall medical care of the client.

Autism—a condition characterized by disturbance in the rate of appearance and sequencing of developmental milestones:

- a. abnormal responses to sensations;
- b. delayed or absent speech and language skills while specific thinking capabilities may be present; and
- c. abnormal ways of relating to people and things.

BHSF—Bureau of Health Services Financing. See *Health Services Financing*.

Board Certified Social Worker (BCSW)—a person holding a Master of Social Work (MSW) degree who is licensed by the Louisiana State Board of Certified Social Work Examiners.

Capacity for Independent Living—the ability to maintain a full and varied life in one's own home and community.

Capital Costs—include:

- a. depreciation;
- b. interest expense on capital assets;
- c. leasing expenses;
- d. property taxes; and
- e. other expenses related to capital assets.

Care Related Costs—include in-house and contractual salaries, benefits, taxes, and supplies that help support direct care but do not directly involve caring for the patient and ensuring their well being (e.g., dietary and educational). Care related costs would also include personal items, such as clothing, personal hygiene items (soap, toothpaste, etc), hair grooming, etc.

Cerebral Palsy—a permanently disabling condition resulting from damage to the developing brain, which may occur before, during or after birth and results in loss or impairment of control over voluntary muscles.

Certification—a determination made by the Department of Health and Hospitals (DHH) that an ICF/MR meets the necessary requirements to participate in Louisiana as a provider of Title XIX (Medicaid) Services.

Change in Ownership (CHOW)—any change in the legal entity responsible for the operation of an ICF/MR.

Chief Executive Officer (CEO)—an individual licensed, currently registered, and engaged in the day to day administration/management of an ICF/MR.

Client—an applicant for or recipient of Title XIX (Medicaid) ICF/MR services.

Code of Federal Regulations (CFR)—the regulations published by the federal government. Section 42 includes regulations for ICF/MRs.

Comprehensive Functional Assessment—identifies the client's need for services and provides specific information about the client's ability to function in different environments, specific skills or lack of skills, and how function can be improved, either through training, environmental adaptations, or provision of adaptive, assistive, supportive, orthotic, or prosthetic equipment.

Developmental Disabilities (DD)—severe, chronic disabilities which are attributable to mental retardation, cerebral palsy, autism, epilepsy or any other condition, other than mental illness, found to be closely related to mental retardation. This condition results in an impairment of general intellectual functioning or adaptive behavior similar to that of mental retardation, and requires treatment or services similar to those required for MR/DD are manifested before the person reaches age 22 and are likely to continue indefinitely.

Developmental Period—a period from birth to before a person reaches age 22.

DHH—Department of Health and Hospitals or its designee.

DHHS—the federal Department of Health and Human Services in Washington, D.C.

Direct Care Costs—consist of all costs related to the direct care interaction with the patient. *Direct care costs* include:

- a. in-house and contractual salaries;

- b. benefits; and
- c. taxes for all positions directly related to patient care, including:
 - i. medical;
 - ii. nursing;
 - iii. therapeutic and training;
 - iv. ancillary in-house services; and
 - v. recreational.

Dual Diagnosis—clients who carry diagnoses of both mental retardation and mental illness.

Enrollment—process of executing a contract with a licensed and certified ICF/MR provider for participation in the Medical Assistance Program. Enrollment includes the execution of the provider agreement and assignment of the provider number used for payment.

Epilepsy—disorder of the central nervous system which is characterized by repeated seizures which are produced by uncontrolled electrical discharges in the brain.

Facility—an intermediate care facility for the mentally retarded and developmentally disabled.

Fiscal Intermediary—the private fiscal agent with which DHH contracts to operate the Medicaid Management Information System. It processes the Title XIX (Medicaid) claims for services provided under the Medical Assistance Program and issues appropriate payment(s).

General Intellectual Functioning—results obtained by assessment with one or more of the individually administered general intelligence tests developed for that purpose.

HCFA—Health Care Financing Administration.

Health Services Financing, Bureau of (BHSF)—a division of DHH responsible for administering, overseeing, and monitoring the state's Medicaid Program.

HSS—Health Standards Section within BHSF, the section responsible for licensing, certifying and enrolling ICFs/MR.

ICAP—Inventory for Client and Agency Planning. A standardized instrument for assessing adaptive and maladaptive behavior and includes an overall service score. This ICAP service score combines adaptive and maladaptive behavior scores to indicate the overall level of care, supervision or training required.

ICAP Service Level—ranges from 1 to 9 and indicates the service need intensity. The lower the score the greater is the client need.

ICAP Service Score—indicates the level of service intensity required by an individual, considering both adaptive and maladaptive behavior.

NOTE: The relationship between the service level and service score for ICAP support levels is as follows:

ICAP Relationship Graph		
ICAP Service Level	ICAP Service Score	ICAP Support Levels
		Pervasive+
1	1-19	Pervasive
2	20-29	
3	30-39	Extensive
4	40-49	
5	50-59	Limited
6	60-69	
7	70-79	Intermittent
8	80-89	
9	90+	

Index Factor—this factor will be based on the *Skilled Nursing Home without Capital Market Basket Index* published by Data Resources Incorporated or a comparable index if this index ceases to be published.

Individual Habilitation Plan (IHP)—the written ongoing program of services developed for each client by an interdisciplinary team in order for that client to achieve or maintain his/her potential. The plan contains specific, measurable goals, objectives and provides for data collection.

Individual Plan of Care (IPC)—same as Individual Habilitation Plan.

Individual Program Plan (IPP)—same as Individual Habilitation Plan.

Individual Service Plan (ISP)—same as Individual Habilitation Plan.

Interdisciplinary Team (IDT)—a group of individuals representing the different disciplines in the formulation of a client's individual habilitation plan. That team meets at least annually to develop and review the plans, more frequently if necessary.

Intermediate Care Facility for the Mentally Retarded and Developmentally Disabled (ICF/MR)—same as facility for the mentally retarded or persons with related conditions.

I.Q.—Intelligence Quotient.

Learning—general cognitive competence—the ability to acquire new behaviors, perceptions, and information and to apply previous experiences in new situations.

Legal Status—a designation indicative of an individual's competency to manage their affairs.

Level of Care (LOC)—service needs of the client based upon his/her comprehensive functional status.

Licensed—a determination by the Louisiana Department of Health and Hospitals, Bureau of Health Service Financing, that an ICF/MR meets the state requirements to participate in Louisiana as a provider of ICF/MR services.

Living Unit—a place where a client lives including sleeping, training, dining and activity areas.

LPN—licensed practical nurse.

LSC—life safety code.

LTC—long term care.

Major Life Activities—any one of the following activities or abilities:

- a. self-care;
- b. understanding and use of language;
- c. learning;
- d. mobility;
- e. self-direction;
- f. capacity for independent living.

Measurable Outcomes—a standard or goal by which performance is measured and evaluated.

Mechanical Support—a device used to achieve proper body position or balance.

Medicaid—medical assistance provided according to the State Plan approved under Title XIX of the Social Security Act.

Medicaid Agency—the single state agency responsible for the administration of the Medical Assistance Program (Title XIX). In Louisiana, the Department of Health and Hospitals is the single state agency.

Medicaid Management Information System (MMIS)—the computerized claims processing and information retrieval system which includes all ICF/MR providers eligible for participation in the Medical Assistance Program. This system is an organized method for payment for claims for all Title XIX Services.

Medical Assistance Program (MAP)—another name for the Medicaid Program.

Medicare—the federally administered Health Insurance program for the aged, blind and disabled under the Title XVIII of the Social Security Act.

Medicare Part A—the hospital insurance program authorized under Part A of Title XVIII of the Social Security Act.

Medicare Part B—the supplementary medical insurance program authorized under Part B of Title XVIII of the Social Security Act.

Mental Retardation (MR)—significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior, and manifested during the developmental period.

NOTE: It shall be emphasized that a finding of low I.Q. is never by itself sufficient to make the diagnosis of mental retardation or in evaluating its severity. A low I.Q. shall serve only to help in making a clinical judgment regarding the client's adaptive behavioral capacity. This judgment also includes present functioning, including academic and vocational achievement, motor skills, and social and emotional maturity.

Mobil Nonambulatory—the inability to walk without assistance, but the ability to move from place to place with the use of a device such as a walker, crutches, wheelchair or wheeled platform.

Mobility—motor development and ability to:

- a. use fine and gross motor skills;
- b. move the extremities at will.

Neglect—the failure to provide proper or necessary medical care, nutrition or other care necessary for a client's well being.

New Facility—an ICF/MR newly opened or recently began participating in the Medical Assistance Program.

Nonambulatory—the inability to walk without assistance.

Nursing Facility or Facility—health care facilities such as a private home, institution, building, residence, or other place which provides maintenance, personal care, or nursing services for persons who are unable to properly care for themselves because of illness, physical infirmity or age. These facilities serve two or more persons who are not related by blood or marriage to the operator and may be operated for profit or nonprofit.

Office for Citizens with Developmental Disabilities (OCDD)—the office within DHH responsible for programs serving the MR/DD population.

Operational—admission of at least one client, completion of functional assessments(s) and development of individual program plan(s) for the client(s); and implementation of the program plan(s) in order that the facility actually demonstrate the ability, knowledge, and competence to provide active treatment.

Overall Plan of Care (OPC)—see Individual Habilitation Plan.

Pass through Cost Component—includes the provider fee.

Peer Group—the administrative and operating per diem rate and the capital per diem rate are tiered based on peer group size. Peer groups are as follows:

- a. 1-8 beds;
- b. 9-15 beds;
- c. 16-32 beds;
- d. 33 or more beds.

Provider—any individual or entity enrolled to furnish Medicaid services under a provider agreement with the Medicaid agency.

Qualified Mental Retardation Professional (QMRP)—a person who has specialized training and at least one year or more of experience in treating and/or working directly with and in direct contact with the mentally retarded clients. To

qualify as a QMRP, a person must meet the requirements of 42 CFR 483.430.

Rate Year—a one-year period corresponding to the state fiscal year from July 1 through June 30.

Rebasing—recalculation of the per diem rate components using the latest available audited or desk reviewed cost reports.

Recipient—an individual who has been determined eligible for Medicaid.

Registered Nurse (RN)—a nurse currently registered and licensed by the Louisiana State Board of Nursing.

Representative Payee—a person designated by the Social Security Administration to receive and disburse benefits in the best interest of and according to the needs of the beneficiary.

Responsible Party—a person authorized by the client, agency or sponsor to act as an official delegate or agent in dealing with the Department of Health and Hospitals and/or the ICF/MR.

Self-Care—daily activities which enable a person to meet basic life needs for food, hygiene, appearance and health.

Self-Direction—management and control over one's social and personal life and the ability to make decisions that affect and protect one's own interests. A substantial functional limitation in self-direction would require a person to need assistance in making independent decisions concerning social and individual activities and/or in handling personal finances and/or in protecting his own self-interest.

Significant Assistance—help needed at least one-half of the time for one activity or a need for some help in more than one-half of all activities normally required for self-care.

Significantly Sub-Average—for purposes of certification for ICF/MR an I.Q. score of below 70 on the Wechsler, Stanford-Binet, Cattell, or comparable test will be considered to establish significantly sub-average intellectual functioning.

SNF—Skilled Nursing Facility.

Sponsor—an adult relative, friend, or guardian of the client who has a legitimate interest in or responsibility for the client's welfare. Preferably, this person is designated on the admission forms as "responsible party."

Substantial Functional Limitation—a condition that limits a person from performing normal life activities or makes it unsafe for a person to live alone to such an extent that assistance, supervision, or presence of a second person is required more than half of the time.

Support Levels—describe the levels of support needed by individuals with mental retardation and other developmental disabilities. The five descriptive levels of service intensity using the ICAP assessment are summarized in Subparagraphs a-e below.

a. *Intermittent*—supports on an as needed basis. Characterized as episodic in nature, the person does not always need the support(s), or short-term supports needed during life-span transition (e.g., job loss or an acute medical crisis). Intermittent supports may be high or low intensity when provided.

b. *Limited*—supports characterized by consistency over time, time-limited but not of an intermittent nature, may require fewer staff members and less costs than more intense levels of support (e.g., time-limited employment training or transitional supports during the school to adult provided period).

c. *Extensive*—supports characterized by regular involvement (e.g., daily) in at least some environment (such as work or home) and not time-limited (e.g., long term support and long-term home living support).

d. *Pervasive*—supports characterized by their constancy, high intensity; provided across environments; potential life-sustaining nature. Pervasive supports typically involve more staff members and intrusiveness than do extensive or time-limited supports.

e. *Pervasive Plus*—a time-limited specific assignment to supplement required Level of Need services or staff to provide life sustaining complex medical care or to supplement required direct care staff due to dangerous life threatening behavior so serious that it could cause serious physical injury to self or others and requires additional trained support staff to be at "arms length" during waking hours.

Title XIX—see Medicaid.

Training and Habilitation Services—services intended to aid the intellectual, sensorimotor and emotional development of a client as part of overall plans to help the individual function at the greatest physical, intellectual, social and vocational level he/she can presently or potentially achieve.

Understanding and Use of Language—communication involving both verbal and nonverbal behavior enabling the individual both to understand others and to express ideas and information to others.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:676 (April 1999), LR 31:1590 (July 2005), repromulgated LR 31:2222 (September 2005).

Chapter 303. Provider Enrollment

§30301. General Provisions

A. Scope

1. The standards set forth in this and subsequent sections comply with the Title XIX requirements of the amended Social Security Act. That Act sets the standards for the care, treatment, health, safety, welfare and comfort of

Medical Assistance clients in facilities providing ICF/MR services.

2. These standards apply to ICF/MRs certified and enrolled by the Louisiana Department of Health and Hospitals (DHH) for vendor participation.

3. These standards supplement current licensing requirements applicable to ICF/MRs. Any infraction of these standards may be considered a violation of the provider agreement between DHH and the ICF/MR.

4. In the event any of these standards are not maintained, DHH will determine whether facility certification will continue with deficiencies as is allowed under Title XIX regulations or whether termination of the provider agreement is warranted. Although vendor payment will not be suspended during the determination period, deficiencies which may affect the health, safety, rights and welfare of Medical Assistance clients must be corrected expeditiously in order for the ICF/MR to continue to participate.

5. If a certified ICF/MR is found to have deficiencies which immediately jeopardize the health, safety, rights and welfare of its Medical Assistance clients, DHH may initiate proceedings to terminate the ICF/MR's certification. In the event of less serious deficiencies, DHH may impose interim sanctions (see Chapter 323, Sanctions).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 42 CFR 442- 483.400 and 435.1008.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Undersecretary, Bureau of Health Services Financing, LR 25:682 (April 1999), repromulgated LR 31:2225 (September 2005).

§30303. General Admission and Funding

A. Capacity. The ICF/MR will admit only the number of individuals that does not exceed its rated capacity as determined by the BHSF's HSS and its capacity to provide adequate programming.

B. Admission Requirements. Except on a short term emergency basis, an ICF/MR may not admit individuals as clients unless their needs can be met and an interdisciplinary professional team has determined that admission is the best available plan for them. The team must do the following:

1. conduct a comprehensive evaluation of each individual that covers physical, emotional, social and cognitive factors; and

2. perform the following tasks prior to admission:

a. define the individual's need for service without regard to the availability of those services; and

b. review all appropriate programs of care, treatment, and training and record the findings;

3. ensure that the ICF/MR takes the following action if admission is not the best plan but the individual must nevertheless be admitted:

a. clearly acknowledges that admission is inappropriate; and

b. initiates plans to actively explore alternatives.

C. Prohibitions on Federal Financial Participation

1. Federal funds in the Title XIX ICF/MR program are not available for clients whose individual treatment plans are totally or predominately vocational and/or educational. ICF/MR services are designed essentially for those individuals diagnosed as developmentally disabled; having developmental lags which are considered amendable to treatment in a 24-hour managed care environment where they will achieve maximum growth. Services to treat educational and vocational deficits are available at the community level while the client lives in his home or in another community level placement and are not considered amendable to treatment in a 24-hour managed care environment.

2. Admissions through the Court System

a. Court ordered admissions do not guarantee Medicaid vendor payment to a facility. A court can order that a client be placed in a particular facility but cannot mandate that the services be paid for by the Medicaid program.

b. Incarcerated individuals are not eligible for Medicaid. The only instance in which such an individual may qualify is if he/she is paroled or released on medical furlough.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 42 CFR 483.440.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Undersecretary, Bureau of Health Services Financing, LR 25:682 (April 1999), repromulgated LR 31:2225 (September 2005).

§30305. Program Enrollment

A. An ICF/MR may enroll for participation in the Medical Assistance Program (Title XIX) when all the following criteria have been met:

1. the ICF/MR has received Facility Need Review approval from DHH;

2. the ICF/MR has received approval from DHH/OCDD;

3. the ICF/MR has completed an enrollment application for participation in the Medical Assistance Program;

4. the ICF/MR has been surveyed for compliance with federal and state standards, approved for occupancy by the Office of Public Health (OPH) and the Office of the State Fire Marshal, and has been determined eligible for certification on the basis of meeting these standards; and

5. the ICF/MR has been licensed and certified by DHH.

B. Procedures for Certification of New ICF/MRs. The following procedures must be taken in order to be certified as a new ICF/MR.

1. The ICF/MR shall apply for a license and certification.

2. DHH shall conduct or arrange for surveys to determine compliance with Title XIX, Title VI (Civil Rights), Life Safety, and Sanitation Standards.

3. Facilities must be operational a minimum of two weeks (14 calendar days) prior to the initial certification survey. Facilities are not eligible to receive payment prior to the certification date.

a. *Operational* is defined as admission of at least one client, completion of functional assessment and development of individual program plan for each client; and implementation of the program plan(s) in order for the facility to actually demonstrate the ability, knowledge, and competence to provide active treatment.

b. Fire and health approvals must be obtained from the proper agencies prior to a client's admission to the facility.

c. The facility must comply with all standards of the State of Louisiana licensing requirements for residential care providers.

d. A certification survey will be conducted to verify that the facility meets all of these requirements.

4. A new ICF/MR shall be certified only if it is in compliance with all conditions of participation found in 42 CFR 442 and 42 CFR 483.400 et seq.

5. The effective date of certification shall be no sooner than the exit date of the certification survey.

C. Certification Periods

1. DHH may certify an ICF/MR which fully meets applicable requirements for a maximum of 12 months.

2. Prior to the agreement expiration date, the provider agreement may be extended for up to two months after the agreement expiration date if the following conditions are met:

a. the extension will not jeopardize the client's health, safety, rights and welfare; and

b. the extension is needed to prevent irreparable harm to the ICF/MR or hardship to its clients; or

c. the extension is needed because it is impracticable to determine whether the ICF/MR meets certification standards before the expiration date.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 42 CFR 483.440.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Undersecretary, Bureau of Health Services

Financing, LR 25:682 (April 1999), repromulgated LR 31:2226 (September 2005).

§30307. Ownership

A. Disclosure. All participating Title XIX ICF/MRs are required to supply the DHH Health Standards Section with a completed HCFA Form 1513 (Disclosure of Ownership) which requires information as to the identity of the following individuals:

1. each person having a direct or indirect ownership interest in the ICF/MR of 5 percent or more;

2. each person owning (in whole or in part) an interest of 5 percent or more in any property, assets, mortgage, deed of trust, note or other obligation secured by the ICF/MR;

3. each officer and director when an ICF/MR is organized as a corporation;

4. each partner when an ICF/MR is organized as a partnership;

5. within 35 days from the date of request, each provider shall submit the complete information specified by the BHSF/HSS regarding the following:

a. the ownership of any subcontractor with whom this ICF/MR has had more than \$25,000 in business transactions during the previous 12 months; and

b. information as to any significant business transactions between the ICF/MR and the subcontractor or wholly owned suppliers during the previous five years.

B. The authorized representative must sign the provider agreement.

1. If the provider is a nonincorporated entity and the owner does not sign the provider agreement, a copy of power of attorney shall be submitted to the DHH/HSS showing that the authorized representative is allowed to sign on the owner's behalf.

2. If one partner signs on behalf of another partner in a partnership, a copy of power of attorney shall be submitted to the DHH/HSS showing that the authorized representative is allowed to sign on the owner's behalf.

3. If the provider is a corporation, the board of directors shall furnish a resolution designating the representative authorized to sign a contract for the provision of services under DHH's state Medical Assistance Program.

C. Change in Ownership (CHOW)

1. A Change in Ownership (CHOW) is any change in the legal entity responsible for the operation of the ICF/MR.

2. As a temporary measure during a change of ownership, the BHSF/HSS shall automatically assign the provider agreement and certification, respectively to the new owner. The new owner shall comply with all participation prerequisites simultaneously with the ownership transfer. Failure to promptly complete with these prerequisites may result in the interruption of vendor payment. The new owner shall be required to complete a new provider agreement and

enrollment forms referred to in Continued Participation. Such an assignment is subject to all applicable statutes, regulations, terms and conditions under which it was originally issued including, but not limited to, the following:

- a. any existing correction action plan;
- b. any expiration date;
- c. compliance with applicable health and safety standards;
- d. compliance with the ownership and financial interest disclosure requirements;
- e. compliance with Civil Rights requirements;
- f. compliance with any applicable rules for Facility Need Review;
- g. acceptance of the per diem rates established by DHH/BHSF's Institutional Reimbursement Section; and
- h. compliance with any additional requirements imposed by DHH/BHSF/HSS.

3. For an ICF/MR to remain eligible for continued participation after a change of ownership, the ICF/MR shall meet all the following criteria:

- a. state licensing requirements;
- b. all Title XIX certification requirements;
- c. completion of a signed provider agreement with the department;
- d. compliance with Title VI of the Civil Rights Act; and
- e. enrollment in the Medical Management Information system (MMIS) as a provider of services.

4. A facility may involuntarily or voluntarily lose its participation status in the Medicaid Program. When a facility loses its participation status in the Medicaid Program, a minimum of 10 percent of the final vendor payment to the facility is withheld pending the fulfillment of the following requirements:

- a. submission of a limited scope audit of the client's personal funds accounts with findings and recommendations by a qualified accountant of the facility's choice to the department's Institutional Reimbursement Section:
 - i. the facility has 60 days to submit the audit findings to Institutional Reimbursement once it has been notified that a limited scope audit is required;
 - ii. failure of the facility to comply with the audit requirement is considered a Class E violation and will result in fines as outlined in Chapter 323, Sanctions;
- b. the facility's compliance with the recommendations of the limit scope audit;
- c. submittal of an acceptable final cost report by the facility to Institutional Reimbursement;

d. once these requirements are met, the portion of the payment withheld shall be released by the BHSF's Program Operations Section.

5. Upon notification of completion of the ownership transfer and the new owner's licensing, DHH/HSS will notify the fiscal intermediary regarding the effective dates of payment and to whom payment is to be made.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 42 CFR 420.205, 440.14, 442.15, 455.100, 455.101, 455.102, and 455.103.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Undersecretary, Bureau of Health Services Financing, LR 25:682 (April 1999), repromulgated LR 31:2226 (September 2005).

§30309. Provider Agreement

A. In order to participate as a provider of ICF/MR services under Title XIX, an ICF/MR must enter into a provider agreement with DHH. The provider agreement is the basis for payments by the Medical Assistance Program. The execution of a provider agreement and the assignment of the provider's Medicaid vendor number is contingent upon the following criteria.

1. Facility Need Review Approval Required. Before the ICF/MR can enroll and participate in Title XIX, the Facility Need Review Program must have approved the need for the ICF/MR's enrollment and participation in Title XIX. The Facility Need Review process is governed by Department of Health and Hospitals regulations promulgated under authority of Louisiana R.S. 40:2116.

a. The approval shall designate the appropriate name of the legal entity operating the ICF/MR.

b. If the approval is not issued in the appropriate name of the legal entity operating the ICF/MR, evidence shall be provided to verify that the legal entity that obtained the original Facility Need Review approval is the same legal entity operating the ICF/MR.

2. ICF/MR's Medicaid Enrollment Application. The ICF/MR shall request a Title XIX Medicaid enrollment packet from the Medical Assistance Program Provider Enrollment Section. The information listed below shall be returned to that office as soon as it is completed:

a. two copies of the Provider Agreement Form with the signature of the person legally designated to enter into the contract with DHH;

b. one copy of the Provider Enrollment Form (PE 50) completed in accordance with accompanying instructions and signed by the administrator or authorized representative;

c. one copy of the Title XIX Utilization Review Plan Agreement Form showing that the ICF/MR accepts DHH's Utilization Review Plan;

d. copies of information and/or legal documents as outlined in §30307 (Ownership).

3. The Effective Date of the Provider Agreement. The ICF/MR must be licensed and certified by the BHSF/HSS in accordance with provisions in 42 CFR 442.100-115 and provisions determined by DHH. The effective date of the provider agreement shall be determined as follows.

a. If all federal requirements (health and safety standards) are met on the day of the BHSF/HSS survey, then the effective date of the provider agreement is the date the on-site survey is completed or the day following the expiration of a current agreement.

b. If all requirements are specified in Subparagraph a above are not met on the day of the BHSF/HSS survey, the effective date of the provider agreement is the earliest of the following dates:

i. the date on which the provider meets all requirements; or

ii. the date on which the provider submits a corrective action plan acceptable to the BHSF/HSS; or

iii. the date on which the provider submits a waiver request approved by the BHSF/HSS; or

iv. the date on which both Clause ii and Clause iii above are submitted and approved.

4. ICF/MR's "Per Diem" Rate. After the ICF/MR facility has been licensed and certified, a per diem rate will be issued by the department.

5. Provider Agreement Responsibilities. The responsibilities of the various parties are spelled out in the Provider Agreement Form. Any changes will be promulgated in accordance with the Administrative Procedure Act.

6. Provider Agreement Time Periods. The provider agreement shall meet the following criteria in regard to time periods.

a. It shall not exceed 12 months.

b. It shall coincide with the certification period set by the BHSF/HSS.

c. After a provider agreement expires, payment may be made to an ICF/MR for up to 30 days.

d. The provider agreement may be extended for up to two months after the expiration date under the following conditions:

i. it is determined that the extension will not jeopardize the client's health, safety, rights and welfare; and

ii. it is determined that the extension is needed to prevent irreparable harm to the ICF/MR or hardship to its clients; or

iii. it is determined that the extension is needed because it is impracticable to determine whether the ICF/MR meets certification standards before the expiration date.

7. Tuberculosis (TB) Testing as Required by the OPH. All residential care facilities licensed by DHH shall comply with the requirements found in LAC 51:II.Chapter 5

regarding screening for communicable disease of employees, residents, and volunteers whose work involves direct contact with clients. For questions regarding TB testing, contact the local office of Public Health.

8. Criminal History Checks. Effective July 15, 1996, the Office of State Police will perform criminal history checks on nonlicensed personnel of health care facilities in accordance with R.S. 40:1300.51-R.S. 40:1300.56.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and 42 CFR 431.107, 442.10, 442.12, 442.13, 442.15, 442.16, 442.100 and 442.101.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:679 (April 1999), repromulgated LR 31:2227 (September 2005).

Chapter 305. Admission Review

§30501. Admission Process

A. ICF/MRs will be subject to a review of each client's need for ICF/MR services.

B. Interdisciplinary Team (ID Team). Before admission to an ICF/MR, or before authorization for payment, an interdisciplinary team of health professionals will make a comprehensive medical, social and psychological evaluation of each client's need for care in the ICF/MR.

1. Other professionals as appropriate will be included on the team, and at least one member will meet the definition of Qualified Mental Retardation Professional (QMRP) as stated in these standards.

2. Appropriate participation of nursing services on this team should be represented by a Louisiana licensed nurse.

C. Exploration of Alternative Services. If the comprehensive evaluations recommend ICF/MR services for a client whose needs could be met by alternative services that are currently unavailable, the ICF/MR will enter this fact in the client's record and begin to look for alternative services.

D. ICF/MR Submission of Data

1. Evaluative data for medical certification for ICF/MR level of care will be submitted to the appropriate regional Health Standards Office on each client. This will include the following information:

a. initial application;

b. applications for clients transferring from one ICF/MR to another;

c. applications for clients transferring from an acute care hospital to an ICF/MR;

d. applications for clients who are patients in a mental health facility; and

e. applications for clients already in an ICF/MR program.

2. Time Frames for Submission of Data. A complete packet of admission information must be received by BHSF/HSS within 20 working days following the completion of the ISP for newly admitted clients.

a. Notice within the 20-day time frame will also be required for readmissions and transfers.

b. If an incomplete packet is received, denial of certification will be issued with the reasons(s) for denial.

c. If additional information is subsequently received within the initial 20-working-day time frame, and the client meets all requirements, the effective date of certification is the date of admission.

d. If the additional information is received after the initial 20-working-day time frame and the client meets all requirements, the effective date of certification is no earlier than the date a completed packet is received by HSS.

3. Data may be submitted before admission of the client if all other conditions for the admission are met.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 456.350-456.438.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:697 (April 1999), repromulgated LR 31:2228 (September 2005).

§30503. Certification Requirements

A. The following documentation and procedures are required to obtain medical certification for ICF/MR Medicaid vendor payment. The documentation should be submitted to the appropriate HSS regional office.

1. Social evaluation:

a. must not be completed more than 90 days prior to admission and no later than date of admission; and

b. must address the following:

i. family, educational and social history including any previous placements;

ii. treatment history that discusses past and current interventions, treatment effectiveness, and encountered negative side effects;

iii. current living arrangements;

iv. family involvement, if any;

v. availability and utilization of community, educational, and other sources of support;

vi. habilitation needs;

vii. family and/or client expectations for services;

viii. prognosis for independent living; and

ix. social needs and recommendation for ICF/MR placement.

2. Psychological evaluation:

a. must not be completed more than 90 days prior to admission and no later than the date of admission; and

b. must include the following components:

i. comprehensive measurement of intellectual functioning;

ii. a developmental and psychological history and assessment of current psychological functioning;

iii. measurement of adaptive behavior using multiple informants when possible;

iv. statements regarding the reliability and validity of informant data including discussion of potential informant bias;

v. detailed description of adaptive behavior strengths and functional impairments in self-care, language, learning, mobility, self-direction, and capacity for independent living;

vi. discussion of whether impairments are due to a lack of skills or noncompliance and whether reasonable learning opportunities for skill acquisition have been provided; and

vii. recommendations for least restrictive treatment alternative, habilitation and custodial needs and needs for supervision and monitoring to ensure safety.

3. A psychiatric evaluation must be completed if the client has a primary or secondary diagnosis of mental illness, is receiving psychotropic medication, has been hospitalized in the past three years for psychiatric problems, or if significant psychiatric symptoms were noted in the psychological evaluation or social assessment. The psychiatric evaluation:

a. shall not be completed more than 90 days prior to admission and no later than the date of admission;

b. should include a history of present illness, mental status exam, diagnostic impression, assessment of strengths and weaknesses, recommendations for therapeutic interventions, and prognosis; and

c. may be requested at the discretion of HSS to determine the appropriateness of placement if admission material indicates the possible need for psychiatric intervention due to behavior problems.

4. Physical, occupational, or speech therapy evaluation(s) may be requested when the client receives services or is in need of services in these areas.

5. An individual service plan (ISP) developed by the interdisciplinary team, completed within 30 days of admission that describes and documents the following:

a. habilitation needs;

b. specific objectives that are based on assessment data;

c. specific services, accommodations, and/or equipment needed to augment other sources of support to facilitate placement in the ICF/MR; and

d. participation by the client, the parent(s) if the client is a minor, or the client's legal guardian unless participation is not possible or inappropriate.

NOTE: Document the reason(s) for any nonparticipation by the client, the client's parent(s), or the client's legal guardian.

6. Form 90-L (Request for Level of Care Determination) must be submitted on each admission or readmission. This form must:

a. not be completed more than 30 days before admission and not later than the date of admission;

b. be completed fully and include prior living arrangements and previous institutional care;

c. be signed and dated by a physician licensed to practice in Louisiana. Certification will not be effective any earlier than the date the Form 90-L is signed and dated by the physician;

d. indicate the ICF/MR level of care; and

e. include a diagnosis of mental retardation/developmental disability or related condition as well as any other medical condition.

7. Form 148 (Notification of Admission or Change):

a. must be submitted for each new admission to the ICF/MR;

b. must be submitted when there is a change in a client's status: death, discharge, transfer, readmission from a hospital;

c. for clients' whose application for Medicaid is later than date of admission, the date of application must be indicated on the form.

8. Transfer of a Client

a. Transfer of a Client Within an Organization

i. Form 148 must be submitted by both the discharging facility and the admitting facility. It should indicate the date the client was discharged from the transferring facility plus the name of the receiving facility and the date admitted.

ii. An updated individual service plan must be submitted from the discharging facility to the receiving facility. The previous plan can be used but must show any necessary revisions that the receiving facility ID team feels appropriate and/or necessary.

iii. The receiving facility must submit minutes of an ID team meeting addressing the reason(s) for the transfer, the family and client's response to the move, and the signatures of the persons attending the meeting.

b. Transfer of a Client Not Within the Same Organization. Certification requirements involving the transfer of a client from one ICF/MR facility to another not within the same organization or network will be the same as for a new admission.

i. The discharging facility will notify HSS of the discharge by submitting Form 148 giving the date of discharge and destination.

ii. The receiving facility must follow all steps for a new admission.

9. Readmission of a Client Following Hospitalization

a. Form 148 must be submitted showing the date Medicaid billing was discontinued and the date of readmission to the facility.

b. Documentation must be submitted that specifies the client's diagnosis, medication regime, and includes the physician's signature and date. The documentation can be:

i. Form 90-L;

ii. hospital transfer form;

iii. hospital discharge summary; or

iv. physician's orders.

c. An updated ISP must be submitted showing changes, if any, as a result of the hospitalization.

10. Readmission of a Client Following Exhausted Home Leave Days

a. Form 148 must be submitted showing the date billing was discontinued and the date of readmission.

b. An updated ISP must be submitted showing changes, if any, as a result of the extended home leave.

11. Transfer of a Client From an ICF/MR Facility to a Nursing Facility. When a client's medical condition has deteriorated to the extent that they cannot participate in or benefit from active treatment and require 24-hour nursing care, the ICF/MR may request prior approval from HSS to transfer the client to a nursing facility by submitting the following information:

a. Form 148 showing that transfer to a nursing facility is being requested;

b. Form 90-L completed within 30 days prior to request for transfer indicating that nursing facility level of care is needed;

c. Level 1 PASARR completed within 30 days prior to request for transfer;

d. ID team meeting minutes addressing the reason for the transfer, the family and client's response to the move, and the signatures of the persons attending the meeting; and

e. any other medical information that will support the need for nursing facility placement.

12. Inventory for Client and Agency Planning (ICAP) service score;

13. Level of Needs and Services (LONS) summary sheet.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:698 (April 1999), LR 30:1702 (August 2004), repromulgated LR 31:2229 (September 2005).

Chapter 307. Records

Subchapter A. Client Records

§30701. General Requirements

A. Written Policies and Procedures. An ICF/MR facility shall have written policies and procedures governing access to, publication of, and dissemination of information from client records.

B. Protection of Records. Client records are the property of the ICF/MR residents and as such shall be protected from loss, damage, tampering, or use by unauthorized individuals. Records may be removed from the ICF/MR's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute.

C. Confidentiality. An ICF/MR facility shall ensure confidential treatment of client records, including information contained in automatic data banks.

1. The client's written consent, if the client is determined competent, shall be required for the release of information to any persons not otherwise authorized under law to receive it. If the client is not documented as competent, a member of the family, responsible party or advocate shall be required to sign.

NOTE: "Blanket" signed authorizations for release of information from client records are time limited.

2. A record of all disclosures from client's records shall be kept.

3. All staff shall be trained in the policies regarding confidentiality during orientation to the ICF/MR and in subsequent on-the-job and in-service training.

4. Any information concerning a client or family considered too confidential for general knowledge by the ICF/MR staff shall be kept in a separate file by the chief executive officer, his designee, or social worker. A notation regarding the whereabouts of this information shall be made in the client's record.

D. Availability of Records. The ICF/MR shall make necessary records available to appropriate state and federal personnel upon request.

E. Records Service System

1. The ICF/MR shall maintain an organized central record service for collecting and releasing client information. Copies of appropriate information shall be available in the client living units.

2. A written policy shall be maintained regarding a "charge out system" by which a client's record may be located when it is out of file.

3. The ICF/MR shall maintain a master alphabetical index of all clients.

4. All records shall be maintained in such a fashion as to protect the legal rights of clients, the ICF/MR, and ICF/MR staff.

F. General Contents of Records. A written record shall be maintained for each client.

1. Records shall be adequate for planning and for continuously evaluating each client's habilitation plan and documenting each client's response to and progress in the habilitation plan.

2. Records shall contain sufficient information to allow staff members to execute, monitor and evaluate each client's habilitation program.

G. Specifics Regarding Entries into Client Records. The following procedures shall be adhered to when making entries into a client's record.

1. All entries shall be legible, signed, and dated by the person making the entry.

2. All corrections shall be initialed and completed in such a manner that the original entry remains legible.

3. Entries shall be dated only on the date when they are made.

4. The ICF/MR shall maintain a roster of signatures, initials and identification of individuals making entries in each record.

H. Components of Client Records. Components of client records shall include, but shall not be limited to, the following:

1. admission records;
2. personal property records;
3. financial records;
4. medical records.

a. This includes records of all treatments, drugs, and services for which vendor payments have been made, or which are to be made, under the Medical Assistance Program.

b. This includes the authority for and the date of administration of such treatment, drugs, or services.

c. The ICF/MR shall provide sufficient documentation to enable DHH to verify that each charge is due and proper prior to payment.

5. All other records which DHH finds necessary to determine a ICF/MR's compliance with any federal or state law, rule or regulation promulgated by the DHH.

I. Retention of Records. The ICF/MR shall retain records for whichever of the following time frames is longer:

1. until records are audited and all audit questions are answered;
2. in the case of minors, three years after they become 18 years of age; or
3. three years after the date of discharge, transfer, or death of the client.

J. Interdicted Client. If the ICF/MR client has been interdicted, a copy of the legal documents shall be contained in the client's records.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 42 CFR 433 and 42 CFR 483.400.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:684 (April 1999), repromulgated LR 31:2230 (September 2005).

§30703. Admission Records

A. At the time of admission to the ICF/MR, information shall be entered into the client's record which shall identify and give a history of the client. This identifying information shall at least include the following:

1. a recent photograph;
2. full name;
3. sex;
4. date of birth;
5. ethnic group;
6. birthplace;
7. height;
8. weight;
9. color of hair and eyes;
10. identifying marks;
11. home address, including street address, city, parish and state;
12. Social Security Number;
13. medical assistance identification number;
14. Medicare claim number, if applicable;
15. citizenship;
16. marital status;
17. religious preference;
18. language spoken or understood;

19. dates of service in the United States Armed Forces, if applicable;

20. legal competency status if other than competent;

21. sources of support: social security, veterans' benefits, etc.;

22. father's name, birthplace, Social Security Number, current address, and current phone number;

23. mother's maiden name, birthplace, Social Security Number, current address, and current phone number;

24. name, address, and phone number of next of kin, legal guardian, or other responsible party;

25. date of admission;

26. name, address and telephone number of referral agency or hospital;

27. reason for admission;

28. admitting diagnosis;

29. current diagnosis, including primary and secondary DSM III diagnosis, if applicable;

30. medical information, such as allergies and general health conditions;

31. current legal status;

32. personal attending physician and alternate, if applicable;

33. choice of other service providers;

34. name of funeral home, if appropriate; and

35. any other useful identifying information. Refer to *Admission Review* for procedures.

B. First Month After Admission. Within 30 calendar days after a client's admission, the ICF/MR shall complete and update the following:

1. review and update the pre-admission evaluation;

2. develop a prognosis for programming and placement;

3. ensure that an interdisciplinary team completes a comprehensive evaluation and designs an individual habilitation plan (IHP) for the client which includes a 24-hour schedule.

C. Entries into Client Records During Stay at the ICF/MR. The following information shall be added to each client's record during his/her stay at the ICF/MR:

1. reports of accidents; seizures, illnesses, and treatments for these conditions;

2. records of immunizations;

3. records of all periods where restraints were used, with authorization and justification for each, and records of monitoring in accordance with these standards;

4. reports of at least an annual review and evaluation of the program, developmental progress, and status of each client, as required in these standards;

5. behavior incidents and plans to manage inappropriate behavior;

6. records of visits and contacts with family and other persons;

7. records of attendance, absences, and visits away from the ICF/MR;

8. correspondence pertaining to the client;

9. periodic updates of the admission information (such updating shall be performed in accordance with the written policy of the ICF/MR but at least annually); and

10. appropriate authorizations and consents.

D. Entries at Discharge. At the time of a client's discharge, the QMRP or other professional staff, as appropriate, shall enter a discharge summary into the client's record. This summary shall address the findings, events, and progress of the client while at the ICF/MR and a diagnosis, prognosis, and recommendations for future programming.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Undersecretary, Bureau of Health Services Financing, LR 25:685 (April 1999), repromulgated LR 31:2231 (September 2005).

§30705. Medical Records

A. General Requirements. The ICF/MR shall maintain medical records which include clinical, medical, and psychosocial information on each client.

B. Components of Medical Records. Each client's record shall consist of a current active medical section and the ICF/MR's medical files or folders.

1. Active Medical Section. The active medical section shall contain the following information:

a. at least six months of current pertinent information relating to the active ongoing medical care;

b. physician certification of the clients' need for admission to the ICF/MR;

c. physician recertification that the client continues to require the services of the ICF/MR;

d. nurses quarterly physical assessment. See §31101, Client Health and Habilitative Services;

e. quarterly, the pharmacy consultant must review the drug regimen of each client;

f. certification that each IHP has been periodically reviewed and revised.

2. Medical Files. As the active medical section becomes bulky, the outdated information shall be removed and filed in the ICF/MR's medical files.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Undersecretary, Bureau of Health Services Financing, LR 25:685 (April 1999), repromulgated LR 31:2232 (September 2005).

§30707. Personal Property Records

A. The ICF/MR shall permit clients to maintain and use their personal property. The number of personal possessions may be limited only for health and safety reasons. When such limitations are imposed, documentation is required in the client's records.

1. Within 24 hours after admission, the ICF/MR shall prepare a written inventory of the personal property a client brings to the ICF/MR.

2. The facility authorized representative shall sign and retain the written inventory and shall give a copy to the client, family or responsible party.

3. The ICF/MR shall revise the written inventory to show if acquired property is lost, destroyed, damaged, replaced or supplemented.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 42 CFR 483.420.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:686 (April 1999), repromulgated LR 31:2232 (September 2005).

§30709. Financial Records

A. General Requirements. Clients have the right to maintain their personal funds or to designate someone to assume this responsibility for them. Clients' income may be from social security, supplemental security income (SSI), optional state supplementation, other sources (VA or insurance benefits, etc.) or earnings of the client. A portion of the clients' income is used to pay the clients' share (liability) of the monthly charges for the ICF/MR. The ICF/MR shall:

1. have written policies and procedures for protecting clients' funds and for counseling clients concerning the use of their funds;

2. develop written procedures for the recording and accounting of client's personal funds;

NOTE: ICF/MRs shall ensure the soundness and accuracy of the client fund account system.

3. train clients to manage as many of their financial affairs as they are capable. Documentation must support that training was provided and the results of that training;

4. maintain current records that include the name of the person (client or person designated) handling each client's personal funds;

5. be responsible for the disbursements, deposits, soundness, and accuracy of the clients' personal funds account when arrangements are made with a federal or state insured banking institution to provide banking services for the clients;

NOTE: All bank charges, including charges for ordering checks, shall be paid by the ICF/MR and not charged to the clients' personal funds account(s).

6. maintain current, written individual ledger sheet records of all financial transactions involving client's personal funds which the facility is holding and safeguarding;

NOTE: ICF/MRs shall keep these records in accordance with requirements of law for a trustee in a fiduciary relationship.

7. make personal fund account records available upon request to the client, family, responsible party, and DHH.

B. Components Necessary for a Client Fund Account System. The ICF/MR shall:

1. maintain current, written individual records of all financial transactions involving clients' personal funds which the ICF/MR is holding, safeguarding, and accounting;

2. keep these records in accordance with requirements of law for a trustee in a fiduciary relationship which exists for these financial transactions;

3. develop the following procedures to ensure a sound and workable fund accounting system.

a. Individual Client Participation File. Client=s ledger sheet shall consist of the following criteria.

i. A file shall exist for each participating client. Each file or record shall contain all transactions pertinent to the account, including the following information:

- (a). name of the client and date of admission;
- (b). deposits
 - (i). date;
 - (ii). source; and
 - (iii). amount;
- (c). withdrawals:
 - (i). date;
 - (ii). check/petty cash voucher number;
 - (iii). payee (if check is issued);
 - (iv). purpose of withdrawal; and
 - (v). amount;
- (d). fund balance after each transaction.

NOTE: Checks shall not be payable to "cash" or employees of the facility.

ii. Maintain receipts or invoices for disbursements that shall include the following information:

- (a). the date;
- (b). the amount;
- (c). the description of items purchased; and
- (d). the signature of the client, family, or responsible party to support receipt of items.

iii. Supporting documentation shall be maintained for each withdrawal as follows:

- (a). cash register receipt with canceled check or petty cash voucher signed by the client; or
- (b). invoice with canceled check or petty cash voucher signed by the client; or
- (c). petty cash voucher signed by the client; or
- (d). canceled check.

NOTE: Canceled checks written to family members or responsible parties are sufficient receipts for disbursements if coupled with information regarding the purpose of expenditures.

iv. Supporting documentation shall be maintained for each deposit as follows:

- (a). receipts for all cash received on behalf of the residents; and
- (b). copies of all checks received on behalf of the residents.

v. All monies, either spent on behalf of the client or withdrawn by the client, family, or responsible party, shall be supported on the individual ledger sheet by a receipt, invoice, canceled check, or signed voucher on file.

NOTE: It is highly recommended that the functions for actual disbursement of cash and reconciling of the cash disbursement record be performed by separate individuals.

vi. The file shall be available to the client, family, or other responsible party upon request during the normal administrative work day.

b. Client's Personal Funds Bank Account(s). ICF/MRs may deposit clients' money in individual or collective bank account(s). The individual or collective account(s) shall:

- i. be separate and distinct from all ICF/MR facility accounts;
- ii. consist solely of clients' money and shall not be commingled with the ICF/MR facility account(s);
- iii. personal fund record shall be:
 - (a). maintained at the facility; and
 - (b). available daily upon request during banking hours.

c. Reconciliations of Client's Personal Funds Account(s). There shall be a written reconciliation, at least

monthly, by someone other than the custodian of the client's personal funds account(s). Assets (cash in bank, both checking and savings) must equal liabilities [ledger sheet balance(s)]. Collective bank accounts shall be reconciled to the total of client's ledger sheet balances. The reconciliation shall be reviewed and approved by someone other than the preparer or custodian of the client's personal funds account.

d. Unallowable Charges to Client's Personal Funds Account(s). It is the intent of the State of Louisiana that ICF/MRs provide total maintenance for recipients. The client's personal funds should be set aside for individual wants or to spend as the client sees fit. In the event that a client desires to purchase a certain brand, he/she has the right to use his/her personal funds in this manner; however, the client must be made aware of what the facility is providing prior to making his/her decision. Written documentation must be maintained to support that the client was made aware of products or services the facility is obligated to provide. Listed below (but not limited to) are items that shall not be charged to a client's personal funds account(s), the client's family or responsible party(s):

i. clothing. If a client does not have adequate seasonal clothing (including shoes, etc.), it is the responsibility of the facility to provide the clothing;

ii. personal hygiene items;

iii. haircuts;

iv. dentures/braces, etc.;

v. eyeglasses;

vi. hearing and other communication aids;

vii. support braces;

viii. any other devices identified by the interdisciplinary team;

ix. wheelchairs;

x. repair and maintenance of items listed in Clauses iv-ix;

xi. damage to facility property or the client's possessions. The client may not be charged for damage to facility property or the property of others caused by that individual's destructive behavior. ICF/MRs have a general responsibility to maintain the environment as a cost of doing business. Property of clients damaged or stolen by others must be replaced by the facility;

xii. transportation;

xiii. prescription or over-the-counter drugs;

xiv. recreational costs included in the IHP;

xv. medical expenses of any nature;

xvi. tips, gifts, expenses for staff;

xvii. supplies or items to meet goals of IHP.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 42 CFR 483.420(b).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:686 (April 1999), repromulgated LR 31:2232 (September 2005).

§30711. Cash on Hand

A. ICF/MRs shall have a minimum of cash on hand to meet client's spending needs. Cash on hand shall be maintained on the imprest petty cash system which includes pre-numbered petty cash vouchers. Petty cash shall be maintained at the facility and shall be available to the clients 24 hours a day, seven days a week.

B. The facility shall provide the funds to implement the petty cash system and replenish it, as necessary, from the clients' personal funds based on signed vouchers. Vouchers may be signed by clients, families, or responsible parties. When residents cannot sign their name, vouchers shall be signed by two witnesses. Checks issued to replenish the fund should be made payable to a Custodian of Petty Cash. When funds are withdrawn from the clients' savings account to cover signed vouchers, a receipt signed by the custodian of petty cash shall be maintained in lieu of a canceled check.

C. There shall be a written reconciliation, at least weekly, by someone other than the custodian of the petty cash fund. The reconciliation shall be reviewed and approved by someone other than the preparer or custodian of the petty cash fund.

NOTE: The facility is responsible for shortages.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Undersecretary, Bureau of Health Services Financing, LR 25:687 (April 1999), repromulgated LR 31:2234 (September 2005).

§30713. Access to Funds

A. Clients shall have access to their funds during hours compatible to banking institutions in the community where they live. Large ICF/MRs shall post the times when clients shall have access to their funds.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:688 (April 1999), repromulgated LR 31:2234 (September 2005).

§30715. Closing a Discharged Client's Fund Account

A. When a client is discharged, the ICF/MR shall refund the balance of a client's personal account and that portion of any advance payment not applied directly to the ICF/MR fee. The amount shall be refunded to the client, family or other responsible party within 30 days following the date of discharge. Date, check number, and "to close account"

should be noted on the ledger sheet. When the facility is the payee for a social security check or other third party payments, the change in payee should be initiated immediately by the facility.

NOTE: The facility shall allow the client to withdraw a minimum of \$25 from his/her personal funds account on the date of discharge.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:688 (April 1999), repromulgated LR 31:2234 (September 2005).

§30717. Disposition of Deceased Client's Personal Funds

A. ICF/MRs, upon a client's death, shall submit written notification within 10 business days to the next of kin disclosing the amount of funds in the deceased's account as of the date of death. The ICF/MR shall hold the funds until the next of kin notifies the ICF/MR whether a succession will be opened.

1. Succession Opened. If a succession is to be opened, the ICF/MR shall release the funds to the administrator of the estate, if one, or according to the judgment of possession.

2. Succession Not Opened. If no succession is to be opened, the ICF/MR shall make the funds payable to the deceased's estate and shall release the funds to the responsible party of record.

B. Release of Funds. In any case in which funds are released in accordance with a court order, judgment of possession, or affidavit, the funds shall be made available to the persons or parties cited by the court order. The signed statement shall be attached to the written authority and filed in the ICF/MR records.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:688 (April 1999), repromulgated LR 31:2234 (September 2005).

§30719. Disposition of Deceased Client's Unclaimed Personal Funds

A. If the ICF/MR retains the funds and the responsible party (legal guardian, administrator of the estate, or person placed in possession by the court judgment) fails to obtain the funds within three months after the date of death, or if the ICF/MR fails to receive notification of the appointment of or other designation of a responsible party within three months after the death, the ICF/MR shall notify the secretary of the Department of Revenue, Unclaimed Property Section. The notice shall provide detailed information about the decedent, his next of kin, and the amount of funds.

1. The facility shall continue to retain the funds until a court order specifies that the funds are to be turned over to secretary of the Department of Revenue.

2. If no order or judgment is forthcoming, the ICF/MR shall retain the funds for five years after date of death.

3. After five years, the ICF/MR is responsible for delivering the unclaimed funds to the secretary of Revenue.

4. A termination date of the account and the reason for termination shall be recorded on the client's participation file. A notation shall read, "to close account." The endorsed canceled check with check number noted on the ledger sheet shall serve as sufficient receipt and documentation.

5. Where the legislature has enacted a law governing the disposition of personal funds belonging to residents of state schools for the mentally retarded or developmentally disabled that law shall be applicable.

B. References. References for §§30717 and 30719 are as follows:

1. *Civil Code* Article 2951 which deals with deposits of a deceased person;

2. *Code of Civil Procedure*, Articles 3421-3434, which deals with small successions requiring no judicial proceedings. Section 3431 specifically refers to persons who die intestate leaving no immovable property and whose sole heirs are his descendants, ascendants or surviving spouse.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:688 (April 1999), repromulgated LR 31:2234 (September 2005).

Subchapter B. Facility Records

§30739. General Requirements

A. The ICF/MR shall retain such records on file as required by DHH and shall have them available for inspection at request for three years from the date of service or until all audit exceptions are resolved, whichever period is longer.

B. Provider Agreement. The ICF/MR shall retain a copy of the Provider Agreement and any document pertaining to the licensing or certification of the ICF/MR.

C. Accounting Records

1. Accounting records must be maintained in accordance with generally accepted accounting principles as well as state and federal regulations. The accrual method of accounting is the only acceptable method for private providers.

NOTE: Purchase discounts, allowance and refunds will be recorded as a reduction of the cost to which they related.

2. Each facility must maintain all accounting records, books, invoices, canceled checks, payroll records, and other

documents relative to client care costs for a period of three years or until all audit exceptions are resolved, whichever period is longer.

3. All fiscal and other records pertaining to client care costs shall be subject at all times to inspection and audit by DHH, the legislative auditor, and auditors of appropriate federal funding agencies.

D. Daily Census Records. Each facility must maintain statistical information related to the daily census and/or attendance records for all clients receiving care in the facility.

E. Employee Records

1. The ICF/MR shall retain written verification of hours worked by individual employees.

a. Records may be sign-in sheets or time cards, but shall indicate the date and hours worked.

b. Records shall include all employees even on a contractual or consultant basis.

2. Verification of criminal background check.

3. Verification of employee orientation and in-service training.

4. Verification of the employee's communicable disease screening.

F. Billing Records

1. The ICF/MR shall maintain billing records in accordance with recognized fiscal and accounting procedures. Individual records shall be maintained for each client. These records shall meet the following criteria.

a. Records shall clearly detail each charge and each payment made on behalf of the client.

b. Records shall be current and shall clearly reveal to whom charges were made and for whom payments were received.

c. Records shall itemize each billing entry.

d. Records shall show the amount of each payment received and the date received.

2. The ICF/MR shall maintain supporting fiscal documents and other records necessary to ensure that claims are made in accordance with federal and state requirements.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, 42 CFR 433 and 42 CFR 442.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:690 (April 1999), repromulgated LR 31:2235 (September 2005).

Chapter 309. Transfers and Discharges

§30901. Written Agreements with Outside Resources

A. Each client must have the services which are required to meet his needs including emergency and other health care. If the service is not provided directly, there must be a written agreement with an outside resource. The written agreement for hospital transfers must be with hospitals within close proximity and must provide for prompt transfer of clients.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and CFR 483.410(d), 483.410(d)(1)-483.410(d)(2)(ii) and 483.440(b)(1)-483.440(b)(5)(ii).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:688 (April 1999), repromulgated LR 31:2235 (September 2005).

§30903. Facility Responsibilities for Planned or Voluntary Transfer or Discharge Policies

A. Facility record shall document that the client was transferred or discharged for good cause which means for any reason that is in the best interest of the individual.

B. Any decision to move a client shall be part of an interdisciplinary team process. The client, family, legal representative, and advocate, if there is one, shall participate in the decision making process.

C. Planning for a client's discharge or transfer shall allow for at least 30 days to prepare the client and parents/guardian for the change except in emergencies.

D. Planning for release of a client shall include providing for appropriate services in the client's new environment, including protective supervision and other follow-up services which are detailed in his discharge plan.

E. The client and/or legal representative must give their written consent to all nonemergency situations. Notification shall be made to the parents or guardians as soon as possible.

F. Both the discharging and receiving facilities shall share responsibility for ensuring the interchange of medical and other programmatic information which shall include:

1. an updated active treatment plan;
2. appropriate transportation and care of the client during transfer; and
3. the transfer of personal effects and of information related to such items;

G. Representatives from the staff of both the sending and receiving facilities shall confer as often as necessary to share appropriate information regarding all aspects of the client's care and habilitation training. The transferring facility is responsible for developing a final summary of the client's developmental, behavioral, social, health, and nutritional status, and with the consent of the client and/or legal

guardian, providing a copy to authorized persons and agencies.

H. The facility shall establish procedures for counseling clients or legal representatives, concerning the advantages and disadvantages of the possible release. This counseling shall include information regarding after care services available through agency and community resources.

I. All clients being transferred or discharged shall be given appropriate information about the new living arrangement. Counseling shall be provided if they are not in agreement. (See "Involuntary Transfers" if client is being transferred against his will).

J. The basic policy of client's right to the most appropriate placement which will meet his needs shall govern all transfer/discharge planning. Clients are not to be maintained in inappropriate placements or replacements in which their needs cannot adequately be 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 Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:689 (April 1999), repromulgated LR 31:2235 (September 2005).

§30905. Involuntary Transfer or Discharge

A. Conditions. Involuntary transfer or discharge of a client may occur only under the following conditions:

1. the transfer or discharge is necessary for the client's welfare and the client's needs cannot be met in the facility;
2. the transfer or discharge is appropriate because the client's health has improved sufficiently, therefore, the client no longer needs the services provided by the facility;
3. the safety of individuals in the facility is endangered;
4. the health of individuals in the facility would otherwise be endangered;
5. the client has failed, after reasonable and appropriate notice, to pay for the portion of the bill for services for which he/she is liable or when the client loses financial eligibility for Medicaid. When a client becomes eligible for Medicaid after admission to a facility, the facility may charge the client only allowable charges under Medicaid; and
6. the facility ceases to operate.

B. When the facility proposes to transfer or discharge a client under any of the circumstances specified in Paragraphs A.1-5 above, the client's clinical records must be fully documented. The documentation must be made by the following:

1. the client's physician when transfer or discharge is necessary as specified in Paragraph A.1 or 2 as listed above; or

2. any physician when transfer or discharge is necessary as specified in Paragraph A.4 as listed above. Before an interfacility transfer or discharge occurs the facility must:

a. notify the client of the transfer or discharge and the reason for the move. The notification shall be in writing and in a language and manner that the client understands. A copy of the notice must be placed in the client's clinical record and a copy transmitted to:

- i. the client;
- ii. a family member of the client, if known;
- iii. the client's legal representative and legal guardian, if known;
- iv. the Community Living Ombudsman Program;
- v. DHH – Health Standards Section;
- vi. the regional office of OCDD for assistance with the placement decision;
- vii. the client's physician;
- viii. appropriate educational authorities; and
- ix. a representative of the client's choice;

b. record the reasons in the client's clinical record;

c. a interdisciplinary team conference shall be conducted with the client, family member or legal representative and an appropriate agency representative to update the plan and develop discharge options that will provide reasonable assurances that the client will be transferred or discharged to a setting that can be expected to meet his/her needs.

3. the facility must issue the notice of transfer or discharge in writing at least 30 days before the resident is transferred or discharged, except under the circumstances described in Subparagraph a below.

a. Notice may be made as soon as practicable before transfer or discharge when:

- i. the safety of individuals in the facility would be endangered;
- ii. the health of individuals in the facility would be endangered;
- iii. the client's health improves sufficiently to allow a more immediate transfer or discharge; or
- iv. an immediate transfer or discharge is required by the client's urgent medical needs as determined by a physician.

b. Notice may be made at least 15 days before transfer or discharge in cases of nonpayment of a bill for cost of care.

c. The written notice must include:

- i. the reason for transfer or discharge;

- ii. the effective date of transfer or discharge;
- iii. the location to which the client is transferred or discharged;
- iv. an explanation of the client's right to have personal and/or third party representation at all stages of the transfer or discharge process;
- v. the address and telephone number of the Community Living Ombudsman Program;
- vi. the mailing address and telephone number of the agency responsible for the protection of individuals with developmental disabilities;
- vii. names of facility personnel available to assist the client and family in decision making and transfer arrangements;
- viii. the date, time and place for the follow-up interdisciplinary team conference to make a final decision on the client's/legal representative's choice of new facility of alternative living arrangement;
- ix. an explanation of the client's right to register a complaint with DHH within three days after the follow-up interdisciplinary team conference;

- x. a statement regarding appeal rights that reads:

“You or someone acting on your behalf has the right to appeal the health facility's decision to discharge you. The written request for a hearing must be postmarked within 30 days after you receive this notice or prior to the effective date of the transfer or discharge. If you request a hearing, it will be held within 30 days after the facility notifies the Bureau of Appeals of the witnesses who shall testify at the discharge hearing as well as the documents that will be submitted as evidence. You will not be transferred/discharged from the facility until a decision on the appeal has been rendered;” and

- xi. the name of the director, and the address, telephone number, and hours of operation of the Bureau of Appeals of the Louisiana Department of Health and Hospitals;

C. The facility shall provide all services required prior to discharge that are contained in the final update of the individual habilitation plan and in the transfer or discharge plan.

D. The facility shall be responsible for keeping the client, whenever medical or other conditions warrant such action, for as long as necessary even if beyond the proposed date of transfer or discharge, except in emergency situations.

E. The facility shall provide transportation to the new residence unless other arrangements are preferred by the client/legal representative or the receiving facility.

F. Appeal of Transfer or Discharge. If the client appeals the transfer or discharge, the ICF/MR facility must permit

the client to remain in the facility and must not transfer or discharge the client from the facility until the final appeal decision has been reached or a pre-hearing conference is held at the request of the facility. Failure to comply with these requirements will result in termination of the facility's provider agreement.

G. If nonpayment is the basis of a transfer or discharge, the client shall have the right to pay the balance owed to the facility up to the date of the transfer or discharge and then is entitled to remain in the facility.

H. If an ICF/MR client requests a hearing, the Louisiana Department of Health and Hospitals shall hold a hearing at the ICF/MR facility, or by telephone if agreed upon by the appellant, within 30 days from the date the appeal is filed with the Bureau of Appeals and witness and exhibit lists are submitted by the facility. The Louisiana Department of Health and Hospitals shall issue a decision within 30 days from the date of the client hearing. The ICF/MR facility must convince the department by a preponderance of the evidence that the transfer or discharge is justified. If the department determines that the transfer is appropriate and no appeal and/or pre-hearing conference has been lodged with the Bureau of Appeals, the client must not be required to leave the ICF/MR facility within 30 days after the client's receipt of the initial transfer or discharge notice unless an emergency exists.

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 LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:690 (April 1999), LR 30:1700 (August 2004), repromulgated LR 31:2236 (September 2005).

§30907. Mass Transfer of Clients

A. The following provisions shall apply to any mass transfer.

1. ICF/MR Decertification. When DHH/BHSF determines that an ICF/MR no longer meets state and federal Title XIX certification requirements, decertification action is taken. Usually an advance decertification date is set unless clients are in immediate danger.

2. ICF/MR Decertification Notice. On the date the ICF/MR is notified of its decertification, DHH shall begin notifying clients, families, responsible parties, and other appropriate agencies or individuals of the decertification action and of the services available to ensure an orderly transfer and continuity of care.

3. ICF/MR Closing or Withdrawing from Title XIX Program. In institutions where an ICF/MR either voluntarily or involuntarily discontinues its operations or participation in the Medical Assistance Program, clients, families, responsible parties, and other appropriate agencies or individuals shall be notified as far in advance of the effective date as possible to insure an orderly transfer and continuity of care.

a. If the ICF/MR is closing its operations, plans shall be made for transfer.

b. If the ICF/MR is voluntarily or involuntarily withdrawing from Title XIX participation, the client has the option of remaining in the ICF/MR on a private-pay basis.

4. **Payment Limitation.** Payments may continue for clients up to 30 days following the effective date of the ICF/MR's decertification.

a. There shall be no payments approved for Title XIX clients admitted after an ICF/MR receives a notice of decertification.

b. The payment limitation also applies to Title XIX clients admitted prior to the decertification notice.

c. Payment is continued to the ICF/MR for clients certified prior to the decertification only if the ICF/MR totally cooperates in the orderly transfer of clients to other Title XIX facilities or other placements of their choice.

NOTES:

The ICF/MR's failure to comply with the transfer team's requests may result in denial of reimbursement during the extension period.

The ICF/MR still retains its usual responsibility during the transfer/discharge process to notify the BHSF Medicaid Eligibility Parish Office promptly of all changes in the client's status.

5. **Client Rights.** Nothing in the transfer or discharge plan shall interfere with client's exercise of his rights.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:690 (April 1999), repromulgated LR 31:2237 (September 2005).

Chapter 311. Health Services

§31101. Client Health and Habilitative Services

A. Intermediate Care Facilities for the Mentally Retarded (ICF/MR) are defined as intermediate care facilities whose primary purpose is to provide health or habilitative services for mentally retarded individuals or persons with related conditions and meet the standards in 42 CFR 442 and 483.400.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:691 (April 1999), repromulgated LR 31:2238 (September 2005).

§31103. Habilitative Treatment Services

A. Active Treatment Services. The facility must provide or arrange for each client to receive a continuous active treatment program consisting of needed interventions and

services in sufficient number and frequency to support the achievement of the objectives identified in the individual habilitation plan (IHP). These services include but are not limited to occupational, speech, physical and recreational therapies; psychological, psychiatric, audiology, social work, special education, dietary and rehabilitation counseling.

NOTE: Supplies, equipment, etc., needed to meet the goals of the IHP cannot be charged to the client or their responsible parties.

B. Active Treatment Components

1. **Individual Habilitation Plan.** Each client must have an individual habilitation plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to identifying the client's needs as described by the programs that meet those needs.

a. The facility must document in the individual habilitation plan (IHP) the presence, or the reason for absence, at the individual's staffing conference of the client, family members and relevant disciplines, professions or service areas as identified in the comprehensive functional assessment.

b. Within 30 days after admission, the interdisciplinary team must do assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.

c. The comprehensive functional assessment must take into consideration the client's age and the implications for active treatment at each stage as applicable. It must contain the following components:

i. the presenting problems and disabilities and where possible, their causes including diagnosis, symptoms, complaints and complications;

ii. the client's specific developmental strengths;

iii. the client's specific developmental and behavioral management needs.

d. An identification of the client's needs for services without regard to the actual availability of the services.

e. The comprehensive functional assessment must cover the following developmental areas:

i. physical development and health;

ii. nutritional status;

iii. sensorimotor development;

iv. affective development;

v. speech and language development;

vi. auditory functioning;

vii. cognitive development;

viii. social development;

ix. adaptive behaviors or independent living skills necessary for the client to be able to function in the community;

x. vocational skills as applicable;

xi. psychological development.

2. Specific Objectives. Within 30 days after admission, the interdisciplinary team must prepare for each client an IHP that states specific objectives necessary to meet the client's needs, as identified by the comprehensive functional assessment, and states the plan for achieving these objectives.

a. Components for these objectives must be:

i. stated separately, in terms of a single behavioral outcome;

ii. be assigned projected completion dates;

iii. be expressed in behavioral terms that provide measurable indices of performance;

iv. be organized to reflect a developmental disability;

v. be assigned priorities.

b. A copy of each client's individual habilitation plan must be made available to all relevant staff, including staff of other agencies who work with the client, the client, parents, if the client is a minor, or legal guardian. The individual's habilitation plan must be implemented within 14 calendar days of its development.

c. The facility must develop and make available to relevant staff an active treatment schedule that outlines the current active treatment program.

d. Each written training program designed to implement these objectives in the individual habilitation plan must specify:

i. the methods to be used;

ii. the schedule for use of the methods;

iii. the person responsible for the program;

iv. the type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives;

v. the inappropriate client behavior(s), if applicable; and

vi. a provision for the appropriate expression and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.

e. The IHP must also:

i. describe relevant interventions to support the individual toward independence;

ii. identify the location where program strategy information (which must be accessible to any person responsible for implementation) can be found;

iii. include, for those clients who lack them, training in personal skills essential for privacy and independence (including skills and activities of daily living) until it has been demonstrated that the client is developmentally incapable of applying them;

iv. plans for discharge.

f. The IHP must identify mechanical supports, if needed, to achieve proper body position, balance, or alignment. This plan must specify:

i. the reason for each support;

ii. the situation in which each is to be applied;

iii. a schedule for the use of each support.

g. Clients who have multiple disabling conditions must be provided the opportunity to spend a major portion of each working day out of bed and outside the bedroom area, moving about by various methods and devices whenever possible.

h. The IHP must include opportunities for client choice and self management.

3. Documentation. The facility must document data relevant to the accomplishment of the criteria specified in the client's individual habilitation plan objectives. This data must meet certain criteria.

a. Data must be documented in measurable outcomes;

b. Significant events related to the client's individual habilitation plan and assessment and that contribute to an overall understanding of his ongoing level and quality of function must be documented;

c. The individual habilitation plan must be reviewed by a qualified mental retardation professional at least quarterly or as needed and revised as necessary, including but not limited to, situations in which the client:

i. has successfully completed an objective or objectives identified in the individual habilitation plan;

ii. is regressing or losing skills;

iii. is failing to progress toward identified objectives after reasonable efforts have been made;

iv. is being considered for training toward new objectives.

d. At least annually, the comprehensive assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. The individual habilitation plan must be revised as needed or at least by the three hundred sixty-fifth day after the last review.

NOTE: For admission requirements, refer to Chapter 303, Provider Enrollment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR

13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:691 (April 1999), repromulgated LR 31:2238 (September 2005).

§31105. Professional Services

A. Physician Services

1. The health care of each client shall be under the continuing supervision of a Louisiana licensed physician. The facility must ensure the availability of physician services 24 hours a day. The facility must provide or obtain preventive and general medical care plus annual physical examinations of each client.

2. The client, the family or the responsible party shall be allowed a choice of physicians.

3. If the client does not have a personal physician, the ICF/MR shall provide referrals to physicians in the area, identifying physicians that participate in the Medicaid Program.

NOTE: The cost of physician services cannot be charged to the client or their responsible parties.

B. Nursing Services

NOTE: The cost for nursing services cannot be charged to the client or their legal representative.

1. The facility must provide each client nursing services as prescribed by a physician or as identified by the individual habilitation plan and client needs. Nursing services must include:

a. the development, with a physician, of a medical care plan of treatment for a client when the physician has determined that an individual client requires such a plan;

b. twenty-four-hour nursing service as indicated by the medical care plan or other nursing care as prescribed by the physician or as identified by client needs;

c. review of individual client health status on a quarterly or more frequent basis;

d. training clients and staff as needed in appropriate health and hygiene methods and self-administration of medications;

e. notify the physician of any changes in the client's health status.

2. If the facility utilizes only licensed practical nurses to provide health services, it must have a formal arrangement with a registered nurse licensed to practice in Louisiana to be available for verbal or on-site consultation to the licensed practical nurse.

C. Dental Services. The facility must provide or arrange for comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists either through organized dental services in-house or through arrangement. The facility must ensure that dental treatment services include dental care needed for relief of pain and infections, restoration of teeth and maintenance of dental health. The facility must

ensure the availability of emergency treatment on a 24-hour per day basis by a licensed dentist.

NOTE: The cost for these dental services cannot be charged to the client or their responsible party.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:691 (April 1999), repromulgated LR 31:2239 (September 2005).

§31107. Pharmaceutical Services

A. The facility must provide or arrange for the provision of routine and emergency drugs and biologicals to its clients. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy.

B. Routine administration of medications shall be done at the facility where the client resides. Clients may not be transported elsewhere for the sole purpose of medication administration.

C. The ICF/MR shall neither expect, nor require, any provider to give a discount or rebate for prescription services rendered by the pharmacists.

D. The ICF/MR shall order at least a one month supply of medications from a pharmacy of the client's, family's, or responsible party's choice. Less than a month's supply is ordered only when the attending physician specifies that a smaller quantity of medication is necessary for a special medical reason.

E. The ICF/MR chief executive officer or the authorized representative shall certify receipt of prescribed medications by signing and dating the pharmacy billing.

NOTE: The costs for drugs and biologicals cannot be charged to the client, family or responsible party including any additional charges for the use of the unit dose or blister pack system of packing and storing medications.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:691 (April 1999), repromulgated LR 31:2240 (September 2005).

§31109. Aids and Equipment

A. The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communication aids, braces, and other devices identified by the interdisciplinary team as needed by the client.

NOTE: The costs for aids and equipment cannot be charged to the clients or their legal representatives.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:691 (April 1999), repromulgated LR 31:2240 (September 2005).

§3111. Nutritional Services

A. The facility must provide a nourishing, well-balanced diet for each client, including modified and specially prescribed diets. The nutritional component must be under the guidance of a licensed dietitian.

NOTE: Nutritional services are included in the per diem rate. Residents of ICF/MR facilities are not eligible for food stamps, commodities, or other subsidized food programs.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:691 (April 1999), repromulgated LR 31:2240 (September 2005).

§3113. Clothing

A. The facility should provide adequate seasonal clothing for the client. *Adequate* is defined as a seven-day supply in good repair and properly fitting. Work uniforms or special clothing/equipment for training will be provided in addition to the seven-day supply.

B. The facility must maintain a current clothing inventory for each client.

1. A client with adequate clothing may purchase additional clothing using his/her personal funds if he/she desires.

2. If a client desires to purchase a certain brand, the client has the right to use his/her personal funds in this manner; however, the client must be made aware of what the facility is providing prior to making his/her decision.

NOTE: For more information on services that must be provided by the ICF/MR facility or may be purchased by the client, see §33101, Income Consideration in Determining Payment.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:691 (April 1999), repromulgated LR 31:2240 (September 2005).

Chapter 313. Client Behavior Management

§31301. Written Policies and Procedures

A. A facility must develop and implement written policies and procedures for the management of conduct between staff and clients. These policies and procedures will:

1. specify conduct to be allowed and not allowed by staff and/or clients;
2. provide for client choice and self determination to the extent possible;
3. be readily available to all clients, parent(s), staff, and legal guardians;
4. be developed with the participation of clients to the extent possible.

B. A facility must develop and implement written policies and procedures for the management of inappropriate client behavior. These policies and procedures must:

1. specify all facility approved interventions to manage inappropriate client behavior;
2. designate these interventions on a hierarchy ranging from the most positive and least restrictive to the least positive and most restrictive;
3. insure that, prior to the use of more restrictive techniques, the client's record document that programs incorporating the use of less intrusive or more positive techniques have been tried first and found to be ineffective;
4. address the use of:
 - a. time-out rooms;
 - b. physical restraints;
 - c. drugs used to manage inappropriate behavior;
 - d. application of painful or noxious stimuli;
 - e. the staff members who may authorize use of a particular intervention;
 - f. a mechanism for monitoring and controlling use of the intervention.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 40:2009.2, R.S. 40:2009.20, R.S. 403.2, 42 CFR 483.420, 483.440, and 483.450.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:693 (April 1999), repromulgated LR 31:2240 (September 2005).

§31303. Interventions to Manage Inappropriate Client Behavior

A. Safety and Supervision. Interventions to manage inappropriate client behavior must be used within sufficient safeguards and supervision to insure that the safety, welfare, and civil and human rights of clients are adequately protected. These interventions must:

1. never be used:
 - a. for disciplinary purposes;
 - b. for the convenience of staff; or
 - c. as a substitute for an active treatment program;
2. never include corporal punishment;

3. never include discipline of one client by another except as part of an organized system of self government as set forth in facility policy.

B. Individual Plans and Approval. Individual programs to manage inappropriate client behavior must be incorporated into the client's individual program plan and must be reviewed, approved, and monitored by the Specially Constituted Committee. Written informed consent by the client or legal representative is required prior to implementation of a behavior management plan involving any risks to client's rights. (See Chapter 315, Client Rights, which addresses informed consent.)

C. Standing Programs. Standing or as needed programs to control inappropriate behavior are not permitted. To send a client to his room when his behavior becomes inappropriate is not acceptable unless part of a systematic program of behavioral interventions for the individual client.

D. Time-out Rooms

1. Use of time-out rooms is not permitted in group or community homes.

2. In institutional settings, it is permitted only when professional staff is on-site and only under the following conditions:

a. the placement in a time-out room is part of an approved systematic behavior program as required in the individual program to manage inappropriate behavior discussed under §31303.A.1-3; emergency placement is not allowed;

b. the client is under direct constant visual supervision of designated staff;

c. if the door to the room is closed, it must be held shut only by use of constant physical pressure from a staff member;

d. placement in time-out room does not exceed one hour;

e. clients are protected from hazardous conditions while in time-out rooms;

f. a record is kept of time-out activities.

E. Physical Restraint. *Physical restraint* is defined as any manual method or physical or mechanical device that the individual cannot remove easily and which restricts free movement.

1. Examples of manual methods include:

a. therapeutic or basket holds; and

b. prone or supine containment.

2. Examples of physical or mechanical devices include:

a. barred enclosure which must be no more than 3 feet in height and must not have tops;

b. chair with a lap tray used to keep an ambulatory client seated;

c. wheelchair tied to prevent movement of a wheelchair mobile client;

d. straps used to prevent movement while client is in chair or bed.

3. Physical restraints can be used only:

a. when absolutely necessary to protect the client from injuring himself or others in an emergency situation;

b. when part of an individual program plan intended to lead to less restrictive means of managing the behavior the restraints are being used to control;

c. as a health related protection prescribed by a physician but only if absolutely necessary during a specific medical, dental, or surgical procedure or while a medical condition exists;

d. when the following conditions are met:

i. orders for restraints are not obtained for use on a standing or on an as needed basis;

ii. restraint authorizations are not in effect longer than 12 consecutive hours and are obtained as soon as possible after restraint has occurred in emergency situations;

iii. clients in restraints are checked at least every 30 minutes and released as quickly as possible. Record of restraint checks and usage is required;

iv. restraints are designed and used so as not to cause physical injury and so as to cause the least possible discomfort;

v. opportunities for motion and exercise are provided for not less than 10 minutes during each two-hour period and a record is kept; and

vi. restraints are applied only by staff who have had training in the use of these interventions.

F. Drugs. Drugs used for control of inappropriate behavior may be used only under the following conditions:

1. drugs must be used only in doses that do not interfere with the client's daily living activities;

2. drugs used for control of inappropriate behavior must be approved by the interdisciplinary team, the client, legal representative, and specially constituted committee. These drugs must be used only as part of the client's individual program plan that is directed toward eliminating the behavior the drugs are thought to control;

3. prior to the use of any program involving a risk to client protection and rights, including the use of drugs to manage inappropriate behavior, written informed consent must be obtained from:

a. client; or

b. family, legal representative, or advocate if client is a minor or client is mentally unable to understand the intended program or treatment;

4. informed consent consists of permission given voluntarily on a time limited basis not to exceed 365 days by the client or the legally appropriate party after having been informed of the:

- a. specific issue treatment or procedure;
- b. client's specific status with regard to the issue;
- c. attendant risks regarding the issue;
- d. acceptable alternatives to the issue;
- e. right to refuse;
- f. consequences of refusal;

5. drugs must not be used until it can be justified that the beneficial effects of the drug on the client's behavior clearly outweighs the potentially harmful effects of the drug;

6. drugs must be clearly monitored in conjunction with the physician, the pharmacist, and facility staff;

7. unless clinical evidence justifies that this is contraindicated, drugs for control of inappropriate behavior must be gradually reduced at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 40:2009.2, R.S. 40:2009.20, R.S. 403.2, 42 CFR 483.420, 483.440, and 483.450.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:693 (April 1999), repromulgated LR 31:2241 (September 2005).

Chapter 315. Client Rights

§31501. Written Policies

A. The ICF/MR will establish written policies that safeguard clients' rights and define their responsibilities. The ICF/MR chief executive officer and ICF/MR staff will be trained in, and will adhere to, client rights policies and procedures. ICF/MR personnel will protect and promote clients' civil rights and rights to a dignified existence, self-determination, communication with and access to persons and services inside and outside the facility and to exercise their legal rights. The chief executive officer will be responsible for staff compliance with client rights policies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153, R.S. 28.390, 42 CFR 483.420 and 483.410 (1), (2), (3), Title XIX of the Social Security Act, Section 601 of Title VI of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1973; and Age Discrimination Act of 1975.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:694 (April 1999), repromulgated LR 31:2242 (September 2005).

§31503. Notification of Rights

A. All clients, families, and/or responsible parties will sign a statement that they have been fully informed verbally and in writing of the following information at the time of admission and when changes occur during the client's stay in the facility:

1. the facility's rules;
2. their rights;
3. their responsibilities to obey all reasonable rules and respect the personal rights and private property of clients; and
4. rules for conduct at the time of their admissions and subsequent changes during their stay in the facility.

B. Changes in client right policies will be conveyed both verbally and in writing to each client, family, and/or responsible party at the time of or before the change.

C. Receipt of the change will be acknowledged in writing by:

1. each client who is capable of doing so;
2. client's family; and/or
3. responsible party.

D. A client's written acknowledgment will be witnessed by a third person.

E. Each client must be fully informed in writing of all services available in the ICF/MR and of the charges for these services including any charges for services not paid for by Medicaid or not included in the facility's basic rate per day charges. The facility must provide this information either before or at the time of admission and on a continuing basis as changes occur in services or charges during the client's stay.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153, R.S. 28.390, 42 CFR 483.420 and 483.410 (1), (2), (3), Title XIX of the Social Security Act, Section 601 of Title VI of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1973; and Age Discrimination Act of 1975.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:694 (April 1999), repromulgated LR 31:2242 (September 2005).

§31505. Statute Authority

A. Civil Rights Act of 1964 (Title VI). Title VI of the Civil Rights Act of 1964 states: "No persons in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance." The facility will meet the following criteria in regards to the above-mentioned Act.

1. Compliance. The facility will be in compliance with Title VI of the Civil Rights Act of 1964 and will not

discriminate, separate, or make any distinction in housing, services, or activities based on race, color, or national origin.

2. **Written Policies.** The facility will adopt and implement written policies for compliance with the Civil Rights Act. All employees and contract service providers who provide services to clients will be notified in writing of the Civil Rights policy.

3. **Community Notification.** The facility will notify the community that admission to the ICF/MR, services to clients, and other activities are provided without regard to race, color, or national origin.

a. Notice to the community may be given by letters to and meetings with physicians, local health and welfare agencies, paramedical personnel, and public and private organizations having interest in equal opportunity.

b. Notices published in newspapers and signs posted in the facility may also be used to inform the public.

4. **Housing.** All clients will be housed without regard to race, color, or national origin.

a. ICF/MRs will not have dual accommodations to effect racial segregation.

b. Biracial occupancy of rooms on a nondiscriminatory basis will be required. There will be a policy prohibiting assignment of rooms by race.

c. Clients will not be asked if they are willing to share a room with a person of another race, color, or national origin.

d. Client transfer will not be used to evade compliance with Title VI of the Civil Rights Act of 1964.

5. **Open Admission Policy.** An open admission policy and desegregation of ICF/MR will be required, particularly when the facility previously excluded or primarily serviced clients of a particular race, color, or national origin. Facilities that exclusively serve clients of one race have the responsibility for taking corrective action, unless documentation is provided that this pattern has not resulted from discriminatory practices.

6. **Client Services.** All clients will be provided medical, nonmedical, and volunteer services without regard to race, color, or national origin. All administrative, medical and nonmedical services are covered by this requirement.

7. All ICF/MR staff will be permitted to provide client services without regard to race, color, or national origin.

a. Medical, paramedical, or the professional persons, whether engaged in contractual or consultative capacities, will be selected and employed in a nondiscriminatory manner.

b. Opportunity for employment will not be denied to qualified persons on the basis of race color, or national origin.

c. Dismissal from employment will not be based upon race, color, or national origin.

B. **Rehabilitation Act of 1973—Section 504.** Facilities will comply with Section 504 of the Rehabilitation Act of 1973 that states: "No qualified person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from federal financial assistance."

C. **Age Discrimination Act of 1975.** This Act prohibits discrimination on the basis of age in programs or activities receiving federal financial assistance. All ICF/MRs must be in compliance with this Act.

D. **Americans with Disabilities Act of 1990.** All ICF/MR facilities must be in compliance with this Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153, R.S. 28:390, 42 CFR 483.420 and 483.410 (1), (2), (3), Title XIX of the Social Security Act, Section 601 of Title VI of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1973; and Age Discrimination Act of 1975.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:694 (April 1999), repromulgated LR 31:2242 (September 2005).

§31507. Client Rights

A. The facility must comply with 42 CFR 483.420 and with the provisions below.

1. Each client must:

a. be fully informed by a physician of his health and medical condition unless the physician decides that informing the client is medically contraindicated;

b. be given the opportunity to participate in planning his total care and medical treatment;

c. be given the opportunity to refuse treatment; and

d. give informed, written consent before participating in experimental research.

2. If the physician decides that informing the client of his health and medical condition is medically contraindicated, he must document this decision in the client's record.

3. Each client must be transferred or discharged only in accordance with the discharge plans in the IHP (see Chapter 311, Health Services).

4. Each client must be:

a. encouraged and assisted to exercise his rights as a client of the facility and as a citizen; and

b. allowed to submit complaints or recommendations concerning the policies and services of the ICF/MR to staff or to outside representatives of the client's choice or both, free from restraining, interference, coercion, discrimination, or reprisal. This includes the right to due process.

5. Each client must be allowed to manage his personal financial affairs and taught to do so to the extent of individual capability. If a client requested assistance from the facility in managing his personal financial affairs:

a. the request must be in writing; and

b. the facility must comply with the record keeping requirements of Chapter 307, Subchapters A and B, Client Records and Facility Records.

6. Freedom from Abuse and Restraints

a. Each client must be free from physical, verbal, sexual or psychological abuse or punishment.

b. Each client must be free from chemical and physical restraints unless the restraints are used in accordance with §31303, Interventions to Manage Inappropriate Client Behavior.

7. Privacy

a. Each client must be treated with consideration, respect, and full recognition of his dignity and individuality.

b. Each client must be given privacy during treatment and care of personal needs.

c. Each client's records, including information in an automatic data base, must be treated confidentially.

d. Each client must give written consent before the facility may release information from his record to someone not otherwise authorized by law to receive it.

e. A married client must be given privacy during visits by his spouse.

NOTE: If both husband and wife are residents of the facility, they must be permitted to share a room.

8. No client may be required to perform services for the facility. Those clients who by choice work for the facility must be compensated for their efforts at prevailing wages and commensurate with their abilities.

9. Each client must be allowed to:

a. communicate, associate, and meet privately with individuals of his choice, unless this infringes on the rights of another client;

b. send and receive personal mail unopened; and

c. have access to telephones with privacy for incoming and outgoing local and long distance calls except as contraindicated by factors identified within his individual program plan.

10. Each client must be allowed to participate in social, religious, and community group activities.

11. Each client must be allowed to retain and use his personal possessions and clothing as space permits.

12. Each client may be allowed burial insurance policy(s). The facility administrator or designee, with the client's permission, may assist the resident in acquiring a burial policy, provided that the administrator, designee, or

affiliated persons derive no financial or other benefit from the resident's acquisition of the policy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 483.420.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:694 (April 1999), repromulgated LR 31:2243 (September 2005).

§31509. Violation of Rights

A. A person who submits or reports a complaint concerning a suspected violation of a client's rights or concerning services or conditions in an ICF/MR or who testifies in any administrative or judicial proceedings arising from such complaints will have immunity from any criminal or civil liability therefore, unless that person has acted in bad faith with malicious purpose, or if the court finds that there was an absence of a justifiable issue of either law or fact by the complaining party.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 483.420.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:694 (April 1999), repromulgated LR 31:2244 (September 2005).

Chapter 317. Complaints

§31701. Purpose and Scope

A. Under the provisions of Louisiana R.S. 40:2009.13-40:2009.20 and 14:4032 federal regulation 42 CFR 483.405, 483.420, 483.440 and the state Operations Manual published by the Department of Health and Hospitals and Health Care Financing Administration, the following procedures are established for receiving, evaluating, investigating, and correcting grievances concerning client care in ICF/MR licensed and certified ICF/MR facilities. The procedures in this Chapter 317 also provide mandatory reporting of abuse and neglect in ICF/MR facilities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 40:2009.13, R.S. 40:2009.20, R.S. 14:4032, Title XIX of the Social Security Act, 42 CFR 483.405, 483.420, and 483.440.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:696 (April 1999), repromulgated LR 31:2244 (September 2005).

§31703. Applicability

A. Any person having knowledge of the alleged abuse or neglect of a client or knowledge of a client being denied care and treatment may submit a complaint, preferably in writing.

B. Any person may submit a complaint if he/she has knowledge that a state law, standard, rule, correction order, or certification rule issued by the Department of Health and Hospitals has been violated.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 40:2009.13, R.S. 40:2009.20, R.S. 14:4032, Title XIX of the Social Security Act, 42 CFR 483.405, 483.420, and 483.440.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:696 (April 1999), repromulgated LR 31:2244 (September 2005).

§31705. Duty to Report

A. All incidents or allegations of abuse and/or neglect must be reported by telephone or fax within 24 hours to DHH's Health Standards Section. This must be followed by a copy of the results of the facility's internal investigation within five working days. Complete investigative reports with all pertinent documents shall be maintained at the facility. Failure to submit this information timely could result in a deficiency and/or a sanction. Those who must make a report of abuse and/or neglect are:

1. physicians or other allied health professionals;
2. social services personnel;
3. facility administration;
4. psychological or psychiatric treatment personnel;
5. registered nurses;
6. licensed practical nurses; and
7. direct care staff.

B. Penalties for Failure to Make Complaint. Any person who knowingly and willfully fails to report an abuse or neglect situation shall be fined not more than \$500 or imprisoned not more than two months or both. The same sanctions shall apply to an individual who knowingly and willingly files a false report. Penalties for committing cruelty or negligent mistreatment to a resident of a health care facility shall be not more than \$10,000 or imprisoning with or without hard labor for more than 10 years, or both.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 40:2009.13, R.S. 40:2009.20, R.S. 14:4032, Title XIX of the Social Security Act, 42 CFR 483.405, 483.420, and 483.440.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:696 (April 1999), repromulgated LR 31:2244 (September 2005).

§31707. Where to Submit Complaint

A. A complaint can be filed as follows:

1. it may be submitted in writing to the Health Standards Section at Box 3767, Baton Rouge, LA 70821-3767; or
2. it may be made by calling Health Standards Section at 1-888-810-1819, or (225) 342-0082, and the FAX number (225) 342-5292;
3. in addition, it may be submitted to any local law enforcement agency.

B. DHH's Referral of Complaints for Investigation

1. Complaints involving clients of ICF/MRs received by DHH shall be referred to the Health Standards Section.

2. If it has been determined that complaints involving alleged violations of any criminal law concerning a facility are valid, the investigating office of DHH shall furnish copies of the complaints for further investigation to the Office of the Attorney General, Medicaid Fraud Control Unit.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 40:2009.13, R.S. 40:2009.20, R.S. 14:4032, Title XIX of the Social Security Act, 42 CFR 483.405, 483.420, and 483.440.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:696 (April 1999), repromulgated LR 31:2244 (September 2005).

§31709. Disposition of Complaints

A. After the investigation DHH may take any of the following actions.

1. Valid Complaint with Deficiencies Written. The Department of Health and Hospitals shall notify the administrator who must provide an acceptable plan of correction as specified below.

a. If it is determined that a situation presents a threat to the health and safety of the client, the facility shall be required to take immediate corrective action. DHH may certify noncompliance, revoke or suspend the license, or impose sanctions.

b. In all other instances of violation, an expeditious correction, not to exceed 90 days, shall be required. If the provider is unable or unwilling to correct the violation, DHH may take any of the actions listed in Subparagraph 1.a.

c. In cases of abuse and/or neglect, referral for appropriate corrective action shall be made to the Office of the Attorney General, Medicaid Fraud Control Unit.

2. Unsubstantiated Complaint. DHH shall notify the complainant and the facility of this finding.

3. Repeat Violations. When violations continue to exist after the corrective action was taken, the Department of Health and Hospitals may take any of the actions listed in Subparagraph 1.a.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 40:2009.13, R.S. 40:2009.20, R.S. 14:4032, Title XIX of the Social Security Act, 42 CFR 483.405, 483.420, and 483.440.

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§31711. Informal Reconsideration

A. A complainant or a facility dissatisfied with any action taken by DHH's response to the complaint

investigation may request an informal reconsideration as provided in R.S. 40:2009.11 et seq.

B. Retaliation by ICF/MR Facility. Facilities are prohibited from taking retaliatory action against complainants. Persons aware of retaliatory action or threats in this regard should contact DHH.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 40:2009.13, R.S. 40:2009.20, R.S. 14:4032, Title XIX of the Social Security Act, 42 CFR 483.405, 483.420, and 483.440.

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§31713. Tracking Incidents

A. For each client who is involved in an accident or incident, an incident report shall be completed including the name, date, time, details of accident or incident, circumstances under which it occurred, witnesses and action taken.

1. Incidents or accidents involving clients must be documented in the client's record. These records should also contain all pertinent medical information.

2. The examples listed below are not all inclusive, but are presented to serve as a guideline to assist those facility employees responsible for reporting incident reports.

a. Suspicious Death. Death of a client or on-duty employee when there is suspicion of death other than by natural causes.

b. Abuse and/or Neglect. All incidents or allegations of abuse and/or neglect.

c. Runaways. Runaways considered dangerous to self or others.

d. Law Enforcement Involvement. Arrest, incarceration, or other serious involvement of residents with law enforcement authorities.

e. Mass Transfer. The voluntary closing of a facility or involuntary mass transfer of residents from a facility.

f. Violence. Riot or other extreme violence.

g. Disasters. Explosions, bombings, serious fires.

h. Accidents/Injuries. Severe accidents or serious injury involving residents or on-duty employees caused by residents such as life threatening or possible permanent and/or causing lasting damage.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 40:2009.13, R.S. 40:2009.20, R.S. 14:4032, Title XIX of the Social Security Act, 42 CFR 483.405, 483.420, and 483.440.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:696 (April 1999), repromulgated LR 31:2245 (September 2005).

Chapter 319. Utilization Review

§31901. Utilization Review

A. If it is determined by HSS that continued stay is not needed, the client's attending physician or qualified mental retardation professional (QMRP) shall be notified within one working day and given two working days from the notification date to present his/her views before a final decision on continued stay is made.

B. If the attending physician or QMRP does not present additional information or clarification of the need for continued stay, the decision of the utilization review (UR) group is final.

C. If the attending physician or QMRP presents additional information or clarification, the need for continued stay is reviewed by the physician member(s) of the UR group in cases involving a medical determination.

D. The decision of the UR group is the final medical eligibility decision. Recourse for the client is to exercise his/her appeal rights according to the Administrative Procedure Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 456.350 through 456.438.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:700 (April 1999), repromulgated LR 31:2245 (September 2005).

Chapter 321. Appeals

§32101. Administrative Appeals

A. DHH reserves the right to reject a request for Title XIX participation, impose sanctions or terminate participation status when an ICF/MR:

1. fails to abide by the rules promulgated by DHH;
2. fails to obtain compliance or is otherwise not in compliance with Title VI of the Civil Rights Act;
3. engages in practice not in the best interest of Medicaid (Title XIX) clients;
4. has previously been sanctioned for violation of state and/or federal rules; or
5. has previously been decertified from participation as a Title XIX provider. Prior to such rejection or termination, DHH may conduct an Informal Reconsideration at the ICF/MR's request. The ICF/MR also has the right to an administrative appeal pursuant to the Administrative Procedure Act.

B. Informal Reconsideration. When an ICF/MR receives a written notification of adverse action and a copy of the findings upon which the decision was based, the ICF/MR may provide written notification to BHSF/HSS within 10

calendar days of receiving the notification, and request an Informal Reconsideration.

1. The ICF/MR may submit written documentation or request an opportunity to present oral testimony to refute the findings of DHH on which the adverse action is based.

2. DHH will review all oral testimony and documents presented by the ICF/MR and, after the conclusion of the Informal Reconsideration, will advise the ICF/MR in writing of the results of the reconsideration which may be that:

- a. the original decision has been upheld;
- b. the original decision has been modified; or
- c. the original decision has been reversed.

C. Evidentiary HearingXGeneral Requirements. The ICF/MR may also request an administrative appeal. To request such an appeal, the facility must submit their request, in writing, within 30 days of the receipt of the adverse action to the Bureau of Appeals, Box 4183, Baton Rouge, LA 70821-4183. The Bureau of Appeals will attempt to conduct the hearing within 120 days of the original notice of adverse action.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 431.151 - 431.154.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:700 (April 1999), repromulgated LR 31:2246 (September 2005).

§32103. Notice and Appeal Procedure

A. When DHH imposes a sanction on a health care provider, it will give the provider written notice of the imposition. The notice will be given by certified mail and will include the following:

1. the nature of the violation(s) and whether the violation(s) is classified as a repeat violation;
2. the legal authority that established the violation(s);
3. the civil fine assessed for each violation;
4. inform the administrator of the facility that the facility has 10 days from receipt of the notice within which to request an informal reconsideration of proposed sanction;
5. inform the administrator of the facility that the facility has 30 days from receipt of the notice within which to request an administrative appeal of the proposed sanction and that the request for an informal reconsideration does not extend the time limit for requesting an administrative appeal; and
6. inform the administrator of the facility that the consequences of failing to request an informal reconsideration and/or an administrative appeal will be that DHH's decision is final and that no further administrative or judicial review may be had.

B. The provider may request an informal reconsideration of DHH's decision to impose a civil fine. This request must be written and made to DHH within 10 days of receipt of the notice of the imposition of the fine.

1. This reconsideration will be conducted by designated employees of DHH who did not participate in the initial decision to recommend imposition of a sanction.

2. Oral presentation can be requested by the provider representative, and if requested, will be made to the designated employees.

3. Reconsideration will be made on the basis of documents and oral presentations made by the provider to the designated employees at the time of the reconsideration.

4. Correction of the deficient practice for which the sanction was imposed will not be the basis of the reconsideration.

5. The designated employees will only have the authority to confirm, reduce or rescind the civil fine.

6. DHH will notify the provider of the results of the reconsideration within 10 working days after the oral presentation.

7. This process is not in lieu of the administrative appeal and does not extend the time limits for filing an administrative appeal.

C. The facility may request an administrative appeal. If an administrative appeal is requested in a timely manner, the appeal will be held as provided in the Administrative Procedure Act (R.S. 49:950 et seq.) An appeal bond will be posted with the Bureau of Appeals as provided in R.S. 40:2199(D) or the provider may choose to file a devolutive appeal. A devolutive appeal means that the civil fine must be paid in full within 10 days of filing the appeal.

D. The provider may request judicial review of the administrative appeal decision as provided in the Administrative Procedure Act.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:701 (April 1999), repromulgated LR 31:2046 (September 2005).

§32105. Collection of Fines

A. Fines are final when:

1. an appeal is not requested within the specified time limits;
2. the facility admits the violations and agrees to pay the fine; or
3. the administrative hearing affirms DHH's findings of violations and time for seeking judicial review has expired.

B. When civil fines become final, they will be paid in full within 10 days of their commencement unless DHH allows a payment schedule in light of documented financial hardship. Arrangements with DHH for a payment schedule must commence within 10 days of the fines becoming final. Interest will begin to accrue at the current judicial rate on the day the fines become final.

C. If payment of assessed fines is not received within the prescribed time period after becoming final and the provider is a Medicaid provider, DHH will deduct the full amount plus the accrued interest from money otherwise due to the provider as Medicaid reimbursement in its next (quarterly or monthly) payment. If the provider is not a Medicaid provider, DHH will institute civil actions as necessary to collect fines due.

D. No provider may claim imposed fines or interest as reimbursable costs, nor increase charges to residents, clients, or patients as a result of such fines or interest.

E. Civil fines collected will be deposited in the Health Care Facility Fund maintained by the state treasury.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:701 (April 1999), repromulgated LR 31:2246 (September 2005).

Chapter 323. Sanctions

§32301. Noncompliance

A. When ICF/MRs are not in compliance with the requirements set forth in the ICF/MR Standards for Payment, DHH may impose sanctions. Sanctions may involve:

1. withholding of vendor payments;
2. civil fines;
3. denial of payments for new admissions; or
4. nonfinancial measures such as termination of the ICF/MR's certification as a Title XIX provider.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:701 (April 1999) repromulgated LR 31:2247 (September 2005).

§32303. Authority

A. Public Law 95-142, dated October 25, 1977, permits the federal government's Health Care Financing Administration (HCFA) to impose a fine and/or imprisonment of facility personnel for illegal admittance and retention practices. HCFA is also authorized to terminate an agreement with a Title XIX ICF/MR provider as a result of

deficiencies found during their surveys, which are re-reviews of the state's surveys. Furthermore, the federal government's Office of Inspector General (OIG) is authorized to terminate an agreement with a Title XIX ICF/MR provider for willful misrepresentation of financial facts or for not meeting professionally recognized standards of health care.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:701 (April 1999), repromulgated LR 31:2249 (September 2005).

§32305. Special Staffing

A. When the secretary of DHH determines that additional staffing or staff with specific qualifications would be beneficial in correcting deficient practices, DHH may require a facility to hire additional staff on a full-time or consultant basis until the deficient practices have been corrected. This provision may be invoked in concert with, or instead of, the sanctions cited in §32307.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:701 (April 1999), repromulgated LR 31:2247 (September 2005).

§32307. Withholding of Vendor Payments

A. Withholding of Vendor Payments. DHH may withhold vendor payments in whole or in part in the following situations, which are not all inclusive.

1. **Delinquent Staffing Report.** When the ICF/MR provider fails to timely submit a required, completed staffing report. After DHH notifies the provider of the delinquent report, vendor payment may be withheld until the completed report is received.

2. **Unapproved Staffing Shortage.** When a staffing report indicates an unapproved staffing shortage, vendor payment may be withheld until staffing is brought into compliance.

3. **Incorrect/Inappropriate Charges.** When DHH determines that the ICF/MR provider has incorrectly or inappropriately charged clients, families, or responsible parties, or there has been misapplication of client funds, vendor payment may be withheld until the provider does the following:

- a. makes restitution; and
- b. submits documentation of such restitution to BHSF's Institutional Reimbursement Section.

4. **Delinquent Cost Report.** When an ICF/MR provider fails to submit a cost report within 90 days from the fiscal year end closing date, a penalty of 5 percent of the total

monthly payment for the first month and a progressive penalty of 5 percent of the total monthly payment for each succeeding month may be levied and withheld from the vendor's payment for each month that the cost report is due, not extended, and not received. The penalty is nonrefundable.

NOTE: DHH's Institutional Reimbursement Section may grant a 30-day extension of the 90-day time limit, when requested by the ICF/MR provider, if just cause has been established. Extensions beyond 30 days may be approved for situations beyond the ICF/MR provider's control.

5. **Cost Reports Errors.** Cost reports errors greater than 10 percent in the aggregate for the ICF/MR provider for the cost report year may result in a maximum penalty of 10 percent of the current per diem rate for each month the cost report errors are not correct. The penalty is nonrefundable.

6. **Corrective Action for Audit Findings.** Vendor payments may be withheld when an ICF/MR facility fails to submit corrective action in response to financial and compliance audit findings within 15 days after receiving the notification letter until such time compliance is achieved.

7. **Failure to Respond or Adequately Respond to Requests for Financial/Statistical Information.** When an ICF/MR facility fails to respond or adequately respond to requests from DHH for financial and statistical information within 15 days after receiving the notification letter, vendor payments may be withheld until such time the requested information is received.

8. **Insufficient Medical Recertification.** When an ICF/MR provider fails to secure recertification of a client's need for care and services, the vendor's payment for that individual may be withheld or recouped until compliance is achieved.

9. **Inadequate Review/Revision of Plan of Care (IHP).** When an ICF/MR provider repeatedly fails to ensure that an adequate plan of care for a client is reviewed and revised at least at required intervals, the vendor's payment may be withheld or recouped until compliance is achieved.

10. **Failure to Submit Response to Survey Reports.** When an ICF/MR provider fails to submit an acceptable response within 30 days after receiving a survey report from DHH, HCFA, OIG and the legislative auditor, vendor payments may be withheld until an adequate response is received, unless the appropriate agency extends the time limit.

11. **Corrective Action on Complaints.** When an ICF/MR fails to submit an adequate corrective action plan in response to a complaint within seven days after receiving the complaint report, vendor payments may be withheld until an adequate corrective action plan is received, unless the time limit is extended by the DHH.

12. **Delinquent Utilization Data Requests.** Facilities will be required to timely submit utilization data requested by the DHH. Providers will be given written notice when such utilization data has not been received by the due date. Such notice will advise the provider of the date the

utilization data must be received by to avoid withholding of vendor payments. The due date will never be less than 10 days from the date the notice is mailed to the provider. If the utilization data is not received by the due date provided in the notice, the medical vendor's payment will be withheld until the utilization data is received.

13. **Termination or Withdrawal from the Medicaid Program.** When a provider is terminated or withdraws from the Medicaid Program, vendor payment will be withheld until all programmatic and financial issues are resolved.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:701 (April 1999), repromulgated LR 31:2247 (September 2005).

§32309. Civil Fines

A. Louisiana R.S. 40:2199 authorized DHH to impose monetary sanctions on those health care facilities found to be out of compliance with any state or federal law or rule concerning the operation and services of the health care provider.

1. Any ICF/MR found to be in violation of any state or federal statute, regulation, or any Department of Health and Hospitals (DHH) rule adopted pursuant to the Act governing the administration and operation of the facility may be sanctioned as provided in the schedule of fines listed under Paragraph 2 below.

a. A *repeat violation* is defined as a violation of a similar nature as a previously cited violation that occurs within 18 months of the previously cited violation. DHH has the authority to determine when a violation is a *repeat violation*.

b. The opening or operation of a facility without a license or registration will be a misdemeanor, punishable upon conviction by a fine of not less than \$1,000 nor more than \$5,000.

i. Each day's violations will constitute a separate offense.

ii. On learning of such an operation, DHH will refer the facility to the appropriate authorities for prosecution.

c. Any ICF/MR found to have a violation that poses a threat to the health, safety, rights, or welfare of a resident or client may be liable for civil fines in addition to any criminal action that may be brought under other applicable laws.

B. Description of Violations and Applicable Civil Fines

1. Class A Violations

a. A Class A violation is a violation of a rule that creates a condition or occurrence relating to the maintenance or operation of a facility that results in death or serious harm

to a resident or client. Examples of Class A violations include, but are not limited to:

i. acts or omissions by an employee or employees of a facility that either knowingly or negligently resulted in the death of a resident or client; and

ii. acts or omissions by an employee or employees of a facility that either knowingly or negligently resulted in serious harm to a resident or client.

b. Civil fines for Class A violations may not exceed:

i. \$2,500 for the first violation; or

ii. \$5,000 per day for repeat violations.

2. Class B Violations

a. A Class B violation is a violation of a rule in which a condition or occurrence relating to the maintenance or operation of a facility is created that results in the substantial probability that death or serious harm to the client or resident will result if the condition or occurrence remains uncorrected. Examples of Class B violations include, but are not limited to, the following:

i. medications or treatments improperly administered or withheld;

ii. lack of functioning equipment necessary to care for clients;

iii. failure to maintain emergency equipment in working order;

iv. failure to employ a sufficient number of adequately trained staff to care for clients; and

v. failure to implement adequate infection control measures.

b. Civil fines for Class B violations may not exceed:

i. \$1,500 for the first violation; or

ii. \$3,000 per day for repeat violations.

3. Class C Violations

a. A Class C violation is a violation of a rule in which a condition or occurrence relating to the maintenance or operation of the facility is created that threatens the health, safety, or welfare of a client or resident. Examples of Class C violations include, but are not limited to, the following:

i. failure to perform treatments as ordered by the physician;

ii. improper storage of poisonous substances;

iii. failure to notify physician and family of changes in condition of the client or resident;

iv. failure to maintain equipment in working order;

v. inadequate supply of needed equipment;

vi. lack of adequately trained staff necessary to meet clients' needs; and

vii. failure to adhere to professional standards in giving care to the client.

b. Civil fines for Class C violations may not exceed:

i. \$1,000 for the first violation;

ii. \$2,000 per day for repeat violations.

4. Class D Violations

a. Class D violations are violations of rules related to administrative and reporting requirements that do not threaten the health, safety, rights, or welfare of a client or resident. Examples of Class D violations include, but are not limited to, the following:

i. failure to submit written reports of accidents;

ii. failure to timely submit a Plan of Correction;

iii. falsification of a record; and

iv. failure to maintain clients financial records as required by rules or regulations.

b. Civil fines for Class D violations may not exceed:

i. \$100 for the first violation;

ii. \$250 per day for repeat violations.

5. Class E Violations. Class E violations occur when a facility fails to submit a statistical or financial report in a timely manner when such a report is required by a rule.

a. Civil fines for Class E violations may not exceed:

i. \$50 for the first violation;

ii. \$100 per day for repeat violations.

C. Maximum Amount for a Civil Fine

1. The aggregate fines assessed for violations determined in any one month may not exceed \$10,000 for a Class A and Class B violations.

2. The aggregate fines assessed Class C, Class D, and Class E violations determined in any one month may not exceed \$5,000.

D. DHH will have the authority to determine whether a violation is a repeat violation and sanction the provider accordingly. Violations may be considered repeat violations by DHH when the following conditions exist:

1. when DHH has established the existence of a violation as of a particular date and the violation is one that may be reasonably expected to continue until corrective action is taken, DHH may elect to treat said continuing violation as a repeat violation subject to appropriate fines for each day following the date on which the initial violation is established, until such time as there is evidence that the violation has been corrected; or

2. when DHH has established the existence of a violation and another violation that is the same or substantially similar to the cited violation occurs within 18 months, the second and all similar subsequent violations occurring within the 18-month time period will be considered repeat violations and sanctioned accordingly.

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 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:701 (April 1999), repromulgated LR 31:2248 (September 2005).

Chapter 325. Decertification

§32501. Termination of Certification

A. An ICF/MR may voluntarily or involuntarily lose its participating status in the Medical Assistance Program.

B. Reasons for Decertification of an ICF/MR

1. The ICF/MR may voluntarily withdraw from the program for reasons of its own. The owner and administrator will submit a written notice of withdrawal to the DHH's HSS at least 60 days in advance.

2. A new owner may decide against participation in the program. A written 60-day notice of withdrawal will be submitted to DHH's HSS.

3. DHH may decertify an ICF/MR for failure to comply with Title XIX standards, thus canceling the facility's provider agreement.

4. DHH may decertify an ICF/MR if deficiencies pose immediate jeopardy to the client's health, safety, rights, or welfare.

5. The ICF/MR may allow its provider agreement to expire. A written 60-day advance notice of withdrawal will be submitted to the DHH's HSS.

6. DHH may cancel the provider agreement if and when it is determined that the ICF/MR is in material breach of the contract.

C. Recertification of an Involuntarily Decertified ICF/MR. After involuntary decertification, an ICF/MR cannot participate as a medical assistance provider unless the following conditions are met:

1. the reasons for the decertification or nonrenewal of the contract no longer exist;

2. reasonable assurance exists that the factors causing the decertification will not recur;

3. the ICF/MR demonstrates compliance with the required standards for a 60-day period prior to reinstatement in a participating status; and

4. a professional medical review reports that clients are receiving proper care and services.

D. Denial of Payments for New Admissions

1. New Admissions. New admissions refer to the admission of a person who has never been a Title XIX client in the ICF/MR or, if previously admitted, had been discharged or had voluntarily left the ICF/MR. This term does not include the following:

a. individuals who were in the ICF/MR before the effective date of denial of payment for new admissions, even if they become eligible for Title XIX after that date;

b. individuals who, after a temporary absence from the ICF/MR, are readmitted to beds reserved for them in accordance with the admission process.

2. Basis for Denial of Payment. DHH may deny payment for new admissions to an ICF/MR that no longer meets applicable requirements as specified in these standards.

a. ICF/MR's deficiencies do not pose immediate jeopardy (serious threat). If DHH finds that the ICF/MR's deficiencies do not pose immediate jeopardy to clients' health, safety, rights, or welfare, DHH may either terminate the ICF/MR's provider agreement or deny payment for new admissions.

b. ICF/MR's deficiencies do pose immediate jeopardy (serious threat). If DHH finds that the ICF/MR's deficiencies do pose immediate jeopardy to clients' health, safety, rights, or welfare, and thereby terminates the ICF/MR's provider agreement, DHH may additionally seek to impose the denial of payment for new admissions.

3. DHH Procedures. Before denying payments for new admissions, DHH will be responsible for the following:

a. providing the ICF/MR a time frame of up to 60 days to correct the cited deficiencies and comply with the standards for ICF/MRs;

b. giving the ICF/MR notice of the intent to deny payment for new admissions and an opportunity to request an Informal Reconsideration if the facility has not achieved compliance at the end of the 60-day period;

c. providing an informal hearing if requested by the ICF/MR that included the following:

i. giving the ICF/MR the opportunity to present before a state Medicaid official not involved in the initial determination, evidence or documentation, in writing or in person, to refute the decision that the ICF/MR is out of compliance with the applicable standards for participation; and

ii. submitting a written decision setting forth the factual and legal basis pertinent to a resolution of the dispute.

d. providing the facility and the public at least 15 days advance notice of the effective date of the sanction and reasons for the denial of payments for new admissions should the informal hearing decision be adverse to the ICF/MR.

4. Duration of Denial of Payments and Subsequent Termination

a. **Period of Denial.** The denial of payments for new admissions will continue for 11 months after the month it was imposed unless, before the end of that period, DHH determines:

i. the ICF/MR has corrected the deficiencies or is making a good faith effort to achieve compliance with the standards for ICF/MR participation; or

ii. the deficiencies are such that it is now necessary to terminate the ICF/MR's provider agreement.

b. **Subsequent Termination.** DHH must terminate an ICF/MR's provider agreement under the following conditions:

i. upon finding that the ICF/MR has been unable to achieve compliance with the standards for participation during the period that payments for new admissions had been denied;

ii. effective the day following the last day of the denial of payments;

iii. in accordance with the procedures for appeal of termination set forth in Chapter 321, Appeals.

E. **Examples of Situations Determined to Pose Immediate Jeopardy (Serious Threat).** Listed below are some examples of situations determined to pose immediate jeopardy (serious threat) to the health, safety, rights, and welfare of clients in ICF/MR. These examples are not intended to be all inclusive. Other situations adversely affecting clients could constitute sufficient basis for the imposition of sanctions.

1. **Poisonous Substances.** An ICF/MR fails to provide proper storage of poisonous substances, and this failure results in death of or serious injury to a client or directly threatens the health, safety, or welfare of a client.

2. **Falls.** An ICF/MR fails to maintain required direct care staffing and/or a safe environment as set forth in the regulations, and this failure directly causes a client to fall resulting in death or serious injury or directly threatens the health, safety, or welfare of a client. Examples:

a. equipment not properly maintained; or

b. personnel not responding to a client's request for assistance.

3. Assaults

a. **By Other Clients.** An ICF/MR fails to maintain required direct care staffing and fails to take measures when it is known that a client is combative and assaultive with other clients, and this failure causes an assault upon another client, resulting in death or serious injury or directly threatens the health, safety, and welfare of another client.

b. **By Staff.** An ICF/MR fails to take corrective action (termination, legal action) against an employee who has a history of client abuse and assaults a client causing

death or the situation directly threatens the health, safety, and welfare of a client.

4. **Physical Restraints Resulting in Permanent Injury.** ICF/MR personnel improperly apply physical restraints contrary to published regulations or fail to check and release restraints as directed by regulations or physician's written instructions, and such failure results in permanent injury to a client's extremity or death or directly threatens the health, safety and welfare of a client.

5. **Control of Infections.** An ICF/MR fails to follow or meet infection control standards as ordered in writing by the physician, and this failure results in infections leading to the death of or serious injury to a client or directly threatens the health, safety, and welfare of a client.

6. Medical Care

a. An ICF/MR fails to secure proper medical assistance for a client, and this failure results in the death of or serious injury to the client.

b. A client's condition declined and no physician was informed, and this failure directly threatens the health, safety, or welfare of the client. This would also include the following:

i. failure to follow up on unusual occurrences of negative findings;

ii. failure to obtain information regarding appropriate care before and after a client's hospitalization;

iii. failure to timely hospitalize a client during a serious illness.

c. ICF/MR personnel have not followed written physician's orders, and this failure directly threatens the health, safety, or welfare of a client. This includes failure to fill prescriptions timely.

7. **Natural Disaster/Fire.** An ICF/MR fails to train its staff members in disaster/fire procedures as required by state rules for licensing of ICF/MRs or an ICF/MR fails to meet staffing requirements, and such failures result in the death of or serious injury to a client during natural disaster, fire or directly threatens the health, safety, or welfare of a client.

8. **Decubitus Ulcers (Bed Sores).** An ICF/MR fails to follow decubitus ulcer care measures in accordance with a physician's written orders, and such failure results in the death of, serious injury to, or discomfort of the client or directly threatens the health, safety, and welfare of a client.

9. **Elopement.** An ICF/MR fails to provide necessary supervision of its clients or take measures to prevent a client with a history of elopement problems from wandering away and such failure results in the death of or serious harm to the client or directly threatens the health, safety, and welfare of the client. Examples of preventive measures include, but are not limited to:

a. documentation that the elopement problem has been discussed with the client's family and the Interdisciplinary Team; and

b. that personnel have been trained to make additional efforts to monitor these clients.

10. Medications

a. An ICF/MR knowingly withholds a client's medications and such actions results in the death of or serious harm to the client or directly threatens the health, safety, and welfare of the client.

NOTE: The client does have the right to refuse medications. Such refusal must be documented in the client's record and brought to the attention of the physician and ID team.

- b. medication omitted without justification;
- c. excessive medication errors;
- d. improper storage of narcotics or other prescribed drugs, mishandling of drugs or other pharmaceutical problems.

11. Environment/Temperature. An ICF/MR fails to reasonably maintain its heating and air-conditioning system as required by regulations, and this failure results in the death of, serious harm to, or discomfort of a client or creates the possibility of death or serious injury. Isolated incidents of breakdown or power failure will not be considered immediate jeopardy.

12. Improper Treatments

a. ICF/MR personnel knowingly perform treatment contrary to a physician's order, and such treatment results in the death of or serious injury to the client or directly threatens the health, safety, and welfare of the client.

b. An ICF/MR fails to feed clients who are unable to feed themselves as set forth in physician's instructions.

NOTE: Meals should be served at the required temperature.

c. An ICF/MR fails to obtain a physician's order for use of chemical or physical restraints; the improper application of a physical restraint; or failure of facility personnel to check and release the restraints periodically as specified in state regulations.

13. Life Safety. An ICF/MR knowingly fails to maintain the required Life Safety Code System such as:

- a. properly functioning sprinklers, fire alarms, smoke sensors, fire doors, electrical wiring;
- b. the practice of fire or emergency evacuation plans; or
- c. stairways, hallways and exits free from obstruction; and noncompliance with these requirements results in the death of or serious injury to a client or directly threatens the health, safety, and welfare of a client.

14. Staffing. An ICF/MR consistently fails to maintain minimum staffing that directly threatens the health, safety, or welfare of a client. Isolated incidents where the facility does not maintain staffing due to personnel calling in sick or other emergencies are excluded.

15. Dietary Services. An ICF/MR fails to follow the minimum dietary needs or special dietary needs as ordered by a physician, and failure to meet these dietary needs threatens the health, safety or welfare of a client. The special diets must be prepared in accordance with physician's orders or a diet manual approved by the American Dietary Association.

16. Sanitation. An ICF/MR fails to maintain state and federal sanitation regulations, and those violations directly affect and threaten the health, safety, or welfare of a client. Examples are:

- a. strong odors linked to a lack of cleanliness;
- b. dirty buildup on floors and walls;
- c. dirty utensils, glasses and flatware;
- d. insect or rodent infestation.

17. Equipment and Supplies. An ICF/MR fails to provide equipment and supplies authorized in writing by a physician as necessary for a client's care, and this failure directly threatens the health, safety, welfare or comfort of a client.

18. Client Rights

a. An ICF/MR violates its clients' rights and such violations result in the clients' distress to such an extent that their psychosocial functions are impaired or such violations directly threaten their psychosocial functioning. This includes psychological abuse.

b. The ICF/MR permits the use of corporal punishment.

c. The ICF/MR allows the following responses to clients by staff members and employment supervisors:

- i. physical exercise or repeated physical motions;
 - ii. excessive denial of usual services;
 - iii. any type of physical hitting or other painful physical contacts except as required by medical, dental, or first aid procedures necessary to preserve the individual's life or health;
 - iv. requiring the individual to take on an extremely uncomfortable position;
 - v. verbal abuse, ridicule, or humiliation;
 - vi. requiring the individual to remain silent for a long period of time;
 - vii. denial of shelter, warmth, clothing or bedding;
- or
- viii. assignment of harsh physical work.

d. The ICF/MR fails to afford the client with the opportunity to attend religious services.

e. The ICF/MR denies the client the right to bring his or her personal belongings to the program, to have

access, and to acquire belongings in accordance with the service plan.

f. The ICF/MR denies a client a meal without a doctor's order.

g. The ICF/MR does not afford the client with suitable supervised opportunities for interaction with members of the opposite sex, except where a qualified professional responsible for the formulation of a particular individual's treatment/habilitation plan writes an order to the contrary and explains the reasons.

NOTE: The secretary of DHH has the final authority to determine what constitutes "immediate jeopardy" or serious threat.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 442.12-442.117.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:701 (April 1999), repromulgated LR 31:2249 (September 2005).

Chapter 327. Emergency Awareness

§32701. Disaster Preparedness

A. Written Plans. ICFs/MR shall have written procedures complete with instructions to be followed in the event of an internal or external disaster such as fire or other emergency actions, including:

1. specifications of evacuation routes and procedures;
2. instructions for the care of injuries and/or casualties (client and personnel) arising from such disaster;
3. procedures for the prompt transfer of records;
4. instructions regarding methods of containing fire; and
5. procedures for notification of appropriate persons.

B. Employee Training. All ICF/MR employees shall be trained in disaster preparedness as part of employment orientation. The disaster preparedness training shall include orientation, ongoing training, and drills for all personnel. The purpose shall be that each employee promptly and correctly carry out his/her specific role in the event of a disaster. The facility shall periodically rehearse these procedures for disaster preparedness. The minimum requirements shall be drills once each quarter for each shift.

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 30:1702 (August 2004), repromulgated LR 31:2252 (September 2005).

Chapter 329. Reimbursement Methodology

Subchapter A. Non-State Facilities

§32901. Cost Reports

A. Intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) are required to file annual cost reports to the bureau in accordance with the following instructions.

1. Each ICF/IID is required to report all reasonable and allowable costs on a regular facility cost report, including any supplemental schedules designated by the bureau.

2. Separate cost reports must be submitted by central/home offices and habilitation programs when costs of those entities are reported on the facility cost report.

B. Cost reports must be prepared in accordance with cost reporting instructions adopted by the bureau using definitions of allowable and nonallowable cost contained in the Medicare provider reimbursement manual unless other definitions of allowable and nonallowable cost are adopted by the bureau.

1. Each provider shall submit an annual cost report for fiscal year ending June 30. The cost reports shall be filed within 90 days after the state's fiscal year ends.

2. Exceptions. Limited exceptions for extensions to the cost report filing requirements will be considered on an individual facility basis upon written request by the provider to the Medicaid director or designee. Providers must attach a statement describing fully the nature of the exception request. The extension must be requested by the normal due date of the cost report.

C. Direct Care Floor

1. A facility wide direct care floor may be enforced upon deficiencies related to direct care staffing requirements cited during the HSS annual review or resulting from an HSS complaint investigation.

2. For providers receiving pervasive plus supplements in accordance with §32903.H or other client specific adjustments to the rate in accordance with §32903.I, the facility wide direct care floor is established at 94 percent of the per diem direct care payment and at 100 percent of any rate supplements or add-on payments received by the provider, including the pervasive plus supplement, the complex care add-on payment and other client specific adjustments to the rate. The direct care floor will be applied to the cost reporting year in which the facility receives a pervasive plus supplement and/or a client specific rate adjustment. In no case, however, shall a facility receiving a pervasive plus supplement and/or client specific rate adjustment have total facility payments reduced to less than a safe harbor percentage of 104 percent of the total facility cost as a result of imposition of the direct care floor, except as noted in §32901.C.4.a.

3. For providers receiving complex care add-on payment in accordance with §32915, but not receiving pervasive plus supplements in accordance with §32903.H or other client specific adjustments to the rate in accordance with §32903.I, the facility wide direct care floor is established at 85 percent of the per diem direct care payment and at 100 percent of the complex care add-on payment. The direct care floor will be applied to the cost reporting year in which the facility receives a complex care add-on payment. In no case shall a facility receiving a complex care add-on payment have total facility payments reduced to less than a safe harbor percentage of 104 percent of the total facility cost as a result of imposition of the direct care floor, except as noted in §32901.C.4.a.

4. For facilities for which the direct care floor applies, if the direct care cost the facility incurred on a per diem basis is less than the appropriate facility direct care floor, the facility shall remit to the bureau the difference between these two amounts times the number of facility Medicaid days paid during the cost reporting period. This remittance shall be payable to the bureau upon submission of the cost report.

a. For dates of service on or after July 1, 2022, if a provider receiving complex care or pervasive plus add-on payments in accordance with §32915 or §32903.H, respectively, has facility payments reduced as a result of imposition of the direct care floor, the department may, at its discretion, levy a non-refundable administrative penalty separate from any other reduction in facility payments. The administrative penalty is not subject to any facility specific safe harbor percentage specified in §32901.C, and is calculated solely on the final reduced payment amount for the cost report period in question. Under LAC 50.I.4147 of the Surveillance and Utilization Review Subsystem (SURS) Rule, the department may impose sanctions for noncompliance with Medicaid laws, regulations, rules, and policies. Facilities who have payments reduced as a result of imposition of the direct care floor that have consecutive subsequent years of reduced payments shall have the following safe harbor and administrative penalty impacts:

Consecutive Cost Report Period with Reduced Payments	Administrative Penalty Levied on Reduced Payments	Safe Harbor Percentages
1st Year	0 percent	104 percent
2nd Year	0 percent	102 percent
3rd Year	5 percent	100 percent
4th Year and Onwards	10 percent	100 percent

b. At its discretion, LDH may terminate provider participation in the complex care or pervasive plus add-on payment programs as a result of imposition of the direct care floor.

5. Upon completion of desk reviews or audits, facilities will be notified by the bureau of any changes in amounts due based on audit or desk review adjustments.

a. Direct care floor recoupment and/or administrative penalty assessed as a result of a facility not meeting the required direct care per diem floor is considered effective 30

days from the issuance of the original notice of determination. Should an informal reconsideration be requested, the recoupment and/or penalty will be considered effective 30 days from the issuance of the results of an informal hearing. The filing of a timely and adequate notice of an administrative appeal does not suspend or delay the imposition of a recoupment(s) and/or penalty.

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 31:1592 (July 2005), repromulgated LR 31:2252 (September 2005), amended LR 33:461 (March 2007), amended by the Department of Health, Bureau of Health Services Financing, LR 44:1446 (August 2018), LR 46:28 (January 2020), LR 47:1124 (August 2021), LR 48:1581 (June 2022).

§32903. Rate Determination

A. Resident per diem rates are calculated based on information reported on the cost report. ICFs/IID will receive a rate for each resident. The rates are based on cost components appropriate for an economic and efficient ICF/IID providing quality service. The resident per diem rates represent the best judgment of the state to provide reasonable and adequate reimbursement required to cover the costs of economic and efficient ICF/IID.

B. The cost data used in setting base rates will be from the latest available audited or desk reviewed cost reports. The initial rates will be adjusted to maintain budget neutrality upon transition to the ICAP reimbursement methodology. For rate periods between rebasing, the rates will be trended forward using the index factor contingent upon appropriation by the legislature.

C. A resident’s per diem rate will be the sum of:

1. direct care per diem rate;
2. care related per diem rate;
3. administrative and operating per diem rate;
4. capital rate;
5. provider fee; and

6. dental pass-through/add-on per diem rate (effective for dates of service on or after May 1, 2023).

D. Determination of Rate Components

1. The direct care per diem rate shall be a set percentage over the median adjusted for the acuity of the resident based on the ICAP, tier based on peer group. The direct care per diem rate shall be determined as follows.

a. Median Cost. The direct care per diem median cost for each ICF/IID is determined by dividing the facility’s total direct care costs reported on the cost report by the facility’s total days during the cost reporting period. Direct care costs for providers in each peer group are arrayed from low to high and the median (50th percentile) cost is determined for each peer group.

PUBLIC HEALTH—MEDICAL ASSISTANCE

b. Median Adjustment. The direct care component shall be adjusted to 105 percent of the direct care per diem median cost in order to achieve reasonable access to care.

c. Inflationary Factor. These costs shall be trended forward from the midpoint of the cost report period to the midpoint of the rate year using the index factor.

d. Acuity Factor. Each of the ICAP levels will have a corresponding acuity factor. The median cost by peer group, after adjustments, shall be further adjusted by the acuity factor (or multiplier) as follows.

ICAP Support Level	Acuity Factor (Multiplier)
Pervasive	1.35
Extensive	1.17
Limited	1.00
Intermittent	.90

e. Direct Service Provider Wage Enhancement. For dates of service on or after February 9, 2007, the direct care reimbursement in the amount of \$2 per hour to ICF/IDD providers shall include a direct care service worker wage enhancement incentive. It is the intent that this wage enhancement be paid to the direct care staff. Non-compliance with the wage enhancement shall be subject to recoupment.

i. At least 75 percent of the wage enhancement shall be paid to the direct support professional and 25 percent shall be used to pay employer-related taxes, insurance and employee benefits.

ii. The wage enhancement will be added on to the current ICAP rate methodology as follows:

(a). Per diem rates for recipients residing in 1-8 bed facilities will increase \$16.00;

(b). Per diem rates for recipients residing in 9-16 bed facilities will increase \$14.93; and

(c). Per diem rates for recipients residing in 16+ bed facilities will increase \$8.

2. The care related per diem rate shall be a statewide price at a set percentage over the median and shall be determined as follows.

a. Median Cost. The care related per diem median cost for each ICF/IID is determined by dividing the facility's total care related costs reported on the cost report by the facility's actual total resident days during the cost reporting period. Care related costs for all providers are arrayed from low to high and the median (50th percentile) cost is determined.

b. Median Adjustment. The care related component shall be adjusted to 105 percent of the care related per diem median cost in order to achieve reasonable access to care.

c. Inflationary Factor. These costs shall be trended forward from the midpoint of the cost report period to the midpoint of the rate year using the index factor.

3. The administrative and operating per diem rate shall be a statewide price at a set percentage over the median, tier based on peer group. The administrative and operating component shall be determined as follows.

a. Median Cost. The administrative and operating per diem median cost for each ICF/IID is determined by dividing the facility's total administrative and operating costs reported on the cost report by the facility's actual total resident days during the cost reporting period. Administrative and operating costs for all providers are arrayed from low to high and the median (50th percentile) cost is determined.

b. Median Adjustment. The administrative and operating component shall be adjusted to 103 percent of the administrative and operating per diem median cost in order to achieve reasonable access to care.

c. Inflationary Factor. These costs shall be trended forward from the midpoint of the cost report period to the midpoint of the rate year using the index factor.

4. The capital per diem rate shall be a statewide price at a set percentage over the median, tier based on peer group. The capital per diem rate shall be determined as follows.

a. Median Cost. The capital per diem median cost for each ICF/IID is determined by dividing the facility's total capital costs reported on the cost report by the facility's actual total resident days during the cost reporting period. Capital costs for providers of each peer group are arrayed from low to high and the median (50th percentile) cost is determined for each peer group.

b. Median Adjustment. The capital cost component shall be adjusted to 103 percent of the capital per diem median cost in order to achieve reasonable access to care.

c. Inflationary Factor. Capital costs shall not be trended forward.

d. The provider fee shall be calculated by the department in accordance with state and federal rules.

i. Effective for dates of service on or after April 1, 2014, the add-on amount to each ICF/ID's per diem rate for the provider fee shall be increased to \$16.15 per day.

5. The dental add-on per diem rate shall be a statewide price, and the pass-through, once calculated, will be facility specific. This pass-through/add-on may be adjusted annually and will not follow the rebasing and inflationary adjustment schedule. The dental pass-through/add-on per diem rate shall be determined as follows:

a. Prior to inclusion of these costs on facility cost reports, a per diem add on will be created based on estimates provided by the state's actuary and should reflect the costs associated with those basic dental services that are excluded from the dental PMPMs paid to the Louisiana Medicaid dental managed care entity(ies).

b. The above dental add-on per-diem, but not the pass-through rate, paid to each facility will be subject to a wholly separate and distinct floor calculation for each cost

report year that the per-diem is in effect, beginning July 1, 2023. The total sum of the per-diem add-on paid to each facility will be compared to each facilities costs associated with basic dental services that are excluded from the dental PMPMs paid to the Louisiana Medicaid dental managed care entity(ies). Should 95 percent of the total per-diem add-on paid exceed the facilities noted cost, the facility shall remit to the bureau the difference between these two amounts.

c. Once these dental expenses have been recognized in a facility cost report with a year ended on or after June 30, 2024 that is utilized in a rate rebase period, the add-on will no longer be paid to that facility and a facility specific pass-through per-diem rate will be calculated as the total dental cost reported on the cost report divided by total cost report patient days. These per-diem rates and costs will follow the same oversight procedures as noted at Section 32909. The facility specific pass-through per-diem may be reviewed and adjusted annually, at the discretion of the department.

E. The rates for the 1-8 bed peer group shall be set based on costs in accordance with §32903.B–D.4.d. The reimbursement rates for peer groups of larger facilities will also be set in accordance with §32903.B–D.4.d; however, the rates, excluding any dental pass-through/add-on will be limited as follows.

1. The 9-15 peer group reimbursement rates will be limited to 95 percent of the 1-8 bed peer group reimbursement rates.

2. The 16-32 bed peer group reimbursement rates will be limited to 95 percent of the 9-15 bed peer group reimbursement rates.

3. The 33 and greater bed peer group reimbursement rates will be set in accordance with §32903.B–D.4.d, limited to 95 percent of the 16-32 bed peer group reimbursement rates.

F. Rebasing of rates will occur at least every three years utilizing the most recent audited and/or desk reviewed cost reports.

G. Adjustments to the Medicaid daily rate may be made when changes occur that eventually will be recognized in updated cost report data (such as a change in the minimum wage or FICA rates). These adjustments would be effective until such time as the data base used to calculate rates fully reflect the change. Adjustments to rates may also be made when legislative appropriations would increase or decrease the rates calculated in accordance with this rule. The secretary of the Department of Health and Hospitals makes the final determination as to the amount and when adjustments to rates are warranted.

H. A facility requesting a pervasive plus rate supplement shall bear the burden of proof in establishing the facts and circumstances necessary to support the supplement in a format and with supporting documentation specified by the LDH ICAP Review Committee.

1. The LDH ICAP Review Committee shall make a determination of the most appropriate staff required to provide requested supplemental services.

2. The amount of the Pervasive Plus supplement shall be calculated using the Louisiana Civil Service pay grid for the appropriate position as determined by the LDH ICAP Review Committee and shall be the 25th percentile salary level plus 20 percent for related benefits times the number of hours approved.

I. Other Client Specific Adjustments to the Rate. A facility may request a client specific rate supplement for reimbursement of the costs for enteral nutrition, ostomy or tracheotomy medical supplies or a vagus nerve stimulator.

1. The provider must submit sufficient medical supportive documentation to the LDH ICAP Review Committee to establish medical need for enteral nutrition, ostomy or tracheotomy medical supplies.

a. The amount of reimbursement determined by the ICAP Review Committee shall be based on the average daily cost for the provision of the medical supplies.

b. The provider must submit annual documentation to support the need for the adjustment to the rate.

2. Prior authorization for implementation for the Vagus nerve stimulator shall be requested after the evaluation has been completed but prior to stimulator implantation. The request to initiate implantation shall come from the multi-disciplinary team as a packet with the team's written decision regarding the recipient's candidacy for the implant and the results of all pre-operative testing. The PA-01 form for the device and surgeon shall be included in the packet forwarded to Unisys.

a. The amount of reimbursement shall be the established fee on the Medicaid Fee Schedule for medical equipment and supplies.

J. Effective for dates of service on or after September 1, 2009, the reimbursement rate for non-state intermediate care facilities for persons with developmental disabilities shall be increased by 1.59 percent of the per diem rate on file as of August 31, 2009.

K. Effective for dates of service on or after August 1, 2010, the per diem rates for non-state intermediate care facilities for persons with developmental disabilities (ICFs/IID) shall be reduced by 2 percent of the per diem rates on file as of July 31, 2010.

1. Effective for dates of service on or after December 20, 2010, non-state ICFs/IID which have downsized from over 100 beds to less than 35 beds prior to December 31, 2010 shall be excluded from the August 1, 2010 rate reduction.

L. Effective for dates of service on or after August 1, 2010, the per diem rates for ICFs/IID which have downsized from over 100 beds to less than 35 beds prior to December 31, 2010 shall be restored to the rates in effect on January 1, 2009.

M. Effective for dates of service on or after July 1, 2012, the per diem rates for non-state intermediate care facilities for persons with developmental disabilities (ICFs/IID) shall be reduced by 1.5 percent of the per diem rates on file as of June 30, 2012.

N. Pursuant to the provisions of Act 1 of the 2020 First Extraordinary Session of the Louisiana Legislature, effective for dates of service on or after July 1, 2020, private ICF/IID facilities that downsized from over 100 beds to less than 35 beds prior to December 31, 2010 without the benefit of a cooperative endeavor agreement (CEA) or transitional rate and who incurred excessive capital costs, shall have their per diem rates (excluding provider fees) increased by a percent equal to the percent difference of per diem rates (excluding provider fees and dental pass through) they were paid as of June 30, 2019. See chart below with the applicable percentages:

	Intermittent	Limited	Extensive	Pervasive
1-8 beds	6.2 percent	6.2 percent	6.2 percent	6.1 percent
9-15 beds	3.2 percent	6.2 percent	6.2 percent	6.1 percent
16-32 beds	N/A	N/A	N/A	N/A
33+ beds	N/A	N/A	N/A	N/A

1. The applicable differential shall be applied anytime there is a change to the per diem rates (for example, during rebase, rate reductions, inflationary changes, or special legislative appropriations). This differential shall not extend beyond December 31, 2024.

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 31:2253 (September 2005), amended LR 33:462 (March 2007), LR 33:2202 (October 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:1555 (July 2010), LR 37:3028 (October 2011), LR 39:1780 (July 2013), LR 39:2766 (October 2013), LR 41:539 (March 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 47:370 (March 2021), LR 49:687 (April 2023).

§32904. Temporary Reimbursement for Private Facilities

A. The department shall establish temporary Medicaid reimbursement rates of \$352.08 per day per individual for a 15-bed private ICF/IID community home and \$327.08 for an 8-bed private ICF/IID community home that meet the following criteria. The community home:

1. shall have a fully executed cooperative endeavor agreement (CEA) with the Office for Citizens with Developmental Disabilities for the private operation of the facility;

a. the provider shall be subject to the direct care floor as outlined in the executed CEA;

2. shall have a high concentration of people who have intellectual/developmental disabilities, significant behavioral

health needs, high risk behavior, i.e. criminal-like resulting in previous interface with the judicial system, use of restraint, and elopement. These shall be people for whom no other private ICF/IID provider is able to support as confirmed by the Office for Citizens with Developmental Disabilities;

3. incurs or will incur higher existing costs not currently captured in the private ICF/IID rate methodology; and

4. shall have no more than 15 beds in one facility and 8 beds the second facility.

B. The temporary Medicaid reimbursement rate shall only be for the period of four years.

C. The temporary Medicaid reimbursement rate is all-inclusive and incorporates the following cost components:

1. direct care staffing;
2. medical/nursing staff;
3. medical supplies;
4. transportation;
5. administrative;
6. the provider fee; and
7. dental pass-through/add-on per diem rate (effective for dates of service on or after January 1, 2023).

D. The temporary rate and supplement shall not be subject to the following:

1. inflationary factors or adjustments;
2. rebasing;
3. budgetary reductions; or
4. other rate adjustments.

E. The Medicaid daily rate will include a direct care \$12 add-on to reimburse providers for increased cost related to retaining and hiring direct care staff. This add-on will be discontinued upon the next rebase, or at the discretion of the department.

NOTE: Medicaid providers have up to a year from the date of service to bill Medicaid for their claims. The provisions of this Subsection will apply to claims effective for dates of service on or after January 1, 2022.

1. Effective April 1, 2022, the minimum hourly wage floor paid to directly employed (non-contracted) non-nursing/physician direct care worker shall be \$9 per hour.

a. Directly employed non-nursing/physician direct care workers will include any employee whose wage expense is reported on sch H - expenses lines A.2. - A.8. on the Medicaid cost report.

b. Providers shall submit to the department or its representatives all requested documentation to verify compliance with the direct care wage floor.

i. This documentation may include, but is not limited to, payroll records, wage and salary documents, payroll check stubs, and supplemental cost report schedules.

ii. Providers shall produce the required documentation upon request and within the time frame indicated by the department, or the provider may be subject to sanctions, full recoupment of add-on payments received, and/or disenrollment in the Medicaid Program.

c. Providers with directly employed non-nursing/physician direct care worker(s) that is (are) identified as not meeting the minimum hourly wage floor requirement shall be subject to a recoupment that is calculated as the differential between the minimum hourly wage floor and the actual hourly wage paid for all hours worked during the reporting period by the specific employee(s) that did not meet the minimum hourly wage floor requirement. This recoupment shall not exceed the total amount paid to the provider for the \$12 direct care add-on in a state fiscal year. This penalty is not mutually exclusive of any other direct care floor or related penalty. Additionally, any recoupment as a result of the wage floor will not impact any other direct care floor recoupment calculation.

i. The hourly wage of a directly employed non-nursing/physician direct care worker will be calculated as the total regular (non-overtime) wage expense (exclusive of bonus, benefits, etc.) divided by the total regular (non-overtime) hours worked during the reporting period.

2. Effective April 1, 2022, a facility wide direct care floor is established at 75 percent of the per diem for direct care payment and at 100 percent of the \$12 direct care add-on payment for year. In no case shall a facility receiving this add-on payment have total facility payments reduced to less than 104 percent of the total facility cost as a result of imposition of the direct care floor. For facilities that also receive add-on payments related to complex care or pervasive plus, the greater of the direct care floors will be applicable.

a. If the direct care cost the facility incurred on a per diem basis, plus add-on, is less than the appropriate facility direct care floor, the facility shall remit to the bureau the difference between these two amounts times the number of facility Medicaid days paid during the cost reporting period. This remittance shall be payable to the bureau upon submission of the cost report.

b. Upon completion of desk reviews or audits, facilities will be notified by the bureau of any changes in amounts due based on audit or desk review adjustments.

c. Direct care floor recoupment as a result of a facility not meeting the required direct care per diem floor is considered effective 30 days from the issuance of the original notice of determination. Should an informal reconsideration be requested, the recoupment will be considered effective 30 days from the issuance of the results of an informal hearing. The filing of a timely and adequate notice of an administrative appeal does not suspend or delay the imposition of a recoupment(s).

d. The direct care floor recoupment is not mutually exclusive of any penalty related to not meeting the minimum direct care wage floor or any other penalty.

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 47:593 (May 2021), amended LR 48:2129 (August 2022), LR 49:688 (April 2023).

§32905. ICAP Requirements

A. An ICAP must be completed for each recipient of ICF/IID services upon admission and while residing in an ICF/IID in accordance with departmental regulations.

B. Providers must keep a copy of the recipient's current ICAP protocol and computer scored summary sheets in the recipient's file. If a recipient has changed ICAP service level, providers must also keep a copy of the recipient's ICAP protocol and computer scored summary sheets supporting the prior level.

C. ICAPs must reflect the resident's current level of care.

D. Providers must submit a new ICAP to the Regional Health Standards office when the resident's condition reflects a change in the ICAP level that indicates a change in reimbursement.

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 31:1593 (July 2005), repromulgated LR 31:2254 (September 2005), LR 49:688 (April 2023).

§32907. ICAP Monitoring

A. ICAP scores and assessments will be subject to review by LDH and its contracted agents. The reviews of ICAP submissions include, but are not limited to:

1. reviews when statistically significant changes occur within an ICAP submission or submissions;
2. random selections of ICAP submissions;
3. desk reviews of a sample of ICAP submissions; and
4. on-site field reviews of ICAPs.

B. ICAP Review Committee

1. Requests for Pervasive Plus must be reviewed and approved by the LDH ICAP Review Committee.

2. The ICAP Review Committee shall represent DHH should a provider request an informal reconsideration regarding the Regional Health Standards' determination.

3. The ICAP Review Committee shall make final determination on any ICAP level of care changes prior to the appeals process.

4. The ICAP Review Committee shall be made up of the following:

- a. the director of the Health Standards Section or his/her appointee;

- b. the director of Rate and Audit Review Section or his/her appointee;
- c. the assistant secretary for the Office for Citizens with Developmental Disabilities or his/her appointee;
- d. other persons as appointed by the secretary.

C. When an ICAP score is determined to be inaccurate, the department shall notify the provider and request documentation to support the level of care. If the additional information does not support the level of care, an ICAP rate adjustment will be made to the appropriate ICAP level effective the first day of the month following the determination.

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 31:1594 (July 2005), repromulgated LR 31:2254 (September 2005), amended by the Department of Health, Bureau of Health Services Financing, LR 49:688 (April 2023).

§32909. Audits

A. Each ICF/IID shall file an annual facility cost report and a central office cost report.

B. ICF/IID shall be subject to financial and compliance audits.

C. All providers who elect to participate in the Medicaid Program shall be subject to audit by state or federal regulators or their designees. Audit selection for the department shall be at the discretion of LDH.

1. A representative sample of the ICF/IID shall be fully audited to ensure the fiscal integrity of the program and compliance of providers with program regulations governing reimbursement.

2. Limited scope and exception audits shall also be conducted as determined by LDH.

3. LDH conducts desk reviews of all the cost reports received. LDH also conducts on-site audits of provider records and cost reports.

a. LDH seeks to maximize the number of on-site audited cost reports available for use in its cost projections although the number of on-site audits performed each year may vary.

b. Whenever possible, the records necessary to verify information submitted to LDH on Medicaid cost reports, including related-party transactions and other business activities engaged in by the provider, must be accessible to LDH audit staff in the state of Louisiana.

D. Cost of Out-of-State Audits

1. When records are not available to LDH audit staff within Louisiana, the provider must pay the actual costs for LDH staff to travel and review the records out-of-state.

2. If a provider fails to reimburse LDH for these costs within 60 days of the request for payment, LDH may place a hold on the vendor payments until the costs are paid in full.

E. In addition to the exclusions and adjustments made during desk reviews and on-site audits, LDH may exclude or adjust certain expenses in the cost-report data base in order to base rates on the reasonable and necessary costs that an economical and efficient provider must incur.

F. The facility shall retain such records or files as required by LDH and shall have them available for inspection for five years from the date of service or until all audit exceptions are resolved, whichever period is longer.

G. If LDH's auditors determine that a facility's records are unauditible, the vendor payments may be withheld until the facility submits an acceptable plan of correction to reconstruct the records. Any additional costs incurred to complete the audit shall be paid by the provider.

H. Vendor payments may also be withheld under the following conditions:

1. a facility fails to submit corrective action plans in response to financial and compliance audit findings within 15 days after receiving the notification letter; or

2. a facility fails to respond satisfactorily to LDH's request for information within 15 days after receiving the department's letter.

I. If LDH's audit of the residents' personal funds account indicate a material number of transactions were not sufficiently supported or material noncompliance, then LDH shall initiate a full scope audit of the account. The cost of the full scope audit shall be withheld from the vendor payments.

J. The ICF/IID shall cooperate with the audit process by:

1. promptly providing all documents needed for review;

2. providing adequate space for uninterrupted review of records;

3. making persons responsible for facility records and cost report preparation available during the audit;

4. arranging for all pertinent personnel to attend the exit conference;

5. insuring that complete information is maintained in client's records; and

6. correcting areas of noncompliance with state and federal regulations immediately after the exit conference time limit of 15 days.

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 31:1594 (July 2005), repromulgated LR 31:2254 (September 2005), amended by the Department of Health, Bureau of Health Services Financing, LR 49:688 (April 2023).

§32911. Exclusions from Database

A. Providers with disclaimed audits and providers with cost reports for other than a 12-month period will be excluded from the database used to calculate the rates.

B. Providers who do not submit ICAP scores will be paid at the Intermittent level until receipt of ICAP scores.

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 31:1594 (July 2005), repromulgated LR 31:2255 (September 2005).

§32913. Leave of Absence Days

A. The reimbursement to non-state ICFs/IID for hospital leave of absence days is 85 percent of the current applicable per diem rate.

B. The reimbursement for leave of absence days is 100 percent of the applicable per diem rate.

1. A leave of absence is a temporary stay outside of the ICF/IID, for reasons other than for hospitalization, provided for in the recipient's written individual habilitation plan.

C. The reimbursement to non-state ICFs/IID for leave of absence days is 85 percent of the current applicable per diem rate provided for in this Chapter.

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 27:57 (January 2001), repromulgated LR 31:2255 (September 2005), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1897 (September 2009), amended by the House of Representatives, House Concurrent Resolution No. 4 of the 2022 Regular Legislative Session, LR 48:2024 (July 2022), amended by the Department of Health, Bureau of Health Services Financing, LR 49:689 (April 2023).

§32915. Complex Care Reimbursements

A. Private (non-state) intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) may receive an add-on payment to the per diem rate for providing complex care to Medicaid beneficiaries, when medically necessary. The add-on payment shall be a flat fee daily amount and consists of payment for one of the following components alone or in combination:

1. direct service worker add-on;
2. skilled nursing add-on; and
3. equipment add-on.

B. To qualify, beneficiaries must meet medical necessity criteria established by the Medicaid Program. Supporting medical documentation must also be submitted as specified by the Medicaid Program. The duration of approval of the add-on payment(s) is at the sole discretion of the Medicaid Program and shall not exceed one year.

C. Medical necessity of the add-on payment(s) shall be reviewed and re-determined by the Medicaid Program no less than annually from the date of initial approval of each add-on payment. This review shall be performed in the same manner and using the same medical necessity criteria as the initial review.

D. Each add-on payment requires documentation that the enhanced supports are already being provided to the beneficiary, as specified by the Medicaid program.

E. One of the following admission requirements must be met in order to qualify for the add-on payment:

1. the beneficiary has been admitted to the facility for more than 30 days with supporting documentation of medical necessity; or
2. the beneficiary is transitioning from another similar agency with supporting documentation of medical necessity.

F. The Medicaid Program shall require compliance with all applicable laws, rules, and regulations as a condition of an ICF/IID's qualification for any complex care add-on payment(s) and may evaluate such compliance in its initial annual qualifying reviews.

G. The following additional requirements apply:

1. Beneficiaries receiving enhanced rates must be included in annual surveys to ensure continuation of supports and review of individual outcomes.
2. Fiscal analysis and reporting is required annually.

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 42:276 (February 2016), amended LR 44:1447 (August 2018), LR 45:273 (February 2019), LR 48:2294 (September 2022).

§32917. Dedicated Program Funding Pool Payments

A. Effective for providers active and Medicaid certified as of September 1, 2019; a one-time lump sum payment will be made to intermediate care facilities for individuals with intellectual disabilities (ICFs/IID).

B. Methodology

1. Payment will be based on each provider's specific pro-rated share of an additional dedicated program funding pool totaling \$4,665,635.

2. The pro-rated share for each provider will be determined utilizing the provider's percentage of total annualized program Medicaid days. Annualized program Medicaid days will be calculated utilizing the most recently desk reviewed or audited cost reports as of July 1, 2019.

3. The additional dedicated program funding pool lump sum payments shall not exceed the Medicare upper payment limit in the aggregate for the provider class.

4. The one-time payment will be made on or before June 30, 2020.

5. Payment of the one-time lump sum payment is subject to approval by the U.S. Department of Health and Human Services, Centers for Medicaid and Medicare Services (CMS).

C. Effective for providers active and Medicaid certified as of July 1, 2022, a one-time, lump sum payment will be made to non-state, non-public intermediate care facilities for individuals with intellectual disabilities (ICFs/IID).

1. Methodology

a. Payment will be based on each provider's specific pro-rated share of an additional dedicated program funding pool totaling \$27,974,178.

b. The pro-rated share for each provider will be determined utilizing the provider's percentage of program Medicaid days for dates of service in a three consecutive month period selected by the department occurring between January 1, 2022 and December 31, 2022.

c. If the additional dedicated program funding pool lump sum payments exceed the Medicare upper payment limit in the aggregate for the provider class, the department shall recoup the overage using the same means of distribution in §32917.C.1.b above.

d. The one-time payment will be made on or before June 30, 2023.

e. All facilities receiving payment shall be open and operating as an ICF/IID at the time the payment is made.

f. Payment of the one-time, lump sum payment is subject to approval by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS).

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 46:28 (January 2020), amended LR 48:2972 (December 2022).

Subchapter C. Public Facilities

§32965. State-Owned and Operated Facilities

A. Medicaid payments to state-owned and operated intermediate care facilities for persons with developmental disabilities are based on the Medicare formula for determining the routine service cost limits as follows:

1. calculate each state-owned and operated ICF/IID's per diem routine costs in a base year;

2. calculate 112 percent of the average per diem routine costs; and

3. inflate 112 percent of the per diem routine costs using the skilled nursing facility (SNF) market basket index of inflation.

B. Each state-owned and operated facility's capital and ancillary costs will be paid by Medicaid on a "pass-through" basis.

C. The sum of the calculations for routine service costs and the capital and ancillary costs "pass-through" shall be the per diem rate for each state-owned and operated ICF/IID. The base year cost reports to be used for the initial calculations shall be the cost reports for the fiscal year ended June 30, 2002.

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 39:325 (February 2013), amended by the Department of Health, LR 49:689 (April 2023).

§32967. Quasi-Public Facilities

A. Medicaid payment to quasi-public facilities is a facility-specific prospective rate based on budgeted costs. Providers shall be required to submit a projected budget for the state fiscal year beginning July 1.

B. The payment rates for quasi-public facilities shall be determined as follows:

1. determine each ICF/IID's per diem for the base year beginning July 1;

2. calculate the inflation factor using an average CPI index applied to each facility's per diem for the base year to determine the inflated per diem;

3. calculate the median per diem for the facilities' base year;

4. calculate the facility's routine cost per diem for the SFY beginning July 1 by using the lowest of the budgeted, inflated or median per diem rates plus any additional allowances; and

5. calculate the final approved per diem rate for each facility by adding routine costs plus any "pass through" amounts for ancillary services, provider fees, and grant expenses.

C. Providers may request a final rate adjustment subject to submission of supportive documentation and approval by the department.

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 39:326 (February 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 49:689 (April 2023).

§32969. Transitional Rates for Public Facilities

A. Effective October 1, 2012, the department shall establish a transitional Medicaid reimbursement rate of \$302.08 per day per individual for a public ICF/IID facility over 50 beds that is transitioning to a private provider, as long as the provider meets the following criteria:

1. shall have a fully executed cooperative endeavor agreement (CEA) with the Office for Citizens with Developmental Disabilities (OCDD) for the private operation of the facility;

2. shall have a high concentration of medically fragile individuals being served, as determined by the department;

a. for purposes of these provisions, a medically fragile individual shall refer to an individual who has a medically complex condition characterized by multiple, significant medical problems that require extended care;

3. incurs or will incur higher existing costs not currently captured in the private ICF/IID rate methodology; and

4. shall agree to downsizing and implement a pre-approved OCDD plan:

a. any ICF/IID home that is a cooperative endeavor agreement (CEA) to which individuals transition to satisfy downsizing requirements, shall not exceed 6-8 beds.

B. The transitional Medicaid reimbursement rate shall only be for the period of transition, which is defined as the term of the CEA or a period of four years, whichever is shorter.

1. The department may extend the period of transition up to September 30, 2020, if deemed necessary, for an active CEA facility that is:

- a. a large facility of 100 beds or more;
- b. serves a medically fragile population; and
- c. provides continuous (24-hour) nursing coverage.

C. The transitional Medicaid reimbursement rate is all-inclusive and incorporates the following cost components:

1. direct care staffing;
2. medical/nursing staff, up to 23 hours per day;
3. medical supplies;
4. transportation;
5. administrative; and
6. the provider fee.

D. If the community home meets the above criteria and the individuals served require that the community home has a licensed nurse at the facility 24 hours per day, seven days per week, the community home may apply for a supplement to the transitional rate. The supplement to the rate shall not exceed \$25.33 per day per individual.

E. The total transitional Medicaid reimbursement rate, including the supplement, shall not exceed \$327.41 per day per individual.

F. The transitional rate and supplement shall not be subject to the following:

1. inflationary factors or adjustments;
2. rebasing;
3. budgetary reductions; or
4. other rate adjustments.

G. Effective for dates of service on or after October 1, 2014, the transitional Medicaid reimbursement rate shall be increased by \$1.85 of the rate in effect on September 30, 2014.

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 39:326 (February 2013), amended LR 40:2588 (December 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 44:60 (January 2018), LR 44:772 (April 2018), LR 45:273 (February 2019), LR 45:435 (March 2019), LR 49:689 (April 2023).

Chapter 331. Vendor Payments

§33101. Income Consideration in Determining Payment

A. Clients receiving care under Title XIX. The client's applicable income (liability) will be determined when computing the ICF/MR's vendor payments. Vendor payments are subject to the following conditions.

1. Vendor payments will begin with the first day the client is determined to be categorically and medically eligible or the date of admission, whichever is later.

2. Vendor payment will be made for the number of eligible days as determined by the ICF/MR per diem rate less the client's per diem applicable income.

3. If a client transfers from one facility to another, the vendors' payment to each facility will be calculated by multiplying the number of eligible days times the ICF/MR per diem rate less the client's liability.

B. Client Personal Care Allowance. The ICF/MR will not require that any part of a client's personal care allowance be paid as part of the ICF/MR's fee. Personal care allowance is an amount set apart from a client's available income to be used by the client for his/her personal use. The amount is determined by DHH.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:682 (April 1999), repromulgated LR 31:2257 (September 2005).

§33103. Payment Limitations

A. Temporary Absence of the Client. A client's temporary absence from an ICF/ID will not interrupt the monthly vendor payment to the ICF/ID, provided the following conditions are met:

1. the ICF/ID keeps a bed available for the client's return; and

2. the absence is for one of the following reasons:

a. hospitalization, which does not exceed seven days per hospitalization for treatment of an acute condition; or

b. leave of absence. A temporary stay outside the ICF/ID provided for in the client's written individual habilitation plan. A leave of absence will not exceed 60 days per fiscal year (July 1 through June 30) and will not exceed 45 consecutive days in any single occurrence. Certain leaves of absence will be excluded from the annual 60-day limit as long as the leave does not exceed the 45-consecutive day limit and is included in the written individual habilitation plan. These exceptions are as follows:

- i. Special Olympics;
- ii. roadrunner-sponsored events;
- iii. Louisiana planned conferences;
- iv. trial discharge leave—14 days per occurrence;
- v. official state holidays; and
- vi. two days for bereavement of close family members.

(a). *Close Family Members*—parent, step-parent, child, step-child, brother, step-brother, sister, step-sister, spouse, mother-in-law, father-in-law, grand-parent, or grandchild;

c. the following leaves of absence will be excluded from both the annual 60-day limit and the 45-consecutive day limit as long as the leave of absence is included in the written individual habilitation plan:

- i. any leave of absence during a declared federal public emergency by the Department of Health and Human Services.

NOTE: Elopements and unauthorized absences under the written individual habilitation plan count against allowable leave days. However, Title XIX eligibility is not affected if the absence does not exceed 30 consecutive days and if the ICF/ID has not discharged the client.

3. the period of absence shall be determined by counting the first day of absence as the day on which the first 24-hour period of absence expires;

4. a period of 24 continuous hours or more shall be considered an absence. Likewise, a temporary leave of absence for hospitalization or a home visit is broken only if the client returns to the ICF/ID for 24 hours or longer;

5. upon admission, a client must remain in the ICF/ID at least 24 continuous hours in order for the ICF/ID to submit a payment claim for a day of service or reserve a bed;

EXAMPLE: A client admitted to an ICF/ID in the morning and transferred to the hospital that afternoon would not be eligible for any vendor payment for ICF/ID services.

6. if a client transfers from one facility to another, the unused leave days for the fiscal year also transfer. No additional leave days are allocated as a result of a transfer;

7. the ICF/ID shall promptly notify DHH of absences beyond the applicable forty-five- or seven-day limitations. Payment to the ICF/MR shall be terminated from the forty-sixth or eighth day, depending upon the leave of absence. Payment will commence after the individual has been

determined eligible for Title XIX benefits and has remained in the ICF/ID for 30 consecutive days;

8. the limit on Title XIX payment for leave days does not mean that further leave days are prohibited when provided for in the individual habilitation plan. After the Title XIX payment limit is met, further leave days may be arranged between the ICF/ID and the client, family or responsible party. Such arrangements may include the following options.

a. The ICF/ID may charge the client, family or responsible party an amount not to exceed the Title XIX daily rate.

b. The ICF/ID may charge the client, family or responsible party a portion of the Title XIX daily rate.

c. The ICF/ID may absorb the cost into its operation costs.

B. *Temporary Absence of the Client Due to Evacuations*. When local conditions require evacuation of ICF/ID residents, the following procedures apply.

1. When clients are evacuated to a family's or friend's home at the ICF/ID's request, the ICF/MR shall not submit a claim for a day of service or leave day, and the client's liability shall not be collected.

2. When clients go home at the family's request or on their own initiative, a leave day shall be charged.

3. When clients are admitted to the hospital for the purpose of evacuation of the ICF/ID, Medicaid payment shall not be made for hospital charges.

C. *Payment Policy in regard to Date of Admission, Discharge, or Death*

1. Medicaid (Title XIX) payments shall be made effective as of the admission date to the ICF/ID. If the client is medically certified as of that date and if either of the following conditions is met:

a. the client is eligible for Medicaid benefits in the ICF/ID (excluding the medically needy); or

b. the client was in a continuous institutional living arrangement (nursing home, hospital, ICF/ID, or a combination of these institutional living arrangements) for 30 consecutive days; the client must also be determined financially eligible for medical assistance.

2. The continuous stay requirement is:

a. considered met if the client dies during the first 30 consecutive days;

b. not interrupted by the client's absence from the ICF/ID when the absence is for hospitalization or leave of absence which is part of the written individual habilitation plan.

3. The client's applicable income is applied toward the ICF/ID fee effective with the date Medicaid payment is to begin.

4. Medicaid payment is not made for the date of discharge; however, neither the client, the family, nor responsible party is to be billed for the date of discharge.

5. Medicaid payment is made for the day of client's death.

NOTE: The ICF/ID shall promptly notify LDH/BHSF of admissions, death, and/or all discharges.

D. Advance Deposits

1. An ICF/ID shall neither require nor accept an advance deposit from an individual whose Medicaid (Title XIX) eligibility has been established.

EXCEPTION: An ICF/ID may require an advance deposit for the current month only on that part of the total payment which is the client's liability.

2. If advance deposits or payments are required from the client, family, or responsible party upon admission when Medicaid (Title XIX) eligibility has not been established, such a deposit shall be refunded or credited to the person upon receipt of vendor payment.

E. Retroactive Payment. When individuals enter an ICF/ID before their Medicaid (Title XIX) eligibility has been established payment for ICF/ID services is made retroactive to the first day of eligibility after admission.

F. Timely Filing for Reimbursements. Vendor payments cannot be made if more than 12 months have elapsed between the month of initial services and submittal of a claim for these services. Exceptions for payments of claims over 12 months old can be made with authorization from LDH/BHSF only.

G. Refunds to Clients

1. When the ICF/ID receives vendor payments, it shall refund any fees for services collected from clients, family or responsible party by the end of the month in which vendor payment is received.

2. Advance payments for a client's liability (applicable income) shall be refunded promptly if he/she leaves the ICF/ID.

3. The ICF/ID shall adhere to the following procedures for refunds.

a. The proportionate amount for the remaining days of the month shall be refunded to the client, family, or the responsible party no later than 30 days following the date of discharge. If the client has not yet been certified, the procedures spelled out in §33103.G.1 above shall apply.

b. No penalty shall be charged to the client, family, or responsible party even if the circumstances surrounding the discharge occurred as follows:

- i. without prior notice; or
- ii. within the initial month; or
- iii. within some other "minimum stay" period established by the ICF/ID.

c. Proof of refund of the unused portion of the applicable income shall be furnished to BHSF upon request.

H. ICF/ID Refunds to the Department

1. Nonparticipating ICF/ID. Vendor payments made for services performed while an ICF/ID is in a nonparticipating status with the Medicaid Program shall be refunded to the department.

2. Participating ICF/ID. A currently participating Title XIX, ICF/ID shall correct billing or payment errors by use of appropriate adjustment void or patient liability (PLI) adjustment forms.

I. Sitters. An ICF/ID will neither expect nor require a client to have a sitter. However, the ICF/ID shall permit clients, families, or responsible parties directly to employ and pay sitters when indicated, subject to the following limitations.

1. The use of sitters will be entirely at the client's, family's, or responsible party's discretion. However, the ICF/ID shall have the right to approve the selection of a sitter. If the ICF/ID disapproves the selection of the sitter, the ICF/ID will provide written notification to the client, family, and/or responsible party, and to the department stating the reasons for disapproval.

2. Payment to sitters is the direct responsibility of the client, family or responsible party, unless:

- a. the hospital's policy requires a sitter;
- b. the attending physician requires a sitter; or
- c. the individual habilitation plan (IHP) requires a sitter.

NOTE: Psychiatric Hospitals are excluded from this requirement.

3. Payment to sitters is the direct responsibility of the ICF/ID facility when:

- a. the hospital's policy requires a sitter and the client is on hospital leave days;
- b. the attending physician requires a sitter;
- c. the IHP requires a sitter.

4. A sitter will be expected to abide by the ICF/ID's rules, including health standards and professional ethics.

5. The presence of a sitter does not absolve the ICF/ID of its full responsibility for the client's care.

6. The ICF/ID is not responsible for providing a sitter if one is required while the resident is on home leave.

J. Tips. The ICF/ID shall not permit tips for services rendered by its employees.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services

Financing, LR 25:682 (April 1999), LR 31:1082 (May 2005), repromulgated LR 31:2257 (September 2005), amended by the Department of Health, Bureau of Health Services Financing, LR 43:325 (February 2017), LR 44:61 (January 2018), amended by the House of Representatives, 2020 Second Extraordinary Session, LR 46:1640 (November 2020), LR 50:386 (March 2024).

§33105. Evacuation and Temporary Sheltering Costs

A. Intermediate care facilities for persons with intellectual disabilities required to participate in an evacuation, as directed by the appropriate parish or state official, or which act as a host shelter site may be entitled to reimbursement of its documented and allowable evacuation and temporary sheltering costs.

1. The expense incurred must be in excess of any existing or anticipated reimbursement from any other sources, including the Federal Emergency Management Agency (FEMA) or its successor.

2. ICFs/ID must first apply for evacuation or sheltering reimbursement from all other sources and request that the department apply for FEMA assistance on their behalf.

3. ICFs/ID must submit expense and reimbursement documentation directly related to the evacuation or temporary sheltering of Medicaid residents to the department.

B. Eligible Expenses. Expenses eligible for reimbursement must occur as a result of an evacuation and be reasonable, necessary, and proper. Eligible expenses are subject to audit at the department's discretion and may include the following.

1. Evacuation Expenses. Evacuation expenses include expenses from the date of evacuation to the date of arrival at a temporary shelter or another ICF/ID. Evacuation expenses include:

a. resident transportation and lodging expenses during travel;

b. nursing staff expenses when accompanying residents, including:

i. transportation;

ii. lodging; and

iii. additional direct care expenses, when a direct care expense increase of 10 percent or more is documented:

(a). the direct care expense increase must be based on a comparison to the average of the previous two pay periods or other period comparisons determined acceptable by the department;

c. any additional allowable costs that are directly related to the evacuation and that would normally be allowed under the ICF/ID rate methodology.

2. Non-ICF/ID Facility Temporary Sheltering Expenses. Non-ICF/ID facility temporary sheltering expenses include expenses from the date the Medicaid residents arrive at a non-ICF/ID facility temporary shelter to

the date all Medicaid residents leave the shelter. A non-ICF/ID facility temporary shelter includes shelters that are not part of a licensed ICF/ID and are not billing for the residents under the ICF/ID reimbursement methodology or any other Medicaid reimbursement system. Non-ICF/ID facility temporary sheltering expenses may include:

a. additional nursing staff expenses including:

i. lodging; and

ii. additional direct care expenses, when a direct care expense increase of 10 percent or more is documented:

(a). the direct care expense increase must be based on a comparison to the average of the previous two pay periods or other period comparisons determined acceptable by the department;

b. care-related expenses incurred in excess of care-related expenses prior to the evacuation;

c. additional medically necessary equipment such as beds and portable ventilators that are not available from the evacuating nursing facility and are rented or purchased specifically for the temporary sheltered residents; and

i. these expenses will be capped at a daily rental fee not to exceed the total purchase price of the item;

ii. the allowable daily rental fee will be determined by the department;

d. any additional allowable costs as determined by the department and that are directly related to the temporary sheltering and that would normally be allowed under the ICF/ID reimbursement methodology.

3. Host ICF/ID Temporary Sheltering Expenses. Host ICF/ID temporary sheltering expenses include expenses from the date the Medicaid residents are admitted to a licensed ICF/ID to the date all temporary sheltered Medicaid residents are discharged from the ICF/ID, not to exceed a six-month period.

a. The host ICF/ID shall bill for the residents under Medicaid's ICF/ID reimbursement methodology.

b. Additional direct care expenses may be submitted when a direct care expense increase of 10 percent or more is documented.

i. The direct care expense increase must be based on a comparison to the average of the previous two pay periods or other period comparisons determined acceptable by the department.

C. Payment of Eligible Expenses

1. For payment purposes, total eligible Medicaid expenses will be the sum of nonresident-specific eligible expenses multiplied by the facility's Medicaid occupancy percentage plus Medicaid resident-specific expenses.

a. If Medicaid occupancy is not easily verified using the evacuation resident listing, the Medicaid occupancy from the most recently filed cost report will be used.

2. Payments shall be made as quarterly lump-sum payments until all eligible expenses have been submitted and paid. Eligible expense documentation must be submitted to the department by the end of each calendar quarter.

3. All eligible expenses documented and allowed under §33105 will be removed from allowable expenses when the ICF/ID's Medicaid cost report is filed. These expenses will not be included in the allowable cost used to set ICF/ID reimbursement rates in future years.

a. Equipment purchases that are reimbursed on a rental rate under §33105.B.2.c may have their remaining basis included as allowable cost on future costs reports provided that the equipment is in the ICF/ID and being used. If the remaining basis requires capitalization then depreciation will be recognized.

4. Payments shall remain under the upper payment limit cap for ICFs/ID.

D. When an ICF/ID resident is evacuated to a temporary sheltering site (an unlicensed sheltering site or a licensed ICF/ID) for less than 24 hours, the Medicaid vendor payment to the evacuating facility will not be interrupted.

E. When an ICF/ID resident is evacuated to a temporary sheltering site (an unlicensed sheltering site or a licensed NF) for greater than 24 hours, the evacuating ICF/ID may submit the claim for Medicaid vendor payment for a maximum of five days, provided that the evacuating ICF/ID provides sufficient staff and resources to ensure the delivery of essential care and services to the resident at the temporary shelter site.

F. When an ICF/ID resident is evacuated to a temporary shelter site, which is an unlicensed sheltering site, for greater than five days, the evacuating ICF/ID may submit the claim for Medicaid vendor payment for up to an additional 15 days, provided that the evacuating ICF/ID:

1. has received an extension to stay at the unlicensed shelter site; and
2. provides sufficient staff and resources to ensure the delivery of essential care and services to the resident, and to ensure the needs of the resident are met.

G. When an ICF/ID resident is evacuated to a temporary shelter site, which is a licensed ICF/ID, for greater than 5

days, the evacuating ICF/ID may submit the claim for Medicaid vendor payment for an additional period, not to exceed 55 days, provided that:

1. the host/receiving ICF/ID has sufficient licensed and certified bed capacity for the resident, or the host/receiving ICF/ID has received departmental and/or CMS approval to exceed the licensed and certified bed capacity for a specified period; and

2. the evacuating ICF/ID provides sufficient staff and resources to ensure the delivery of essential care and services to the resident, and to ensure the needs of the resident are met.

H. If an ICF/ID resident is evacuated to a temporary shelter site which is a licensed ICF/ID, the receiving/host ICF/ID may submit claims for Medicaid vendor payment under the following conditions:

1. beginning day two and continuing during the "sheltering period" and any extension period, if the evacuating nursing home does not provide sufficient staff and resources to ensure the delivery of essential care and services to the resident and to ensure the needs of the residents are met;

2. upon admission of the evacuated residents to the host/receiving ICF/ID; or

3. upon obtaining approval of a temporary hardship exception from the department, if the evacuating ICF/ID is not submitting claims for Medicaid vendor payment.

I. Only one ICF/ID may submit the claims and be reimbursed by the Medicaid Program for each Medicaid resident for the same date of service.

J. An ICF/ID may not submit claims for Medicaid vendor payment for non-admitted residents beyond the expiration of its extension to exceed licensed (and/or certified) bed capacity or expiration of its temporary hardship exception.

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 43:327 (February 2017).

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE

Part IX. Professional Services Program

Subpart 1. General Provisions

Chapter 6. Outpatient Physician Services

§601. General Provisions

A. The Medicaid Program provides coverage and reimbursement for outpatient physician visits. There shall be no limits placed on the number of physician visits payable by the Medicaid Program for eligible beneficiaries.

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 41:2652 (December 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 47:48 (January 2021).

Chapter 7. Diabetes Education Services

§701. General Provisions

A. Effective for dates of service on or after February 20, 2011, the Medicaid Program provides coverage of diabetes self-management training (DSMT) services rendered to Medicaid beneficiaries diagnosed with diabetes mellitus.

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 39:2509 (September 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 47:48 (January 2021).

§703. Scope of Services

A. DSMT shall consist of individual and group instruction on diabetes self-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 Hospitals, Bureau of Health Services Financing, LR 39:2509 (September 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 47:48 (January 2021).

§705. Provider Participation

A. To receive reimbursement, members of the DSMT instructional team must be either employed by or have a contract with, a Medicaid-enrolled professional services provider that will submit the claims for reimbursement of DSMT services rendered by the team.

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

39:2510 (September 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 47:48 (January 2021).

Chapter 9. Fluoride Varnish Application Services

§901. General Provisions

A. Effective for dates of service on or after December 1, 2011, the Medicaid Program provides coverage of fluoride varnish application services to beneficiaries under the age of 21.

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 40:315 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 47:49 (January 2021).

§903. Scope of Services

A. Fluoride varnish application services performed in a physician office setting shall be reimbursed by the Medicaid Program when rendered by the appropriate professional services providers.

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 40:315 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 47:49 (January 2021).

§905. Provider Participation

A. The entity seeking reimbursement for fluoride varnish application services must be an enrolled Medicaid provider.

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 40:315 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1524 (September 2016), LR 47:49 (January 2021).

Chapter 11. Tobacco Cessation Counseling Services

§1101. General Provisions

A. Effective for dates of service on or after June 20, 2023, the Medicaid Program provides coverage for tobacco cessation counseling services to beneficiaries who use tobacco products or who are being treated for tobacco use.

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 49:1086 (June 2023).

§1103. Scope of Services

A. Tobacco cessation counseling services shall be reimbursed by the Medicaid Program when rendered by the beneficiary's primary care provider (PCP) or other appropriate healthcare professionals. Beneficiaries may receive up to four tobacco cessation counseling sessions per quit attempt, up to two quit attempts per calendar year, for a maximum of eight counseling sessions per calendar year. These limits may be exceeded, if deemed medically necessary.

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 49:1086 (June 2023).

§1105. Provider Participation

A. The entity seeking reimbursement for tobacco cessation counseling services must be an enrolled Medicaid provider.

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 49:1086 (June 2023).

Chapter 13. Physician Directed Treatment-In-Place Ambulance Services

§1301. General Provisions

A. Effective for dates of service on or after May 12, 2023, the Louisiana Medicaid Program provides coverage for initiation and facilitation of telehealth services by qualified Louisiana Medicaid enrolled ambulance providers.

B. Ambulance providers interested in offering physician directed treatment-in-place telehealth services must complete the following:

1. enroll as a CMS ET3 model participant;
2. enter into a partnership with a qualified, Louisiana Medicaid enrolled healthcare provider to furnish treatment-in-place telehealth services to Louisiana Medicaid beneficiaries; and
3. notify the Department of Health of its partnerships with each telehealth provider.

C. Reimbursement for initiation and facilitation of telehealth services shall be made according to the established physician directed treatment-in-place telehealth service fee schedule or billed charges, whichever is the lesser amount.

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 49:1566 (September 2023).

§1303. Scope of Services

A. Initiation and facilitation of physician directed treatment-in-place telehealth services are performed by Louisiana Medicaid enrolled ambulance providers on site, with no transport, using audio and video telecommunications systems that permit real-time communication between a qualified, Medicaid enrolled, licensed medical practitioner and the beneficiary.

B. All services provided by ambulance providers during the initiation and facilitation of the physician directed treatment-in-place intervention are covered by the associated BLS-E, emergency base rate, or the ALS1-E, Level 1 emergency base rate.

C. Ambulance providers are not eligible to submit a claim for reimbursement or receive payment for other services (except for supplies) at the scene.

D. If a beneficiary must be transported to an emergency department (ED) due to poor internet connection, which resulted in a failed physician directed treatment-in-place encounter, or the beneficiary's condition deteriorates, the ambulance provider may submit a claim for reimbursement and receive compensation for the transport to the ED, but not for initiation and facilitation of the telehealth service.

E. The entity seeking reimbursement for the corresponding physician directed treatment-in-place telehealth service must be an enrolled Louisiana Medicaid provider.

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 49:1566 (September 2023).

§1305. Reimbursement

A. Reimbursement to the ambulance providers for initiation and facilitation of the physician directed treatment-in-place telehealth service requires a corresponding treatment-in-place telehealth service. The corresponding treatment-in-place telehealth service is demonstrated via a Louisiana Medicaid paid treatment-in-place telehealth service claim.

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 49:1566 (September 2023).

Subpart 3. Licensed Professionals (Reserved)

Subpart 5. Formerly School Based Health Centers (Reserved)

Subpart 7. Immunizations

Chapter 83. Children's Immunizations

§8301. General Provisions

A. The Medicaid Program shall provide coverage for the administration of childhood and adolescent vaccines recommended by the Advisory Committee on Immunization Practices and available through the Louisiana Immunization Program/Vaccines for Children Program.

B. To qualify for Medicaid reimbursement for vaccine administration, a provider must be:

1. a licensed health care provider who has the authority under Louisiana state law to administer childhood and adolescent vaccines;
2. an enrolled Medicaid provider; and
3. an enrolled Louisiana Immunization Program/Vaccines for Children Program provider.

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 35:70 (January 2009), amended by the Department of Health, Bureau of Health Services Financing LR 47:49 (January 2021).

§8305. Reimbursement Methodology

A. There shall be no reimbursement for the cost of vaccines that are available from the Louisiana Immunization Program/Vaccines for Children Program.

B. For vaccine administration, providers shall be reimbursed according to the established fee schedule or billed charges, whichever is the lesser amount.

C. The reimbursement for the administration of childhood and adolescent vaccines shall be 90 percent of the 2008 Louisiana Medicare Region 99 allowable or billed charges, whichever is the lesser amount, unless otherwise stipulated. The reimbursement shall not exceed the maximum regional charge for vaccine administration as determined by the Centers for Medicare and Medicaid Services (CMS).

1. The reimbursement shall remain the same for those vaccine administration services that are currently being reimbursed at a rate that is between 90 percent and 120 percent of the 2008 Louisiana Medicare Region 99 allowable, but not to exceed the maximum regional charge for vaccine administration as determined by CMS.

D. Administration of vaccines related to a declared public health emergency shall be reimbursed at up to 100 percent of the Louisiana Region 99 Medicare rate for the duration deemed necessary by the Medicaid Program to ensure access. If providers are required to purchase vaccines, the vaccines will be reimbursed.

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 35:71 (January 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Public Health, LR 39:96 (January 2013), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1289 (July 2015), amended by the Department of Health, Bureau of Health Services Financing LR 47:49 (January 2021), LR 47:887 (July 2021).

Chapter 85. Adult Immunizations

§8501. General Provisions

A. The Medicaid Program shall provide coverage for vaccines recommended by the Advisory Committee on Immunization Practices for beneficiaries age 19 and older.

B. To qualify for Medicaid reimbursement for the vaccine and vaccine administration, a provider must be a licensed health care provider who has the authority under Louisiana state law to administer vaccines and be an enrolled Medicaid provider.

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 34:1035 (June 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 47:50 (January 2021).

§8505. Reimbursement Methodology

A. For the vaccine and vaccine administration, providers shall be reimbursed according to the established fee schedule or billed charges, whichever is the lesser amount.

B. The reimbursement methodology for the vaccine is as a physician-administered drug under the provisions of LAC 50:XXIX.949.

C. The reimbursement methodology for vaccine administration for beneficiaries age 19 and older is the same as for beneficiaries younger than 19 years old under the provisions of §8305 of this Part.

D. Administration of vaccines related to a declared public health emergency shall be reimbursed at up to 100 percent of the Louisiana Region 99 Medicare rate for the duration deemed necessary by the Medicaid Program to ensure access. If providers are required to purchase vaccines, the vaccines will be reimbursed.

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 39:97 (January 2013), amended by the

Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1290 (July 2015), amended by the Department of Health, Bureau of Health Services Financing LR 47:50 (January 2021), LR 47:887 (July 2021).

Subparts 9. - 13. Reserved.

Subpart 15. Reimbursement

Chapter 151. Reimbursement Methodology

Subchapter A. General Provisions

§15101. Enhanced Federal Medical Assistance Percentage Rate for Preventive Services

A. Effective for dates of service on or after May 15, 2017, the federal medical assistance percentage (FMAP) rate received by the department for specified adult vaccines and clinical preventive services shall increase one percentage point of the rate on file as of May 14, 2017.

1. Services covered by this increase are those assigned a grade of A or B by the United States Preventive Services Task Force (USPSTF) and approved vaccines and their administration as recommended by the Advisory Committee on Immunization Practices (ACIP).

2. The increased FMAP rate applies to these qualifying services whether the services are provided on a fee-for-service (FFS) or managed care basis.

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 43:1758 (September 2017).

§15103. Diabetes Education Services

A. Effective for dates of service on or after February 20, 2011, the Medicaid Program shall provide reimbursement for diabetes self-management training services rendered by qualified health care professionals.

B. Reimbursement for DSMT services shall be a flat fee based on the appropriate healthcare common procedure coding (HCPC) code.

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 39:2510 (September 2013).

§15105. Fluoride Varnish Application Services

A. Effective for dates of service on or after December 1, 2011, the Medicaid Program shall provide reimbursement for fluoride varnish application services rendered by qualified health care professionals in a physician office setting.

B. Reimbursement for fluoride varnish application services shall be a flat fee based on the appropriate HCPCS code.

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 40:315 (February 2014).

§15106. Tobacco Cessation Counseling Services

A. Effective for dates of service on or after June 20, 2023, the Medicaid Program shall provide reimbursement for tobacco cessation counseling services rendered by qualified health care professionals.

B. Reimbursement for tobacco cessation counseling services shall be a flat fee based on the appropriate HCPCS code.

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 49:1086 (June 2023).

§15107. Never Events

A. Effective for dates of service on or after July 1, 2012, the Medicaid Program will not provide reimbursement to providers in the Professional Services Program for “never events” or medical procedures performed in error which are preventable and have a serious, adverse impact to the health of the Medicaid recipient. Reimbursement will not be provided when the following “never events” occur:

1. the wrong surgical procedure is performed on a patient;
2. surgical or invasive procedures are performed on the wrong body part; or
3. surgical or invasive procedures are performed on the wrong patient.

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 38:1964 (August 2012).

§15109. Elective Deliveries

A. Induced deliveries and cesarean sections by physicians or nurse midwives shall not be reimbursed when performed prior to 39 weeks gestation. This shall not apply to deliveries when there is a documented medical condition that would justify delivery prior to 39 weeks gestation.

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 40:1533 (August 2014).

§15110. State-Owned or Operated Professional Services Practices

A. Qualifying Criteria. Effective for dates of service on or after February 1, 2018, in order to qualify to receive enhanced rate payments for services rendered to Medicaid recipients under these provisions, physicians and other eligible professional service practitioners must be:

1. licensed by the state of Louisiana;
2. enrolled as a Louisiana Medicaid provider; and
3. employed by, or under contract to provide services in affiliation with, a state-owned or operated entity, such as a state-operated hospital or other state entity, including a state academic health system, which:
 - a. has been designated by the department as an essential provider. Essential providers include:
 - i. LSU School of Medicine—New Orleans;
 - ii. LSU School of Medicine—Shreveport; and
 - iii. LSU state-operated hospitals (Lallie Kemp Regional Medical Center and Villa Feliciana Geriatric Hospital).

B. State-owned or operating entities shall identify to the department which professional service practitioners/groups qualify for the enhanced rate payments.

C. Payment Methodology

1. Effective for dates of service on or after February 1, 2018, payments shall be made at the community rate level for services rendered by physicians and other eligible professional service practitioners who qualify under the provisions of §15110.A.

a. *Community Rate Level*—the rates paid by commercial payers for the same service.

b. The provider's average commercial rate (ACR) demonstration will be updated at least every three years.

c. Enhanced rates are based on average commercial rates effective during the state fiscal year proceeding the fiscal year in which the ACR is calculated for each service designated by a current procedural terminology (CPT) code recognized by the Medicaid program as a covered service.

2. For services rendered by physicians and other professional services practitioners, in affiliation with a state-owned or operated entity, the department will collect from the state-owned or operated entity its current commercial rates/fee schedules by CPT code for their top three commercial payers by volume.

3. The department will calculate the average commercial rate for each CPT code for each professional services practice that provides services in affiliation with a state-owned or operated entity.

4. The department will extract from its paid claims history file, for the preceding fiscal year, all paid claims for those physicians and professional practitioners who will qualify for the enhanced reimbursement rates. The department will align the average commercial rate for each CPT code to each Medicaid claim for the physician or professional services practitioner/practice plan and calculate the average commercial payments for the claims.

5. The department will also align the same paid Medicaid claims with the Medicare rates for each CPT code for the physician or professional services practitioner and

calculate the Medicare payment amounts for those claims. The Medicare rates will be the most currently available national non-facility rates.

6. The department will calculate an overall Medicare to commercial conversion factor by dividing the total amount of the average commercial payments for the claims by the total Medicare payments for the claims.

7. This conversion factor will be applied to the current Medicare rates for all procedure codes payable for Medicaid to create the enhanced reimbursement rate.

D. Payment to physician-employed physician assistants and registered nurse practitioners shall be 80 percent of the maximum allowable rate paid to physicians.

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 44:62 (January 2018).

Subchapter B. Physician Services

§15111. General Provisions

A. Physicians shall be reimbursed according to the established fee schedule or billed charges, whichever is the lesser amount.

B. Optometrists rendering eye care services shall be reimbursed using the same methodology as physicians rendering the same eye care services.

C. Advanced practice registered nurses, physician assistants, and licensed midwives shall be reimbursed as a percentage of physician reimbursement, as specified by the Medicaid Program.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3300 (December 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 47:477 (April 2021).

§15113. Reimbursement Methodology

A. For newly added procedure codes for beneficiaries age 0 through 15 years old, the Medicaid fee shall be set at 90 percent of the current year's Louisiana Region 99 Medicare allowable fee. For newly added procedure codes for beneficiaries age 16 years and older, the Medicaid fee shall be set at 75 percent of the current year's Louisiana Region 99 Medicare allowable fee.

1. If there is no equivalent Medicare fee, the Medicaid fee shall be set based on the Medicare fee for a similar service. In the absence of any applicable Medicare fee, the fee shall be set at the Medicaid fee for a similar service or the Medicaid fee for other states.

2. If establishing a Medicaid fee based on Medicare rates results in a fee that is reasonably expected to be insufficient to ensure that the service is available to beneficiaries, an alternate methodology shall be used. The

fee shall be set at the Medicaid fee for a similar service or the Medicaid fee for other states.

B. Effective for dates of service on or after October 15, 2007, the reimbursement for selected physician services shall be 90 percent of the 2007 Louisiana Medicare Region 99 allowable or billed charges, whichever is the lesser amount, unless otherwise stipulated.

1. The reimbursement shall remain the same for those services that are currently being reimbursed at a rate that is between 90 percent and 120 percent of the 2007 Louisiana Medicare Region 99 allowable.

2. For those services that are currently reimbursed at a rate above 120 percent of the 2007 Louisiana Medicare Region 99 allowable, effective for dates of service on or after October 15, 2007, the reimbursement for these services shall be reduced to 120 percent of the 2007 Louisiana Medicare Region 99 allowable.

C. Effective for dates of service on or after January 1, 2008, the reimbursement for selected physician services shall be 90 percent of the 2008 Louisiana Medicare Region 99 allowable or billed charges, whichever is the lesser amount, unless otherwise stipulated.

1. The reimbursement shall remain the same for those services that are currently reimbursed at a rate that is between 90 percent and 120 percent of the 2008 Louisiana Medicare Region 99 allowable.

2. For those services that are currently reimbursed at a rate above 120 percent of the 2008 Louisiana Medicare Region 99 allowable, effective for dates of service on or after January 1, 2008, the reimbursement for these services shall be reduced to 120 percent of the 2008 Louisiana Medicare Region 99 allowable.

D. Effective for dates of service on or after August 4, 2009, the reimbursement for all physician services rendered to recipients 16 years of age or older shall be reduced to 80 percent of the 2009 Louisiana Medicare Region 99 allowable or billed charges, whichever is the lesser amount.

1. For those services that are currently reimbursed at a rate below 80 percent of the Louisiana Medicare Region 99 allowable, effective for dates of service on or after August 4, 2009, the reimbursement for these services shall be increased to 80 percent of the Louisiana Medicare Region 99 allowable or billed charges, whichever is the lesser amount.

2. The following physician services are excluded from the rate adjustment:

- a. preventive medicine evaluation and management;
- b. immunizations;
- c. family planning services; and
- d. select orthopedic reparative services.

3. Effective for dates of service on or after November 20, 2009, the following physician services are excluded from the rate adjustment:

- a. prenatal evaluation and management; and
- b. delivery services.

E. Effective for dates of service on or after January 22, 2010, physician services rendered to recipients 16 years of age or older shall be reduced to 75 percent of the 2009 Louisiana Medicare Region 99 allowable or billed charges, whichever is the lesser amount.

1. The following physician services rendered to recipients 16 years of age or older shall be reimbursed at 80 percent of the 2009 Louisiana Medicare Region 99 allowable or billed charges, whichever is the lesser amount:

- a. prenatal evaluation and management services;
- b. preventive medicine evaluation and management services; and
- c. obstetrical delivery services.

F. Effective for dates of service on or after January 22, 2010, physician services rendered to recipients 16 years of age or older shall be reduced to 75 percent of the 2009 Louisiana Medicare Region 99 allowable or billed charges, whichever is the lesser amount.

G. Effective for dates of service on or after January 22, 2010, all physician services that are currently reimbursed below the reimbursement rates in §15113.D-F shall be increased to the rates in §15113.D-F.

H. Effective for dates of service on or after December 1, 2010, reimbursement shall be 90 percent of the 2009 Louisiana Medicare Region 99 allowable for the following obstetric services when rendered to recipients 16 years of age and older:

1. vaginal-only delivery (with or without postpartum care);
2. vaginal delivery after previous cesarean (VBAC) delivery; and
3. cesarean delivery following attempted vaginal delivery after previous cesarean delivery. The reimbursement for a cesarean delivery remains at 80 percent of the 2009 Louisiana Medicare Region 99 allowable when the service is rendered to recipients 16 years of age and older.

I. Effective for dates of service on or after July 1, 2012, reimbursement shall be as follows for the designated physician services:

1. reimbursement for professional consultation services (procedure codes 99241-99245 and 99251-99255) shall be discontinued;
2. reimbursement for cesarean delivery (procedure codes 59514-59515) shall be reduced to equal reimbursement for vaginal delivery fees (procedure codes 59409-59410); and
3. reimbursement for all other professional services procedure codes shall be reduced by 3.4 percent of the rates on file as of June 30, 2012.

J. Effective for dates of service on or after February 1, 2013, the reimbursement for certain physician services shall be reduced by 1 percent of the rate in effect on January 31, 2013.

K. Effective for dates of service on or after February 1, 2018, physicians, who qualify under the provisions of §15110 for services rendered in affiliation with a state-owned or operated entity that has been designated as an essential provider, shall receive enhanced reimbursement rates up to the community rate level for qualifying services as determined in §15110.C.

L. Effective for dates of service on or after May 1, 2021, the fee on file for inpatient neonatal critical care services (as specified in CPT) shall be increased by 5 percent.

M. Administration of treatments related to a declared public health emergency shall be reimbursed at up to 100 percent of the Louisiana Region 99 Medicare rate for the duration deemed necessary by the Medicaid Program to ensure access.

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 36:1252 (June 2010), amended LR 36:2282 (October 2010), LR 37:904 (March 2011), LR 39:3300, 3301 (December 2013), LR 41:541 (March 2015), LR 41:1119 (June 2015), LR 41:1291 (July 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:62 (January 2018), amended by the Department of Health, Bureau of Health Services Financing, LR 44:62 (January 2018), LR 47:477 (April 2021), LR 47:887 (July 2021), LR 48:1100 (April 2022).

Subchapter C. Adjunct Services

§15121. Payment for Adjunct Services

A. Effective for dates of service on or after October 20, 2007, the Medicaid Program shall provide reimbursement for the payment of adjunct services in addition to the reimbursement for evaluation and management services and the associated ancillary services when these professional services are rendered in settings other than hospital emergency departments during evening, weekend or holiday hours.

B. The reimbursement for adjunct services is a flat fee, based on the Current Procedural Terminology (CPT) procedure code, in addition to the reimbursement for the associated evaluation and management services and associated ancillary services.

C. Reimbursement is limited to services rendered between the hours of 5 p.m. and 8 a.m. Monday through Friday, on weekends and state legal holidays. Documentation relative to this reimbursement must include the time that the services were rendered.

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 34:1035 (June 2008).

Subchapter D. Anesthesia Services

§15131. General Provisions

A. The most appropriate procedure codes and modifiers shall be used when billing for surgical anesthesia procedures and/or other services performed under the professional licensure of the physician (anesthesiologist or other specialty) or certified registered nurse anesthetist (CRNA).

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 36:1251 (June 2010).

§15133. Formula-Based Reimbursement

A. Reimbursement is based on formulas related to a percentage of the 2009 Louisiana Medicare Region 99 allowable.

B. Effective for dates of service on or after January 22, 2010, the reimbursement for formula-based anesthesia services rendered by a physician shall be:

1. 75 percent of the 2009 Louisiana Medicare Region 99 allowable for services rendered to Medicaid recipients ages 16 and older; and

2. 90 percent of the 2009 Louisiana Medicare Region 99 allowable for services rendered to Medicaid recipients under the age of 16.

C. Effective for dates of service on or after January 22, 2010, the reimbursement for formula-based anesthesia services rendered by a CRNA shall be:

1. 75 percent of the 2009 Louisiana Medicare Region 99 allowable for services rendered to Medicaid recipients ages 16 and older; and

2. 90 percent of the 2009 Louisiana Medicare Region 99 allowable for services rendered to Medicaid recipients under the age of 16.

D. Effective for dates of service on or after July 1, 2012, the reimbursement for formula-based anesthesia services shall be reduced by 3.7 percent of the rates in effect on June 30, 2012.

E. Effective for dates of service on or after July 20, 2012, the 3.7 percent reimbursement rate reduction for formula-based anesthesia services shall be adjusted to 3.4 percent of the rates in effect on June 30, 2012.

F. Effective for dates of service on or after July 20, 2012, the reimbursement for formula-based anesthesia services rendered by a CRNA shall be reduced by 3.4 percent of the rates in effect on July 19, 2012.

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 36:1251 (June 2010), amended LR 36:2282 (October 2010), LR 39:1781 (July 2013).

§15135. Flat Fee Reimbursement

A. Reimbursement for maternity related anesthesia services is a flat fee, except for general anesthesia related to a vaginal delivery which is reimbursed according to a formula.

B. Other anesthesia services that are performed under the professional licensure of the physician (anesthesiologist or other specialty) or CRNA are reimbursed a flat fee based on the appropriate procedure code.

C. Effective for dates of service on or after February 26, 2009, the reimbursement rates paid to CRNAs will be reduced by 3.5 percent of the reimbursement as of February 25, 2009.

D. Effective for dates of service on or after August 4, 2009, the reimbursement rates paid for anesthesia services that are performed under the professional licensure of a physician (anesthesiologist or other specialty) shall be reduced by 3.5 percent of the rates in effect on August 3, 2009.

1. Effective for dates of service on or after November 20, 2009, maternity-related anesthesia services and anesthesia services rendered to recipients under the age of 16 shall be exempt from the August 4, 2009 rate reduction on anesthesia services performed by a physician (anesthesiologist or other specialty).

E. Effective for dates of service on or after July 1, 2012, the flat fee reimbursement rates paid for anesthesia services shall be reduced by 3.7 percent of the rates in effect on June 30, 2012.

F. Effective for dates of service on or after July 20, 2012, the 3.7 percent rate reduction for flat fee reimbursement of anesthesia services shall be adjusted to 3.4 percent of the rates in effect on June 30, 2012.

G. Effective for dates of service on or after July 20, 2012, the flat fee reimbursement for anesthesia services rendered by a CRNA shall be reduced by 3.4 percent of the rates in effect on July 19, 2012.

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 36:1251 (June 2010), amended LR 36:1251 (June 2010), LR 39:1781 (July 2013).

Subchapter E. Family Planning Services

§15141. General Provisions

A. Reimbursement for family planning services shall be made according to the established fee schedule or billed charges, whichever is the lesser amount.

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 47:478 (April 2021).

§15143. Reimbursement

A. The reimbursement methodology for family planning services is the same as for physician services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2566 (November 2010), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Public Health, LR 39:96 (January 2013), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:1781 (July 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 47:478 (April 2021).

Subchapter F. Supplemental Payments

§15151. State-Owned or Operated Professional Services Practices

A. Qualifying Criteria. Effective for dates of service on or after February 21, 2017, in order to qualify to receive supplemental payments, physicians and other eligible professional service practitioners must be:

1. licensed by the state of Louisiana;
2. enrolled as a Louisiana Medicaid provider; and
3. employed by, or under contract to provide services in affiliation with, a state-owned or operated entity, such as a state-operated hospital or other state entity, including a state academic health system, which:
 - a. has been designated by the department as an essential provider. Essential providers include:
 - i. LSU School of Medicine—New Orleans;
 - ii. LSU School of Medicine—Shreveport;
 - iii. LSU School of Dentistry; and
 - iv. LSU—state-operated hospitals (Lallie Kemp Regional Medical Center and Villa Feliciana Geriatric Hospital); and
 - b. has furnished satisfactory data to LDH regarding the commercial insurance payments made to its employed physicians and other professional service practitioners.

B. Qualifying Provider Types. For purposes of qualifying for supplemental payments under this Section, services provided by the following professional practitioners will be included:

1. physicians;
2. physician assistants;
3. certified registered nurse practitioners;
4. certified nurse anesthetists; and
5. dentists.

C. Payment Methodology

1. The supplemental payment to each qualifying physician or other eligible professional services practitioner in the practice plan will equal the difference between the Medicaid payments otherwise made to these qualifying providers for professional services and the average amount that would have been paid at the equivalent community rate. The *community rate* is defined as the average amount that would have been paid by commercial insurers for the same services.

2. The supplemental payments shall be calculated by applying a conversion factor to actual charges for claims paid during a quarter for Medicaid services provided by the state-owned or operated practice plan providers. The commercial payments and respective charges shall be obtained for the state fiscal year preceding the reimbursement year. If this data is not provided satisfactorily to LDH, the default conversion factor shall equal "1". This conversion factor shall be established annually for qualifying physicians/practitioners by:

a. determining the amount that private commercial insurance companies paid for commercial claims submitted by the state-owned or operated practice plan or entity; and

b. dividing that amount by the respective charges for these payers.

3. The actual charges for paid Medicaid services shall be multiplied by the conversion factor to determine the maximum allowable Medicaid reimbursement. For eligible non-physician practitioners, the maximum allowable Medicaid reimbursement shall be limited to 80 percent of this amount.

4. The actual base Medicaid payments to the qualifying physicians/practitioners employed by a state-owned or operated entity shall then be subtracted from the maximum Medicaid reimbursable amount to determine the supplemental payment amount.

D. Supplemental payments for services provided by the qualifying state-owned or operated physician practice plan will be implemented through a quarterly supplemental payment to providers, based on specific Medicaid paid claim data.

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 40:544 (March 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1390 (July 2017), LR 44:921 (May 2018).

§15153. Non-State-Owned or Operated Professional Services Practices

A. Qualifying Criteria. Effective for dates of service on or after February 21, 2017, in order to qualify to receive supplemental payments, physicians and other eligible professional service practitioners must be:

1. licensed by the state of Louisiana;
2. enrolled as a Louisiana Medicaid provider; and

3. employed by, or under contract to provide services at a non-state owned or operated governmental entity and identified by the non-state owned or operated governmental entity as a physician that is employed by, or under contract to provide services at or in affiliation with said entity.

B. Qualifying Provider Types. For purposes of qualifying for supplemental payments under this Section, services provided by the following professional practitioners will be included:

1. physicians;
2. physician assistants;
3. certified registered nurse practitioners; and
4. certified nurse anesthetists.

C. The supplemental payment will be determined in a manner to bring payments for these services up to the community rate level.

1. For purposes of this Section, the *community rate* shall be defined as the rates paid by commercial payers for the same service.

D. The non-state governmental entity shall periodically furnish satisfactory data for calculating the community rate as requested by LDH.

E. Payment Methodology

1. The supplemental payment amount shall be determined by establishing a Medicare to community rate conversion factor for the physician or physician practice plan.

2. At the end of each quarter, for each Medicaid claim paid during the quarter, a Medicare payment amount will be calculated and the Medicare to community rate conversion factor will be applied to the result.

3. Medicaid payments made for the claims paid during the quarter will then be subtracted from this amount to establish the supplemental payment amount for that quarter.

F. The supplemental payments shall be made on a quarterly basis and the Medicare to community rate conversion factor shall be recalculated periodically as determined by the department.

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 40:544 (March 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1390 (July 2017), LR 44:921 (May 2018).

§15155. Qualifying Criteria—Professional Services of Practitioners Affiliated with Tulane School of Medicine

A. Effective for dates of service on or after July 1, 2012, physicians and other eligible professional service practitioners who are employed by a physician group affiliated with Tulane University School of Medicine located

in the city of New Orleans may qualify for supplemental payments for services rendered to Medicaid recipients. To qualify for the supplemental payment, the physician or professional service practitioner must be:

1. licensed by the state of Louisiana;
2. enrolled as a Louisiana Medicaid provider; and
3. identified by Tulane University School of Medicine as a physician or other professional service practitioner that is employed by, or under contract to provide services for that entity.

B. The following professional services practitioners shall qualify to receive supplemental payments:

1. physicians;
2. physician assistants;
3. certified registered nurse practitioners; and
4. certified registered nurse anesthetists.

C. The supplemental payment shall be calculated in a manner that will bring payments for these services up to the community rate level.

1. For purposes of these provisions, the community rate shall be defined as the rates paid by commercial payers for the same service.

D. The private physician group shall periodically furnish satisfactory data for calculating the community rate as requested by the department.

E. The supplemental payment amount shall be determined by establishing a Medicare to community rate conversion factor for the private physician group. At the end of each quarter, for each Medicaid claim paid during the quarter, a Medicare payment amount will be calculated and the Medicare to community rate conversion factor will be applied to the result. Medicaid payments made for the claims

paid during the quarter will then be subtracted from this amount to establish the supplemental payment amount for that quarter.

F. The supplemental payments shall be made on a quarterly basis and the Medicare to community rate conversion factor shall be recalculated at least every three years.

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 38:1964 (August 2012).

Subchapter G. Midwifery Services

§15161. General Provisions

A. Certified nurse midwives and licensed midwives shall be reimbursed as a percentage of physician reimbursement according to the established fee schedule.

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 49:1935 (November 2023).

§15163. Reimbursement Methodology

A. Effective for dates of service on or after August 1, 2023, services related to pregnancy and childbirth provided by certified nurse midwives (including licensed midwives), shall be reimbursed at 95 percent of the physician fee on file.

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 49:1935 (November 2023).

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part XI. Clinic Services

Subpart 1. Rehabilitation Clinics

Chapter 1. General Provisions

§101. Definitions

Less Care by Others—the ability of the client to use a minimum of assistance to take care of personal needs.

Rehabilitation—a program to prevent further impairment of physical deformity and malfunction, and enable significantly increased ability of the individual to require less care by others.

Self-Care and Self Help—the ability of the individual to take care of personal needs, e.g., eating, dressing, ability to walk, talk, or use devices unassisted.

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 9:130 (March 1983), repromulgated for inclusion in LAC, LR 30:1021 (May 2004).

§103. Services

A. Voice evaluation or voice therapy coverage is excluded from the Title XIX Medical Assistance Program. This includes instructions in use and hygiene of the voice as treatment for vocal cord nodules or hoarseness, and related conditions, unless it is serious enough to interfere with normal speech.

B. Effective for dates of service on or after February 1, 2013, the department terminates the coverage of all rehabilitation services to recipients 21 years of age and older.

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 9:13 (January 1983), repromulgated for inclusion in LAC, LR 30:1021 (May 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1533 (August 2014).

Chapter 3. Reimbursement

§301. Rehabilitation (Ages 3 and Over)

A. The Medicaid Program provides reimbursement for physical therapy, occupational therapy and speech therapy rendered in rehabilitation clinics to recipients under the age of 21.

B. Effective for dates of service on or after February 1, 2013, reimbursement shall not be made for services rendered to recipients 21 years of age and older.

C. Effective for dates of service on or after February 13, 2014, reimbursement for physical and occupational therapy services shall be 85 percent of the 2013 Medicare published rate. There shall be no automatic enhanced rate adjustment for physical and occupational therapy services.

D. Speech/language therapy services shall continue to be reimbursed at the flat fee in place as of February 13, 2014 and in accordance with the Medicaid published fee schedule for speech/language therapy services provided to recipients under the age of 21 in rehabilitation clinics.

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 22:109 (February 1996), amended LR 23:731 (June 1997), repromulgated for inclusion in LAC, LR 30:1021 (May 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1533 (August 2014), LR 41:707 (April 2015).

Subpart 3. Reserved

Subpart 5. Family Planning

Chapter 35. Reimbursement

§3501. Reimbursement Methodology

A. The reimbursement for family planning clinics is a flat fee for each covered service as specified on the established Medicaid fee schedule. Fee schedule rates are based on a percentage of the Louisiana Medicare Region 99 allowable for a specified year.

B. Effective for dates of service on or after August 1, 2010, the reimbursement rates for family planning clinic services shall be 75 percent of the 2009 Louisiana Medicare Region 99 allowable or billed charges, whichever is the lesser amount minus any third party liability coverage.

C. Effective for dates of service on or after July 1, 2012, the reimbursement rates for family planning clinics shall be equal to the reimbursement rates for family planning services in the Professional Services 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 Services, LR 4:210 (May 1978), (repromulgated for inclusion in the LAC) promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:1022 (May 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1600 (June 2011), amended by

the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Public Health, LR 39:93 (January 2013), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:506 (March 2013).

Subpart 7. Prenatal Health Care

Chapter 51. General Provisions

§5101. Covered Services

A. Prenatal health care services, provided by public prenatal health care clinics under the auspices of the Office of Preventive and Public Health Services shall be reimbursed under Title XIX as a covered service. Public health care service clinics enrolled in the Title XIX Medicaid Program shall have reimbursement limited to services each clinic is qualified to provide, and authorized under 42 CFR 440.90.

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 13:183 (March 1987), repromulgated for inclusion in LAC, LR 30:1022 (May 2004).

Subpart 9. End Stage Renal Disease Facilities

Chapter 69. Reimbursement

§6901. General Provisions

A. End stage renal disease (ESRD) facilities are reimbursed a hemodialysis composite rate. The composite rate is a comprehensive payment for the complete hemodialysis treatment in which the facility assumes responsibility for providing all medically necessary routine dialysis services.

B. Covered non-routine dialysis services, continuous ambulatory peritoneal dialysis (CAPD), continuous cycling peritoneal dialysis (CCPD), epogen (EPO) and injectable drugs are reimbursed separately from the composite rate.

1. Covered non-routine laboratory services may be billed by either the ESRD facility or the facility's contracted outside laboratory.

C. Effective for dates of service on or after February 26, 2009, the reimbursement to ESRD facilities shall be reduced by 3.5 percent of the rates in effect on February 25, 2009.

D. Effective for dates of service on or after January 22, 2010, the reimbursement to ESRD facilities shall be reduced by five percent of the rates in effect on January 21, 2010.

E. Effective for dates of service on or after August 1, 2010, the reimbursement to ESRD facilities shall be reduced by 4.6 percent of the rates in effect on July 31, 2010.

F. Effective for dates of service on or after January 1, 2011, the reimbursement to ESRD facilities shall be reduced by 2 percent of the rates in effect on December 31, 2010.

G. Effective for dates of service on or after July 1, 2012, the reimbursement to ESRD facilities shall be reduced by 3.7 percent of the rates in effect on June 30, 2012.

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 30:1022 (May 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1891 (September 2009), LR 36:2040 (September 2010), LR 37:1599 (June 2011), LR 39:1284 (May 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 46:1392 (October 2020).

§6903. Medicare Part B Claims

A. For Medicare Part B claims, ESRD facilities are reimbursed for full co-insurance and deductibles.

B. The Medicare payment plus the amount of the Medicaid payment (if any) shall be considered to be payment in full for the service. The recipient does not have any legal liability to make payment for the service.

C. Effective for dates of service on or after February 26, 2009, the reimbursement to ESRD facilities for Medicare Part B claims shall be reduced by 3.5 percent of the rates in effect on February 25, 2009.

D. Effective for dates of service on or after January 22, 2010, the reimbursement to ESRD facilities for Medicare Part B claims shall be reduced by five percent of the rates in effect on January 21, 2010.

E. Effective for dates of service on or after August 1, 2010, the reimbursement to ESRD facilities for Medicare Part B claims shall be reduced by 4.6 percent of the rates in effect on July 31, 2010.

F. Effective for dates of service on or after January 1, 2011, the reimbursement to ESRD facilities for Medicare Part B claims shall be reduced by 2 percent of the rates in effect on December 31, 2010.

G. Effective for dates of service on or after July 1, 2012, the reimbursement to ESRD facilities for Medicare Part B claims shall be reduced by 3.7 percent of the rates in effect on June 30, 2012.

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 35:1891 (September 2009), amended LR 36:2040 (September 2010), LR 37:1599 (June 2011), LR 39:1284 (May 2013).

Subpart 11. Ambulatory Surgical Centers

Chapter 75. Reimbursement

§7501. General Provisions

A. The services rendered by ambulatory surgical centers must be medically necessary preventive, diagnostic, therapeutic, rehabilitative or palliative services furnished to

an outpatient by or under the direction of a physician or dentist in a facility which is not part of a hospital but which is organized and operated to provide medical care to patients.

B. This type of facility will not provide services or accommodations for patients to stay overnight. Therefore, the ambulatory surgical center shall have a system to transfer patients requiring emergency admittance or overnight care to a fully licensed and certified Title XIX hospital following any surgical procedure performed at the facility.

C. Never Events. Effective for dates of service on or after July 1, 2012, the Medicaid Program will not provide reimbursement to ambulatory surgical centers for “never events” or medical procedures performed in error which are preventable and have a serious, adverse impact to the health of the Medicaid recipient. Reimbursement will not be provided when the following “never events” occur:

1. the wrong surgical procedure is performed on a patient;
2. surgical or invasive procedures are performed on the wrong body part; or
3. surgical or invasive procedures are performed on the wrong patient.

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 35:1888 (September 2009), amended LR 38:1961 (August 2012).

§7503. Reimbursement Methodology

A. The reimbursement for surgical procedures performed in an ambulatory surgical center is a flat fee per service in accordance with the four payment groups established for ambulatory surgery services as specified on the Medicaid fee schedule.

1. The flat fee reimbursement is for facility charges only, which covers all operative functions associated with the performance of a medically necessary surgery including admission, patient history and physical, laboratory tests, operating room staffing, recovery room charges, all supplies related to the surgical care of the patient and discharge.

2. The flat fee excludes payments for the physician performing the surgery, the radiologist and the anesthesiologist when these professionals are not under contract with the ambulatory surgery center.

3. Effective for dates of service on or after September 20, 2021, the Medicaid Program shall provide reimbursement for COVID-19 laboratory testing in addition to the ambulatory surgical center flat fee reimbursement amount.

B. For those surgical procedures not included in the payment groupings on the Medicaid fee schedule, the reimbursement is the established flat fee for the service.

C. Effective for dates of service on or after February 26, 2009, the reimbursement for surgical services provided by

an ambulatory surgical center shall be reduced by 3.5 percent of the rate in effect on February 25, 2009.

D. Effective for dates of service on or after February 5, 2010, the reimbursement for surgical services provided by an ambulatory surgical center shall be reduced by 5 percent of the rate in effect on February 4, 2010.

E. Effective for dates of service on or after August 1, 2010, the reimbursement for surgical services provided by an ambulatory surgical center shall be reduced by 4.4 percent of the fee amounts on file as of July 31, 2010.

F. Effective for dates of service on or after January 1, 2011, the reimbursement for surgical services provided by an ambulatory surgical center shall be reduced by 2 percent of the fee amounts on file as of December 31, 2010.

G. Effective for dates of service on or after July 1, 2012, the reimbursement for surgical services provided by an ambulatory surgical center shall be reduced by 3.7 percent of the fee amounts on file as of June 30, 2012.

H. Effective for dates of service after March 20, 2024, an ambulatory surgical center (ASC) shall be reimbursed based on the Louisiana Medicaid Louisiana State University (LSU) enhanced fee schedule, published on the Medicaid provider website at www.lamedicaid.com, if the following conditions are met:

1. The ASC is owned and/or operated by LSU School of Dentistry, LSU Health Sciences Center, or LSU Healthcare network;
2. The ASC is licensed within the state of Louisiana; and
3. The ASC is Medicaid enrolled.

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 35:1889 (September 2009), amended LR 36:2278 (October 2010), LR 37:1572 (June 2011), LR 39:317 (February 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 47:1311 (September 2021), LR 50:380 (March 2024).

Subpart 13. Federally-Qualified Health Centers

Chapter 101. General Provisions

§10101. Purpose

A. Section 330 of the Public Health Service (PHS) Act of 1991 authorized the development of federally qualified health centers (FQHCs) through a grant funding program to provide care and improve the health status of medically underserved populations.

B. The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), certifies the FQHC status of organizations that receive grant funding under Section 330 of the PHS Act.

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 32:1901 (October 2006).

Chapter 103. Services

§10301. Scope of Services

[Formerly §10501]

A. Medicaid reimbursement is limited to medically necessary services that are covered by the Medicaid State Plan and would be covered if furnished by a physician. The following services shall be covered:

1. services furnished by a physician within the scope of practice of his profession under Louisiana law;
2. services furnished by a:
 - a. physician assistant;
 - b. nurse practitioner;
 - c. nurse midwife;
 - d. clinical social worker;
 - e. clinical psychologist; or
 - f. dentist;
3. services and supplies that are furnished as an incident to professional services furnished by all eligible professionals;
4. other ambulatory services; and
5. diabetes self-management training (DSMT) services.

B. The department shall provide coverage of diabetes self-management training services rendered to Medicaid beneficiaries diagnosed with diabetes mellitus.

C. The department shall provide coverage for fluoride varnish applications performed in the FQHC.

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 30:2328 (October 2004), repromulgated LR 30:2487 (November 2004), amended LR 32:1902 (October 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:2629 (September 2011), LR 39:3076 (November 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1520 (September 2016), LR 47:46 (January 2021).

§10303. Service Limits

[Formerly §10503]

A. There shall be no limits placed on the number of federally qualified health center visits (encounters) payable by the Medicaid program for eligible beneficiaries.

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 32:1902 (October 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2280 (October 2010), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:2629 (September 2011), LR 41:2637 (December 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 47:46 (January 2021).

Chapter 105. Provider Participation

§10501. Provider Enrollment

[Formerly §10301]

A. In order to enroll and participate in the Medicaid Program, an FQHC must submit a completed provider enrollment packet that includes a copy of the HRSA grant approving its FQHC status.

B. The effective date of a FQHC's enrollment to participate in the Medicaid Program shall not be prior to the date of receipt of the completed enrollment packet.

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 30:2328 (October 2004), repromulgated LR 30:2487 (November 2004), amended LR 32:1901 (October 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:2630 (September 2011).

§10503. Standards for Participation

[Formerly §10303]

A. Federally qualified health centers must comply with the applicable licensure, accreditation and program participation standards for all services rendered. If a FQHC wishes to initiate participation, it shall be responsible for meeting all of the enrollment criteria of the program. The FQHC provider shall:

1. maintain an acceptable fiscal record keeping system that readily distinguishes one type of service from another type of service that may be provided;
2. retain all records necessary to fully disclose the extent of services provided to beneficiaries for five years from the date of service and furnish such records, and any payments claimed for providing such services, to the Medicaid Program upon request; and
3. abide by and adhere to all federal and state regulations and policy manuals.

B. If a FQHC receives approval for a satellite site, the satellite site must enter into a separate provider agreement and obtain its own Medicaid provider number.

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 30:2328 (October 2004), repromulgated LR 30:2488 (November 2004), amended LR 32:1901 (October 2006), amended LR 37:2630 (September 2011), amended by the

Department of Health, Bureau of Health Services Financing, LR 44:1253 (July 2018), LR 47:47 (January 2021).

Chapter 107. Reimbursement Methodology

§10701. Prospective Payment System

A. Payments for Medicaid covered services will be made under a prospective payment system (PPS) and paid on a per visit basis.

B. A visit is defined as a face-to-face encounter between a facility health professional and a Medicaid eligible patient for the purpose of providing medically necessary outpatient services.

1. Encounters with more than one facility health professional that take place on the same day and at a single location constitute a single encounter.

2. Services shall not be arbitrarily delayed or split in order to bill additional encounters.

NOTE: Refer to the FQHC and Physician's Current Procedural Terminology (CPT) Manuals for the definition of an encounter.

3. Effective for dates of service on or after February 20, 2011, the Medicaid Program shall include coverage for diabetes self-management training services rendered by qualified health care professionals in the FQHC encounter rate.

a. Separate encounters for DSMT services are not permitted and the delivery of DSMT services alone does not constitute an encounter visit.

4. Effective for dates of service on or after December 1, 2011, the Medicaid Program shall include coverage for fluoride varnish applications in the FQHC encounter rate.

a. Fluoride varnish applications shall only be reimbursed to the FQHC when performed on the same date of service as an office visit or preventive screening. Separate encounters for fluoride varnish services are not permitted and the application of fluoride varnish does not constitute an encounter visit.

C. If an FQHC receives approval for a satellite site, the PPS per visit rate paid for the services performed at the satellite site would be the weighted average cost payment rate per encounter for all FQHCs.

D. The PPS per visit rate for a facility which enrolls and receives approval to operate shall be the weighted average cost payment rate per encounter for all FQHCs.

E. The PPS per visit rate for each facility will be increased on July 1 of each year by the percentage increase in the published *Medicare Economic Index* (MEI) for primary care services.

F. Federally qualified health center services furnished to dual eligibles will be reimbursed reasonable cost which is equivalent to the provider specific prospective payment rate.

G. Cost Reports. FQHCs shall submit cost reports when there is an increase or decrease in their scope of services.

1. *Change in Scope of Services*—an addition, removal or relocation of services sites, and the addition or deletion of specialty and non-primary care services that were not included in the base line rate calculation.

2. The final PPS rate shall be calculated using the first two years of audited Medicaid cost reports, which shall include documentation of the change in scope.

3. Cost reports shall not be accepted for rate changes without a change in the scope of service.

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 32:1902 (October 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:2630 (September 2011), LR 39:3076 (November 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 44:1253 (July 2018), LR 47:47 (January 2021).

§10703. Alternate Payment Methodology

A. Effective for dates of service on or after October 20, 2007, the Medicaid Program establishes an alternate payment methodology for adjunct services provided by federally qualified health centers (FQHCs) when these professional services are rendered during evening, weekend or holiday hours. This alternate payment methodology is in addition to the prospective payment system methodology established for FQHC services.

1. A payment for adjunct services is not allowed when the encounter is for dental services only.

B. The reimbursement for adjunct services is a flat fee, based on the current procedural terminology (CPT) procedure code, in addition to the reimbursement for the associated office encounter.

C. Reimbursement is limited to services rendered between the hours of 5 p.m. and 8 a.m. Monday through Friday, on weekends and state legal holidays. Documentation relative to this reimbursement must include the time that the services were rendered.

D. Effective for dates of service on or after January 1, 2019, FQHCs shall be reimbursed a separate payment outside of the prospective payment system (PPS) rate for long acting reversible contraceptives (LARCs).

1. Reimbursement for LARCs shall be at the lesser of, the rate on file or the actual acquisition cost for entities participating in the 340B program. Federally qualified health centers eligible for 340B pricing must bill Medicaid at their 340B actual acquisition cost for reimbursement.

E. Effective for dates of service on or after April 1, 2019, the Medicaid Program shall establish an alternative payment methodology for behavioral health services provided in FQHCs by one of the following practitioners:

1. physicians with a psychiatric specialty;
2. nurse practitioners or clinical nurse specialist with a psychiatric specialty;
3. licensed clinical social workers; or
4. clinical psychologist.

F. The reimbursement for behavioral health services will equal the all-inclusive prospective payment system rate on file for the date of service. This reimbursement will be in addition to any all-inclusive prospective payment system rate on the same date for a medical/dental visit.

G. Dental services shall be reimbursed at the all-inclusive encounter prospective payment system rate on file for fee for service for the date of service. This reimbursement will be in addition to any all-inclusive prospective payment system rate made on the same date for a medical/behavioral health visit.

H. During the Coronavirus Disease 2019 (COVID-19) public health emergency, Louisiana Medicaid will establish an alternative payment methodology (APM) for FQHC providers to be reimbursed at the standard vaccine administration payment rates listed on the COVID-19 vaccine and treatment fee schedule outside of the facility's current all-inclusive prospective payment system rate on file. This APM will only be allowed when the COVID-19 vaccine is administered without the performance of an evaluation and management procedure on the same date of service.

I. Effective for dates of service on or after January 1, 2022, the Medicaid Program shall reimburse for community health worker services through a separate payment outside the PPS rate.

J. Effective for dates of service on or after July 20, 2023, Medicaid will increase FQHC payments by \$30 per encounter. This payment shall be reimbursed through an alternative payment methodology when these services are provided on the same date as a medical/dental/behavioral health visit that includes an evaluation and management procedure code as one of the detailed lines on the claim. The APM will pay FQHCs an add-on amount of \$30 in addition to the PPS rate on file for the date of service. The APM must be agreed to by the department and the FQHC and must result in a payment to the FQHC, which is at least the PPS rate on file for the date of service.

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 34:1033 (June 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 44:1894 (October 2018), LR 44:2162 (December 2018), LR 45:434 (March 2019), amended LR 46:182 (February 2020), LR 47:1528 (October 2021), LR 47:1875 (December 2021), LR 49:1214 (July 2023).

Subpart 15. Rural Health Clinics

Chapter 161. General Provisions

§16101. Purpose

A. The Rural Health Clinic (RHC) Act of 1977 authorized the development of rural health clinics to encourage and stabilize the provision of outpatient primary care in rural areas through cost-based reimbursement.

B. Rural health clinic regulations distinguish between two types of rural health clinics.

1. The independent RHC is a free-standing practice that is not part of a hospital, skilled nursing facility, or home health agency.

2. The provider-based RHC is an integral and subordinate part of a hospital, skilled nursing facility, or home health agency.

C. Rural health clinics improve the health status of Louisiana residents in rural and underserved areas by working proactively to build community health systems' capacity to provide integrated, efficient and effective health care services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:1904 (October 2006), repromulgated LR 32:2266 (December 2006).

Chapter 163. Services

§16301. Scope of Services

[Formerly §16501]

A. Medicaid reimbursement is limited to medically necessary services that are covered by the Medicaid State Plan and would be covered if furnished by a physician. The following services shall be covered:

1. services furnished by a physician, within the scope of practice of his profession under Louisiana law;
2. services furnished by a:
 - a. physician assistant;
 - b. nurse practitioner;
 - c. nurse midwife;
 - d. clinical social worker;
 - e. clinical psychologist; or
 - f. dentist;
3. services and supplies that are furnished as an incident to professional services furnished by all eligible professionals;
4. other ambulatory services; and
5. diabetes self-management training (DSMT) services.

B. The department shall provide coverage of diabetes self-management training services rendered to Medicaid beneficiaries diagnosed with diabetes mellitus.

C. The department shall provide coverage for fluoride varnish applications performed in the RHC.

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 32:1905 (October 2006), repromulgated LR 32:2267 (December 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:2631 (September 2011), LR 40:83 (January 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1524 (September 2016), LR 47:50 (January 2021).

§16303. Service Limits

[Formerly §16503]

A. There shall be no limits placed on rural health clinic visits (encounters) payable by the Medicaid program for eligible beneficiaries.

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 32:1905 (October 2006), repromulgated LR 32:2267 (December 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:2632 (September 2011), LR 41:2653 (December 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 47:50 (January 2021).

Chapter 165. Provider Participation

[Formerly Chapter 163]

§16501. Provider Enrollment

[Formerly §16301]

A. In order to enroll and participate in the Medicaid Program, a RHC must submit a completed provider enrollment packet.

B. The effective date of enrollment to participate in the Medicaid Program shall not be prior to the date of receipt of the completed enrollment packet.

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 32:1904 (October 2006), repromulgated LR 32:2267 (December 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:2632 (September 2011).

§16503. Standards for Participation

[Formerly §16303]

A. Rural health clinics must comply with the applicable licensure, accreditation and program participation standards for all services rendered. If a RHC wishes to initiate participation, it shall be responsible for meeting all of the enrollment criteria of the program. The RHC provider shall:

1. maintain an acceptable fiscal record keeping system that readily distinguishes one type of service from another type of service that may be provided;

2. retain all records necessary to fully disclose the extent of services provided to beneficiaries for five years from the date of service and furnish such records, and any payments claimed for providing such services, to the Medicaid Program upon request; and

3. abide by and adhere to all federal and state regulations and policy manuals.

B. Medicaid enrollment can be no sooner than Medicaid's receipt of the complete enrollment packet. A complete enrollment packet for RHCs must include a copy of the CMS provider certification letter approving rural health clinic status.

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 32:1905 (October 2006), repromulgated LR 32:2267 (December 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:2632 (September 2011), amended by the Department of Health, Bureau of Health Services Financing, LR 47:51 (January 2021).

Chapter 167. Reimbursement Methodology

§16701. Prospective Payment System

A. Payments for Medicaid covered services will be made under a Prospective Payment System (PPS) and paid on a per visit basis.

B. A visit is defined as a face-to-face encounter between a facility health professional and a Medicaid eligible patient for the purpose of providing medically needed outpatient services.

1. Encounters with more than one facility health professional that take place on the same day and at a single location constitute a single encounter.

2. Services shall not be arbitrarily delayed or split in order to bill additional encounters.

NOTE: Refer to the RHC and Physician's Current Procedural Terminology (CPT) Manuals for the definition of an encounter.

3. Effective for dates of service on or after February 20, 2011, the Medicaid Program shall include coverage for diabetes self-management training services rendered by qualified health care professionals in the RHC encounter rate.

a. Separate encounters for DSMT services are not permitted and the delivery of DSMT services alone does not constitute an encounter visit.

4. Effective for dates of service on or after December 1, 2011, the Medicaid Program shall include coverage for fluoride varnish applications in the RHC encounter rate.

a. Fluoride varnish applications shall only be reimbursed to the RHC when performed on the same date of service as an office visit or preventive screening. Separate encounters for fluoride varnish services are not permitted

and the application of fluoride varnish does not constitute an encounter visit.

C. For an RHC which enrolls and receives approval to operate, the facility's initial PPS per visit rate shall be determined through a comparison to other RHCs in the same town/city/parish. The scope of services shall be considered in determining which proximate RHC most closely approximates the new provider. If no RHCs are available in the proximity, comparison shall be made to the nearest RHC offering the same scope of service. The rate will be set to that of the RHC comparative to the new provider.

D. The PPS per visit rate for each facility will be increased on July 1 of each year by the percentage increase in the published *Medicare Economic Index (MEI)* for primary services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:1905 (October 2006), repromulgated LR 32:2267 (December 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:2632 (September 2011), LR 40:83 (January 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 47:51 (January 2021).

§16703. Alternate Payment Methodology

A. Effective for dates of service on or after October 20, 2007, the Medicaid Program establishes an alternate payment methodology for adjunct services provided by rural health clinics (RHCs) when these professional services are rendered during evening, weekend or holiday hours. This alternate payment methodology is in addition to the Prospective Payment System methodology established for RHC services.

1. A payment for adjunct services is not allowed when the encounter is for dental services only.

B. The reimbursement for adjunct services is a flat fee, based on the Current Procedural Terminology (CPT) procedure code, in addition to the reimbursement for the associated office encounter.

C. Reimbursement is limited to services rendered between the hours of 5 p.m. and 8 a.m. Monday through Friday, on weekends and State legal holidays. Documentation relative to this reimbursement must include the time that the services were rendered.

D. Effective for dates of service on or after January 1, 2019, RHCs shall be reimbursed a separate payment outside of the prospective payment system (PPS) rate for long acting reversible contraceptives (LARCs).

1. Reimbursement for LARCs shall be at the lesser of, the rate on file or the actual acquisition cost for entities participating in the 340B program. Rural health clinics eligible for 340B pricing must bill Medicaid at their 340B actual acquisition cost for reimbursement.

E. Effective for dates of service on or after April 1, 2019, the Medicaid Program shall establish an alternative payment methodology for behavioral health services provided in RHCs by one of the following practitioners:

1. physicians with a psychiatric specialty
2. nurse practitioners or clinical nurse specialists with a psychiatric specialty
3. licensed clinical social workers; or
4. clinical psychologists

F. The reimbursement for behavioral health services will equal the all-inclusive encounter PPS rate on file for fee for service on the date of service. This reimbursement will be in addition to any all-inclusive PPS rate on the same date for a medical/dental visit.

G. Dental services shall be reimbursed at the all-inclusive PPS rate on file for fee-for-service on the date of service. This reimbursement will be in addition to any all-inclusive PPS rate made on the same date for a medical/behavioral health visit.

H. During the Coronavirus Disease 2019 (COVID-19) public health emergency, Louisiana Medicaid will establish an alternative payment methodology (APM) for RHC providers to be reimbursed at the standard vaccine administration payment rates listed on the COVID-19 vaccine and treatment fee schedule outside of the facility's current all-inclusive prospective payment system rate on file. This APM will only be allowed when the COVID-19 vaccine is administered without the performance of an evaluation and management procedure on the same date of service.

I. Effective for dates of service or after January 1, 2022, the Medicaid Program shall reimburse for community health worker services through a separate payment outside the PPS rate.

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 34:1036 (June 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 44:1903 (October 2018), LR 44:2168 (December 2018), LR 45:435 (March 2019), amended LR 46:185 (February 2020), LR 47:1528 (October 2021), LR 47:1875 (December 2021).

§16705. Hospital-Based Rural Health Clinics

A. Effective for dates of service on or after July 1, 2008, the reimbursement methodology for services rendered by a rural health clinic that was licensed as part of a small rural hospital as of July 1, 2007 shall be as follows:

1. Hospital-based rural health clinics shall be reimbursed in the aggregate at 110 percent of reasonable costs.

2. The interim payment for claims shall be the Medicaid Benefits Improvement and Protection Act of 2000 (BIPA) Prospective Payment System (PPS) per visit rate

currently in effect for each provider. Final reimbursement shall be the greater of BIPA PPS payments or the alternative payment methodology of 110 percent of allowable costs as calculated through the cost settlement process.

3. The payment received under this methodology will be compared each year to the BIPA PPS rate to assure the clinic that their payment under this alternative payment methodology (APM) is at least equal to the BIPA PPS rate. If the payment calculation at 110 percent of allowable cost is less than the BIPA PPS payments, the clinic will be paid the difference.

B. Effective for dates of service on or after July 1, 2023, the reimbursement methodology for services rendered by a rural health clinic licensed as part of a small rural hospital and included as a hospital outpatient department on the hospital's fiscal year end cost report prior to July 1, 2023 shall be eligible for the APM at 110 percent of allowable costs as calculated through cost settlement. Reimbursement shall be as follows:

1. The reimbursement methodology will be in accordance with §16705.A.1-3 as indicated above.

2. Future qualifications for the 110 percent alternative payment methodology reimbursement shall be determined on an annual basis for hospital-based rural health clinics enrolling and licensing as hospital outpatient departments during the hospital's fiscal year end cost reporting periods subsequent to June 30, 2023. Payments shall begin effective for dates of service beginning on July 1 after qualification.

3. Hospital-based rural health clinics that terminate their licensing as hospital outpatient departments will no longer be eligible for the alternative payment methodology at 110 percent of allowable costs upon termination.

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 35:957 (May 2009), amended by the Department of Health, Bureau of Health Services Financing, LR 49:1743 (October 2023).

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE

Part XIII. Home Health Program

Subpart 1. Home Health Services

Chapter 1. General Provisions

§101. Definitions

[Formerly LAC 50:XIX.101]

A. The following words and terms, when used in this Subpart 1, shall have the following meanings, unless the context clearly indicates otherwise:

Authorized Healthcare Provider—a physician, nurse practitioner, clinical nurse specialist, or physician assistant licensed, certified, registered, or otherwise authorized to order home healthcare services consistent with Louisiana law.

Home Health Aide Services—direct care services to assist in the treatment of the patient’s illness or injury provided under the supervision of a registered nurse and in compliance with the standards of nursing practice governing delegation, including assistance with the activities of daily living such as mobility, transferring, walking, grooming, bathing, dressing or undressing, eating, or toileting.

Home Health Services—patient care services provided in the patient’s home or place of residence under the order of an authorized healthcare provider that are necessary for the diagnosis and treatment of the patient’s illness or injury, including one or more of the following services:

- a. skilled nursing;
- b. physical therapy;
- c. speech-language therapy;
- d. occupational therapy;
- e. home health aide services; or
- f. medical supplies, equipment and appliances suitable for use in the patient’s home or place of residence.

NOTE: Medical supplies, equipment and appliances for home health are reimbursed through the Durable Medical Equipment Program and must be prior authorized.

Occupational Therapy Services—medically prescribed treatment to improve, maintain or restore a function which has been impaired by illness or injury or, when the function has been permanently lost or reduced by illness or injury, to improve the individual’s ability to perform those tasks required for independent functioning.

Physical Therapy Services—rehabilitative services necessary for the treatment of the patient’s illness or injury or, restoration and maintenance of function affected by the patient’s illness or injury. These services are provided with

the expectation, based on the authorized healthcare provider’s assessment of the patient’s rehabilitative potential, that:

- a. the patient’s condition will improve materially within a reasonable and generally predictable period of time; or
- b. the services are necessary for the establishment of a safe and effective maintenance program.

Place of Residence—location where normal life activities take place but does not include a hospital, intermediate care facility for individuals with intellectual disabilities, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

Skilled Nursing Services—nursing services provided on a part-time or intermittent basis by a registered nurse or licensed practical nurse that are necessary for the diagnosis and treatment of a patient’s illness or injury. These services shall be consistent with:

- a. established Medicaid policy;
- b. the nature and severity of the recipient’s illness or injury;
- c. the particular medical needs of the patient; and
- d. the accepted standards of medical and nursing practice.

Speech-Language Therapy Services—those services necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities, and for the diagnosis and treatment of swallowing disorders (dysphagia), regardless of a communication disability.

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 30:431 (March 2004), amended by the Department of Health, Bureau of Health Services Financing, LR 44:59 (January 2018), LR 49:876 (May 2023).

§103. Requirements for Home Health Services
[Formerly LAC 50:XIX.103]

A. Home health services shall be based on an expectation that the care and services are medically reasonable and appropriate for the treatment of an illness or injury, and that the services can be performed adequately by the agency in the recipient’s home or place of residence. For initial ordering of home health services, the authorized healthcare

provider must document a face-to-face encounter that is related to the primary reason the recipient requires home health services. This face-to-face encounter must occur no more than 90 days before or 30 days after the start of services. For the initial ordering of medical supplies, equipment and appliances, the authorized healthcare provider must document that a face-to-face encounter that is related to the primary reason the recipient requires medical equipment occurred no more than six months prior to the start of services. A written plan of care for services shall be evaluated and signed by the authorized healthcare provider every 60 days. This plan of care shall be maintained in the recipient's medical records by the home health agency.

B. Home health services shall be provided in the recipient's home or place of residence.

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 30:431 (March 2004), amended by the Department of Health, Bureau of Health Services Financing, LR 44:59 (January 2018), LR 49:876 (May 2023).

§105. Home Health Agency Responsibilities
[Formerly LAC 50:XIX.105]

A. Home health agencies must comply with the following requirements as condition for participation in the Medicaid Program.

1. The home health agency must provide to the bureau, upon request, the supporting documentation verifying that the recipient meets the medical necessity criteria for services.

2. Home health services shall be terminated when the goals outlined in the plan of care have been achieved, regardless of the number of days or visits that have been approved.

3. The home health agency must ensure that the family is instructed on a home maintenance exercise program which has been established by the treating physical therapist.

4. The home health agency shall discharge a patient once it has been determined that the patient or his/her legally responsible caregiver is noncompliant with the treatment regimen, keeping medical appointments and/or assisting with medication compliance and med-pack setups.

5. The home health agency must report complaints and suspected cases of abuse or neglect of a home health recipient to the appropriate authorities if the agency has knowledge that a minor child, a non-consenting adult or a mentally incompetent adult has been abused or is not receiving proper medical care due to neglect or lack of cooperation on the part of the legal guardians or caretakers. This includes knowledge that a recipient is routinely taken out of the home by a legal guardian or caretaker against medical advice or when it is obviously medically contraindicated.

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 30:431 (March 2004).

§121. Cost Reporting Requirements

A. Effective July 1, 2012, the department shall implement mandatory cost reporting requirements for providers of home health services. The cost reports will be used to verify expenditures and to support rate setting for the services rendered to Medicaid recipients.

B. Each home health agency shall complete the DHH approved cost report and submit the cost report(s) to the department no later than five months after the state fiscal year ends (June 30).

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 39:509 (March 2013).

Chapter 3. Medical Necessity

§301. General Provisions
[Formerly LAC 50:XIX.301]

A. Medical necessity for home health services is determined by the recipient's illness and/or injury and functional limitations. All home health services shall be medically reasonable and appropriate. To be considered medically reasonable and appropriate, the care must be necessary to prevent further deterioration of a recipient's condition regardless of whether the illness or injury is acute, chronic or terminal. The services must be reasonably determined to:

1. diagnose, cure, correct or ameliorate defects, physical and mental illnesses, and diagnosed conditions of the effects of such conditions; or

2. prevent the worsening of conditions, or the effects of conditions, that:

a. endanger life or cause pain;

b. result in illness or infirmity; or

c. have caused, or threatened to cause, a physical or mental dysfunction, impairment, disability, or developmental delay; or

3. effectively reduce the level of direct medical supervision required or reduce the level of medical care or services received in an inpatient or residential care setting; or

4. restore or improve physical or mental functionality, including developmental functioning, lost or delayed as the result of an illness, injury, or other diagnosed condition or the effects of the illness, injury or condition; or

5. provide assistance in gaining access to needed medical, social, educational and other services required to diagnose, treat, or support a diagnosed condition or the

effects of the condition, in order that the recipient might attain or retain:

- a. independence;
- b. self-care;
- c. dignity;
- d. self-determination;
- e. personal safety; and
- f. integration into all natural family, community, and facility environments and activities.

B. Home health skilled nursing and aide services are considered medically reasonable and appropriate when the recipient's medical condition and medical records accurately justify the medical necessity for services to be provided in their residential setting or any setting in which normal life activities take place, other than a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities or any setting in which payment is, or could be made, under Medicaid for inpatient services that include room and board rather than in a physician's office, clinic, or other outpatient setting according to guidelines as stated in this Subpart.

C. Home health services are appropriate when a recipient's illness, injury, or disability causes significant medical hardship and would interfere with the effectiveness of the treatment if he/she had to go to a physician's office, clinic, or other outpatient setting for the needed service. Any statement on the plan of care regarding this medical hardship must be supported by the totality of the recipient's medical records.

D. The following circumstances are not considerations when determining medical necessity for home health services:

1. inconvenience to the recipient or the recipient's family;
2. lack of personal transportation; or
3. failure or lack of cooperation by a recipient or a recipient's legal guardians or caretakers to obtain the required medical services in an outpatient setting.

E. Home health services will be authorized upon medical necessity determination based on the state's medical necessity criteria pursuant to LAC 50:I.1101.

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 30:431 (March 2004), amended by the Department of Health, Bureau of Health Services Financing, LR 44:59 (January 2018).

§303. Provisions for Infants and Toddlers **[Formerly LAC 50:XIX.303]**

A. For the purpose of this Subpart 1, *Infants or Toddlers* are defined as young children, up to age 3, who have not learned to ambulate without assistance.

B. Home health services are considered to be medically necessary for an infant or toddler when the primary care physician has advised against removing the infant or toddler from the home because it would:

1. place the infant or toddler at serious risk of infection;
2. greatly delay or hamper the recovery process;
3. cause significant further debilitation of an existing medical condition or physical infirmity;
4. seriously threaten to cause or aggravate a handicap or a physical deformity or malfunction;
5. cause great suffering or pain;
6. seriously endanger the well-being of the infant or toddler; or
7. otherwise be considered medically contraindicated.

C. The following circumstances are not considered when determining the medical necessity of home health services for infants and toddlers:

1. the provision of services in the home is solely a matter of convenience;
2. a lack of personal transportation; or
3. failure or lack of cooperation by the child's legal guardian(s) to obtain the required medical services in an outpatient setting.

NOTE: The fact that an infant or toddler cannot ambulate or travel without assistance from another is not a factor in determining medical necessity for services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:432 (March 2004), amended by the Department of Health, Bureau of Health Services Financing, LR 44:59 (January 2018).

§305. Extended Nursing Services for Ages 0-21

A. Extended nursing services may be provided to a Medicaid recipient who is age birth through 21 when it is determined to be medically necessary for the recipient to receive a minimum of three continuous hours per day of nursing services. Medical necessity for extended nursing services exists when the recipient has a medically complex condition characterized by multiple, significant medical problems that require nursing care as defined by the Louisiana Nurse Practice Act.

B. Multiple nursing visits on the same date of service may be provided to a recipient who is age birth through 21 when the medical necessity criteria for extended nursing

services are met and these services cannot be provided during the course of one visit.

C. Extended and multiple daily nursing services must be prior authorized in accordance with the certifying physician's orders and home health plan of care. All nursing services shall be provided in accordance with the Louisiana Nurse Practice Act.

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 32:406 (March 2006), amended by the Department of Health, Bureau of Health Services Financing, LR 44:59 (January 2018).

Chapter 5. Retrospective Review

§501. Home Health Visits [Formerly LAC 50:XIX.501]

A. Home health services provided to recipients are subject to post-payment review in order to determine if the recipient's condition warrants high utilization.

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 30:432 (March 2004), amended by the Department of Health, Bureau of Health Services Financing, LR 44:60 (January 2018).

Chapter 7. Reimbursement Methodology

§701. Nursing and Home Health Aide Services

A. Effective for dates of service on or after July, 20, 2007, the reimbursement rates for extended nursing services are increased as follows:

1. nurse care in home performed by a registered nurse (RN) is increased to \$34 per hour;
2. nurse care in home performed by a licensed practical nurse (LPN) is increased to \$32 per hour;
3. multiple visits - nurse care in home performed by an RN is increased to \$17 per hour; and
4. multiple visits - nurse care in home performed by an LPN is increased to \$16 per hour.

B. Reimbursement for intermittent nursing services and home health aide services is a prospective maximum rate per visit.

1. A separate reimbursement rate is established for nursing services at 80 percent of the rate in effect on January 31, 2000 when the nursing services are performed by a licensed practical nurse (LPN).

2. The rate in effect on January 31, 2000 continues to be paid when the nursing service is performed by a registered nurse (RN).

3. Effective for dates of service on or after February 9, 2010, the reimbursement rates for intermittent nursing services (performed by either a RN or LPN) and home health aide services shall be reduced by 5 percent of the rates in effect on February 8, 2010.

C. Effective for dates of service on or after January 1, 2011, the reimbursement rates for extended nursing services shall be reduced by 2 percent of the rates in effect on December 31, 2010.

D. Effective for dates of service on or after July 1, 2012, the reimbursement rates for intermittent and extended nursing services and home health aide services shall be reduced by 3.7 percent of the rates in effect on June 30, 2012.

E. Effective for dates of service on or after April 3, 2023, the reimbursement rates for all home health services shall be reimbursed based on the Louisiana Medicaid fee schedule. All rates in the fee schedule are published on the Medicaid provider website at www.lamedicaid.com.

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 34:654 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2281 (October 2010), LR 37:2159 (July 2011), LR 39:1051 (April 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 49:1389 (August 2023).

Chapter 8. American Rescue Plan Act Funding

§801. Nursing Recruitment and Retention Payments

A. General Provisions

1. Nurses that provide extended home health (EHH) services may be eligible to receive recruitment and retention bonuses through March 2025.

2. A nurse is defined as an individual who possesses and maintains a valid license as a licensed practical nurse (LPN) or registered nurse (RN).

3. All payments shall be administered by the home health agency (HHA) that employs the nurse. If a nurse is employed at multiple agencies, only one HHA may pay the recruitment and retention payment.

4. HHAs shall submit an invoice and supporting documentation for each nurse that meets the requirements outlined in this Chapter on a monthly basis and shall comply with all other requirements established by LDH to receive a payment.

5. HHAs shall disburse the entire payment to the nurse and are prohibited from reducing the payment for any purpose other than required state or federal withholdings.

6. HHAs that provide the required documentation, comply with all applicable requirements, and have at least one nurse a month receiving a bonus payment will be

eligible to invoice LDH for an administrative fee of \$2,500 each month.

B. Recruitment

1. Recruitment is the hiring of a new nurse who commits to providing a minimum of 120 hours of EHH services to beneficiaries under the age of 21 who are in a Medicaid waiver program in each calendar month.

2. A one-time, lump sum payment of \$5,000 may be paid to any nurse who is hired by the HHA and commits to providing a minimum of 120 hours of EHH services to beneficiaries in a waiver program and has not received the retention lump sum bonus payment outlined in this Chapter.

3. Each nurse may only receive the lump sum recruitment bonus payment once.

C. Retention

1. Existing nurses who commit to providing a minimum of 120 hours of EHH services to eligible waiver beneficiaries in a calendar month and have not received the recruitment or retention lump sum bonus payment will receive a \$5,000 retention bonus.

2. Nurses who receive the recruitment or retention lump sum bonus payment shall be eligible to receive a monthly payment of \$200 if they provided at least 120 hours of EHH services to eligible waiver beneficiaries during the previous calendar 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, Bureau of Health Services Financing, LR 49:875 (May 2023), amended LR 50:215 (February 2024).

Chapter 9. Rehabilitation Services

§901. General Provisions

A. The Medicaid Program provides coverage for rehabilitation services rendered in the Home Health Program. Home Health rehabilitation services include:

1. physical therapy;
2. occupational therapy; and
3. speech/language therapy.

B. All home health rehabilitation services must be medically necessary and prior authorized.

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 41:1288 (July 2015).

§905. Reimbursement Methodology

A. The Medicaid Program provides reimbursement for physical therapy, occupational therapy and speech/language therapy covered under the Home Health Program.

B. Effective for dates of service on or after February 13, 2014, reimbursement for physical and occupational therapy

services shall be 85 percent of the 2013 Medicare published rate. There shall be no automatic enhanced rate adjustment for physical and occupational therapy services.

C. Speech/language therapy services shall continue to be reimbursed at the flat fee in place as of February 13, 2014 and in accordance with the Medicaid published fee schedule for speech/language therapy services provided in the Home Health Program.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1288 (July 2015).

Subpart 3. Medical Equipment, Supplies and Appliances

Chapter 85. Provider Participation

§8501. Accreditation Requirements

A. Effective for dates of service on or after August 1, 2011, all providers seeking reimbursement for medical equipment, supplies and appliances must be accredited by one of the following Medicare deemed accreditation organizations:

1. The Joint Commission (JC);
2. National Association of Boards of Pharmacy (NABP);
3. Board of Certification/Accreditation International;
4. The Compliance Team, Inc.;
5. American Board for Certification in Orthotics and Prosthetics, Inc. (ABC);
6. The National Board of Accreditation for Orthotic Suppliers (NBAOS);
7. Commission on Accreditation of Rehabilitation Facilities (CARF);
8. Community Health Accreditation Program (CHAP);
9. HealthCare Quality Association on Accreditation (HQAA); or
10. Accreditation Commission for Health Care, Inc. (ACHC).

B. Verification of accreditation must be received by the department on or before July 31, 2011. A provider's prior authorization privileges will be revoked on August 1, 2011 if this verification is not received.

C. Pharmacies. These accreditation requirements do not apply to pharmacies that provide medical equipment, supplies and appliances.

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

36:512 (March 2010), amended LR 37:2159 (July 2011), amended by the Department of Health, Bureau of Health Services Financing, LR 44:2006 (November 2018).

§8503. Provider Responsibilities

A. Providers shall not initially deliver more than a one month allotment of approved supplies. All subsequently approved supplies must be delivered in increments not to exceed a one month allotment.

B. It is the provider's responsibility to verify that the recipient is Medicaid eligible on the date of service in order for payment to be made. The date of service is the date of delivery, unless the item is delivered through a mail courier service.

1. The date of shipping will be considered the date of service for all items delivered through a mail courier service.

C. Providers who make or sell medical equipment, supplies and appliances must provide a warranty which lasts at least one year from the time the item is delivered to the recipient. If, during that year, the item does not work, the manufacturer or dealer must repair or replace the item.

D. Providers who rent medical equipment must provide a full-service warranty covering the authorized period(s) of the rental equipment.

E. Providers must furnish a comparable, alternate device while repairing the recipient's device during a warranty period.

F. For any appliance which requires skill and knowledge to use, the provider must provide appropriate training for the recipient. Documentation of plans for training must be furnished to the prior authorization unit 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 Hospitals, Bureau of Health Services Financing, LR 36:512 (March 2010).

Chapter 103. Reimbursement Methodology

§10301. General Provisions

A. Unless otherwise stated in this Part XIII, the reimbursement for all medical equipment, supplies and appliances is established at:

1. 70 percent of the 2000 Medicare fee schedule for all procedure codes that were listed on the 2000 Medicare fee schedule and at the same amount for the Health Insurance Portability and Accountability Act (HIPAA) compliant codes which replaced them; or

2. 70 percent of the Medicare fee schedule under which the procedure code first appeared; or

3. 70 percent of the manufacturer's suggested retail price (MSRP) amount; or

4. billed charges, whichever is the lesser amount.

B. If an item is not available at the rate of 70 percent of the applicable established flat fee or 70 percent of the MSRP, the flat fee that will be utilized is the lowest cost at which the item has been determined to be widely available by analyzing usual and customary fees charged in the community.

C. Effective for dates of service on or after February 1, 2009, the reimbursement paid for the following medical equipment, supplies, appliances and repairs shall be reduced by 3.5 percent of the rate on file as of January 31, 2009:

1. ambulatory equipment;
2. bathroom equipment;
3. hospital beds, mattresses and related equipment; and
4. the cost for parts used in the repair of medical equipment, including the parts used in the repair of wheelchairs.

D. Effective for dates of service on or after August 4, 2009, the reimbursement paid for medical equipment, supplies and appliances shall be reduced by 4 percent of the rates on file as of August 3, 2009.

1. The following medical equipment, supplies and appliances are excluded from the rate reduction:

- a. enteral therapy, pumps and related supplies;
- b. intravenous therapy and administrative supplies;
- c. apnea monitor and accessories;
- d. nebulizers;
- e. hearing aids and related supplies;
- f. respiratory care (other than ventilators and oxygen);
- g. tracheostomy and suction equipment and related supplies;
- h. ventilator equipment;
- i. oxygen equipment and related supplies;
- j. vagus nerve stimulator and related supplies; and
- k. augmentative and alternative communication devices.

2. Effective for dates of service on or after September 1, 2009, medical equipment, supplies and appliances provided to recipients under the age of 21 are exempt from the 4 percent rate reduction implemented on August 4, 2009.

E. Effective for dates of service on or after January 22, 2010, the reimbursement paid for medical equipment, supplies and appliances shall be reduced by five percent of the rates on file as of January 21, 2010.

1. The following medical equipment, supplies and appliances are excluded from this rate reduction:

- a. enteral therapy, pumps and related supplies;

- b. intravenous therapy and administration supplies;
- c. apnea monitor and accessories;
- d. nebulizers;
- e. hearing aids and related supplies;
- f. respiratory care (other than oxygen);
- g. tracheostomy and suction equipment and related supplies;
- h. ventilators and related equipment;
- i. vagus nerve stimulator and related supplies; and
- j. augmentative and alternative communication devices.

2. Effective for dates of service on or after February 20, 2010, oxygen, equipment and related supplies shall also be excluded from the rate reduction.

F. Effective for dates of service on or after July 1, 2012, the reimbursement paid for medical equipment, supplies and appliances shall be reduced by 3.7 percent of the rates on file as of June 30, 2012.

G. Effective for dates of service on or after October 1, 2022, fees for enteral formulas will be set at 90 percent of 2021 Rural Medicare fees. For enteral formulas without a corresponding Medicare fee, the Medicaid fees will be set at the lowest fee at which the item has been determined to be widely available based on a review of similar formulas, usual and customary fees charged in the community, and other Medicaid states.

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 35:1894 (September 2009), amended LR 36:1247 (June 2010), LR 36:2041 (September 2010), LR 39:1050 (April 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 48:2293 (September 2022).

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XV. Services for Special Populations

**Subpart 1. Applied Behavior Analysis-
Based Therapy Services**

Chapter 1. General Provisions

§101. Program Description and Purpose

A. Applied behavior analysis-based (ABA) therapy is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement, and functional analysis of the relations between environment and behavior. ABA-based therapies teach skills through the use of behavioral observation and reinforcement or prompting to teach each step of targeted behavior. ABA-based therapies are based on reliable evidence and are not experimental.

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 41:926 (May 2015).

§103. Recipient Criteria

A. In order to qualify for ABA-based therapy services, a Medicaid recipient must meet the following criteria. The recipient must:

1. be from birth up to 21 years of age;
2. exhibit the presence of excesses and/or deficits of behaviors that significantly interfere with home or community activities (examples include, but are not limited to aggression, self-injury, elopement, impaired development in the areas of communication and/or social interaction, etc.);
3. be diagnosed by a qualified health care professional with a condition for which ABA-based therapy services are recognized as therapeutically appropriate, including autism spectrum disorder; and
4. have a comprehensive diagnostic evaluation that prescribes and/or recommends ABA services that is conducted by a qualified health care professional.

B. All of the criteria in §103.A must be met to receive services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:926 (May 2015).

Chapter 3. Services

§301. Covered Services and Limitations

A. Medicaid covered ABA-based therapy services must be:

1. medically necessary;
2. prior authorized by the Medicaid Program or its designee; and
3. delivered in accordance with the recipient's treatment plan.

B. Services must be provided directly or billed by behavior analysts licensed by the Louisiana Behavior Analyst Board.

C. Medical necessity for ABA-based therapy services shall be determined according to the provisions of the *Louisiana Administrative Code* (LAC), Title 50, Part I, Chapter 11 (*Louisiana Register*, Volume 37, Number 1).

D. ABA-based therapy services may be prior authorized for a time period not to exceed 180 days. Services provided without prior authorization shall not be considered for reimbursement, except in the case of retroactive Medicaid eligibility.

E. Service Limitations

1. Services shall be based upon the individual needs of the child, and must give consideration to the child's age, school attendance requirements, and other daily activities as documented in the treatment plan.

2. Services must be delivered in a natural setting (e.g., home and community-based settings, including schools and clinics).

a. Services delivered in a school must not duplicate services rendered under an individualized family service plan (IFSP) or an individualized educational program (IEP) as required under the federal Individuals with Disabilities Education Act (IDEA).

3. Any services delivered by direct line staff must be under the supervision of a lead behavior therapist who is a Louisiana licensed behavior analyst.

F. Not Medically Necessary/Non-Covered Services. The following services do not meet medical necessity criteria, nor qualify as Medicaid covered ABA-based therapy services:

1. therapy services rendered when measureable functional improvement or continued clinical benefit is not

expected, and therapy is not necessary for maintenance of function or to prevent deterioration;

2. services that are primarily educational in nature;
3. services delivered outside of the school setting that are duplicative services under an individualized family service plan (IFSP) or an individualized educational program (IEP), as required under the federal Individuals with Disabilities Education Act (IDEA);
4. treatment whose purpose is vocationally- or recreationally-based; and
5. custodial care;
 - a. for purposes of these provisions, custodial care:
 - i. shall be defined as care that is provided primarily to assist in the activities of daily living (ADLs), such as bathing, dressing, eating, and maintaining personal hygiene and safety;
 - ii. is provided primarily for maintaining the recipient's or anyone else's safety; or
 - iii. could be provided by persons without professional skills or training.

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 41:926 (May 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2498 (December 2017), LR 48:2755 (November 2022).

§303. Treatment Plan

A. ABA-based therapy services shall be rendered in accordance with the individual's treatment plan. The treatment plan shall:

1. be person-centered and based upon individualized goals;
2. be developed by a licensed behavior analyst;
3. delineate both the frequency of baseline behaviors and the treatment development plan to address the behaviors;
4. identify long, intermediate, and short-term goals and objectives that are behaviorally defined;
5. identify the criteria that will be used to measure achievement of behavior objectives;
6. clearly identify the schedule of services planned and the individual providers responsible for delivering the services;
7. include care coordination involving the parents or caregiver(s), school, state disability programs, and others as applicable;
8. include parent/caregiver training, support, and participation;

9. have objectives that are specific, measurable, based upon clinical observations, include outcome measurement assessment, and tailored to the individual; and

10. ensure that interventions are consistent with ABA techniques.

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 41:927 (May 2015).

Chapter 5. Provider Participation

§501. General Provisions

A. ABA-based therapy services must be provided by or under the supervision of a behavior analyst who is currently licensed by the Louisiana Behavior Analyst Board, or a licensed psychologist, or a licensed medical psychologist.

B. Licensed behavior analysts that render ABA-based therapy services shall meet the following provider qualifications:

1. be licensed by the Louisiana Behavior Analyst Board;
2. be covered by professional liability insurance to limits of \$1,000,000 per occurrence, \$1,000,000 aggregate;
3. have no sanctions or disciplinary actions on their Board Certified Behavior Analyst (BCBA®) or Board Certified Behavior Analyst-Doctoral (BCBA-D) certification and/or state licensure;
4. not have Medicare/Medicaid sanctions, or be excluded from participation in federally funded programs (i.e., Office of Inspector General's list of excluded individuals/entities (OIG-LEIE), system for award management (SAM) listing and state Medicaid sanctions listings); and
5. have a completed criminal background check to include federal criminal, state criminal, parish criminal and sex offender reports for the state and parish in which the behavior analyst is currently working and residing.

a. Criminal background checks must be performed at the time of hire and at least five years thereafter.

b. Background checks must be current, within a year prior to the initial Medicaid enrollment application. Background checks must be performed at least every five years thereafter.

C. Certified assistant behavior analyst that render ABA-based therapy services shall meet the following provider qualifications:

1. must be certified by the Louisiana Behavior Analyst Board;
2. must work under the supervision of a licensed behavior analyst;

a. the supervisory relationship must be documented in writing;

3. must have no sanctions or disciplinary actions, if state-certified or board-certified by the BACB®;

4. may not have Medicaid or Medicare sanctions or be excluded from participation in federally funded programs (OIG-LEIE listing, SAM listing and state Medicaid sanctions listings); and

5. have a completed criminal background check to include federal criminal, state criminal, parish criminal and sex offender reports for the state and parish in which the certified assistant behavior analyst is currently working and residing.

a. Evidence of this background check must be provided by the employer.

b. Criminal background checks must be performed at the time of hire and an update performed at least every five years thereafter.

D. Registered line technicians that render ABA-based therapy services shall meet the following provider qualifications:

1. must be registered by the Louisiana Behavior Analyst Board;

2. must work under the supervision of a licensed behavior analyst;

a. the supervisory relationship must be documented in writing;

3. may not have Medicaid or Medicare sanctions or be excluded from participation in federally funded programs (OIG-LEIE listing, SAM listing and state Medicaid sanctions listings); and

4. have a completed criminal background check to include federal criminal, state criminal, parish criminal and sex offender reports for the state and parish in which the certified assistant behavior analyst is currently working and residing.

a. Evidence of this background check must be provided by the employer.

b. Criminal background checks must be performed at the time of hire and an update performed at least every five years thereafter.

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 41:927 (May 2015).

Chapter 7. Reimbursements

§701. General Provisions

A. The Medicaid Program shall provide reimbursement for ABA-based therapy services to enrolled behavior analysts who are currently licensed and in good standing

with the Louisiana Behavior Analyst Board. Reimbursement shall only be made for services billed by a licensed behavior analyst, licensed psychologist, or licensed medical psychologist.

B. Reimbursement for ABA services shall not be made to, or on behalf of services rendered by, a parent, a legal guardian or legally responsible person.

C. Reimbursement shall only be made for services authorized by the Medicaid Program or its designee.

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 41:928 (May 2015).

§703. Reimbursement Methodology

A. Reimbursement for ABA-based therapy services shall be based upon a percentage of the commercial rates for ABA-based therapy services in the state of Louisiana.

B. Effective for dates of service on or after January 1, 2017, ABA rates and codes in effect on December 31, 2016 may be realigned to be consistent with Louisiana commercial rates or ABA codes adopted by the American Medical Association via current procedural terminology (CPT) codes.

1. Prior authorizations already in effect on the promulgation date of these provisions will be honored. Those services shall be paid at the rate in effect on December 31, 2016.

2. New prior authorizations with a begin date after the promulgation date of these provisions must use the codes in effect prior to January 1, 2017 for those services provided and to be delivered prior to January 1, 2017, and for any services provided after January 1, 2017, the codes in effect at the time of service delivery.

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 41:928 (May 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:662 (April 2017), LR 45:1597 (November 2019).

Subpart 3. Hospice

Chapter 31. General Provisions

§3101. Introduction

A. Hospice care is an alternative treatment approach that is based on a recognition that impending death requires a change from curative treatment to palliative care for the terminally ill patient and supporting family. Palliative care focuses on comfort care and the alleviation of physical, emotional and spiritual suffering. Instead of hospitalization, its focus is on maintaining the terminally ill patient at home with minimal disruptions in normal activities and with as much physical and emotional comfort as possible.

B. The bureau terminates the pilot project for hospice care and establishes hospice as a covered service under the Medicaid State Plan.

C. The bureau will continue to make Medicaid payments under certain circumstances for specified services provided in conjunction with Medicare hospice care for dually eligible individuals who reside in Medicaid reimbursed nursing facilities as provided in §4307 of this Subpart and in accordance with §1905(o)(3) of the Social Security Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1466 (June 2002), amended LR 30:1024 (May 2004).

Chapter 33. Provider Participation

§3301. Conditions for Participation

A. Statutory Compliance

1. Coverage of Medicaid hospice care shall be in accordance with:

- a. 42 USC 1396d(o); and
- b. the Medicare Hospice Program guidelines as set forth in 42 CFR Part 418.

B. In order to participate, a hospice shall maintain compliance with the Medicare conditions of participation for hospices as set forth in 42 CFR Part 418.50-418.100 and shall have a valid Medicaid provider agreement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1466 (June 2002), amended LR 30:1024 (May 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:129 (January 2015).

Chapter 35. Recipient Eligibility

§3501. Election of Hospice Care

A. In order to be eligible to elect hospice care under Medicaid, a recipient must be terminally ill. An individual is considered to be terminally ill if the individual has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course.

B. An election statement must be filed with a particular hospice for the individual who meets the eligibility requirements as set forth in §3501.A above.

1. The election must be filed by the eligible individual or by a person authorized by law (legal representative) to consent to medical treatment for such individual.

a. A legal representative does not have the authority to elect, revoke, or appeal the denial of hospice services if the recipient is able to and wishes to convey a contrary choice.

2. For dually eligible recipients, hospice care must be elected for both the Medicaid and Medicare programs at once.

C. Duration (Periods). Subject to the conditions set forth in §3501, an individual may elect to receive hospice care during one or more of the following election periods:

1. an initial 90-day period;
2. subsequent 90-day period; and
3. subsequent periods of 60 days each. These periods require prior authorization as outlined in §4101 of these rules.

D. Order of Election. The periods of care are available in the order listed and may be used consecutively or at different times during the recipient's life span. The hospice interdisciplinary team shall help manage the patient's hospice election periods by continually assessing the patient's appropriateness for Medicaid hospice care, especially before the patient enters a new election period.

E. An individual may designate an effective date for the election period that begins with the first day of hospice care or any subsequent day of hospice care, but an individual may not designate an effective date that is earlier than the date that the election is made.

F. Loss of Remaining Days in Period. When a recipient revokes or is discharged alive during an election period, the recipient loses any remaining days in the election period.

G. Election Statement Requirements. The election statement must include:

1. identification of the particular hospice that will provide care to the individual;
2. the individual's or his/her legal representative's acknowledgment that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the individual's terminal illness;
3. acknowledgment that certain Medicaid services, as set forth in §3503 are waived by the election;
4. the effective date of the election, which may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement; and
5. the signature of the individual or his/her legal representative.

H. Duration of Election. An election to receive hospice care will be considered to continue through the initial election period and through the subsequent election periods without a break in care as long as the individual:

1. remains in the care of a hospice;
2. does not revoke the election under the provisions of §3505; and
3. is not discharged from hospice in accordance with §3505.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 19:749 (June 1993), amended LR 28:1466 (June 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:129 (January 2015).

§3503. Waiver of Payment for Other Services

A. Hospice providers must provide services to beneficiaries that are comparable to the Medicaid-covered services that could have been received prior to the election of hospice. This requirement refers to all Medicaid-covered services including, but not limited to, durable medical equipment, prescription drugs, and physician-administered drugs.

B. Beneficiaries who are age 21 and over may be eligible for additional personal care services as defined in the Medicaid State Plan. Services furnished under the personal care services benefit may be used to the extent that the hospice provider would otherwise need the services of the hospice beneficiary's family in implementing the plan of care.

C. Beneficiaries under age 21 who are approved for hospice may continue to receive life-prolonging treatments. Life-prolonging treatments are defined as Medicaid-covered services provided to a beneficiary with the purpose of treating, modifying, or curing a medical condition to allow the beneficiary to live as long as possible, even if that medical condition is also the hospice qualifying diagnosis. The hospice provider and other providers must coordinate life-prolonging treatments and these should be incorporated into the plan of care.

D. Beneficiaries under the age of 21 who are approved for hospice may also receive early and periodic screening, diagnostic and treatment personal care, extended home health, and pediatric day health care services concurrently. The hospice provider and the other service providers must coordinate services and develop the patient's plan of care as set forth in §3705.

E. For beneficiaries under the age of 21, the hospice provider is responsible for making a daily visit, unless specifically declined by the beneficiary or family, to coordinate care and ensure that there is no duplication of services. The daily visit is not required if the beneficiary is not in the home due to hospitalization or inpatient respite or inpatient hospice stays.

F. In the event that the federal or state government declares an emergency or disaster, the Medicaid Program may temporarily waive the provision requiring daily visits by the hospice provider to all clients under the age of 21 to facilitate continued care while maintaining the safety of staff and beneficiaries. Visits will still be completed based on clinical need of the beneficiary, family, and availability of staff, as requested by the family. The use of telemedicine visits as an alternative is allowed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1467 (June 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:129 (January 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 46:1563 (November 2020), LR 48:2294 (September 2022).

§3505. Revoking the Election of Hospice Care/Discharge

A. An individual or his/her representative may revoke the individual's election of hospice care for a particular election period at any time during an election period.

1. Required Statement of Revocation. To revoke the election of hospice care, the individual or his/her representative must file a statement with the hospice that includes:

a. a signed statement that the individual or his/her representative revokes the individual's election for Medicaid coverage of hospice care for the remainder of that election period;

b. the date that the revocation is to be effective. (An individual or his/her representative may not designate an effective date earlier than the date that the revocation is made.)

2. If a recipient is eligible for Medicare as well as Medicaid and elects hospice care, it must be revoked simultaneously under both programs.

3. Discharge

a. The hospice benefit is available only to individuals who are terminally ill; therefore, a hospice must discharge a patient if it discovers that the patient is not terminally ill.

b. Patients shall be discharged only in the circumstances as detailed in the Licensing Standards for Hospices (LAC 48:I.8229).

4. Service Availability upon Revocation or Discharge. An individual, upon discharge or revocation of the election of Medicaid coverage of hospice care for a particular election period:

a. is no longer covered under Medicaid for hospice care; and

b. resumes Medicaid coverage of the benefits waived as provided under §3503.

5. Re-election of Hospice Benefits. If an election has been revoked in accordance with the provisions of this §3505, the individual or his/her representative may at any time file an election, in accordance with §3501, for any other election period that is still available to the individual.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1467 (June 2002), amended by the

Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:130 (January 2015).

§3507. Change of Designated Hospice

A. An individual or his/her representative may change, once in each election period, the designation of the particular hospice from which hospice care will be received. The change of the designated hospice is not a revocation of the election for the period in which it is made. To change the designation of hospice programs, the individual or his/her representative must file, with the hospice from which care has been received and with the newly designated hospice, a statement that includes:

1. the name of the hospice from which the individual has received care and the name of the hospice from which he or she plans to receive care; and
2. the date the change is to be effective.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1467 (June 2002).

Chapter 37. Provider Requirements

§3701. Requirements for Coverage

A. To be covered, a certification of terminal illness must be completed as set forth in §3703, the election of hospice care form must be completed in accordance with §3501, and a plan of care must be established in accordance with §3705. A written narrative from the referring physician explaining why the patient has a prognosis of six months or less must be included in the certificate of terminal illness.

B. Prior authorization requirements stated in Chapter 41 of these provisions are applicable to all election periods.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1467 (June 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:130 (January 2015).

§3703. Certification of Terminal Illness

A. The hospice must obtain written certification of terminal illness for each of the periods listed in §3501.C, even if a single election continues in effect for two, three, or more periods.

1. For the first 90-day period of hospice coverage, the hospice must obtain a verbal certification no later than two calendar days after hospice care is initiated. If the verbal certification is not obtained within two calendar days following the initiation of hospice care, a written certification must be made within 10 calendar days following the initiation of hospice care. The written certification and notice of election must be obtained before requesting prior authorization for hospice care. If these requirements are not met, no payment is made for the days prior to the certification. Instead, payment begins with the

day certification, i.e., the date all certification forms are obtained.

2. For the subsequent periods, a written certification must be included in an approved prior authorization packet before a claim may be billed.

B. Face-to-Face Encounter

1. A hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient whose total stay across all hospices is anticipated to reach the third benefit period. The face-to-face encounter must occur no more than 30 calendar days prior to the third benefit period recertification, and every benefit period recertification thereafter, to gather clinical findings to determine continued eligibility for hospice care.

2. The physician or nurse practitioner who performs the face-to-face encounter with the patient must attest in writing that he or she had a face-to-face encounter with the patient, including the date of that visit. The attestation of the nurse practitioner or a non-certifying hospice physician shall state that the clinical findings of that visit were provided to the certifying physician for use in determining continued eligibility for hospice care.

C. Content of Certifications

1. Certifications shall be based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness.

2. The certification must specify that the individual's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course.

3. Written clinical information and other documentation that support the medical prognosis must accompany the certification of terminal illness and must be based on the physician's clinical judgment regarding the normal course of the individual's illness filed in the medical record with the written certification, as set forth in §3703.C.

4. The physician must include a brief written narrative explanation of the clinical findings that support a life expectancy of six months or less as part of the certification and recertification forms, or as an addendum to the certification/recertification forms:

a. if the physician includes an addendum to the certification and recertification forms, it shall include, at a minimum:

- i. the patient's name;
- ii. physician's name;
- iii. terminal diagnosis(es);
- iv. prognosis; and

v. the name and signature of the IDG member making the referral;

b. the narrative must reflect the patient's individual clinical circumstances and cannot contain check boxes or standard language used for all patients;

c. the narrative associated with the third benefit period recertification and every subsequent recertification must include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of six months or less, and shall not be the same narrative as previously submitted;

d. prognosis; and

e. the name and signature of the IDG member taking the referral.

5. All certifications and recertifications must be signed and dated by the physician(s), and must include the benefit period dates to which the certification or recertification applies.

D. Sources of Certification

1. For the initial 90-day period, the hospice must obtain written certification statements as provided in §3703.A.1 from:

a. the hospice's medical director or physician member of the hospice's interdisciplinary group; and

b. the individual's referring physician.

i. The referring physician is a doctor of medicine or osteopathy and is identified by the individual, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care.

ii. The referring physician is the physician identified within the Medicaid system as the provider to which claims have been paid for services prior to the time of the election of hospice benefits.

2. For subsequent periods, the only requirement is certification by either the medical director of the hospice or the physician member of the hospice interdisciplinary group.

E. Maintenance of Records. Hospice staff must make an appropriate entry in the patient's clinical record as soon as they receive an oral certification and file written certifications in the clinical record.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 19:749 (June 1993), amended LR 28:1468 (June 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:130 (January 2015).

§3705. Plan of Care

A. A written plan of care must be established and maintained for each individual admitted to a hospice program in accordance with the provisions set forth in the Licensing Standards for Hospices (LAC 48:I.Chapter 82), and the care provided to an individual must be consistent with the plan and be reasonable and necessary for the palliation or management of the terminal illness as well as related conditions.

B. The plan of care must be established before services are provided.

C. When developing the plan of care (POC), the hospice provider must consult with, and collaborate with the recipient, his/her caregiver, and his/her long-term personal care services provider, and if the recipient is under age 21, his/her extended home nursing provider and/or pediatric day health care provider. If the recipient is receiving any of these services at the time of admission to hospice, the hospice provider must ensure that the POC clearly and specifically details the services and tasks, along with the frequency, to be performed by the non-hospice provider(s), as well as the services and tasks, along with the frequency, that are to be performed by the hospice provider to ensure that services are non-duplicative and that the recipient's needs are being met.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1468 (June 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:131 (January 2015).

§3707. Record Keeping

A. The hospice must maintain and retain the business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided.

B. In accordance with the provisions set forth in the Licensing Standards for Hospices (LAC 48:I.Chapter 82), the hospice must establish and maintain a clinical record for every individual receiving care and services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1468 (June 2002).

§3709. Self Assessment

A. In accordance with the provisions set forth in the Licensing Standards for Hospices (LAC 48:I.Chapter 82) the hospice must conduct an ongoing, comprehensive, integrated, self-assessment of the quality and appropriateness of care provided, including inpatient care, home care and care provided under arrangements.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1468 (June 2002).

Chapter 39. Covered Services

§3901. Medical and Support Services

A. Hospice is a package of medical and support services for the terminally ill individual. The following services are covered hospice services.

1. Nursing care provided by or under the supervision of a registered nurse.

2. Medical social services provided by a social worker who has at least a master's degree from a school of social work accredited by the Council on Social Work Education, and who is working under the direction of a physician.

3. Physicians' services performed by a physician (as defined in 42 CFR 410.20). In addition to palliation and management of the terminal illness and related conditions, physician employees of the hospice and physicians under contract to the hospice, including the physician member(s) of the interdisciplinary group, must also meet the general medical needs of the patients to the extent that these needs are not met by the attending physician. The medical director of the hospice is to assume overall responsibility for the medical component of the hospice's patient care program.

4. Counseling services must be available to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other caregiver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death. Counseling includes bereavement counseling, provided after the patient's death as well as dietary, spiritual and any other counseling services for the individual and family provided while the individual is enrolled in the hospice.

a. There must be an organized program for the provision of bereavement services under the supervision of a qualified professional. The plan of care for these services should reflect family needs, as well as a clear delineation of services to be provided and the frequency of service delivery (up to one year following the death of the patient).

i. Bereavement counseling is a required hospice service but it is not reimbursable.

b. Dietary counseling, when required, must be provided by a qualified individual.

c. The hospice must make reasonable efforts to arrange for visits of clergy and other members of religious organizations in the community to patients who request such visits and must advise patients of this opportunity.

d. Additional counseling may be provided by other members of the interdisciplinary group as well as by other qualified professionals as determined by the hospice.

5. Short-term inpatient care provided in a participating hospice inpatient unit, or a participating hospital or nursing facility that additionally meets the special hospice standards regarding staffing and patient areas. Services provided in an inpatient setting must conform to the written plan of care. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home.

6. Medical appliances and supplies, including drugs and biologicals. Only drugs as defined in §1861(t) of the Social Security Act and which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. Appliances may include covered durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness. Equipment is provided by the hospice for use in the patient's home while he or she is under hospice care. Medical supplies include those that are part of the written plan of care.

a. The hospice must have a policy for the disposal of controlled drugs maintained in the patient's home when those drugs are no longer needed by the patient.

b. Drugs and biologicals shall be administered only by a licensed nurse or physician, an employee who has completed a state-approved training program in medication administration, the patient if his or her attending physician has approved, or any other individual in accordance with applicable state and local laws. The persons and each drug and biological they are authorized to administer must be specified in the patient's plan of care.

7. Home Health Aide Services Furnished by Qualified Aides and Homemaker Services. Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Aide services must be provided under the general supervision of a registered nurse. Written instructions for patient care are to be prepared by a registered nurse. A registered nurse must visit the home site at least every 14 days when aide services are being provided, and the visit must include an assessment of the aide services.

8. Physical therapy, occupational therapy and speech-language pathology services provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

9. Any other item or service which is included in the plan of care and for which payment may otherwise be made under Medicaid is a covered service. The hospice is responsible for providing any and all services indicated in the plan of care as necessary for the palliation and management of the terminal illness and related conditions.

10. Core Services

a. Nursing care, physicians' services, medical social services and counseling are core hospice services and must routinely be provided directly by hospice employees, except that physicians' services and counseling services may be provided through contract. Supplemental services may be contracted for during periods of peak patient loads and to obtain physician specialty services. The hospice may contract for a physician to be a member of the hospice's interdisciplinary group. Also, the hospice's Medical Director does not have to be an employee of the hospice. If

contracting is used for any core services, professional, financial and administrative responsibility for the services must be maintained and regulatory qualification requirements of all staff must be assured.

b. If located in a non-urbanized area, a hospice may apply for a waiver of the core nursing, physical therapy, occupational therapy, speech language pathology, and dietary counseling requirements in accordance with 42 USC §1395x(dd).

11. Level of Care. Hospice care is divided into four categories of care rendered to the hospice patient:

a. Routine Home Care Day. A routine home care day is a day on which an individual who has elected to receive hospice care is at home and is not receiving continuous care.

b. Continuous Home Care Day. A continuous home care day is a day on which an individual who has elected to receive hospice care is not in an inpatient facility and receives hospice care consisting predominantly of nursing care on a continuous basis at home. Continuous home care is only furnished during brief periods of crisis and only as necessary to maintain the terminally ill patient at home.

i. If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine home care.

ii. A period of crisis is a period in which a patient requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care.

iii. A minimum of eight hours of care must be provided during a 24-hour day which begins and ends at midnight. This care need not be continuous, i.e., four hours could be provided in the morning and another four hours provided in the evening of that day.

iv. Homemaker and aide services may also be provided to supplement the nursing care.

c. Inpatient Respite Care Day. An inpatient respite care day is a day on which the individual receives care in an approved facility on a short-term basis, not to exceed five days in any one election period, to relieve the family members or other persons caring for the individual at home. An approved facility is one that meets the standards as provided in 42 CFR §418.98(b). This service cannot be delivered to individuals already residing in a nursing facility.

d. General Inpatient Care Day. A general inpatient care day is a day on which an individual receives general inpatient care in an inpatient facility that meets the standards as provided in 42 CFR §418.98(a) and for the purpose of pain control or acute or chronic symptom management which cannot be managed in other settings.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1468 (June 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:131 (January 2015).

Chapter 41. Prior Authorization

§4101. Prior Authorization of Hospice Services

A. Prior authorization is required for all election periods as specified in §3501.C of this Subpart. The prognosis of terminal illness will be reviewed. A patient must have a terminal prognosis and not just certification of terminal illness. Authorization will be made on the basis that a patient is terminally ill as defined in federal regulations. These regulations require certification of the patient's prognosis, rather than diagnosis. Authorization will be based on objective clinical evidence contained in the clinical record which supports the medical prognosis that the patient's life expectancy is six months or less if the illness runs its normal course and not simply on the patient's diagnosis.

1. The Medicare criteria found in local coverage determination (LCD) hospice determining terminal status (L34538) will be used in analyzing information provided by the hospice to determine if the patient meets clinical requirements for this program.

2. Providers shall submit the appropriate forms and documentation required for prior authorization of hospice services as designated by the department in the Medicaid Program's service and provider manuals, memorandums, etc.

B. Written Notice of Denial. In the case of a denial, a written notice of denial shall be submitted to the hospice recipient, recipient's legal representative, and nursing facility, if appropriate.

C. Reconsideration. Claims will only be paid from the date of the hospice notice of election if the prior authorization request is received within 10 days from the date of election and is approved. If the prior authorization request is received 10 days or more after the date on the hospice notice of election, the approved begin date for hospice services is the date the completed prior authorization packet is received.

D. Appeals. If the recipient does not agree with the denial of a hospice prior authorization request, the recipient, the recipient's legal representative, or the hospice on behalf of the recipient, can request an appeal of the prior authorization decision. The appeal request must be filed with the Division of Administrative Law within 30 days from the date of the postmark on the denial letter. The appeal proceedings will be conducted in accordance with the Administrative Procedure Act.

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HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1470 (June 2002), amended by the

Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:131 (January 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1521 (September 2016).

Chapter 43. Reimbursement

§4301. General

A. With the exception of payment for physician services, Medicaid reimbursement for hospice care is made at one of four predetermined rates, as detailed in §4305, for each day in which a Medicaid recipient is under the care of the hospice. The four rates are prospective rates; there are no retroactive adjustments other than the limitation on payments for inpatient care. The rate paid for any particular day varies depending on the level of care furnished to the recipient. The limitation on payment for inpatient care is described in §4309.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1470 (June 2002).

§4303. Levels of Care for Payment

A. Routine Home Care. The routine home care rate is paid for each day the patient is under the care of the hospice and not receiving one of the other categories of hospice care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day and is also paid when the patient is receiving hospital care for a condition unrelated to the terminal condition. This rate is also paid in the following situations:

1. if the patient is in a hospital that is not contracted with the hospice; or
2. if the patient is receiving outpatient services in the hospital; or
3. for the day of discharge alive from general inpatient care or respite care level of care.

B. Continuous Home Care. Continuous home care is to be provided only during a period of crisis (see §3901.A.11.b). If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine home care.

1. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate.
2. A minimum of eight hours must be provided.
3. For every hour or part of an hour of continuous care furnished, the hourly rate is paid for up to 24 hours a day.

C. Inpatient Respite Care. The inpatient respite care rate is paid for each day the recipient is in an approved inpatient facility and is receiving respite care (see §3901.A.11.c). Respite care may be provided only on an occasional basis and payment for respite care may be made for a maximum of five days at a time including the date of admission but not counting the date of discharge. Payment for the day of

discharge in a respite setting shall be at the routine home level-of-care discharged alive rate.

1. Payment for the sixth and any subsequent days is to be made at the routine home care rate.
2. Respite care may not be provided when the hospice patient is a nursing home resident, regardless of the setting, i.e., long-term acute care setting.

D. General Inpatient Care. Payment at the inpatient rate is made when an individual receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings. General inpatient care is a short-term level of care and is not intended to be a permanent solution to a negligent or absent caregiver. A lower level of care must be used once symptoms are under control. General inpatient care and nursing facility or intermediate care facility for persons with intellectual disabilities room and board cannot be reimbursed for the same recipient on the same covered days of service. Payment for the day of discharge in a general inpatient setting shall be at the routine home level-of-care discharged alive rate.

1. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the patient dies as an inpatient.
2. When the patient is deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1470 (June 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:132 (January 2015).

§4305. Payment Methodology

A. Reimbursement for hospice services is made to a designated hospice provider based on the Medicaid rates published annually in a memorandum issued by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), Center for Medicaid and CHIP Services. These rates are effective from October 1 of each year through September 30 of the following year.

1. Payment for hospice care will be made at predetermined rates for each day in which a beneficiary is under the care of the hospice provider. The daily rate is applicable to the type and intensity of services furnished to the beneficiary for that day.
2. For routine home care, continuous home care, and inpatient respite care, only one rate is applicable for each day. For continuous home care, the amount of payment is determined based on the number of hours of continuous care furnished to the recipient on that day.

B. A service intensity add-on (SIA) payment will be reimbursable for a visit by a registered nurse or a social worker, when provided during routine home care in the last

seven days of a patient's life. The SIA payment is made in addition to the routine home care rate.

1. The hospice provider shall submit claims for payment for hospice care only on the basis of the geographic location at which the services are furnished.

a. The nursing facility shall be considered an individual's home if the individual usually lives in the nursing facility.

2. **Payment for Physician Services.** The four basic payment rates for hospice care are designed to reimburse the hospice for the costs of all covered services related to the treatment of the recipient's terminal illness. This includes the administrative and general supervisory activities performed by physicians who are employees of or working under arrangements made with the hospice. These activities are generally performed by the physician serving as the medical director and the physician member of the hospice interdisciplinary group. Group activities include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies. The costs for these services are included in the reimbursement rates for routine home care, continuous home care, and inpatient respite care.

a. The hospice is paid for other physicians' services, such as direct patient care services, furnished to individual patients by hospice employees and for physician services furnished under arrangements made by the hospice unless the patient care services were furnished on a volunteer basis. The physician visit for the face-to-face encounter will not be reimbursed by the Medicaid Program.

b. The hospice is reimbursed in accordance with the usual Medicaid reimbursement policy for physicians' services. This reimbursement is in addition to the daily rates.

c. Physicians who are designated by recipients as the attending physician and who also volunteer services to the hospice are, as a result of their volunteer status, considered employees of the hospice in accordance with the 42 CFR 418.3. All direct patient care services rendered by these physicians to hospice patients are hospice physician services, and are reimbursed in accordance with the procedures outlined in §4305.B.1. Physician services furnished on a volunteer basis are excluded from Medicaid reimbursement. The hospice may be reimbursed on behalf of a volunteer physician for specific services rendered which are not furnished on a volunteer basis (a physician may seek reimbursement for some services while furnishing other services on a volunteer basis). The hospice must have a liability to reimburse the physician for those physician services rendered. In determining which services are furnished on a volunteer basis and which services are not, a physician must treat Medicaid patients on the same basis as other patients in the hospice.

d. An independent attending physician is reimbursed in accordance with the usual Medicaid reimbursement methodology for physician services.

i. The only services billed by the attending physician are the physician's personal professional services. Costs for services such as lab or x-rays are not included on the attending physician's bill.

ii. Services provided by an independent attending physician must be coordinated with any direct care services provided by hospice physicians.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1470 (June 2002), amended LR 34:441 (March 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:132 (January 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 49:1219 (July 2023).

§4307. Payment for Long Term Care Residents

A. Pursuant to Section 1902(a)(13)(B) of the Social Security Act, an additional amount will be paid to hospice providers for routine home care and continuous home care to take into account the room and board furnished by a long term care facility for a Medicaid recipient:

1. who is residing in a nursing facility or intermediate care facility for persons with intellectual disabilities (ICF/ID);

2. who would be eligible under the state plan for nursing facility services or ICF/ID services if he or she had not elected to receive hospice care;

3. who has elected to receive hospice care; and

4. for whom the hospice agency and the nursing facility or ICF/ID have entered into a written agreement in accordance with the provisions set forth in the licensing standards for hospice agencies (LAC 48:I.Chapter 82), under which the hospice agency takes full responsibility for the professional management of the individual's hospice care and the facility agrees to provide room and board to the individual.

B. Under these circumstances, payment to the facility is discontinued and payment is made to the hospice provider which must then reimburse the facility for room and board.

C. The rate reimbursed to hospice providers shall be 95 percent of the per diem rate that would have been paid to the facility for the recipient if he/she had not elected to receive hospice services.

1. This rate is designed to cover "room and board" which includes performance of personal care services, including assistance in the activities of daily living, administration of medication, maintaining the cleanliness of the patient's environment, and supervision and assistance in the use of durable medical equipment and prescribed therapies.

2. This rate is in addition to the routine home care rate or the continuous home care rate.

D. Any patient liability income (PLI) determined by the bureau will be deducted from the additional payment. It is the responsibility of the Medicaid enrolled facility to collect the recipient's PLI.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 19:749 (June 1993), amended LR 28:1471 (June 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1894 (September 2009), LR 41:132 (January 2015).

§4309. Limitation on Payments for Inpatient Care

A. Payments to a hospice for inpatient care are limited according to the number of days of inpatient care furnished to Medicaid patients.

1. A hospice cap period is a 12-month period beginning November 1 of each year and ending October 31 of the following year.

2. Once each year at the end of the hospices' "cap period" the bureau calculates a limitation on payment for inpatient care to ensure that Medicaid payment is not made for days of inpatient care in excess of 20 percent of the total number of days of hospice care furnished to Medicaid patients.

a. Medicaid recipients afflicted with acquired immunodeficiency syndrome (AIDS) are included in the calculation of this inpatient care limitation.

b. Any excess reimbursement is refunded by the hospice.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1472 (June 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:132 (January 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 48:2294 (September 2022), LR 49:1220 (July 2023).

§4311. Coinsurance for Medicare

A. For dually eligible recipients for whom Medicare is the primary payer for hospice services, Medicaid will also provide for payment of any coinsurance amounts imposed under §1813(a)(4) of the Social Security Act.

1. **Drugs and Biologicals.** The coinsurance amount for each prescription approximates 5 percent of the cost of the drug or biological to the hospice, determined in accordance with the drug copayment schedule established by the hospice, except that the coinsurance amount for each prescription may not exceed \$5. The cost of the drug or biological may not exceed what a prudent buyer would pay in similar circumstances.

2. **Respite Care.** The coinsurance amount for each respite care day is equal to 5 percent of the payment made under Medicare for a respite care day. The amount of the individual's coinsurance liability for respite care during a

hospice coinsurance period may not exceed the inpatient hospital deductible applicable for the year in which the hospice coinsurance period began.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1472 (June 2002).

§4313. Services Not Related to Terminal Illness

A. Any covered Medicaid services not related to the treatment of the terminal condition for which hospice care was elected, that are provided during a hospice election period, are billed to the bureau for non-hospice Medicaid payment. Prior authorization is required for any covered Medicaid services not related to the treatment of the terminal condition if such prior authorization is required by the bureau for non-hospice recipients.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1472 (June 2002).

§4315. Life-Prolonging Treatments for Beneficiaries under the Age of 21

A. Reimbursement for life-prolonging treatments is separate from hospice payments and is made to the providers furnishing the services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Louisiana Department of Health, LR 46:1564 (November 2020).

Subpart 5. Early and Periodic Screening, Diagnosis, and Treatment

Chapter 65. General Provisions

§6501. Screening Services

A. All providers of early and periodic screening, diagnosis and treatment (EPSDT) preventive screening services shall be required to submit information to the Medicaid Program regarding recipient immunizations, referrals, and health status.

B. Screening services rendered to Medicaid-eligible children under 21 years of age and reimbursable under the EPSDT Program shall include:

1. health education (including anticipatory guidance) as a minimum component in addition to a comprehensive health and development history (including assessment of both physical and mental health development);
2. a comprehensive unclothed physical exam;
3. appropriate immunizations according to age and health history; and
4. laboratory tests (including blood lead level assessment appropriate for age and risk factors).

C. Vision and hearing services shall be performed according to distinct periodicity schedules which meet reasonable standards of medical practice, as determined after consultation with recognized medical organizations involved in child health care.

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 39:318 (February 2013).

§6503. Service Limit Exemptions

A. The following limitations on services shall not apply to Medicaid-eligible recipients under the age of 21:

1. inpatient hospitalization stay limits;
2. outpatient hospital emergency room limits;
3. physician office visit limits;
4. physician hospital visit limits;
5. home health annual visit limits;
6. home health daily limits on nursing and nurse aide services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 16:973 (November 1990), repromulgated for LAC, LR 29:175 (February 2003).

§6505. Provider Restrictions

A. The Medical Assistance Program of Louisiana prohibits Medicaid providers from charging a fee to Medicaid beneficiaries for completing referral forms to obtain services from other state or federally funded programs.

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 19:1331 (October 1993), repromulgated for LAC codification, LR 29:175 (February 2003).

Chapter 69. Dental Services

§6901. General Provisions

A. Medicaid recipients who are under 21 years of age are eligible to receive services covered by the EPSDT Dental Program.

B. Provider participation is limited to those dentists who are duly licensed and authorized to practice dentistry in the State of Louisiana and who are enrolled in the Medicaid Program as a dental provider.

C. Prior authorization is required for certain dental services covered in the EPSDT Dental Program. Services requiring prior authorization are identified in the Dental Services Manual, EPSDT Dental Program Fee Schedule.

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 27:1240 (August 2001), amended LR 28:2534 (December 2002), repromulgated LR 29:176 (February 2003), amended LR 33:1138 (June 2007).

§6903. Covered Services

A. The dental services covered under the EPSDT Dental Program are organized in accordance with the following 11 categories:

1. diagnostic services which include oral examinations, radiographs and oral/facial images, diagnostic casts and accession of tissue—gross and microscopic examinations;
2. preventive services which include prophylaxis, topical fluoride treatments, sealants, fixed space maintainers and re-cementation of space maintainers;
3. restorative services which include amalgam restorations, composite restorations, stainless steel and polycarbonate crowns, pins, core build-ups, pre-fabricated posts and cores and unspecified restorative procedures;
4. endodontic services which include pulp capping, pulpotomy, endodontic therapy on primary and permanent teeth (including treatment plan, clinical procedures and follow-up care), apexification/recalcification, apicoectomy/periradicular services and unspecified endodontic procedures;
5. periodontal services which include gingivectomy, periodontal scaling and root planning, full mouth debridement, and unspecified periodontal procedures;
6. removable prosthodontics services which include complete dentures, partial dentures, denture repairs, denture relines and unspecified prosthodontics procedures;
7. maxillofacial prosthetics service, which is a fluoride gel carrier;
8. fixed prosthodontics services which include fixed partial denture pontic, fixed partial denture retainer and other unspecified fixed partial denture services;
9. oral and maxillofacial surgery services which include non-surgical extractions, surgical extractions, other surgical procedures, alveoloplasty, surgical incision, temporomandibular joint (TMJ) procedure and other unspecified repair procedures;
10. orthodontic services which include interceptive and comprehensive orthodontic treatments, minor treatment to control harmful habits and other orthodontic services; and
11. adjunctive general services which include palliative (emergency) treatment, anesthesia, professional visits, miscellaneous services, and unspecified adjunctive procedures.

B. Effective November 1, 2006, the following dental procedures are included in the service package for coverage under the EPSDT Dental Program:

1. prefabricated stainless steel crown with resin window; and
2. appliance removal (not by the dentist who placed the appliance), including removal of archbar.

C. Effective December 24, 2008, the following dental procedures are included in the service package for coverage under the EPSDT Dental Program:

1. resin-based composite restorations (1-4 or more surfaces), posterior; and
2. extraction, coronal remnants – deciduous tooth.

D. Effective December 24, 2008, the service limit of six root canals per lifetime is discontinued.

E. Effective August 1, 2010, the prefabricated esthetic coated stainless steel crown-primary tooth dental procedure shall be included in the service package for coverage under the EPSDT Dental 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 Services, LR 3:445 (November 1977), amended LR 8:75 (February 1982), LR 415 (June 1983), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 27:203 (February 2001), LR 27:1240 (August 2001), LR 28:2534 (December 2002), repromulgated for LAC codification, LR 29:175 (February 2003), amended LR 30:252 (February 2004), LR 31:667 (March 2005) LR 33:1138 (June 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1889 (September 2009), LR 37:1598 (June 2011).

§6905. Reimbursement

A. Services covered in the EPSDT Dental Program shall be reimbursed at the lower of either:

1. the dentist's billed charges minus any third party coverage; or
2. the state's established schedule of fees, which is developed in consultation with the Louisiana Dental Association and the Medicaid dental consultants, minus any third party coverage.

B. Effective for dates of service on and after December 24, 2008, the reimbursement fees for EPSDT dental services are increased to the following percentages of the 2008 National Dental Advisory Service comprehensive fee report 70th percentile rate, unless otherwise stated in this Chapter. The reimbursement fees are increased to:

1. 80 percent for all oral examinations;
2. 75 percent for the following services:
 - a. radiograph—periapical and panoramic film;
 - b. prophylaxis;

- c. topical application of fluoride or fluoride varnish; and
- d. removal of impacted tooth;
3. 70 percent for the following services:
 - a. radiograph—complete series, occlusal film and bitewings;
 - b. sealant, per tooth;
 - c. space maintainer, fixed (unilateral or bilateral);
 - d. amalgam , primary or permanent;
 - e. resin-based composite and resin-based composite crown, anterior;
 - f. prefabricated stainless steel or resin crown;
 - g. core buildup, including pins;
 - h. pin retention;
 - i. prefabricated post and core, in addition to crown;
 - j. extraction or surgical removal of erupted tooth;
 - k. removal of impacted tooth (soft tissue or partially bony); and
- and
- l. palliative (emergency) treatment of dental pain; and
- m. surgical removal of residual tooth roots; and
4. 65 percent for the following dental services:
 - a. oral/facial images;
 - b. diagnostic casts;
 - c. re-cementation of space maintainer or crown;
 - d. removal of fixed space maintainer;
 - e. all endodontic procedures except:
 - i. unspecified endodontic procedure, by report;
 - f. all periodontic procedures except:
 - i. unspecified periodontal procedure, by report;
 - g. fluoride gel carrier;
 - h. all fixed prosthodontic procedures except:
 - i. unspecified fixed prosthodontic procedure, by report;
 - i. tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth;
 - j. surgical access of an unerupted tooth;
 - k. biopsy of oral tissue;
 - l. transeptal fiberotomy/supra crestal fiberotomy;
 - m. alveoplasty in conjunction with extractions;
 - n. incision and drainage of abscess;
 - o. occlusal orthotic device;

- p. suture of recent small wounds;
- q. frenulectomy;
- r. fixed appliance therapy; and
- s. all adjunctive general services except:
 - i. palliative (emergency) treatment of dental pain, and
 - ii. unspecified adjunctive procedure, by report.

C. The reimbursement fees for all other covered dental procedures shall remain at the rate on file as of December 23, 2008.

D. Effective for dates of service on or after January 22, 2010, the reimbursement fees for EPSDT dental services shall be reduced to the following percentages of the 2008 National Dental Advisory Service comprehensive fee report 70th percentile, unless otherwise stated in this Chapter:

1. 73 percent for diagnostic oral evaluation services;
2. 70 percent for the following periodic diagnostic and preventive services:
 - a. radiographs—periapical, first film;
 - b. radiograph—periapical, each additional film;
 - c. radiograph—panoramic film;
 - d. prophylaxis—adult and child;
 - e. topical application of fluoride, 0-15 years of age (prophylaxis not included); and
 - f. topical fluoride varnish, therapeutic application for moderate to high caries risk patients (under 6 years of age); and
3. 65 percent for the remainder of the dental services.

E. Effective for dates of service on or after August 1, 2010, the reimbursement fees for EPSDT dental services shall be reduced to the following percentages of the 2009 National Dental Advisory Service comprehensive fee report 70th percentile, unless otherwise stated in this Chapter:

1. 69 percent for the following oral evaluation services:
 - a. periodic oral examination;
 - b. oral examination—patients under three years of age; and
 - c. comprehensive oral examination—new patient;
2. 65 percent for the following annual and periodic diagnostic and preventive services:
 - a. radiographs—periapical, first film;
 - b. radiograph—periapical, each additional film;
 - c. radiograph—panoramic film;
 - d. prophylaxis—adult and child;

- e. topical application of fluoride—adult and child (prophylaxis not included); and
- f. topical fluoride varnish, therapeutic application for moderate to high caries risk patients (under 6 years of age);

3. 50 percent for the following diagnostic and adjunctive general services:

- a. oral/facial images;
- b. non-intravenous conscious sedation; and
- c. hospital call; and

4. 58 percent for the remainder of the dental services.

F. Removable prosthodontics and orthodontic services are excluded from the August 1, 2010 rate reduction.

G. Effective for dates of service on and after January 1, 2011, the reimbursement fees for EPSDT dental services shall be reduced to the following percentages of the 2009 National Dental Advisory Service comprehensive fee report 70th percentile, unless otherwise stated in this Chapter:

1. 67.5 percent for the following oral evaluation services:
 - a. periodic oral examination;
 - b. oral Examination-patients under 3 years of age; and
 - c. comprehensive oral examination-new patients;
2. 63.5 percent for the following annual and periodic diagnostic and preventive services:
 - a. radiographs-periapical, first film;
 - b. radiographs-periapical, each additional film;
 - c. radiographs-panoramic film;
 - d. diagnostic casts;
 - e. prophylaxis-adult and child;
 - f. topical application of fluoride, adult and child (prophylaxis not included); and
 - g. topical fluoride varnish, therapeutic application for moderate to high caries risk patients (under 6 years of age);
3. 73.5 percent for accession of tissue, gross and microscopic examination, preparation and transmission of written report;
4. 70.9 percent for accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report;
5. 50 percent for the following diagnostic and adjunctive general services:
 - a. oral/facial image;
 - b. non-intravenous conscious sedation; and

c. hospital call; and

6. 57 percent for the remainder of the dental services.

H. Removable prosthodontics and orthodontic services are excluded from the January 1, 2011 rate reduction.

I. Effective for dates of service on or after July 1, 2012, the reimbursement fees for EPSDT dental services shall be reduced to the following percentages of the 2009 National Dental Advisory Service comprehensive fee report 70th percentile, unless otherwise stated in this Chapter:

1. 65 percent for the following oral evaluation services:

- a. periodic oral examination;
- b. oral examination-patients under three years of age; and
- c. comprehensive oral examination-new patients;

2. 62 percent for the following annual and periodic diagnostic and preventive services:

- a. radiographs-periapical, first film;
- b. radiographs-periapical, each additional film;
- c. radiographs-panoramic film;
- d. diagnostic casts;
- e. prophylaxis-adult and child;
- f. topical application of fluoride, adult and child (prophylaxis not included); and
- g. topical fluoride varnish, therapeutic application for moderate to high caries risk patients (under six years of age);

3. 45 percent for the following diagnostic and adjunctive general services:

- a. oral/facial image;
- b. non-intravenous conscious sedation; and
- c. hospital call; and

4. 56 percent for the remainder of the dental services.

J. Removable prosthodontics and orthodontic services are excluded from the July 1, 2012 rate reduction.

K. Effective for dates of service on or after August 1, 2013, the reimbursement fees for EPSDT dental services shall be reduced by 1.5 percent of the rate on file July 31, 2013, unless otherwise stated in this Chapter.

1. The following services shall be excluded from the August 1, 2013 rate reduction:

- a. removable prosthodontics; and
- b. orthodontic services.

L. Effective for dates of service on or after July 1, 2023, the reimbursement rates for EPSDT dental services shall be reimbursed based on the Louisiana Medicaid fee schedule.

All rates in the fee schedule are published on the Medicaid provider website at www.lamedicaid.com.

1. Implementation of these rates is subject to approval by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 33:1138 (June 2007), amended LR 34:1032 (June 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1890 (September 2009), LR 36:2040 (September 2010), LR 37:1598 (June 2011), LR 39:1048 (April 2013), LR 40:1007 (May 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 49:1214 (July 2023).

Chapter 71. Health Services

§7101. Recipient Criteria

A. Health services for children are covered if they are included on the individualized family service plan (IFSP) for ages 0 to 3 years of age, and on the individualized education plan (IEP) for ages 3 to 21 years of age.

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 16:971 (November 1990), amended LR 23:413 (April 1996), LR 24:336 (February 1998), repromulgated for LAC codification, LR 29:176 (February 2003), amended LR 30:1034 (May 2004), LR 31:664 (March 2005).

§7103. Covered Services

A. Audiology services are for the identification of children with auditory impairment, using at risk criteria and appropriate audiologic screening techniques. Audiology services include:

- 1. determination of range, nature and degree of hearing loss and communications, by use of audiological procedures;
- 2. referral for medical and other services necessary for the rehabilitation of children with auditory impairment; and
- 3. provision of auditory training, aural rehabilitation, speech reading and listening device orientation and training, and other services.

B. Speech pathology services are for the identification of children with communicative or oropharyngeal disorders and delays in development of communication skills including diagnosis and treatment. These services include:

- 1. referral for medical or other professional services necessary for the rehabilitation of children with communicative or oropharyngeal disorders and delays in development of communication skills; and
- 2. provision of services for the rehabilitation or prevention of communicative or oropharyngeal disorders and delays in development of communication skills.

C. Occupational therapy services address the functional needs of a child related to the performance of self-help skills, adaptive behavior, play and sensory, motor and postural development. Occupational therapy treatment services require a written referral or prescription by a physician licensed in Louisiana on at least an annual basis. An initial evaluation may be done without a referral or prescription. Occupational therapy services include:

1. identification, assessment, and intervention;
2. adaptation of the environment;
3. selection, design, and fabrication of assistive and orthotic devices to facilitate development and promote the acquisition of functional skills; and
4. prevention or reduction of the impact of initial or future impairment, delays in development, or loss of functional ability.

D. Physical therapy services are designed to improve the child's movement dysfunction. Physical therapy treatment requires a written referral or prescription on at least an annual basis by a person licensed in Louisiana to practice medicine, surgery, dentistry, podiatry, or chiropractic. An exception to this requirement is that physical therapy services may be performed without a prescription to a child with a diagnosed developmental disability pursuant to the child's plan of care. An initial evaluation does not require such referral or prescription. Physical therapy services include:

1. screening of infants and toddlers to identify movement dysfunction;
2. obtaining, interpreting and integrating information appropriate to program planning; and
3. services to prevent or alleviate movement dysfunction and related functional problems.

E. Psychological services are designed to obtain, integrate, and interpret information about child behavior, and child and family conditions related to learning, mental health, and development. Psychological services include:

1. administering psychological and developmental tests and other assessment procedures;
2. interpreting assessment results; and
3. planning and managing a program of mental health and behavioral interventions and education programs.

F. Services Provided by Local Education Agencies. Services provided by local education agencies include the health services as defined in Subsections A-E.1-3 above and specified related services as described in Paragraphs 1 and 2 below that are provided to children ages 3 to 21 determined to be medically necessary and are listed on the child's Individualized Education Plan (IEP).

1. Transportation to and from school is covered for Medicaid children only when a child's medical needs require the use of specialized transportation services and when the child receives another covered EPSDT Health Service at the

school on the day the transportation is provided. The EPSDT health service and the child's specialized transportation needs MUST be identified in the child's IEP.

2. Counseling services are services provided to assist the child and/or parents in treating and understanding the child's disability, the special needs of the child, and the child's development. Providers of counseling services must meet all licensing requirements for their respective licensing boards.

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 30:1034 (May 2004), amended LR 31:664 (March 2005), amended by the Department of Health, Bureau of Health Services Financing, LR 46:342 (March 2020).

§7105. Professional Staffing Requirements

A. **Audiological Services.** Audiological services must be provided by an audiologist or physician licensed in Louisiana to provide these services. A referral must be made by the child's physician, preferably the primary care physician, at least annually in accordance with federal Medicaid regulations. The audiologist must meet one of the following criteria:

1. a certificate of clinical competence from the American Speech and Hearing Association;
2. completion of the equivalent educational requirements and work experience necessary for certification; or
3. completion of the academic program and is acquiring supervised work experience to qualify for a certificate.

B. **Speech Pathology Services.** Speech pathology services must be provided by or under direction of a speech pathologist or audiologist in accordance with licensing standards of the State Examiners Board for Speech Pathologists or Audiologists. The speech pathologist or audiologist must be licensed in the State of Louisiana to provide these services and meet one of the following criteria:

1. a certificate of clinical competence from the American Speech and Hearing Association;
2. completion of the equivalent educational requirements and work experience necessary for certification; or
3. completion of the academic program and is acquiring supervised work experience to qualify for a certificate.

C. Occupational Therapy Services

1. Occupational therapy services must be provided by or under the direction of a qualified occupational therapist licensed in Louisiana to provide these services in accordance with the licensing standards of the State Examiners Board of Occupational Therapists. The occupational therapist must also be:

a. a registered occupational therapist (OTR) by the American Occupational Therapy Association, Inc. (AOTA); or

b. a graduate of a program approved by the Council on Medical Education of the American Medical Association and engaged in the supplemental clinical experience before registration by the AOTA.

2. Services provided by an occupational therapist assistant, who is licensed to assist in the practice of occupational therapy and certified by the AOTA, must be provided under the supervision of an occupational therapist licensed in Louisiana.

D. Physical Therapy Services. Physical therapy services must be provided by or under the directions of a qualified physical therapist in accordance with state licensing standards of the State Examiners Board for Physical Therapists. The physical therapist must be a graduate of a program of physical therapy approved by both the Council in Medical Education of the American Medical Association and the American Physical Therapy Association or its equivalent.

E. Psychological services must be provided by either a:

1. Louisiana licensed physician;
2. Louisiana licensed psychiatrist;
3. Louisiana licensed psychologist; or
4. certified school psychologist, under the supervision of a licensed psychologist.

F. Counseling services must be provided by a:

1. licensed professional counselor;
2. licensed clinical social worker; or
3. licensed master social worker under the supervision of a licensed clinical social worker.

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 31:665 (March 2005), amended by the Department of Health, Bureau of Health Services Financing, LR 46:343 (March 2020).

§7107. EarlySteps Reimbursement

A. Effective for dates of service on or after January 1, 2011, the reimbursement for certain Medicaid-covered health services rendered in the EarlySteps Program shall be reduced by 2 percent of the rate in effect on December 31, 2010.

1. The following services rendered in the natural environment shall be reimbursed at the reduced rate:

- a. audiology services;
- b. speech pathology services;
- c. occupational therapy;
- d. physical therapy; and

e. psychological services.

2. Services rendered in special purpose facilities/inclusive child care and center-based special purpose facilities shall be excluded from this rate reduction.

B. Effective for dates of service on or after July 1, 2022, the reimbursement for Medicaid covered health services rendered in the EarlySteps Program (Part C of IDEA) shall be increased by 30 percent of the rate in effect on January 1, 2011.

1. The increased rate shall be applied to services provided in the following settings :

a. natural environment that includes a child's home and settings in the community where children of the same age with no disabilities or special needs participate;

b. special purpose facility/inclusive child care that includes settings such as a child care center, nursery schools, or preschools where at least 50 percent of the children have no disabilities or developmental delays, and

c. center-based special purpose facility that is a facility where only children with disabilities or developmental delays are served.

2. The following services shall be reimbursed at the increased rate:

- a. audiology services;
- b. speech language pathology services;
- c. occupational therapy;
- d. physical therapy; and
- e. psychological services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:800 (April 2004), amended LR 31:2030 (August 2005), LR 35:69 (January 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1599 (June 2011), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:2971 (December 2022).

Chapter 73. Personal Care Services

§7301. Introduction

A. Early Periodic Screening, Diagnosis and Treatment (EPSDT) Personal Care Services (PCS)

1. Personal Care Services are services which prevent institutionalization and enable the beneficiary to live in the community. PCS are tasks which are medically necessary when physical or cognitive limitations due to illness or injury necessitate assistance with:

- a. eating;
- b. toileting;

- c. bathing;
- d. bed mobility;
- e. transferring;
- f. dressing;
- g. locomotion;
- h. personal hygiene; or
- i. bladder or bowel requirements.

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 21:947 (September 1995), repromulgated for LAC codification, LR 29:177 (February 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 45:905 (July 2019).

§7303. Services

A. The beneficiary shall be allowed the freedom of choice to select an EPSDT PCS provider.

B. EPSDT personal care services include:

1. basic personal care, including toileting, grooming, bathing and assistance with dressing;
2. assistance with bladder and/or bowel requirements or problems, including helping the beneficiary to and from the bathroom or assisting the beneficiary with bedpan routines, but excluding catheterization;
3. assistance with eating and food, nutrition, and diet activities, including preparation of meals for the beneficiary only;
4. performance of incidental household services essential to the beneficiary's health and comfort in her/his home. Examples of such activities are changing and washing bed linens and rearranging furniture to enable the beneficiary to move about more easily in his/her own home;
5. accompanying, not transporting the beneficiary to and from his/her physician and/or other medical appointments for necessary medical services; and
6. assistance with locomotion in their place of service, while in bed or from one surface to another. Assisting the beneficiary with transferring and bed mobility.

C. Intent of Services

1. EPSDT PCS shall not be provided to meet childcare needs nor as a substitute for the parent or guardian in the absence of the parent or guardian.
2. EPSDT PCS shall not be used to provide respite care for the primary caregiver.
3. EPSDT PCS provided in an educational setting shall not be reimbursed if these services duplicate services that are provided by or shall be provided by the Department of Education.

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 21:947 (September 1995), repromulgated for LAC codification, LR 29:177 (February 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 45:905 (July 2019).

§7305. Beneficiary Qualifications

A. Conditions for Provision of EPSDT Personal Care Services

1. The person must be a categorically-eligible Medicaid beneficiary birth through 20 years of age (EPSDT eligible) and have been prescribed medically necessary, age appropriate EPSDT PCS by a practitioner (physician, advance practice nurse, or physician assistant).

2. An EPSDT-eligible shall meet medical necessity criteria as established by the Bureau of Health Services Financing (BHSF) which shall be based on functional and medical eligibility and impairment in at least two activities of daily living (ADL), as determined by BHSF or its designee.

3. EPSDT PCS shall be prescribed if medically necessary by the beneficiary's attending practitioner initially and every 180 days thereafter (or rolling six months), and when changes in the plan of care occur. The plan of care shall be acceptable only after the practitioner signs and dates the completed form. The practitioner's signature must be an original signature and not a rubber stamp.

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 21:947 (September 1995), repromulgated for LAC codification, LR 29:177 (February 2003), amended LR 30:253 (February 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:2259 (November 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 45:906 (July 2019).

§7307. Prior Authorization

A. EPSDT personal care services are subject to prior authorization (PA) by BHSF or its designee. A face-to-face medical assessment shall be completed by the practitioner. The beneficiary's choice of a personal care services provider may assist the practitioner in developing a plan of care which shall be submitted by the practitioner for review/approval by BHSF or its designee. The plan of care shall specify:

1. the specific personal care service(s) to be provided (i.e., activities of daily living for which assistance is needed); and
2. the minimum and maximum frequency and the minimum duration of each of these services.

B. Dates of service not included in the plan of care or provided prior to approval of the plan of care by BHSF or its designee are not reimbursable. The beneficiary's attending

practitioner shall review and/or modify the plan of care and sign off on it prior to the plan of care being submitted to BHSF or its designee. A copy of the practitioner's prescription for EPSDT PCS shall be included with the plan of care at the time of submission for prior authorization and may not be dated after delivery of services has started. A copy of the prescription shall be retained in the EPSDT PCS provider's files.

C. A new plan of care shall be submitted at least every 180 days (rolling six months) with approval by the beneficiary's attending practitioner. The plan of care shall reassess the patient's need for EPSDT PCS, including any updates to information which has changed since the previous assessment was conducted (with explanation of when and why the change(s) occurred).

D. Amendments or changes in the plan of care shall be submitted as they occur and shall be treated as a new plan of care which begins a new six-month service period. Revisions of the plan of care may be necessary because of changes that occur in the beneficiary's medical condition which warrant an additional type of service, a change in frequency of service or a change in duration of service. Documentation for a revised plan of care is the same as for a new plan of care. Both a new start date and reassessment date shall be established at the time of reassessment. The EPSDT PCS provider may not initiate services or changes in services under the plan of care prior to approval by BHSF or its designee.

E. Beneficiaries who have been designated by BHSF as chronic needs are exempt from the standard prior authorization process. Although a new request for prior authorization shall still be submitted every 180 days, the EPSDT PCS provider shall only be required to submit a PA request form accompanied by a statement from a practitioner verifying that the beneficiary's condition has not improved and the services currently approved must be continued. Only BHSF or its designee can grant the designation of a chronic needs case to a beneficiary.

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 21:947 (September 1995), repromulgated for LAC codification, LR 29:177 (February 2003), amended LR 30:253 (February 2004), amended by the Department of Health, Bureau of Health Services Financing, LR 45:906 (July 2019).

§7309. Place of Service

A. EPSDT PCS shall be provided if medically necessary in the beneficiary's home or in another location outside of the beneficiary's home. The beneficiary's home is defined as the beneficiary's own home, which includes the following:

1. an apartment;
2. a custodial relative's home;
3. a boarding home;
4. a foster home; or

5. a supervised living facility.

B. Institutions such as hospitals, institutions for mental disease, nursing facilities, intermediate care facilities for individuals with intellectual disabilities, or residential treatment centers are not considered a beneficiary's home.

C. Medicaid prohibits multiple professional disciplines from being present in the beneficiary's residential setting at the same time. However, multiple professionals may provide services to multiple beneficiaries in the same residential setting when it is medically necessary. This includes but is not limited to nurses, home health aides, and therapists. BHSF or its designee will determine medical necessity for fee-for-service beneficiaries.

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 21:948 (September 1995), repromulgated for LAC codification, LR 29:178 (February 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 45:906 (July 2019).

§7311. Service Limits

A. EPSDT PCS are not subject to service limits. The units of service approved shall be based on the physical requirements of the beneficiary and medical necessity for the covered services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:947 (September 1995) repromulgated for LAC codification, LR 29:178 (February 2003), amended LR 30:253 (February 2004), amended by the Department of Health, Bureau of Health Services Financing, LR 45:907 (July 2019).

§7313. Standards for Payment

A. EPSDT PCS shall only be provided to EPSDT beneficiaries and only by a staff member of a licensed personal care services agency enrolled as a Medicaid provider. A copy of the current PCS license must accompany the Medicaid application for enrollment as a PCS provider and copies of current licenses shall be submitted to Provider Enrollment thereafter as they are issued, for inclusion in the enrollment record. The provider's record shall always include a current PCS license at all times. Medicaid enrollment is limited to providers located in Louisiana and certain out-of-state providers located only in the trade areas of Arkansas, Mississippi, and Texas.

B. The unit of service billed by EPSDT PCS providers shall be one-quarter hour, exclusive of travel time to arrive at the beneficiary's home. The entire 15 minutes of the unit of time shall have been spent providing services in order to bill a unit.

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 21:947 (September 1995), repromulgated

for LAC codification, LR 29:178 (February 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 45:907 (July 2019).

§7315. Provider Qualifications

A. Personal care services shall be provided by a licensed personal care services agency which is duly enrolled as a Medicaid provider. Staff assigned to provide personal care services to a beneficiary shall not be a member of the beneficiary's immediate family. Immediate family is defined as the father, mother, sister, brother, spouse, child, grandparent, in-law, or any individual acting as parent or guardian of the beneficiary. Personal care services may be provided by a person of a degree of relationship to the beneficiary other than immediate family, only if the relative is not living in the beneficiary's home, or, if she/he is living in the beneficiary's home solely because her/his presence in the home is necessitated by the amount of care required by the beneficiary.

B. An unrelated staff member of a licensed personal care services provider may not live in the same home as the beneficiary.

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 21:947 (September 1995), repromulgated for LAC codification, LR 29:178 (February 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 45:907 (July 2019).

§7317. Provider Responsibilities

A. The licensed PCS agency is responsible for ensuring that all direct service workers providing EPSDT PCS meet all training requirements applicable under state law and regulations. The direct service worker must successfully complete the applicable examination for certification for PCS. Documentation of the direct service worker's completion of all applicable requirements shall be maintained by the EPSDT PCS provider.

B. The agency shall use an electronic visit verification (EVV) system for time and attendance tracking and billing for EPSDT PCS.

1. EPSDT PCS providers identified by BHSF shall use:

- a. the (EVV) system designated by the department; or
- b. an alternate system that:
 - i. has successfully passed the data integration process to connect to the designated EVV system; and
 - ii. is approved by the department.

2. Reimbursement for services may be withheld or denied if an EPSDT PCS provider:

- a. fails to use the EVV system; or
- b. uses the system not in compliance with Medicaid's policies and procedures for EVV.

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 21:947 (September 1995), repromulgated for LAC codification, LR 29:178 (February 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 45:907 (July 2019).

§7319. EPSDT PCS Provider Responsibilities

A. Documentation

1. Documentation for EPSDT PCS provided shall include at a minimum, the following:

- a. documentation of approval of services by BHSF or its designee;
- b. daily notes by PCS provider denoting date of service and services provided (checklist is adequate);
- c. total number of hours worked;
- d. time period worked;
- e. health condition of beneficiary;
- f. service provision difficulties;
- g. justification for not providing scheduled services; and
- h. any other pertinent information.

2. There shall be a clear audit trail between:

- a. the prescribing practitioner;
- b. the personal care services provider agency;
- c. the person providing the personal care services to the beneficiary; and
- d. the services provided and reimbursed by Medicaid.

B. Agencies providing EPSDT PCS shall conform to all applicable Medicaid regulations as well as all applicable laws and regulations by federal, state, and local governmental entities including, but not limited to:

- 1. wages;
- 2. working conditions;
- 3. benefits;
- 4. Social Security deductions;
- 5. OSHA requirements;
- 6. liability insurance;
- 7. Workman's Compensation; and
- 8. occupational licenses; etc.

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 21:947 (September 1995), repromulgated for LAC codification, LR 29:178 (February 2003), amended by the

Department of Health, Bureau of Health Services Financing, LR 45:907 (July 2019).

§7321. Reimbursement

A. Reimbursement for EPSDT PCS shall be the lesser of billed charges or the maximum unit rate set by the department. The maximum rate is a flat rate for each approved unit of service provided to the beneficiary. This rate shall be adjusted as necessary by the department.

1. One quarter hour (15 minutes) is the standard unit of service, exclusive of travel time to arrive at the beneficiary's home.

2. The entire 15 minutes shall have been spent providing personal care services in order to be reimbursed for a unit.

b. The minimum hourly rate paid to personal care workers shall be the current minimum wage plus 75 percent of the wage enhancement.

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 29:179 (February 2003), amended LR 33:2202 (October 2007), repromulgated LR 33:2425 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2561 (November 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:908 (July 2019), LR 49:262 (February 2023).

§7323. Nonreimbursable Services

A. The following services are not appropriate for personal care and are not reimbursable as EPSDT personal care services:

1. insertion and sterile irrigation of catheters (although changing of a catheter bag is allowable);

2. irrigation of any body cavities which require sterile procedures;

3. application of dressing, involving prescription medication and aseptic techniques, including care of mild, moderate or severe skin problems;

4. administration of injections of fluid into veins, muscles or skin;

5. administration of medicine (an EPSDT PCS direct service worker may only remind/prompt about self-administered medication to an EPSDT eligible beneficiary who is over the age of 18);

6. cleaning of the home in an area not occupied by the beneficiary;

7. laundry, other than that incidental to the care of the beneficiary;

8. shopping for groceries or household items other than items required specifically for the health and maintenance of the beneficiary, and not for items used by the rest of the household;

9. skilled nursing services, as defined in the state Nurse Practices Act, including medical observation, recording of vital signs, teaching of diet and/or administration of medications/injections, or other delegated nursing tasks;

10. teaching a family member or friend how to care for a beneficiary who requires frequent changes of clothing or linens due to total or partial incontinence for which no bowel or bladder training program for the patient is possible;

11. specialized nursing procedures such as:

- a. insertion of nasogastric feeding tube;
- b. in-dwelling catheter;
- c. tracheostomy care;
- d. colostomy care;
- e. ileostomy care;
- f. venipuncture; and/or
- g. injections;

12. rehabilitative services such as those administered by a physical therapist;

13. teaching a family member or friend techniques for providing specific care;

14. palliative skin care with medicated creams and ointments and/or required routine changes of surgical dressings and/or dressing changes due to chronic conditions;

15. teaching of signs and symptoms of disease process, diet and medications of any new or exacerbated disease process;

16. specialized aide procedures such as:

a. rehabilitation of the beneficiary (exercise or performance of simple procedures as an extension of physical therapy services);

b. measuring/recording the beneficiary's vital signs (temperature, pulse, respirations and/or blood pressure, etc.) or intake/output of fluids;

c. specimen collection;

d. special procedures such as:

- i. nonsterile dressings;
- ii. special skin care (nonmedicated);
- iii. decubitus ulcers;;

iv. cast care;

v. assisting with ostomy care;

vi. assisting with catheter care;

vii. testing urine for sugar and acetone;

viii. breathing exercises;

ix. weight measurement; and

- x. enemas;
- 17. home IV therapy;
- 18. custodial care or provision of only instrumental activities of daily living tasks or provision of only one activity of daily living task;
- 19. occupational therapy;
- 20. speech pathology services;
- 21. audiology services;
- 22. respiratory therapy;
- 23. personal comfort items;
- 24. durable medical equipment;
- 25. oxygen;
- 26. orthotic appliances or prosthetic devices;
- 27. drugs provided through the Louisiana Medicaid pharmacy program;
- 28. laboratory services; and
- 29. social worker visits.

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 21:947 (September 1995), repromulgated for LAC codification, LR 29:179 (February 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 45:908 (July 2019).

Chapter 79. Therapeutic Residential Intervention Services—Residential Treatment Facilities (Reserved)

Chapter 85. Durable Medical Equipment—Eyeglasses

§8501. Eye Care

A. EPSDT eyeglasses are limited to three per year with provision for extending if medically necessary.

B. **Billing and Reimbursement.** The Health Care Common Procedure Coding System (HCPCS) shall be used to bill for EPSDT eyewear. Claims for EPSDT eyewear shall be reimbursed in accordance with the Louisiana Medicaid eyewear fee schedule.

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 8:75 (February 1982), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:104 (February 1996), repromulgated for LAC codification, LR 29:180 (February 2003), amended LR 30:1211 (June 2004).

Chapter 87. Durable Medical Equipment—Hearing Devices

Subchapter A. Hearing Aids

§8701. Prior Authorization

A. Hearing aids and related services are only covered for EPSDT recipients up to the age of 21. Approval is granted only when there is significant hearing loss as documented by audiometric or electrophysiologic data from a licensed audiologist and medical clearance and prescription from an ear specialist (otologist).

B. The audiologist must furnish a report, including an audiogram (if applicable) and all test results, indicating the degree and type of hearing loss. A hearing loss greater than 20 decibels with an average hearing level in the range 250-2000 Hz is considered significant. Additional required medical and social information shall include:

1. the recipient's age;
2. expected benefit of the hearing aid;
3. previous and current use of a hearing aid;
4. additional disabilities expected to influence the use of a hearing aid; and
5. referrals made on the recipient's behalf to early intervention programs, special education programs or other rehabilitative services.

C. Hearing aid repairs, batteries, and ear molds shall not require prior authorization. Limitations on the purchase of ear molds are established as follows:

1. one ear mold will be allowed every 90 days for EPSDT recipients from birth through age 4; and
2. one ear mold per year will be allowed for EPSDT recipients from age 5 up to 21.

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 27:547 (April 2001), repromulgated for LAC codification, LR 29:180 (February 2003).

§8703. Reimbursement

A. EPSDT reimbursement is reduced 15 percent for providers for the following procedure codes.

1. X-1092;
2. V5030;
3. V5040;
4. V5050;
5. V5060;
6. V5070;
7. V5080;

8. V5100;
9. V5120;
10. V5130;
11. V5140;
12. V5150;
13. V5170;
14. V5180;
15. V5190;
16. V5210;
17. V5220;
18. V5230; and
19. V5299.

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 22:104 (February 1996), repromulgated LR 29:181 (February 2003).

Subchapter B. Cochlear Device

§8717. Eligibility and Prior Authorization

A. Coverage is available for cochlear implantation for recipients 1 year of age through 20 years of age with profound bilateral sensorineural hearing loss.

B. Prior Authorization. All implantations (CPT Code 69930) must be prior authorized. The request to perform surgery shall come from the cochlear implant team (made up of professionals as described in §8721 who assessed the recipient's hearing.

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 24:1300 (July 1998), repromulgated LR 29:181 (February 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 42:572 (April 2016).

§8719. Recipient Criteria

A. Recipient Criteria (General). The following criteria apply to all candidates. Recipient must:

1. have a profound bilateral sensorineural hearing loss which is a pure tone average of 1,000, 2,000, and 4,000 Hz of 90 dB HL or greater;
2. be a profoundly deaf child, age 1 year or older or be a post-linguistically deafened adult through the age of 20 years;
3. receive no significant benefit from hearing aids as validated by the cochlear implant team;
4. have high motivation to be part of the hearing community as validated by the cochlear implant team;

5. have appropriate expectation;

6. have had radiologic studies that demonstrate no intracranial anomalies or malformations which would contraindicate implantation of the receiver-stimulator or the electrode array;

7. have no medical contraindications for undergoing implant surgery or post-implant rehabilitation; and

8. show that he and his family are well-motivated, possess appropriate post-implant expectations and are prepared and willing to participate in and cooperate with pre and post implant assessment and rehabilitation programs as recommended by the implant team and in conjunction with Federal Drug Administration (FDA) guidelines.

B. Recipient Criteria (Specific)

1. Children 1 Year through 9 Years. In addition to documentation that candidates meet general criteria, the requestor shall provide documentation that:

a. profound-to-total bilateral sensorineural hearing loss which is a pure tone average of 1,000, 2,000, and 4,000 Hz of 90dB HL or greater;

b. appropriate tests were administered and no significant benefit from a hearing aid was obtained in the best aided condition as measured by age-appropriate speech perception materials; and

c. no responses were obtained to Auditory Brainstem Response, Otoacoustic Emission testing, or any other special testing that would be required to determine that the hearing loss is valid and severe enough to qualify for cochlear implantation.

2. Children 10 Years through 17 Years. In addition to documentation that candidates meet general criteria, the requestor shall provide documentation that:

a. profound-to-total bilateral sensorineural hearing loss which is a pure tone average of 1,000, 2,000, and 4,000 Hz of 90dB HL or greater;

b. appropriate tests were administered and no significant benefit from a hearing aid was obtained in the best aided condition as measured by age and language-appropriate speech perception materials;

c. no responses were obtained to Auditory Brainstem Evoked Response, Otacoustic Emission Testing, or any other special testing that would be required to determine that the hearing loss is valid and severe enough to qualify for cochlear implantation;

d. the candidate has received consistent exposure to effective auditory or phonological stimulation in conjunction with oral method of education and auditory training;

e. the candidate utilizes spoken language as his primary mode of communication through one of the following:

- i. an oral/aural (re)habilitational program; or

ii. a total communications educational program with significant oral/aural; and

f. the individual has at least six months' experience with a hearing aid or vibrotactile device except in the case of meningitis (in which case the six-month period will be reduced to three months).

3. Adults 18 Years through 20 Years. In addition to documentation that candidates meet general criteria, the requestor shall provide documentation that:

a. the candidate for implant is post linguistically deafened with severe to profound bilateral sensorineural hearing loss which is a pure tone average of 1,000, 2,000, and 4,000 Hz of 90dB HL or greater;

b. no significant benefit from a hearing aid was obtained in the best aided condition for speech/sentence recognition material;

c. no responses were obtained to Auditory Brainstem Response, Otoacoustic Emission testing, or any other special testing that would be required to determine that the hearing loss is valid and severe enough to qualify for cochlear implantation;

d. the candidate has received consistent exposure to effective auditory or phonological stimulation or auditory communication;

e. the candidate utilizes spoken language as his primary mode of communication through one of the following:

i. an oral/aural (re)habilitation program; or

ii. a total communications educational program with significant oral/aural training; and

f. the candidate has had at least six months' experience with hearing aids or vibrotactile device except in the case of meningitis (in which case the six-month period will be reduced to three months).

4. Multi-Handicapped Children. Criteria appropriate for the child's age group are applied.

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 24:1300 (July 1998), repromulgated LR 29:181 (February 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 42:572 (April 2016).

§8721. Cochlear Implant Team

A. Team Minimum Requirements. The implant team shall be composed of the following members at a minimum:

1. physician/otologist;
2. audiologist;
3. speech/language pathologist;
4. psychiatrist; and

5. educator of the deaf with experience in oral/auditory instruction.

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 24:1300 (July 1998), repromulgated LR 29:182 (February 2003).

§8723. Expenses Covered/Noncovered

A. Covered Expenses. The following expenses related to the maintenance of the cochlear device will be covered if prior authorized:

1. all costs for upgrades and repairs to the component parts of the device; and
2. all costs for cords and batteries.

B. Noncovered Expenses. The following expenses related to the maintenance of the cochlear device are the responsibility of either the recipient or his family or care giver(s):

1. all costs for service contracts and/or extended warranties;
2. all costs for insurance to protect against loss and theft.

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 24:1300 (July 1998), repromulgated LR 29:182 (February 2003).

Chapter 91. School Based Health Centers

Subchapter A. General Provisions

§9101. Purpose

A. The Adolescent School Health Initiative Act of 1991 authorized the development of an adolescent school based health initiative to facilitate and encourage the provision of comprehensive health centers in public middle and secondary schools. Such health centers are referred to in this Chapter as "School Based Health Centers" (SBHCs).

B. A SBHC is a health center that:

1. is located on a school campus (including mobile units);
2. is organized through school, community, and health provider relationships;
3. is administered by a sponsoring facility;
4. provides health services (including, but not limited to, both behavioral and physical health) to children and adolescents through health professionals in accordance with state and local law, including laws related to licensure and certification;

5. provides, at a minimum, health services during school hours to children and adolescents by health professionals in accordance with established standards of care, evidence-based practice, laws, regulations and requirements, including parental consent.

C. For purposes of Subparagraph B.3 the term *sponsoring facility* includes any of the following:

1. a hospital;
2. a federally qualified health center (FQHC);
3. a for-profit or non-profit health care agency; or
4. a school or a school system, in partnership with a health facility.

D. SBHCs provide convenient access to preventive and acute care services for students who might otherwise have limited or no access to health care. This care may be provided onsite or through telehealth.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 40:31.3 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 34:1419 (July 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:365 (February 2012), amended by the Department of Health, Office of Public Health, LR 49:1943 (November 2023).

§9103. Registry of School Based Health Centers

A. The Louisiana Department of Health, Office of Public Health will establish and maintain a registry of all SBHCs. This registry shall be publicly available on the website of the Louisiana Department of Health.

B. SBHCs are required to submit the following information to the registry:

1. name of sponsoring agency;
2. name of school(s) where the SBHC is located;
3. additional schools served by the SBHC (*feeder schools);
4. location of the SBHC (address, including parish);
5. services provided at facility; and
6. point of contact, including name, phone number, and email.

C. The instructions or method of submitting the information required by this Section to the registry shall be made available on the Louisiana Department of Health website.

D. All SBHCs shall submit their initial information, as described in Subsection B. of this Section, to the registry by June 30, 2024.

E. All SBHCs shall review, confirm or update their information by June 30 of each year. Additionally, any change in information shall be provided to the registry within 30 days from the date of the change.

*The Office of Public Health-Adolescent School Health Program defines feeder school as: any school that meets all three of the following criteria:

- (1) the school is near the SBHC and/or in the same school district as the host school,
- (2) the SBHC can be accessed by a student from the school without assistance from a parent/legal guardian, and
- (3) the school had at least 50 students visit the SBHC during the previous year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:31.3

HISTORICAL NOTE: Promulgated by the Department of Health, Office of Public Health, LR 49:1943 (November 2023).

Subchapter B. Provider Participation

§9111. Provider Qualifications

A. The SBHC classification must be verified by the Office of Public Health, Adolescent School Health Program when applying for a Medicaid provider number.

1. Documentation of this verification must be provided upon request.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 40:31.3 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 34:1419 (July 2008).

§9113. Standards of Participation

A. School based health centers must comply with the applicable licensure, certification and program participation standards for all services rendered. The SBHC shall:

1. maintain an acceptable fiscal record keeping system that readily distinguishes one type of service from another type of service that may be rendered;
2. retain all records necessary to fully disclose the extent of services provided to recipients for five years from the date of service and furnish such records, and any payments claimed for providing such services, to the Medicaid Program upon request; and
3. abide by and adhere to all federal and state regulations and policy manuals.

B. The SBHC shall provide comprehensive primary medical and social services, as well as health education, promotion and prevention services to meet the physical health needs of students enrolled in the SBHC in the context of their family, culture and environment.

C. School based health centers shall acquire written parental consent in order to enroll a student as a patient.

D. The SBHC and all partners involved in service delivery must adhere to Health Insurance Portability and Accountability Act (HIPAA) privacy policies and procedures.

E. The SBHC must be enrolled as an EPSDT services provider in addition to enrollment for providing any other services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 40:31.3 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 34:1419 (July 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:366 (February 2012), LR 39:505 (March 2013).

Subchapter C. Services

§9121. Scope of Services

A. The Medicaid Program provides reimbursement for medically necessary preventive health care services provided by school based health centers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 40:31.3 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 34:1420 (July 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:366 (February 2012).

Subchapter D. Staffing Requirements

§9131. Minimum Staffing Requirements

A. School based health centers shall have one or more primary care providers on staff, including a:

- a. physician;
- b. physician assistant; or
- c. nurse practitioner.

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 34:1420 (July 2008).

Subchapter E. Reimbursement

§9141. Reimbursement Methodology

A. Medicaid reimbursement is limited to medically necessary services that are covered by the Medicaid State Plan.

B. Medicaid covered services provided by SBHCs shall be reimbursed at the lower of either:

1. the provider's billed charges minus any third party coverage; or
2. the state's established schedule of fees for the service rendered, minus any third party coverage.

C. Effective for dates of service on or after February 13, 2014, reimbursement for physical and occupational therapy services shall be 85 percent of the 2013 Medicare published rate.

D. Speech/language therapy services shall continue to be reimbursed at the flat fee in place as of February 13, 2014 and in accordance with the Medicaid published fee schedule for speech/language therapy services provided in school based health centers.

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 34:1420 (July 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:708 (April 2015).

Chapter 93. Substance Abuse Services

§9301. General Provisions

A. The Medicaid Program shall provide coverage of substance abuse services rendered to Medicaid eligible recipients, under the age of 21.

B. Medicaid reimbursement for medically necessary substance abuse services shall only be provided to the Office of Behavioral Health for recipients under the age of 21 who receive outpatient treatment only. The Medicaid Program shall not provide reimbursement for inpatient services under these provisions.

C. Substance abuse services covered under the EPSDT Program shall include medically necessary clinic services and other medically necessary substance abuse services rendered to EPSDT recipients.

D. Medicaid recipients shall be the sole recipients of Medicaid covered substance abuse services and these services shall only be billed for the Medicaid recipient despite the presence of others who may be group or family participants.

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 38:2371 (September 2012).

§9303. Covered Services

A. The medical necessity for these rehabilitative services must be determined by, and services recommended by, a licensed mental health practitioner, or as ordered by a staff physician.

B. Outpatient Treatment Program

1. Professionally directed assessment, diagnosis, treatment, and recovery services are provided in an organized non-residential treatment setting by licensed mental health practitioners (LMHPs) and non-licensed professionals under the supervision of a LMHP.

2. Outpatient treatment program hours range from one hour to nine hours/week. The maximum level of hours may be exceeded based on medical necessity.

3. Outpatient treatment program services include, but are not limited to:

- a. individual, group, and family counseling;
- b. medication compliance;
- c. relapse prevention; and
- d. disease concept.

4. Outpatient treatment program services offer comprehensive, coordinated, and defined services that may vary in level of intensity.

C. Intensive Outpatient Treatment Program

1. Professionally directed assessment, diagnosis, treatment, and recovery services are provided in an organized non-residential treatment setting by LMHPs and non-licensed professionals under the supervision of a LMHP.

2. Adolescents in intensive outpatient treatment programs receive a minimum of six hours/week with no specified frequency/week. The maximum is up to 20 hours/week. The maximum level of hours may be exceeded based on medical necessity.

3. Intensive outpatient treatment program services include, but are not limited to:

- a. individual, group, and family counseling; and
- b. education on recovery.

4. Intensive outpatient treatment program services offer comprehensive, coordinated, and defined services that may vary in level of intensity.

5. These services consist of a scheduled series of face-to-face sessions appropriate to the individual's plan of care.

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 38:2371 (September 2012).

§9305. Provider Qualifications

A. Outpatient clinical services shall be provided by Louisiana licensed mental health practitioners within the scope of the State Practice Act and licensing requirements.

B. A mental health practitioner may include a:

1. licensed professional counselor (LPC);
2. licensed clinical social worker (LCSW);
3. licensed addiction counselor (LAC); and
4. licensed marriage and family therapist (LMFT).

C. The following practitioners are also approved service providers:

1. licensed medical doctor;
2. licensed psychologist;
3. licensed nurse practitioner (NP);
4. advanced practice registered nurse (APRN); and
5. registered nurse (RN) with documented evidence of receiving a minimum of five continuing education units (CEUs) annually that are specifically related to behavioral health and medication management issues.

D. Registered addiction counselors (RACs) and certified addiction counselors (CACs) may also provide clinical services with a licensed mental health practitioner on-site.

E. RACs shall meet the following qualifications:

1. is at least 21 years of age;
2. is a legal resident of the United States;
3. is not in violation of any ethical standards subscribed to by the Addictive Disorders Regulatory Authority (ADRA);
4. has not been convicted of a felony;
 - a. The ADRA in its discretion may waive this requirement upon review of the individual's circumstances;
5. has successfully completed 270 clock hours of education approved by the ADRA. One semester hour equals 15 clock hours. One CEU equals 10 clock hours. One hundred eighty of these hours must be specific to addiction treatment. The remaining 90 hours may be related, but are subject to approval by the ADRA. Six of the 90 hours must be in professional ethics;
6. has successfully completed 6,000 hours (three years) of supervised work experience in the treatment of people with addictive disorders. Of these hours, he/she must complete a 300 hour practicum in the core functions and global criteria, with at least twenty 20 hours in each core function. This experience must be supervised by a certified clinical supervisor (CCS) or other qualified professional who has received the proper waiver from the ADRA;
7. has completed and received approval for an application prescribed by the ADRA; and
8. demonstrates competency in addiction counseling by submitting and gaining approval for a typical case study and passing a written examination prescribed by the ADRA.

F. CACs shall meet the following qualifications:

1. is at least 21 years of age and holds a bachelor's degree from an approved and accredited institution of higher education in a human services field;
2. is a legal resident of the United States;
3. is not in violation of any ethical standards subscribed to by the ADRA;
4. has not been convicted of a felony;
 - a. the ADRA in its discretion may waive this requirement upon review of the individual's circumstances;
5. has successfully completed two hundred seventy clock hours of education approved by the ADRA. One semester hour equals fifteen clock hours. One CEU equals ten clock hours. One hundred eighty of these hours must be specific to addiction treatment. The remaining ninety hours may be related, but are subject to approval by the ADRA. Six of the ninety hours must be in professional ethics;
6. has successfully completed 4,000 hours (two years) of supervised work experience in the treatment of people with addictive disorders. Of these hours, he/she must complete a 300 hour practicum in the core functions and global criteria, with at least 20 hours in each core function.

This experience must be supervised by a CCS or other qualified professional who has received the proper waiver from the ADRA;

7. has completed and received approval for an application prescribed by the ADRA; and

8. demonstrates competency in addiction counseling by submitting and gaining approval for a typical case study and passing a written examination prescribed by the ADRA.

G. A registered addiction counselor or a certified addiction counselor may not practice independently and may not render a diagnostic impression, but can practice under the supervision of an LMHP on-site within an agency that is licensed or accredited.

H. Unlicensed practitioners shall only practice under the supervision of a licensed professional, within the scope of the licensed professional's State Practice Act and licensing requirements.

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 38:2371 (September 2012).

§9307. Reimbursement Methodology

A. The Medicaid Program shall provide reimbursement to the Office of Behavioral Health for substance abuse services rendered to EPSDT recipients. Under the provisions of this Rule, payments to OBH for these services shall sunset as of February 29, 2012.

B. Reimbursement for these services shall be based on the most recent actual cost to OBH. Cost data shall be derived from the department's ISIS reporting of costs for the period. The cost period shall be consistent with the state fiscal year. Costs are determined by selecting the expenditures paid from state and local funds for the state fiscal year.

C. OBH encounter data from their database shall be used to identify allowable services. Encounter data for recipients under the age of 21 shall be extracted and used in calculations to determine actual cost to OBH.

D. Costs shall be calculated by using the cost-weighted amount and include Medicaid eligibles under 21 database costs divided by total database costs times OBH's expenditures for the program which were derived from the state's ISIS data.

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 38:2372 (September 2012).

Chapter 95. School-Based Health Services

Subchapter A. School-Based Medicaid Medical Direct Services

§9501. General Provisions

A. EPSDT school-based medical services are provided pursuant to a written plan of care and provided by licensed medical providers within a local education agency (LEA) to Medicaid beneficiaries ages 3 to 21 with or suspected of having a disability. The goal of these services is to prevent or mitigate disease, enhance care coordination, and reduce costs by preventing the need for tertiary care. Providing these services in the school increases access to health care for children and youth resulting in a more efficient and effective delivery of care.

B. School-based medical services shall be covered for all beneficiaries in the school system who are eligible according to Subsection A above. Medical necessity criteria shall be determined according to the provisions of LAC 50:1.Chapter 11.

C. Medically necessary services are defined as those health care services that are in accordance with generally accepted evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care.

1. In order to be considered medically necessary, services must be:

a. deemed reasonably necessary to diagnose, correct, cure, alleviate, or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain, or have resulted or will result in a handicap, physical deformity or malfunction; and

b. those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the beneficiary.

2. Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the beneficiary requires at that specific point in time.

3. Although a service may be deemed medically necessary, it does not mean the service will be covered under the Medicaid Program. Services that are experimental, non-FDA approved, investigational or cosmetic are specifically excluded from Medicaid coverage and will be deemed not medically necessary.

4. The Medicaid director, in consultation with the Medicaid medical director, may consider authorizing services at his/her discretion on a case-by-case basis.

D. All service providers providing EPSDT school-based medical services are required to maintain an active license that is necessary for the applicable service within the state of Louisiana.

E. All participating LEAs are required to maintain an active status with Medicaid. Should an LEA's Medicaid provider number become inactive or one LEA from a group that shares a tax identification becomes inactive, it may cause the entire cost report to be denied and the cost settlement forfeited.

F. Effective for the fiscal year ended June 30, 2021 cost report year, the individual cost settlement amounts for each program (therapy services, behavioral health services, nursing services, personal care services, and other medical direct services) will be combined into one cost settlement for the LEA. Settlement letters will be sent to the LEA with the individual final cost reports for its records. Medicaid administrative claiming (MAC) cost reports are derived by using the MAC-related time study results and cost related to each of the EPSDT programs. All costs will have been certified by the LEA with the EPSDT cost report, so no additional signatures or certifications are required for MAC. Therefore, MAC cost reports shall remain separate.

G. LEAs that terminate business must notify the Louisiana Medicaid fiscal intermediary, immediately. Instructions will need to be provided to Department of Health/Rate Setting and Audit and/or Department of Education as to the final disposition of cost settlements and previous dollars owed to or from Louisiana Medicaid.

1. For LEAs that transfer to new management companies and owe the department, the new owners shall assume all obligations of repayment for the new LEA. Overpayments will be recouped from future earnings of the new management company.

2. For separating LEAs that are owed reimbursements, the department will cut a supplemental check to the LEA or the new management company. However, failure to provide instructions to the department within 10 days of closure may result in forfeiture of payment.

H. Dollars owed will be assessed to all future cost settlements for the LEA and will be applied to the earliest cost report year with an overpayment. For example, if an LEA has an overpayment for nursing services and an amount due to them for therapy services, the payment for therapy services will be applied to the LEA's overpayment for the nursing services. The net balance from this offset will:

1. be used to offset overpayments in other periods (from oldest period moving forward to the current period);
2. create a net overpayment that will be carried forward and offset against future billings and/or payments; and
3. be remitted to the LEA.

I. Service Exclusion. Services are not covered if they are performed for educational purposes (e.g., academic

testing) or determined not medically necessary. Medicaid does not reimburse for social or educational needs.

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 39:2760 (October 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1298 (August 2016), LR 45:561 (April 2019), LR 47:738 (June 2021), LR 49:1382 (August 2023).

§9503. Covered Services

A. The following medically necessary services provided by local education agencies (LEAs) are reimbursable when included on a beneficiary's individualized service plan (IEP), a section 504 accommodation plan, an individualized health care plan, or a medical need based written plan of care:

1. medical and remedial behavioral health care including applied behavior analysis (ABA);
2. personal care services;
3. physical therapy;
4. occupational therapy;
5. speech therapy/pathology; and
6. audiology.

B. Medically necessary services shall be provided by local education agencies (LEAs) that correct or ameliorate a child's health condition.

C. Services must be performed by qualified providers as set forth in the State Plan following Louisiana scope of practice laws for the respective provider furnishing services.

1. Services rendered by certified school psychologists must be practicing under the supervision of a licensed psychologist consistent with R.S. 17:7.1.

2. Licensed master social workers or certified master licensed social worker must practice under the supervision of a licensed clinical social worker.

D. LEAs are responsible for proper medical documentation and record keeping. Services shall promote appropriate continuity of care.

E. The following services are covered for any EPSDT eligible beneficiary in schools.

1. EPSDT Program Periodicity Schedule for Screenings. Qualified individuals employed by a school district may perform any of these screens within their licensure. The results of these screens must be made available as part of the care coordination plan of the district. The screens shall be performed according to the periodicity schedule including any inter-periodic screens.

2. EPSDT Medical/Nursing Assessment/Evaluation Services. A licensed health care provider employed by a school district may perform services to protect the health status of children and correct health problems. These

services may include health counseling and triage of childhood illnesses and conditions.

a. Consultations are to be face-to-face contact in one-on-one sessions. These are services for which a parent would otherwise seek medical attention at a physician or health care provider's office. Telemedicine/telehealth is not a covered service, but is an applicable service delivery method. When otherwise covered by Louisiana Medicaid, telemedicine/telehealth is allowed for all CPT codes located in Appendix P of the CPT manual. This service is available to all Medicaid individuals eligible for EPSDT.

F. Policy transmittals, State Plan amendments, regulations, provider bulletins, provider manuals, and fee schedules, issued by the department are the final authority regarding services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:2760 (October 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 45:562 (April 2019), LR 47:738 (June 2021), LR 49:1384 (August 2023).

§9505. Reimbursement Methodology

A. Cost Reporting. Settlement payments for EPSDT school-based medical direct, therapy, behavioral health, and PCS services shall be based on the most recent school year's actual costs as determined by desk review and/or audit for each LEA provider.

1. Each LEA shall determine cost annually by using LDH's cost report for medical service cost form based on the direct services cost report.

2. Direct costs shall be limited to the amount of total compensation (salaries, vendor payments and fringe benefits) of current medical service providers as allocated to medical services for Medicaid beneficiaries. There are no additional direct costs included in the rate.

3. Indirect costs shall be derived by multiplying the cognizant agency indirect cost unrestricted rate assigned by the Department of Education to each LEA by the allowable costs. There are no additional indirect costs included.

4. To determine the amount of EPSDT services costs that may be attributed to Medicaid; the ratio of total Medicaid students in the LEA is multiplied by total direct (direct plus indirect) cost. Cost data are subject to certification by each LEA. This serves as the basis for obtaining federal Medicaid funding.

B. Licensed master social workers practicing under the supervision of a licensed clinical social worker, and certified school psychologist practicing under the supervision of a licensed psychologist that has the authority to practice in the community/outside of schools will be required to show proof of verification when the cost report is monitored.

C. For the EPSDT services the participating LEA's actual cost of providing the services shall be claimed for

Medicaid federal financial participation (FFP) based on the following methodology.

1. Develop Direct Cost—The Payroll Cost Base and Vendor Cost Base. The state shall gather actual expenditure information for each LEA through its employee payroll/benefits and vendor accounts payable system. Total annual salaries and benefits paid, as well as contracted (vendor) payments, shall be obtained initially from each LEA's payroll/benefits and accounts payable system. This data shall be reported on LDH's direct services cost report form for all direct service personnel (i.e., all personnel providing LEA medical services covered under the state plan).

2. Adjust the Payroll and Vendor Cost Base. The payroll and vendor cost base shall be reduced for amounts reimbursed by non-state and local funding sources (e.g., federal grants). The payroll and vendor cost base shall not include any amounts for staff whose compensation is 100 percent reimbursed by a funding source other than state/local funds. This application results in total adjusted employee salary and vendor cost.

3. Determine the Percentage of Time to Provide All EPSDT Services. A time study, which incorporates the CMS-approved Medicaid administrative claiming (MAC) methodology for direct service employees, shall be used to determine the percentage of time EPSDT service providers spend on EPSDT direct services and general and administrative (G and A) time. This time study will assure that there is no duplicate claiming. The G and A percentage shall be reallocated in a manner consistent with the CMS-approved Medicaid administrative claiming methodology. Total G and A time shall be allocated to all other activity codes based on the percentage of time spent on each respective activity. To reallocate G and A time to EPSDT services, the percentage of time spent on EPSDT services shall be divided by 100 percent minus the percentage of G and A time. This shall result in a percentage that represents the EPSDT services with appropriate allocation of G and A. This percentage shall be multiplied by total adjusted salary cost as determined by the adjusted payroll cost base to allocate cost to school-based services. The product represents total direct cost.

a. A sufficient amount of EPSDT service providers' time shall be sampled to ensure results that will have a confidence level of at least 95 percent with a precision of plus or minus 5 percent overall.

b. Time study moments are to be completed and submitted by all participating LEA participants. Participants will have 48 hours (not counting weekends or holidays) from the time of the moment to complete each moment. Reminder emails will be sent to the participant and the Medicaid coordinator each morning until the moment expires. Once a time study moment has expired, it will no longer be able to be completed and will be deemed not returned. Any LEA that fails to return at least 85 percent of its moments from the time study for two quarters in a cost report year for any

program, will be suspended from that program for the entire cost report year.

c. **Unsupported Time Study Moments.** LEAs will be penalized the lesser of \$1,000 times the number of unsupported moments or 50 percent of their cost report. This only applies to LEAs that cannot support at least 50 percent of the moments selected for testing.

d. The time study percentage used for cost reimbursement calculation is an average of the four quarterly statewide time study results for each school-based Medicaid program. LEAs must participate in all four time study quarters to be reimbursed all costs for the fiscal year. Any LEA that does not submit a cost report for any program for which any billings were submitted will be required to pay back any billing dollars received for that cost report year. This will be handled in the school based claiming cost settlement process.

e. Vendors are not subject to the time study process. Vendors are only at a school to provide the direct service enumerated in the contract. Vendors are not expected to perform G and A tasks and will be reimbursed based on a rate per service. This rate per service should include all direct and indirect costs. The rate per service should cover the time spent providing the direct service, administrative time and any other time related to tasks related to that service.

4. **Determine Indirect Costs.** Indirect costs shall be determined by multiplying each LEA's indirect unrestricted rate assigned by the cognizant agency (the Department of Education) by total adjusted direct cost. No additional indirect costs shall be recognized outside of the cognizant agency's indirect rate. The sum of direct costs and indirect costs shall be the total direct service cost for all students receiving EPSDT services.

D. **Allocate Direct Service Costs to Medicaid.** To determine the costs that may be attributed to Medicaid, total direct service cost (employee and vendor) shall be multiplied by the ratio of Medicaid enrolled 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 EPSDT 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.

E. **Reconciliation of LEA Certified Costs and Medicaid Management Information System (MMIS) Paid Claims.** Each LEA shall complete applicable service cost report(s) and submit the cost report(s) no later than five months after the fiscal year period ends (June 30), and reconciliation should be completed within 12 months from the fiscal year end. All filed 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 therapy, behavioral health services, personal care services, nursing services, and other medical direct services. The Medicaid certified cost expenditures from the 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.

F. **Interim Billing.** The Centers for Medicare and Medicaid Services (CMS) requires each LEA to bill for all Medicaid services provided. CMS and the Office of Inspector General (OIG) rely on interim billing data for documentation of the number of services provided by each LEA and gives them a mechanism to compare the cost reimbursed to the number of services being provided. If there are no claim submissions within an 18 month period, Medicaid management information system (MMIS) automatically terminates eligibility of a provider number making the LEA Medicaid ineligible. Any LEA that is Medicaid ineligible will have all interim claims denied and its cost report for all programs in which the LEA participated will be rejected.

G. **Cost Settlement Process.** As part of its financial oversight responsibilities, the department shall develop a risk assessment and an audit plan to ensure cost reasonableness and accuracy in accordance with current CMS guidelines. Based on the audit plan, the department will develop agreed upon procedures to review and process all final settlements to LEAs. The agreed upon procedures will be performed to review cost reports submitted by LEAs.

1. The financial oversight of all LEAs shall include reviewing the costs reported on the EPSDT services cost report against the allowable costs, performing desk reviews and conducting limited reviews.

2. The department will make every effort to audit each LEA at least every four years. These activities shall be performed to ensure that audit and final settlement occurs no later than two years from the LEA's fiscal year end for the cost reporting period audited. LEAs may appeal audit findings in accordance with LDH appeal procedures.

3. The department shall adjust the affected LEA's payments no less than annually, when any reconciliation or final settlement results in significant underpayments or overpayments to any LEA. By performing the reconciliation and final settlement process, there shall be no instances where total Medicaid payments for services exceed 100 percent of actual, certified expenditures for providing LEA services for each LEA.

4. If the interim payments exceed the actual, certified costs of an LEA's Medicaid services, the department shall recoup the overpayment from current and following years cost report settlement until the amount due is zero.

5. If the actual certified costs of an LEA's Medicaid services exceed interim Medicaid payments, the department will pay this difference to the LEA in accordance with the final actual certification agreement.

6. Type 1 and 3 charter schools in Orleans Parish will be required to submit acceptable documentation (board minutes, letter from the school board, etc.) that authorizes the charter to act as its own LEA, upon enrollment.

Likewise, in order to receive a cost settlement, confirmation that the authorization is still in good standing with the school board will be required to accompany the submission of the cost report. Failure to provide this documentation at the time the cost report is filed may cause the cost report to be rejected and not be considered as timely filed.

H. Delinquent Cost Report Penalty. Cost reports must be submitted annually. In order to be eligible to submit a cost report, LEAs must participate in all four time study quarters for the fiscal year.

1. The due date for filing annual cost reports is November 30. There shall be no automatic extension of the due date for filing of cost reports. If an LEA experiences unavoidable difficulties in preparing its cost report by the prescribed due date, one 30-day extension may be permitted, upon written request submitted to the department or its designee prior to the due date. The request must explain in detail why the extension is necessary. Extensions beyond 30 days may be approved for situations beyond the LEA's control.

2. Delinquent cost reports that have not been received by November 30 and an extension was not received, will be deemed non-compliant and may be subject to a non-refundable reduction of 5 percent of the total cost settlement. This reduction may be increased an additional 5 percent each month until the completed cost report is submitted or the penalties total 100 percent. LEAs that have not filed their cost report by six months or more beyond the due date cannot bill for services until the cost report is filed.

I. State Monitoring. If the department becomes aware of potential instances of fraud, misuse or abuse of LEA services and Medicaid funds, it will perform timely audits and investigations to identify and take necessary actions to remedy and resolve the problem.

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 39:2761 (October 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 45:562 (April 2019), LR 47:739 (June 2021), LR 49:1385 (August 2023).

§9507. Local Education Agency Responsibilities

A. The LEA shall ensure that its licensed and unlicensed EPSDT service professionals are employed or contracted according to the requirement specified under the Individuals with Disabilities Education Act (IDEA).

B. LEAs shall ensure that individual professional requirements are in compliance with Medicaid qualifications, Department of Education Bulletin 746, and Louisiana Standards for State Certification of School Personnel prior to an LEA billing for any services of a clinician under Medicaid.

C. Anyone providing EPSDT services must operate within their scope of practice license or certification under the supervision of a licensed practitioner. Licensed practitioners assume professional liability for

unlicensed/certified practitioners under their supervision and within their scope of practice. The provider shall create and maintain documents to substantiate that all requirements 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, Bureau of Health Services Financing, LR 49:1387 (August 2023).

Subchapter B. School-Based EPSDT Transportation Services

§9511. General Provisions

A. A special transportation trip is only billable to Medicaid on the same day that a Medicaid-eligible child is receiving a Medicaid Service included in the child's individualized service plan (IEP). Transportation shall be provided on a specially adapted bus. The need for transportation must be documented in the child's IEP.

B. School-based EPSDT transportation services shall be covered for all recipients in the school system who are eligible for the service.

C. Local education agency responsibilities shall be followed in accordance with §9507.

D. Service Exclusion. Transportation services are not covered if performed for educational purposes (e.g., academic testing) or, as the result of the assessment and evaluation, it is determined the service is not reflected in an IEP. Medicaid does not reimburse for social or educational needs.

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 45:563 (April 2019), amended LR 47:740 (June 2021), LR 49:1387 (August 2023).

§9515. Reimbursement Methodology

A. Medically necessary specialized transportation that is included on the student's IEP, provided by LEAs to beneficiaries under age 21 is reimbursed based on the most recent school year's actual cost as determined by desk review and/or audit for each LEA provider. Each LEA shall determine cost annually by using LDH's specialized transportation cost report form. There is no time study for the transportation program.

1. Direct cost shall be the cost of fuel, repairs and maintenance, rentals, contracted vehicle use cost and the amount of total compensation (salaries, vendor payments, and fringe benefits) of specialized transportation employees or contract cost for contract drivers, as allocated to special transportation services for Medicaid beneficiaries. There are no additional direct costs included in the rate.

2. Indirect cost is derived by multiplying the direct cost by the cognizant agency's unrestricted indirect cost rate assigned by the Department of Education to each LEA by

the allowable costs. There are no additional indirect costs included.

B. The transportation cost report initially provides the total cost of all special transportation services provided, regardless of payer. To determine the amount of special transportation costs that may be attributed to Medicaid, total cost is multiplied by the ratio of one-way Medicaid eligible trips to one-way trips for all students transported via specialized transportation. This results in total cost that may be certified as Medicaid's portion of school-based specialized transportation services cost. Trip data is derived from transportation logs maintained by drivers for each one-way trip. This ratio functions in lieu of the time study methodology and student ratio used for the direct services cost report. Cost data on the transportation cost report is subject to certification by each parish and serves as the basis for obtaining federal Medicaid funding.

C. The participating LEA's actual cost of providing specialized transportation services will be claimed for Medicaid federal financial participation (FFP) based on the methodology described in the steps below. The state will gather actual expenditure information for each LEA through the LEA's payroll/benefits and accounts payable system. These costs are also reflected in the annual financial report (AFR) that all LEAs are required to certify and submit to the Department of Education. All costs included in the amount of cost to be certified and used subsequently to determine the reconciliation and final settlement amounts as well as interim rates are identified on the CMS-approved transportation cost report and are allowed in OMB Circular A-87.

1. Step 1—Develop Direct Cost—Other. The non-federal share of cost for special transportation fuel, repairs and maintenance, rentals, and contract vehicle use cost are obtained from the LEA's accounts payable system and reported on the transportation cost report form.

2. Step 2—Develop Direct Cost—The Payroll Cost Base. Total annual salaries and benefits paid as well as contract cost (vendor payments) for contract drivers are obtained from each LEA's payroll/benefits and accounts payable systems. This data will be reported on the transportation cost report form for all direct service personnel (i.e. all personnel working in special transportation).

3. Step 3—Determine Indirect Cost. Indirect cost is determined by multiplying each LEA's unrestricted indirect rate assigned by the cognizant agency (the Department of Education) by total direct cost as determined under steps 1 and 2. No additional indirect cost is recognized outside of the cognizant agency indirect rate. The sum of direct costs as determined in steps 1 and 2 and indirect cost is total special transportation cost for all students with an IEP.

4. Step 4—Total Cost. The sum of direct costs and indirect cost is the total specialized transportation direct cost for all students with an IEP indicating medical need.

5. Step 5—Allocate Specialized Transportation Cost to Medicaid. Special transportation drivers shall maintain logs of all students transported on each one-way trip. These logs shall be utilized to aggregate total annual one-way trips which will be reported by each LEA on the special transportation cost report. To determine the amount of special transportation cost that may be attributed to Medicaid, total cost is multiplied by the ratio of one-way trips by Medicaid students to one-way trips for all students transported via special transportation. This results in total cost that may be certified as Medicaid's portion of school based special transportation services cost.

D. Medicaid One-Way Trip Ratios for Specialized Transportation

Calculation—Medicaid trip ratio times specialized transportation costs [(direct services) plus (direct services times indirect rate)].

Denominator—the total number of one-way trips for all children that ride a specialized transportation bus.

Numerator—the number of one-way trips for Medicaid enrolled children who received specialized transportation to and from the IEP service destination will be claimed as a Medicaid eligible trip when the child receives a Medicaid service included in an IEP on a particular day and specialized transportation is specifically listed in the IEP.

E. Reimbursement of LEA Certified Costs. Each LEA shall complete and submit the specialized transportation cost report no later than five months after the fiscal year end (June 30), and reconciliation should be completed within 12 months from the fiscal year end. All filed cost reports shall be subject to desk review or audit by the department's audit contractor. The financial oversight of all LEAs will include reviewing the costs reported on the specialized transportation cost reports against the allowable costs in accordance with 2 CFR 200, performing desk reviews and conducting limited reviews. The department shall issue a notice of final reimbursement, after all reviews, which denotes the amount due to the LEA.

F. As part of financial oversight responsibilities, the department shall develop a risk assessment and audit plan to ensure cost reasonableness and accuracy in accordance with current CMS guidelines. Based on the audit plan, the department will develop agreed upon procedures to review and process all reimbursements to LEAs. The agreed upon procedures will be performed to review cost reports submitted by LEAs.

1. The financial oversight of all LEAs shall include reviewing the costs reported on the specialized transportation cost report against the allowable costs, performing desk reviews and conducting limited reviews.

2. The department shall make every effort to audit each LEA at least every four years. These activities shall be performed to ensure that audit and final reimbursement occurs no later than two years from the LEA's fiscal year end for the cost reporting period audited. LEAs may appeal audit findings in accordance with LDH appeal procedures.

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

H. 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 45:563 (April 2019), amended LR 49:1387 (August 2023).

Subchapter C. School-Based Medicaid Personal Care Services

§9521. General Provisions

A. General provisions shall be followed in accordance with §9501.

B. Early and periodic screening, diagnosis and treatment personal care services must be prescribed by a licensed practitioner within the scope of their practice initially and every 180 days thereafter (or rolling six months) and when changes in the plan of care occur.

C. Local education agency responsibilities shall be followed in accordance with §9507.

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 45:564 (April 2019), amended LR 47:740 (June 2021), LR 49:1388 (August 2023).

§9523. Covered Services

A. The following school-based personal care services shall be covered:

1. basic personal care, toileting, diapering, and grooming activities;
2. assistance with bladder and/or bowel requirements or problems, including helping the child to and from the bathroom, but excluding catheterization;
3. assistance with eating and food, nutrition, and diet activities;
4. accompanying, but not transporting, the beneficiary to and from his/her physician and/or medical facility for necessary medical services;
5. provides assistance with transfers, positioning and repositioning; and
6. provide positive behavior support strategies to assist students with prompting to perform services related to physical and/or behavioral health needs.

B. Documentation for EPSDT PCS provided shall include, at a minimum, the following:

1. daily notes by PCS provider denoting date of service;
2. services provided;

3. total number of hours worked;
4. time period worked;
5. condition of recipient;
6. service provision difficulties;
7. justification for not providing scheduled services; and
8. any other pertinent information.

C. There must be a clear audit trail between:

1. the prescribing physician;
2. the local education agency;
3. the individual providing the personal care services to the recipient; and
4. the services provided and reimbursed by Medicaid.

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 47:740 (June 2021), LR 49:1388 (August 2023).

§9525. Reimbursement Methodology

A. Cost reporting will be handled in accordance with §9505.A.

B. For the personal care services, the participating LEAs' actual cost of providing the services shall be claimed for Medicaid federal financial participation (FFP) based on the following methodology for employees/vendors:

1. Develop Direct Cost-The Payroll Cost Base. Total annual salaries and benefits paid, as well as contracted (vendor) payments, shall be obtained initially from each LEA's payroll/benefits and accounts payable system. This data shall be reported on LDH's direct services cost report form for all personal care service employees or vendors (i.e., all personnel providing LEA personal care treatment services covered under the state plan).
2. Adjust the Payroll/Vendor Cost Base. The payroll cost base shall be reduced for amounts reimbursed by non-state and local funding sources (e.g., federal grants). The payroll/vendor cost base shall not include any amounts for staff whose compensation is 100 percent reimbursed by a funding source other than state/local funds. This application results in total adjusted salary cost.
3. Personal care providers will not be subject to a time study.
4. Determine Indirect Cost. Indirect cost shall be determined by multiplying each LEA's indirect unrestricted rate assigned by the cognizant agency (the Department of Education) by total adjusted direct cost. No additional indirect cost shall be recognized outside of the cognizant agency indirect rate. The sum of direct cost and indirect cost shall be the total direct service cost for all students receiving personal care services.

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

in gaining access to needed medical, social, educational, and other services.

Individualized Family Service Plan (IFSP)—a written plan that is developed jointly by the family and service providers which identifies the necessary services to enhance the development of the child as well as the family’s capacity to meet the needs of their child. The IFSP 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 shall be developed within 45 days following the referral to the 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 shall include all major developmental areas including cognitive development, physical development including:

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

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

- a. 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 47:1129 (August 2021), LR 49:2110 (December 2023).

§10905. Staff Training

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

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

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
EarlySteps Specific Training—Eight Hours	
1 hour	Components of the 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 EarlySteps, child search and early intervention service programs;
- b. child search and family support coordinator roles and responsibilities in depth;
- c. multidisciplinary evaluation (MDE) in depth;
- d. procedural safeguards and complaint procedures;

- e. family perspective, including the grieving process;
- f. cultural diversity;
- g. communication with parents and professionals;
- h. family empowerment and advocacy;
- i. resources, including adaptation of resources to the child's needs; and
- j. arranging access for families to support systems, including informal systems.

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

C. The provider shall ensure that each family support coordinator has completed the required orientation and advanced training during the first 90 days of employment and at least 20 hours of approved in-service education in family service coordination and related areas annually.

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

1. satisfactorily completion of at least the 20 hours of family support coordination and related orientation required of family support coordinators during the first 90 days of employment before assuming supervision of any family service coordination;
2. supervisors shall also complete 20 hours of in-service training each year on such subjects as:
 - a. family support coordination;
 - b. supervision; or
 - c. administration.

E. The provider 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 47:1129 (August 2021), LR 49:2110 (December 2023).

Chapter 113. Early, 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 state Medicaid data contractor for EPSDT case management services. However, for those recipients under 3 years of age, case management services shall continue to be provided through 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 47:1130 (August 2021).

§11303. Recipient Qualifications

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

1. placement on the Request for Services Registry and determined to be eligible for OCDD services through the statement of approval process; or
2. for those who do not meet eligibility, or who are not undergoing 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. receipt of special education services through the state or local education agency; or
- 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. receipt of or application for financial assistance such as SSI because of a medical condition, or the

unemployment of the parent due to the need to provide specialized care for the child; or

d. a report by the recipient's physician 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. the Parents' Evaluation of Pediatric Status;
- ii. the Brigance Screens;
- iii. the Child Development Inventories;
- iv. an appropriate screening tool; or
- v. any other nationally-recognized diagnostic tool.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 26:2797 (December 2000) repromulgated for inclusion in LAC, LR 30:1042 (May 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1130 (August 2021), amended LR 49:2111 (December 2023).

Chapter 117. Individuals with Developmental Disabilities

§11701. Introduction

A. The targeted population for case management services shall consist of individuals with 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), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1131 (August 2021).

§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 in a manner that is 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 47:1131 (August 2021), amended LR 49:2111 (December 2023).

Subpart 9. Personal Care Services

Chapter 129. Long Term Care

§12901. General Provisions

A. The purpose of long term-personal care services (LT-PCS) is to assist individuals with functional impairments with their daily living activities. LT-PCS must be provided in accordance with an approved service plan and supporting documentation. In addition, LT-PCS must be coordinated with the other Medicaid and non-Medicaid services being provided to the participant and will be considered in conjunction with those other services.

B. Each individual requesting or receiving long term-personal care services (LT-PCS) shall undergo a functional eligibility screening utilizing an eligibility screening tool called the level of care eligibility tool (LOCET), or a subsequent eligibility tool designated by the Office of Aging and Adult Services (OAAS).

C. Each LT-PCS applicant/participant shall be assessed using a uniform interRAI home care assessment tool or a subsequent assessment tool designated by OAAS. The assessment is designed to verify that an individual meets eligibility qualifications and to determine resource allocation while identifying an individual's need for support in performance of activities of daily living (ADLs). The assessment generates a score which measures the individual's degree of self-performance of the following activities of daily living:

1. bed mobility;
2. toilet transfer;
3. toilet use; and
4. eating.

D. Based on the individual's ADL Index score, they are assigned and are eligible for a set allocation of weekly service hours associated with that score.

1. If the individual is allocated less than 32 hours per week and believes that they are entitled to more hours, the individual or their responsible representative may request a fair hearing to appeal the decision.

2. The individual may qualify for more hours if it can be demonstrated that:

a. one or more answers to the questions involving the ADLs used in the ADL Index score are incorrect as recorded on the assessment; or

b. they need additional hours to avoid entering into a nursing facility.

E. Requests for LT-PCS shall be accepted from the following individuals:

1. a Medicaid participant who wants to receive LT-PCS;

2. an individual who is legally responsible for a participant who may be in need of LT-PCS; or

3. a responsible representative designated by the participant to act on his/her behalf in requesting LT-PCS.

F. Each individual who requests LT-PCS has the option to designate a responsible representative. For purposes of these provisions, a responsible representative shall be defined as the person designated by the individual to act on his/her behalf in the process of accessing and/or maintaining LT-PCS.

1. The appropriate form authorized by OAAS shall be used to designate a responsible representative.

a. The written designation of a responsible representative does not give legal authority for that individual to independently handle the participant's business without his/her involvement.

b. The written designation is valid until revoked by the participant. To revoke the written designation, the revocation must be submitted in writing to OAAS or its designee.

2. The functions of a responsible representative are to:

a. assist or represent, as needed, the participant in the assessment, care plan development and service delivery processes; and

b. to aid the participant in obtaining all necessary documentation for these processes.

3. No individual may concurrently serve as a responsible representative for more than two participants in OAAS-operated Medicaid home and community-based services. This includes but is not limited to:

a. the Program of All-Inclusive Care for the Elderly;

b. long term-personal care services;

c. the community choices waiver; and

d. the adult day health care waiver.

G. The Department of Health may remove an LT-PCS provider from the LT-PCS provider freedom of choice list and offer freedom of choice to LT-PCS participants when:

1. one or more of the following departmental proceedings are pending against an LT-PCS participant's service provider:

a. revocation of the provider's home and community-based services license;

b. exclusion from the Medicaid Program;

c. termination from the Medicaid Program; or

d. withholding of Medicaid reimbursement as authorized by the department's surveillance and utilization review (SURS) Rule (LAC 50:I.Chapter 41);

2. the service provider fails to timely renew its home and community-based services license as required by the home and community-based services providers licensing standards Rule (LAC 48:I.Chapter 50); or

3. the service provider's assets have been seized by the Louisiana Attorney General's office.

H. The department may offer participants the freedom to choose another provider if/when the owner(s), operator(s), or member(s) of the governing body of the provider agency is/are under investigation related to:

1. bribery or extortion;

2. tax evasion or tax fraud;

3. money laundering;

4. securities or exchange fraud;

5. wire or mail fraud;

6. violence against a person;

7. act(s) against the aged, juveniles or infirmed; or

8. any crime involving public funds.

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 29:911 (June 2003), amended LR 30:2831 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 32:2082 (November 2006), LR 34:2577 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:2450 (November 2009), LR 39:2506 (September 2013), LR 41:540 (March 2015), LR 42:902 (June 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services and the Office for Citizens with Developmental Disabilities, LR 43:1980 (October 2017), LR 49:878 (May 2023).

§12903. Covered Services

A. *LT-PCS* are defined as those services that provide assistance with the distinct tasks associated with the performance of the activities of daily living (ADLs) and the instrumental activities of daily living (IADLs). Assistance may be either the actual performance of the personal care task for the individual or supervision and prompting so the individual performs the task by themselves.

1. ADLs are those personal, functional activities required by the participant. ADLs include tasks such as:

a. eating;

- b. bathing;
- c. dressing;
- d. grooming/personal hygiene;
- e. transferring;
- f. ambulation;
- g. toileting; and
- h. bed mobility.

2. IADLs are those activities that are considered essential but may not require performance on a daily basis. IADLs include tasks such as:

- a. light housekeeping;
- b. food preparation and storage;
- c. shopping;
- d. laundry;
- e. assistance with scheduling medical appointments when necessary;
- f. accompanying to medical appointments when necessary;
- g. assistance with accessing transportation;
- h. medication reminders; and
- i. medically non-complex tasks where the direct service worker has received the proper training pursuant to R.S. 37:1031-1034.

3. Emergency and non-emergency medical transportation is a covered Medicaid service and is available to all participants. Non-medical transportation is not a required component of LT-PCS. However, providers may choose to furnish transportation for participants during the course of providing LT-PCS. If transportation is furnished, the provider agency must accept any liability for their employee transporting a participant. It is the responsibility of the provider agency to ensure that the employee has a current, valid driver's license and automobile liability insurance.

4. Constant or intermittent supervision and/or sitter services are not a component of LT-PCS.

5. For participants receiving LT-PCS with the Adult Day Health Care (ADHC) Waiver, LT-PCS may be provided by one worker for up to three LT-PCS participants who live together, and who have a common direct service provider.

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 29:912 (June 2003), amended LR 30:2831 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2578 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2507 (September 2013), LR 42:902 (June 2016), amended by the Department of Health, Bureau

of Health Services Financing and the Office of Aging and Adult Services, LR 42:1931 (November 2016), LR 47:593 (May 2021), LR 49:879 (May 2023).

§12905. Eligibility Criteria

A. Personal care services shall be available to recipients who are 65 years of age or older, or 21 years of age or older and have a disability. Persons with a disability must meet the disability criteria established by the Social Security Administration.

B. Recipients must meet the eligibility criteria established by OAAS or its designee. Personal care services are medically necessary if the recipient:

1. meets the medical standards for admission to a nursing facility and requires limited assistance with at least one or more activities of daily living;

2. is able, either independently or through a responsible representative, to participate in his/her care and direct the services provided by the personal care services worker. A responsible representative is defined as the person designated by the recipient to act on his/her behalf in the process of accessing and/or maintaining personal care services; and

3. faces a substantial possibility of deterioration in mental or physical condition or functioning if either home and community-based services or nursing facility services are not provided in less than 120 days. This criterion is considered met if:

a. the recipient is in a nursing facility and could be discharged if community-based services were available;

b. is likely to require nursing facility admission within the next 120 days; or

c. has a primary caregiver who has a disability or is over the age of 70.

C. Persons designated as the responsible representative of an individual receiving services under LT-PCS may not be the paid direct service worker of the individual they are representing.

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 29:912 (June 2003), amended LR 30:2831 (December 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office of Aging and Adult Services, LR 32:2082 (November 2006), LR 34:2579 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2507 (September 2013), LR 42:903 (June 2016).

§12907. Recipient Rights and Responsibilities

A. Recipients who receive services under the Long-Term Personal Care Services Program have the right to actively participate in the development of their plan of care and the decision-making process regarding service delivery. Recipients also have the right to freedom of choice in the

selection of a provider of personal care services and to participate in the following activities:

1. interviewing and selecting the personal care worker who will be providing services in their home;
2. developing the work schedule for their personal care worker;
3. training the individual personal care worker in the specific skills necessary to maintain the recipient's independent functioning while maintaining him/her in the home;
4. developing an emergency component in the plan of care that includes a list of personal care staff who can serve as back-up when unforeseen circumstances prevent the regularly scheduled worker from providing services;
5. signing off on payroll logs and other documentation to verify staff work hours and to authorize payment;
6. evaluating the personal care worker's job performance; and
7. changing the personal care worker assigned to provide their services;
8. an informal resolution process to address their complaints and/or concerns regarding personal care services; and
9. a formal resolution process to address those situations where the informal resolution process fails to resolve their complaint.

B. Changing Providers. Recipients may request to change PCS agencies without cause once after each three month interval during the service authorization period. Recipients may request to change PCS providers with good cause at any time during the service authorization period.

Good Cause—the failure of the provider to furnish services in compliance with the plan of care. *Good cause* shall be determined by OAAS or its designee.

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 29:912 (June 2003), amended LR 30:2832 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2579 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2508 (September 2013), LR 42:903 (June 2016).

§12909. Standards for Participation

A. In order to participate as a personal care services provider in the Medicaid Program, an agency:

1. must comply with:
 - a. state licensing regulations;
 - b. Medicaid provider enrollment requirements;

c. the standards of care set forth by the Louisiana Board of Nursing; and

d. any federal or state laws, rules, regulations, policies and procedures contained in the Medicaid provider manual for personal care services, or other document issued by the department. Failure to do may result in sanctions;

2. must possess a current, valid home and community-based services license to provide personal care attendant services issued by the Department of Health, Health Standards Section.

B. In addition, a Medicaid enrolled agency must:

1. maintain adequate documentation as specified by OAAS, or its designee, to support service delivery and compliance with the approved POC and will provide said documentation at the request of the department or its designee; and

2. assure that all agency staff is employed in accordance with Internal Revenue Service (IRS) and Department of Labor regulations.

C. An LT-PCS provider shall not refuse to serve any individual who chooses his agency unless there is documentation to support an inability to meet the individual's needs, or all previous efforts to provide service and supports have failed and there is no option but to refuse services.

1. OAAS or its designee must be immediately notified of the circumstances surrounding a refusal by a provider to render services.

2. This requirement can only be waived by OAAS or its designee.

D. OAAS or its designee is charged with the responsibility of setting the standards, monitoring the outcomes and applying administrative sanctions for failures by service providers to meet the minimum standards for participation.

1. Failure to meet the minimum standards shall result in a range of required corrective actions including, but not limited to:

- a. removal from the Freedom of Choice listing;
- b. a citation of deficient practice;
- c. a request for corrective action plan; and/or
- d. administrative sanctions.

2. Continued failure to meet the minimum standards shall result in the loss of referral of new LT-PCS recipients and/or continued enrollment as an LT-PCS provider.

E. Electronic Visit Verification. An electronic visit verification (EVV) system must be used for automated scheduling, time and attendance tracking and billing for LT-PCS services.

1. LT-PCS providers identified by the department shall use:

- a. the EVV system designated by the department; or
 - b. an alternate system that:
 - i. has successfully passed the data integration process to connect to the designated EVV system; and
 - ii. is approved 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 Medicaid provider manual. All LT-PCS providers shall comply with the respective program's Medicaid provider manual.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:912 (June 2003), amended LR 30:2832 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2579 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:2451 (November 2009), LR 39:2508 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services and the Office for Citizens with Developmental Disabilities, LR 43:1980 (October 2017).

§12911. Staffing Requirements

A. All staff providing direct care to the recipient must meet the qualifications for furnishing personal care services per the licensing regulations. The direct service worker shall demonstrate empathy toward the elderly and persons with disabilities, an ability to provide care to these recipients, and the maturity and ability to deal effectively with the demands of the job.

B. Restrictions

1. The following individuals are prohibited from being reimbursed for providing services to a recipient:
- a. the recipient's spouse;
 - b. the recipient's curator;
 - c. the recipient's tutor;
 - d. the recipient's legal guardian;
 - e. the recipient's designated responsible representative; or
 - f. the person to whom the recipient has given representative and mandate authority (also known as Power of Attorney).

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 30:2832 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2580 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2508 (September 2013), LR 42:903 (June 2016).

§12913. Service Delivery

A. Personal care services shall be provided in the recipient's home or in another location outside of the recipient's home if the provision of these services allows the recipient to participate in normal life activities pertaining to the IADLs cited in the plan of care. The recipient's home is defined as the place where he/she resides such as a house, an apartment, a boarding house, or the house or apartment of a family member or unpaid primary care-giver. IADLs cannot be performed in the recipient's home when the recipient is absent from the home, unless it is approved by OAAS or its designee on a case-by-case basis.

B. The provision of services outside of the recipient's home does not include trips outside of the borders of the state without approval of OAAS or its designee.

C. Participants are not permitted to live in a home or property owned, operated, or controlled by an owner, operator, agent, or employee of a licensed provider of long-term care services, and providers are prohibited from providing and billing for services under these circumstances. Participants may not live in the home of their direct support worker unless the direct support worker is related to, and it is the choice of, the participant.

1. The provisions of §12913.C may be waived with prior written approval by OAAS or its designee.

D. Place(s) of service must be documented in the plan of care.

E. It is permissible for an LT-PCS recipient to use his/her approved LT-PCS weekly allotment flexibly provided that it is done so in accordance with the recipient's preferences and personal schedule and is properly documented in accordance with OAAS policy.

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 29:913 (June 2003), amended LR 30:2833 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2581 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Financing and the Office of Aging and Adult Services, LR 39:2509 (September 2013), LR 41:541 (March 2015), LR 42:903 (June 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR:47:594 (May 2021).

§12915. Service Limitations

A. Personal care services shall be limited to up to 32 hours per week. Authorization of service hours shall be considered on a case-by-case basis as substantiated by the recipient's plan of care and supporting documentation.

B. There shall be no duplication of services.

1. Personal care services may not be provided while the recipient is admitted to or attending a program which provides in-home assistance with IADLs or ADLs or while the recipient is admitted to or attending a program or setting where such assistance is available to the recipient.

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 29:913 (June 2003), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2581 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:2451 (November 2009), LR 39:2509 (September 2013).

§12917. Reimbursement

A. Reimbursement for personal care services shall be a prospective flat rate for each approved unit of service that is provided to the participant. One quarter hour (15 minutes) is the standard unit of service for personal care services. Reimbursement shall not be paid for the provision of less than one quarter hour (15 minutes) of service. Additional reimbursement shall not be available for transportation furnished during the course of providing personal care services.

B. The state has the authority to set and change LT-PCS rates and/or provide lump sum payments to LT-PCS providers based upon funds allocated by the legislature.

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 29:913 (June 2003), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:253 (February 2008), LR 34:2581 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:1901 (September 2009), LR 36:1251 (June 2010), LR 37:3267 (November 2011), LR 39:1780 (July 2013), LR 42:904 (June 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR:47:594 (May 2021), LR 49:697 (April 2023).

§12919. Cost Reporting Requirements

A. LT-PCS providers must complete annual cost reports.

B. Each LT-PCS provider shall complete the LDH approved cost report and submit the cost report(s) to the department no later than five months after the state fiscal year ends (June 30).

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 39:1052 (April 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR:47:594 (May 2021).

§12921. Direct Service Worker Wages, Other Benefits, and Workforce Bonus Payments

A. Establishment of Direct Service Worker Wage Floor and Other Benefits

1. Long term-personal care services (LT-PCS) providers that were providing LT-PCS on or after October 1, 2021 and employing direct service workers (DSWs) will receive the equivalent of a \$4.50 per hour rate increase.

2. This increase or its equivalent will be applied to all service units provided by DSWs with an effective date of service for the LT-PCS provided on or after October 1, 2021.

3. All LT-PCS providers affected by this rate increase shall be subject to passing 70 percent of their rate increases directly to the DSW in various forms. These forms include a minimum wage floor of \$9 per hour and wage and non-wage benefits. This wage floor and wage and non-wage benefits are effective for all affected DSWs of any working status, whether full-time or part-time.

4. The LT-PCS provider rate increases, wage floor and/or wage and non-wage benefits will end March 31, 2025 or when the state's funding authorized under section 9817 of the American Rescue Plan Act of 2021 (Pub. L. No. 117-002) is exhausted.

5. The Department of Health (LDH) reserves the right to adjust the DSW wage floor and/or wage and non-wage benefits as needed through appropriate rulemaking promulgation consistent with the Administrative Procedure Act.

B. Establishment of Direct Service Worker Workforce Bonus Payments

1. LT-PCS providers who provided services from April 1, 2021 to October 31, 2022 shall receive bonus payments of \$300 per month for each DSW that worked with participants for those months.

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

C. Audit Procedures for Direct Service Worker Wage Floor, Other Benefits, and Workforce Bonus Payments

1. The wage enhancements, wage and non-wage benefits and bonus payments reimbursed to LT-PCS providers shall be subject to audit by LDH.

2. LT-PCS providers shall provide LDH or its representative all requested documentation to verify that they are in compliance with the DSW wage floor, wage and non-wage benefits and/or bonus payments.

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

4. LT-PCS providers shall produce the requested documentation upon request and within the timeframe provided by LDH.

5. Non-compliance or failure to demonstrate that the wage enhancement, wage and non-wage benefits and/or bonus payments were paid directly to DSWs may result in the following:

- a. sanctions; or
- b. disenrollment from the Medicaid program.

D. Sanctions for Direct Service Worker Wage Floor, Other Benefits, and Workforce Bonus Payments

1. The LT-PCS provider will be subject to sanctions or penalties for failure to comply with this Rule or with requests issued by LDH pursuant to this Rule. The severity of such action will depend upon the following factors:

a. failure to pass 70 percent of the LT-PCS provider rate increases directly to the DSWs in the form of a floor minimum of \$9 per hour and in other wage and non-wage benefits and/or the \$250 monthly bonus payments;

b. the number of employees identified that the LT-PCS provider has not passed 70 percent of the LT-PCS provider rate increases directly to the DSWs in the form of a floor minimum of \$9 per hour and in other wage and non-wage benefits and/or the \$250 monthly bonus payments;

c. the persistent failure to not pass 70 percent of the LT-PCS provider rate increases directly to the LT-PCS DSWs in the form of a floor minimum of \$9 per hour and in other wage and non-wage benefits and/or 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 and the Office of Aging and Adult Services, LR 49:697 (April 2023).

Subpart 13. Pregnant Women Extended Services

Chapter 163. Substance Use Screening and Intervention Services

§16301. General Provisions

A. The department shall provide coverage of medically necessary substance use screening and intervention services rendered to Medicaid-eligible pregnant women at the discretion of the medical professional providing care to the pregnant woman.

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 40:794 (April 2014), LR 46:184 (February 2020).

§16303. Scope of Services

A. Screening services shall include the screening of pregnant women for:

1. alcohol use;
2. tobacco use;
3. drug use; and/or
4. domestic violence.

B. Intervention services shall include a counseling session, which shall be a minimum of 15-30 minutes in duration, with a health care professional intended to motivate the recipient to develop a plan to moderate or cease their use of alcohol and/or drugs.

C. Service Limits. Substance use screening and intervention services shall be limited to one occurrence per pregnancy, or once every 270 days. Pregnant women may also receive up to eight tobacco cessation counseling sessions per year. Limits may be exceeded, based on medical necessity.

1. If the recipient experiences a miscarriage or fetal death and becomes pregnant within the 270-day period, screening and intervention services shall be reimbursed for the subsequent pregnancy.

D. Tobacco Cessation Counseling and Pharmacotherapy. The department shall provide coverage of diagnostic, therapeutic counseling services and pharmacotherapy for the cessation of tobacco use by pregnant women who use tobacco products or who are being treated for tobacco use. Counseling sessions shall be face-to-face with an appropriate health care professional.

1. Pregnant women may receive four counseling sessions per quit attempt, up to two quit attempts per calendar year. Limits may be exceeded, based on medical necessity. The period of coverage for these services shall include the prenatal period through 12-month postpartum period. Services shall be provided:

- a. by or under the supervision of a physician; or
- b. by any other health care professional who is:
 - i. legally authorized to furnish such services under Louisiana state law and is authorized to provide Medicaid coverable services other than tobacco cessation; or
 - ii. legally authorized to provide tobacco cessation services under Louisiana state law and is designated by the secretary of the department to provide these services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:794 (April 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 46:184 (February 2020), LR 46:954 (July 2020), LR 48:500 (March 2022).

§16305. Reimbursement Methodology

A. Reimbursement for substance use screening and intervention services provided to pregnant women shall be a flat fee based on the appropriate current procedural terminology (CPT) code.

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 40:795 (April 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 46:184 (February 2020), LR 46:954 (July 2020).

Subpart 15. Health Services for American Indians

Chapter 201. General Provisions

§20103. Cancellation of Participation

A. A “638” facility’s participation in the Medicaid Program may be cancelled if it is determined that the facility is not providing care in compliance with Medicaid regulations and/or state laws.

B. The Department of Health and Hospitals may, at its discretion, cancel the participation of these facilities if:

1. it determines that the health care needs of the Louisiana’s American Indian population are not being met by the facility; or

2. CMS discontinues the terms of the Memorandum of Agreement with Indian Health Service which allow states to claim 100 percent federal medical assistance percentage for payments made by the state for services rendered to Medicaid eligible American Indians through an IHS owned or leased facility or a tribal “638” facility.

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 31:2029 (August 2005).

Chapter 203. Provider Participation

§20301. “638” Facilities

A. In order to participate in the Medicaid Program as a “638” facility, the facility must provide health services and be operated by:

1. a federally recognized tribe that meets the definition as set forth in 25 U.S.C. §1603(d); or

2. a tribal organization as that term is defined in 25 U.S.C. §450b(I); or

3. an inter-tribal consortium as that term is defined in 25 U.S.C. §458aaa(a)(5).

B. A “638” facility must:

1. comply with all provider enrollment requirements for the Louisiana Medicaid Program, including an attestation stating they will only seek reimbursement for services

rendered to Medicaid eligible tribe members and Medicaid eligible individuals who are statutorily eligible under 25 U.S.C. §1680c (a) to receive treatment at an IHS facility;

2. employ or have a contractual agreement with the licensed health professionals who will perform the required services included in the encounter rate. These health care professionals must meet the participation standards required for Medicaid enrollment of their respective provider type;

3. comply with the Medicaid rules and regulations governing those services included in the facility’s encounter rate;

4. assure that services will be provided on-site; and

5. have a physician affiliated with the clinic that must spend as much time in the facility as is necessary to ensure that patients are receiving services in a safe and efficient manner in accordance with accepted standards of medical, dental, and behavioral health practice, and other health care professionals available as needed.

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 31:2029 (August 2005), amended by the Department of Health, Bureau of Health Services Financing, LR 49:1726 (October 2023).

Chapter 205. Recipient Eligibility

§20501. Target Population

A. A recipient qualifies as a member of the target population if he/she meets the definition of an Indian as set forth in 25 U.S.C. §1603 (c) or the definition of a statutorily eligible individual as set forth in 25 U.S.C. §1680c(a)(1) and (2).

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 31:2029 (August 2005).

Chapter 207. Covered Services

§20701. Outpatient Services

A. A “638” facility shall provide preventive, diagnostic, therapeutic, rehabilitative or palliative services that are furnished to outpatients by or under the direction of a:

1. physician;

2. dentist;

3. physician’s assistant;

4. psychologist or licensed counselor;

5. nurse practitioner, nurse midwife or clinical nurse specialist;

6. x-ray technician; or

7. pharmacist.

B. The facility shall furnish covered services as an “encounter”, which is defined as a face-to-face visit between a facility health professional and an eligible patient for the purpose of providing outpatient services. An encounter shall, at a minimum, consist of the following:

1. A detailed history (chief complaint, history of present illness, problem pertinent system review, pertinent past history/social);

2. A detailed exam (extended exam of the affected body area(s) and other symptomatic or related organ systems); and.

3. Low to moderate complexity of medical decision making based on the number of possible diagnoses/management options; the amount and complexity of medical records, diagnostic tests and other information to be reviewed; and the risk of complications, morbidity and/or mortality associated with the patient’s presenting problems.

C. The following services shall be provided on-site by the “638” facility and included as part of the encounter:

1. physician and mid-level practitioner services;
2. dental services;
3. psychological services;
4. prescription drugs services;
5. laboratory services;
6. x-ray services; and
7. nutrition services.

D. The facility may not bill an encounter rate if the only “services” performed were tasks incidental to services including, but not limited to:

1. taking blood pressure and temperature;
2. giving an injection;
3. changing dressings;
4. diagnostic procedures;
5. laboratory services such as EKG, Peak Flow, Spirometry Respiratory Flow Volume, Loop and injections; or
6. a referral for other services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:2029 (August 2005).

§20703. Service Limitations

A. Consultations with more than one facility health professional on the same day and at a single location constitute a single encounter. Services shall not be arbitrarily delayed or split in order to bill additional encounters. A maximum of one encounter per recipient per 24-hour period shall be reimbursed.

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 31:2030 (August 2005).

§20705. Reimbursement Methodology

A. Reimbursement shall be the encounter rate established by the U.S. Department of Health and Human Services, Indian Health Service for “638” facilities.

B. Reimbursement for prescribed drugs is included in the encounter rate when the prescription is dispensed during the same time period as a visit with one or more facility health professionals. Reimbursement for refilling a prescription shall be the established encounter rate for the facility.

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 31:2030 (August 2005).

Subpart 17. Family Planning Services

Chapter 251. General Provisions

§25101. Purpose

A. Effective July 1, 2014, the Medicaid Program shall provide coverage of family planning services and supplies under the Medicaid state plan, to a new targeted group of individuals who are otherwise ineligible for Medicaid. This new optional coverage group may also include individuals receiving family planning services through the section 1115 demonstration waiver, Take Charge Program, if it is determined that they meet the eligibility requirements for the state plan family planning services.

B. The primary goals of family planning services are to:

1. increase access to services which will allow improved reproductive and physical health;
2. improve perinatal outcomes; and
3. reduce the number of unintended pregnancies.

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 40:1097 (June 2014), amended LR 41:379 (February 2015).

Chapter 253. Eligibility Criteria

§25301. Recipient Qualifications

A. Recipients who qualify for family planning services in the new categorically needy group include individuals of child bearing age who meet the following criteria:

1. women who are not pregnant and have income at or below 138 percent of the federal poverty level; and
2. men who have income at or below 138 percent of the federal poverty level.

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 40:1097 (June 2014), amended LR 41:379 (February 2015).

Chapter 255. Services

§25501. Covered Services

A. Medicaid covered family planning services include:

1. office visits and necessary re-visits for physical examinations as it relates to family planning or family planning-related services;
2. contraceptive counseling (including natural family planning), education, follow-ups and referrals;
3. laboratory examinations and tests for the purposes of family planning and management of sexual health;
4. pharmaceutical supplies and devices to prevent conception, including all methods of contraception approved by the Federal Food and Drug Administration; and
5. male and female sterilization procedures and follow-up tests provided in accordance with 42 CFR 441, subpart F.

B. Family planning-related services include the diagnosis and treatment of sexually transmitted diseases or infections, regardless of the purpose of the visit at which the disease or infection was discovered. Medicaid covered family planning-related services include:

1. diagnostic procedures, drugs and follow-up visits to treat a sexually transmitted disease, infection or disorder identified or diagnosed at a family planning visit (other than HIV/AIDS or hepatitis);
2. annual family planning visits for individuals, both males and females of child bearing age, which may include:
 - a. a comprehensive patient history;
 - b. physical, including breast exam;
 - c. laboratory tests; and
 - d. contraceptive counseling;
3. vaccine to prevent cervical cancer;
4. treatment of major complications from certain family planning procedures; and
5. transportation services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1098 (June 2014), amended LR 41:379 (February 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:588 (March 2018).

§25503. Service Delivery

A. Family planning services may be delivered through any enrolled Medicaid provider whose scope of practice includes family planning services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1098 (June 2014).

Chapter 257. Reimbursement

§25701. Reimbursement Methodology

A. All Medicaid providers, including federally qualified health centers, rural health clinics and tribal 638 facilities, shall be reimbursed according to the established fee-for-service rates published in the Medicaid fee schedule for family planning services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1098 (June 2014).

Subpart 18. Free-Standing Birthing Centers

Chapter 265. General Provisions

§26501. Purpose

A. The Medicaid Program shall provide coverage and reimbursement for labor and delivery services rendered by free-standing birthing centers (FSBCs). Stays for delivery at the FSBC are typically less than 24 hours and the services rendered for labor and delivery are very limited, or non-existent, in comparison to delivery services rendered during inpatient hospital stays.

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 41:2360 (November 2015).

§26503. Definitions

Birthing Center—a facility, for the primary purpose of performing low-risk deliveries, that is not a hospital or licensed as part of a hospital, where births are planned to occur away from the mother's usual residence following a low-risk pregnancy.

Low-Risk Pregnancy—a normal, uncomplicated prenatal course as determined by documentation of adequate prenatal care and the anticipation of a normal, uncomplicated labor and birth, as defined by reasonable and generally accepted criteria adopted by professional groups for maternal, fetal, and neonatal health care.

Surrounding Hospital—a hospital located within a 20-mile radius of the birthing center in urban areas and within a 30-mile radius of the birthing center in rural areas.

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 41:2360 (November 2015).

Chapter 267. Services

§26701. Scope of Services

A. Free-standing birthing centers shall be reimbursed for labor and low-risk delivery services provided to Medicaid eligible pregnant women by an obstetrician, family practitioner, certified nurse midwife, or licensed midwife. FSBC services are appropriate when a normal, uncomplicated labor and birth is anticipated.

B. Services shall be provided by the attending practitioner from the time of the pregnant woman's admission through the birth and the immediate postpartum period.

C. Service Limitation. FSBC staff shall not administer general or epidural anesthesia services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2360 (November 2015).

Chapter 269. Provider Participation

§26901. General Provisions

A. In order to enroll to participate in the Louisiana Medicaid Program as a provider of labor and delivery services, the FSBC must:

1. be accredited by the Commission for Accreditation of Birth Centers; and

2. be approved/certified by the Medicaid medical director.

B. The FSBC shall be located within a ground travel time distance from a general acute care hospital with which the FSBC shall maintain a contractual relationship, including a transfer agreement, that allows for an emergency caesarian delivery to begin within 30 minutes of the decision a caesarian delivery is necessary.

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 41:2360 (November 2015).

§26903. Staffing Requirements

A. The FSBC shall have on staff:

1. a licensed obstetrician, family practitioner, certified nurse midwife, or licensed midwife who shall attend each woman in labor from the time of admission through birth and the immediate postpartum period.

a. A licensed midwife providing birthing services within the FSBC must:

i. have passed the national certification exam through the North American Registry of Midwives; and

ii. hold a current, unrestricted state license with the Louisiana State Board of Medical Examiners.

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 41:2360 (November 2015).

Chapter 271. Reimbursement

§27101. Reimbursement Methodology

A. Effective for dates of service on or after November 20, 2015, a FSBC shall be reimbursed a one-time payment for labor and delivery services at a rate equal to 90 percent of the average per diem rates of surrounding hospitals providing the same services.

1. Attending physicians shall be reimbursed for birthing services according to the published fee schedule rate for physician services rendered in the Professional Services Program.

2. Certified nurse midwives providing birthing services within a FSBC shall be reimbursed at 80 percent of the published fee schedule rate for physician services rendered in the Professional Services Program.

3. Licensed midwives providing birthing services within a FSBC shall be reimbursed at 75 percent of the published fee schedule rate for physician services in the Professional Services Program.

B. Effective for dates of service on or after August 1, 2023, the reimbursement amounts for certified nurse midwives and licensed nurse midwives will be as follows:

1. certified nurse midwives providing birthing services within a FSBC shall be reimbursed at 95 percent of the published fee schedule rate for physician services rendered in the Professional Services Program; and

2. licensed midwives providing birthing services within a FSBC shall be reimbursed at 95 percent of the published fee schedule rate for physician services in the Professional Services Program.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:2360 (November 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 49:1935 (November 2023).

Subpart 19. Pediatric Day Health Care Program

Chapter 275. General Provisions

§27501. Program Description and Purpose

A. Pediatric Day Health Care (PDHC) Services

1. An array of services that are designed to meet the medical, social and developmental needs of children up to the age of 21 who have a complex medical condition which requires skilled nursing care and therapeutic interventions on an ongoing basis in order to:

- a. preserve and maintain health status;
- b. prevent death;
- c. treat/cure disease;
- d. ameliorate disabilities or other adverse health conditions; and/or
- e. prolong life.

2. PDHC services offer a community-based alternative to traditional long term care services or extended nursing services for children with medically complex conditions.

B. These services are provided in a non-residential setting which is licensed as a PDHC facility and enrolled to participate in the Medicaid Program.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:1557 (July 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 43:83 (January 2017).

§27503. Recipient Criteria

A. In order to qualify for PDHC services, a Medicaid recipient must meet the following criteria. The recipient must:

1. be from birth up to 21 years of age;
2. have a medically complex condition which involves one or more physiological or organ systems and requires skilled nursing and therapeutic interventions performed by a knowledgeable and experienced licensed professional registered nurse (RN) or licensed practical nurse (LPN) on an ongoing basis in order to:
 - a. preserve and maintain health status;
 - b. prevent death;
 - c. treat/cure disease;
 - d. ameliorate disabilities or other adverse health conditions; and/or
 - e. prolong life;
3. have a signed physician's order and plan of care, not to exceed 90 days, for pediatric day health care by the recipient's physician specifying the frequency and duration of services; and
4. be stable for outpatient medical services in a home or community-based setting.

B. If the medical director of the PDHC facility is also the child's prescribing physician, the department reserves the

right to review the prescription for the recommendation of the child's participation in the PDHC Program.

C. Re-evaluation of PDHC services must be performed, at a minimum, every 90 days. This evaluation must include a review of the recipient's current medical plan of care and provider agency documented current assessment and progress toward goals.

D. A face-to-face evaluation shall be held every 90 days by the child's prescribing physician. Services shall be revised during evaluation periods to reflect accurate and appropriate provision of services for current medical status.

E. Physician's orders for services are required to individually meet the needs of each recipient and shall not be in excess of the recipient's needs. Physician orders prescribing or recommending PDHC services do not, in themselves, indicate services are medically necessary or indicate a necessity for a covered service. Eligibility for participation in the PDHC Program must also include meeting the medically complex provisions of this Section.

F. When determining the necessity for PDHC services, consideration shall be given to all of the services the recipient may be receiving, including waiver services and other community supports and services. This consideration must be reflected and documented in the recipient's treatment plan.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:1557 (July 2010), amended LR 41:137 (January 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:83 (January 2017).

Chapter 277. Services

§27701. Service Coverage and Limitations

A. The Medicaid Program will reimburse a pediatric day health care facility for the following covered services:

1. nursing care;
2. respiratory care;
3. physical therapy;
4. speech-language therapy;
5. occupational therapy;
6. social services;
7. personal care services;
8. transportation to and from the PDHC facility; and
9. one or more meals and snacks per day depending on the child's length of stay.

B. Non-Covered Services. The following services do not qualify as covered PDHC services:

1. education and training services;
2. before and after school care;

3. medical equipment, supplies and appliances;
4. parenteral or enteral nutrition; or
5. infant food or formula.

C. PDHC facility services must be prescribed by the recipient's prescribing physician and an individualized plan of care must be developed for the recipient by the PDHC facility.

D. PDHC services must be prior authorized by the Medicaid Program or its approved designee. Services provided without authorization shall not be considered for reimbursement, except in the case of retroactive Medicaid eligibility.

E. Service Limitations. Services may be provided seven days per week and up to 12 hours per day for qualified Medicaid recipients as documented in the plan of care.

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 36:1557 (July 2010).

Chapter 279. Provider Participation

§27901. General Provisions

A. In order to participate in the Medicaid Program, a facility must have a current, valid PDHC facility license issued by the department. Each PDHC facility site shall be separately enrolled in the Medicaid Program.

B. A parent, legal guardian or legally responsible person providing care to a medically complex child in a home or any other extended care or long-term care facility, is not

considered to be a PDHC facility and shall not be enrolled in the Medicaid Program as a PDHC services provider.

C. All enrolled PDHC services providers must comply with all of the licensing standards adopted for pediatric day health care facilities.

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 36:1558 (July 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 43:83 (January 2017).

Chapter 281. Reimbursement Methodology

§28101. General Provisions

A. Reimbursement for PDHC services shall be a statewide fixed per diem rate which is based on the number of hours that a qualified recipient attends the PDHC facility.

1. A full day of service is more than six hours, not to exceed a maximum of 12 hours per day.

2. A partial day of service is six hours or less per day.

B. Reimbursement shall only be made for services authorized by the Medicaid Program or its approved designee.

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 36:1558 (July 2010), amended LR 39:1286 (May 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 43:83 (January 2017), LR 48:2975 (December 2022).

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE

Part XVII. Prosthetics and Orthotics

Subpart 1. General Provisions

Chapter 1. Prior Authorization

§101. Purchase and Repairs

A. Prior authorization is required before payment can be issued for the purchase or repair of prosthetics and orthotics.

B. Prior authorization is performed by the Medicaid fiscal intermediary under contractual arrangement with the Bureau of Health Services Financing and is the responsibility of the Prior Authorization Unit (PAU).

C. Every prior authorization request shall contain:

1. medical information from a physician, including:
 - a. a written prescription from a licensed physician or a physician's order form signed by the prescribing physician;
 - b. the diagnosis related to the request; and
 - c. other medical information to support the need for the requested item, including documentation that the medical criteria specific to the requested items are met;
2. if pertinent, a statement from the prescribing physician or appropriate licensed rehabilitation therapist as to whether the recipient's age and circumstances indicate that he can adapt to or be trained to use the item effectively; and
3. any other pertinent information, such as measurements to assure correct size of the prosthetic or orthotic item.

D. **Emergency Requests.** Emergency requests for prior authorization decisions may be considered for prosthetics or orthotics requested during hospitalization of a recipient which is medically necessary for hospital discharge and is to be furnished for use in an outpatient setting.

E. **Requests for Repairs, Modification, or Additional Components to Equipment**

1. Requests for basic repairs to a prosthetic or orthotic item shall contain medical information from a physician that is required for purchase of the item.

2. Requests for repairs or replacements of original equipment components or parts that were previously approved for purchase by Medicaid do not require a submittal of a new prescription or medical information unless the provider does not have the following identified information:

- a. a copy of the original request for approval;
- b. the original prior authorization number; or

c. a copy of the original prescription.

F. If one or more of these items are available, the provider may submit the prior authorization request with the original prescribing physician's name, prescription date, and diagnosis codes. The original approval date or prior authorization number shall be noted on the request form or a copy of the original prescription attached.

G. If these items are not available, a new request with all required information must be submitted for approval.

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 31:85 (January 2005), repromulgated LR 31:1597 (July 2005).

Chapter 3. Provider Participation

§301. Accreditation Requirements

A. Effective for dates of service on or after January 1, 2009, all providers seeking Medicaid reimbursement for prostheses, orthoses, prosthetic services and orthotic services must be accredited by the American Board of Certification in Orthotics, Prosthetics and Pedorthics, or by the Board of Certification/Accreditation, International.

1. These accreditation provisions shall not apply to a licensed optometrist or a licensed ophthalmologist, and shall not prohibit a licensed occupational therapist or a licensed physical therapist from practicing within his scope of practice.

B. For the purposes of this Section, Orthosis shall not include prefabricated or direct-formed orthotic devices or any of the following assistive technology devices commonly carried in stock by a pharmacy, department store, corset shop, or surgical supply facility:

1. commercially available knee orthoses (used following sports injury or surgery);
2. upper extremity adaptive equipment;
3. wrist gauntlets;
4. finger and hand splints;
5. low-temperature formed plastic splints;
6. trusses;
7. elastic hose;
8. fabric or elastic supports;

9. corsets;
10. face masks used following burns;
11. canes and crutches;
12. wheelchair seating that is an integral part of the wheelchair and not worn by the patient independent of the wheelchair;
13. cervical collars; and
14. dental appliances.

C. For the purposes of this Section, prosthesis shall not include:

1. artificial eyes;
2. artificial ears;
3. artificial noses;
4. dental appliances;
5. ostomy products; and
6. eyelashes and wigs.

D. A provider who is not accredited and provides prosthetic/orthotic services or devices to a recipient and accepts Medicaid reimbursement shall be fined \$2,500 per violation and shall be required to reimburse the Medicaid Program for the cost of the service(s) or device(s).

E. Effective for dates of service on or after April 1, 2010, all providers seeking reimbursement for prosthetic and orthotic services and devices must be accredited by one of the following Medicare deemed accreditation organizations:

1. The Joint Commission (JC);
2. National Association of Boards of Pharmacy (NABP);
3. Board of Certification/Accreditation International;
4. The Compliance Team, Inc.;
5. American Board for Certification in Orthotics and Prosthetics, Inc. (ABC);
6. The National Board of Accreditation for Orthotic Suppliers (NBAOS);
7. Commission on Accreditation of Rehabilitation Facilities (CARF);
8. Community Health Accreditation Program (CHAP);
9. HealthCare Quality Association on Accreditation (HQAA); or
10. Accreditation Commission for Health Care, Inc. (ACHC).

F. Verification of accreditation must be received by the department on or before March 31, 2010. A provider's prior authorization privileges will be revoked on April 1, 2010 if this verification is not received.

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 31:85 (January 2005), repromulgated LR 31:1597 (July 2005), amended LR 34:2638 (December 2008), repromulgated LR 35:71 (January 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:520 (March 2010).

§303. Provider Responsibilities

A. Providers may not deliver more than one month's approval of supplies initially and all subsequently approved supplies must be delivered in increments not to exceed one month's rations.

B. The recipient must be Medicaid eligible on the date of service for payment to be made. The date of service is the date of delivery.

C. The date of shipping will be considered the date of service for all items delivered through mail courier service.

D. Providers who make or sell prosthetic or orthotic items must provide a warranty which lasts at least 90 days, from the time the item is delivered to the customer. If, during those 90 days, the item does not work, the manufacturer or dealer must repair or replace the item.

E. For any appliance which requires skill and knowledge to use, the item provider must provide appropriate training for the recipient and must provide documentation of plans for training upon the request of the prior authorization unit.

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 34:2639 (December 2008), repromulgated LR 35:72 (January 2009).

Chapter 5. Reimbursement

§501. Reimbursement Methodology

A. Effective for dates of service on or after September 6, 2007, the reimbursement for prosthetic and orthotic devices is 90 percent of the 2007 Medicare Fee Schedule amount or billed charges, whichever is the lesser amount, unless otherwise stipulated. If an item is not available at 90 percent of the 2007 Medicare fee schedule amount, the flat fee that will be utilized is the lowest cost at which the item has been determined to be widely available by analyzing usual and customary fees charged in the community.

1. This rate does not apply to prosthetics and orthotics that are:

a. already reimbursed at a higher amount than 90 percent of the 2007 Medicare Fee Schedule; or

b. not included on the 2007 Medicare Fee Schedule, such as customized items for which there is no established fee. These items must be individually priced.

B. Items not listed on the Medicare Fee Schedule will continue to be reimbursed at the lowest cost at which the

item has been determined to be widely available by analyzing usual and customary fees charged in the community for the HCPC procedure code.

C. Effective for dates of service on or after January 1, 2009, reimbursements for prosthetic or orthotic services or devices shall only be paid to an accredited provider.

D. Effective for dates of service on or after March 7, 2009, the reimbursement for prosthetic and orthotic devices shall be reduced by 3.5 percent of the fee amounts on file as of March 6, 2009.

1. The rate reduction shall not apply to items that do not appear on the fee schedule and are individually priced.

E. Effective for dates of service on or after August 4, 2009, the reimbursement for prosthetic and orthotic devices for recipients 21 years of age and older shall be reduced by four percent of the fee amounts on file as of August 3, 2009.

1. The rate reduction shall not apply to items that do not appear on the fee schedule and are individually priced.

F. Effective for dates of service on or after January 22, 2010, the reimbursement for prosthetic and orthotic devices shall be reduced by 5 percent of the fee amounts on file as of January 21, 2010.

1. The rate reduction shall not apply to items that do not appear on the fee schedule and are individually priced.

G. Effective for dates of service on or after July 1, 2012, the reimbursement for prosthetic and orthotic devices shall be reduced by 3.7 percent of the fee amounts on file as of June 30, 2012.

1. The rate reduction shall not apply to items that do not appear on the fee schedule and are individually priced.

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 31:1597 (July 2005), amended LR 34:881 (May 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1903 (September 2009), repromulgated LR 36:521 (March 2010), amended LR 36:1253 (June 2010), LR 36:2567 (November 2010), LR 39:2770 (October 2013).

§503. Medicare Part B Claims

A. The Medicare payment to the Medicaid rate on file is compared to the Medicare Part B claims for the prosthetic or orthotic item. If the Medicare payment exceeds the Medicaid rate, the claim is adjudicated as a paid claim with a zero payment. If the Medicaid rate exceeds the Medicare payment, the claim is reimbursed at the lesser of the co-insurance and deductible or up to the Medicaid maximum payment.

B. If the Medicaid payment is reduced or eliminated as a result of the Medicare/Medicaid payment comparison, the amount of the Medicare payment plus the amount of the Medicaid payment (if any) shall be considered to be

payment in full for the service. The recipient does not have any legal liability to make payment for the service.

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 30:1027 (May 2004), repromulgated LR 31:1598 (July 2005).

Subpart 3. Prosthetic Devices

Chapter 15. Artificial Eyes, Scleral Shell, and Related Services

§1501. Introduction

A. Definitions

Artificial Eye or Ocular Prosthesis—a replacement for a missing or damaged, unsightly eye.

Full Ocular Prosthesis—used for individuals who have the globe removed allowing for the fitting of a regular artificial eye.

Related Services—include polishing or resurfacing of ocular prosthetics, enlargements or reductions of ocular prosthetics, and fabrication or fitting of ocular conformer.

Scleral Shell (or Shield)—

a. a custom-made, thin ocular prosthesis fitted directly over a blind and shrunken globe. It includes the iris (the colored part of the eye) and the sclera (the white part of the eye);

b. a term utilized to describe different types of hard scleral contact lenses. A shell fits over the entire exposed surface of the eye as opposed to a corneal contact lens which covers only the central nonwhite area encompassing the pupil and iris.

B. These procedures require prior authorization.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 30:2830 (December 2004), repromulgated 31:1598 (July 2005).

§1503. Medical Necessity

A. An artificial eye and related services shall be approved if an eyeball is removed and replacement and repair and/or upkeep of an artificial eye are necessary to maintain the contour of the face.

B. A scleral shell may be authorized when the medical criteria as stated in this §1503 are met. A scleral shell may, among other things, obviate the need for surgical enucleation and prosthetic implant and act to support the surrounding orbital tissue of an eye that has been rendered sightless and shrunken by inflammatory disease. In such a case, the device serves essentially as an artificial eye. In this situation, authorization of payment may be made for a scleral shell. Scleral shells are occasionally used in combination with artificial tears in the treatment of “dry eye” of diverse

etiology. Tears ordinarily dry at a rapid rate, and are continually replaced by the lacrimal gland. When the lacrimal gland fails, the half-life of artificial tears may be greatly prolonged by the use of the scleral contact lens as a protective barrier against the drying action of the atmosphere. Thus, the difficult and sometimes hazardous process of frequent installation of artificial tears may be avoided. The lens acts in this instance to substitute, in part, for the functioning of the diseased lacrimal gland and may be covered as a prosthetic device in the rare case when it is used in the treatment of “dry eye.”

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 30:2830 (December 2004), repromulgated LR 31:1598 (July 2005).

§1705. Implanting the Vagus Nerve Stimulator

A. The implantation of a Vagus Nerve Stimulator shall be performed by a surgeon who has been properly trained and is familiar with the carotid sheath.

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 29:2799 (December 2003), amended by House Concurrent Resolution Number 1 of the 2006 Regular Legislative Session, LR 32:1535 (August 2006).

§1707. Programming the Vagus Nerve Stimulator

A. The programming of the VNS stimulator shall be performed by the surgeon who performed the implant procedure or by a licensed neurologist or psychiatrist. Programming subsequent to the first three times may be subject to post authorization review for medical necessity prior to payment of the claim. Authorization for payment will only be considered when there is documented clinical evidence to show that the recipient has experienced seizures since previous programming attempts. Payment for the programming procedure will only be authorized when it is performed as an attempt to reduce or prevent future episodes of seizures.

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 29:2800 (December 2003), amended by House Concurrent Resolution Number 1 of the 2006 Regular Legislative Session, LR 32:1535 (August 2006).

Subpart 5. Orthotic Devices

Chapter 103. Orthopedic Shoes and Corrections

§10307. Orthopedic Shoes

A. Orthopedic shoes and corrections are approved only when the shoes are attached to braces or are needed to

protect gains from surgery or casting. Payment will not be made for:

1. metatarsus adductus; or
2. internal tibial torsion.

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 30:1030 (May 2004), repromulgated LR 31:1599 (July 2005).

Chapter 105. Osteogenic Bone Growth Stimulators

§10501. General Provisions

A. Osteogenic bone growth stimulators are used to augment bone repair associated with either a healing fracture or bone fusion.

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 37:1600 (June 2011).

§10503. Medical Necessity

A. Spinal noninvasive electrical bone growth stimulators may be considered:

1. when a minimum of nine months has elapsed since the patient has had fusion surgery which has resulted in a failed spinal fusion;
2. when there is a history of a previously failed spinal fusion at the same site following spinal fusion surgery and more than nine months has elapsed since fusion surgery was performed at the same level which is being fused again. As long as nine months has passed since the failed fusion surgery, this repeated fusion attempt requires no minimum passage of time for the application of the device; or
3. following a multi-level spinal fusion (i.e., involving three or more contiguous vertebrae, such as L3-L5 or L4-S1). There is no minimum time for application after this surgery.

B. Nonspinal noninvasive ultrasonic bone growth stimulators may be considered for nonunion fractures when a minimum of two sets of radiographs, one before treatment and a second separated by 90 days, are obtained. These radiographs shall include multiple views and be accompanied by a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs.

C. Nonspinal noninvasive electrical bone growth stimulators may be considered:

1. when long bone fractures have failed to heal and a period of six months from the initial date of treatment has elapsed;

2. when a long bone fusion has failed and a period of nine months from the initial date of treatment has elapsed; or
3. for the treatment of congenital pseudoarthroses. There is no minimal time requirement after this diagnosis.

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 37:1601 (June 2011).

§10505. Reimbursement Methodology

A. Medicaid coverage shall be limited to reimbursement for noninvasive types of bone growth stimulators only. Medicaid will not provide reimbursement for invasive types of bone growth stimulators.

B. Noninvasive types of bone growth stimulators shall be reimbursed on an item-by-item basis. Reimbursement amounts may be based on:

1. invoiced costs to providers;
2. comparative prices of providers;
3. manufacturer's suggested retail prices; or
4. a flat fee negotiated between the department and the provider.

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 37:1601 (June 2011).

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XIX. Other Services

Subpart 3. Laboratory and Radiology Services

Chapter 39. General Provisions

§3901. Introduction

A. The Medicaid Program covers medically necessary laboratory and radiology services that are ordered by a physician or other licensed practitioner acting within their scope of practice and:

1. provided by or under the direction of, a physician or other licensed practitioner acting within their scope of practice; or
2. provided by an independent laboratory.

B. This Subpart only applies to laboratory and radiology services provided:

1. in an office or similar facility other than a hospital outpatient department or clinic; or
2. in an independent laboratory.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 47:250 (February 2021).

§3903. Service Limitations

A. Providers may only furnish laboratory services for which they are certified under the clinical laboratory improvement amendments.

B. Providers may only receive reimbursements for services that they personally perform or supervise.

C. Effective for dates of service on or after February 20, 2018, the Medicaid Program terminates coverage of proton beam radiation therapy for beneficiaries 21 years of age and older.

1. For beneficiaries under the age of 21, coverage shall be provided when proton beam radiation therapy services are deemed medically necessary.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 47:250 (February 2021).

Chapter 41. Provider Participation

§4101. Physicians and Other Licensed Practitioners Office Services

A. Physicians and other licensed practitioners must comply with all applicable state and federal laws and regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 8:75 (February 1982), repromulgated LR 28:1023 (May 2002), amended by the Department of Health, Bureau of Health Services Financing, LR 47:250 (February 2021).

§4103. Independent Laboratories

A. Independent laboratories are freestanding laboratory facilities that are independent of the ordering provider, hospital, or both.

B. Independent laboratories must be licensed in accordance with state laws and regulations.

C. Independent laboratories must comply with all applicable state and federal laws and regulations.

D. Independent laboratories must maintain copies of all laboratory orders and laboratory results for a period of at least five years. Records shall be retained in the laboratory in such a manner that permits ready identification and accessibility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 47:250 (February 2021).

Chapter 43. Reimbursement

§4301. Laboratory Services Reimbursement Methodology

A. Providers shall be reimbursed according to the established fee schedule or billed charges, whichever is the lesser.

B. Reimbursement for laboratory services shall not exceed 100 percent of the current year's Medicare fee.

C. For newly added laboratory services, the Medicaid fee shall be set at 75 percent of the current year's Medicare allowable fee.

1. In the absence of a Medicare fee, the fee shall be set at the Medicaid fee for a similar service or the Medicaid fee for other states. In the absence of a similar service or a

Medicaid fee for other states, the fee shall be set at the cost of performing the service.

2. Laboratory services related to a declared public health emergency may be reimbursed at up to 100 percent of the Medicare allowable fee if deemed necessary by the Medicaid Program to ensure access.

D. Effective for dates of service on or after February 26, 2009, the reimbursement rates for laboratory services shall be reduced by 3.5 percent of the fee amounts on file as of February 25, 2009.

E. Effective for dates of service on or after August 4, 2009, the reimbursement rates for laboratory services shall be reduced by 4.7 percent of the fee amounts on file as of August 3, 2009.

F. Effective for dates of services on or after January 22, 2010, the reimbursement rates for laboratory services shall be reduced by 4.42 percent of the fee amounts on files as of January 21, 2010.

G. Effective for dates of service on or after August 1, 2010, the reimbursement rates for laboratory services shall be reduced by 4.6 percent of the fee amounts on file as of July 31, 2010.

H. Effective for dates of service on or after January 1, 2011, the reimbursement rates for laboratory services shall be reduced by 2 percent of the fee amount on file as of December 31, 2010.

I. Effective for dates of service on or after July 1, 2012, the reimbursement rates for laboratory services shall be reduced by 3.7 percent of the fee amounts on file as of June 30, 2012.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153, R.S. 49:1008(A), P.L. 98-369, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 5:388 (December 1979), amended LR 8:75 (February 1982), LR 8:144 (March 1982), LR 10:1034 (December 1984), LR 12:679 (October 1986), LR 22:107 (February 1996), repromulgated (for LAC) LR 28:1024 (May 2002), amended by the Department of Health, Bureau of Health Services Financing, LR 47:251 (February 2021), LR 47:1638 (November 2021).

§4334. Radiology Services Reimbursement Methodology

A. This reimbursement methodology applies to radiology services including portable x-ray and radiation therapy center services.

B. Providers shall be reimbursed according to the established fee schedule or billed charges, whichever is the lesser amount.

C. For newly added radiology services, the Medicaid fee shall be set at 75 percent of the current year's Louisiana Region 99 Medicare allowable fee.

1. In the absence of a Medicare fee, the fee shall be set at the Medicaid fee for a similar service or the Medicaid fee for other states. In the absence of a similar service or a Medicaid fee for other states, the fee shall be set at the cost of performing the service.

D. Effective for dates of service on or after February 26, 2009, the reimbursement rates for radiology services shall be reduced by 3.5 percent of the fee amounts on file as of February 25, 2009.

E. Effective for dates of service on or after August 4, 2009, the reimbursement rates for radiology services shall be reduced by 4.7 percent of the fee amounts on file as of August 3, 2009.

F. Effective for dates of service on or after January 22, 2010, the reimbursement rates for radiology services shall be reduced by 4.42 percent of the fee amounts on file as of January 21, 2010.

G. Effective for dates of service on or after August 1, 2010, the reimbursement rates for radiology services shall be reduced by 4.6 percent of the fee amounts on file as of July 31, 2010.

H. Effective for dates of service on or after January 1, 2011, the reimbursement rates for radiology services shall be reduced by 2 percent of the fee amounts on file as of December 31, 2010.

I. Effective for dates of service on or after July 1, 2012, the reimbursement rates for radiology services shall be reduced by 3.7 percent of the fee amounts on file as of June 30, 2012.

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 35:1897 (September 2009), amended LR 36:1248 (June 2010), LR 36:2563 (November 2010), LR 37:3029 (October 2011), LR 39:1284 (May 2013), LR 41:539 (March 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:283 (February 2018), amended by the Department of Health, Bureau of Health Services Financing, LR 47:252 (February 2021), LR 47:1638 (November 2021).

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXI. Home and Community-Based Services Waivers
Subpart 1. General Provisions

Chapter 1. Freedom of Choice

§101. General Provisions

A. The Department of Health may remove a service provider from the waiver provider freedom of choice list and offer freedom of choice to waiver participants when:

1. one or more of the following departmental proceedings are pending against a waiver participant's service provider:

- a. revocation of the provider's home and community-based services license;
- b. exclusion from the Medicaid Program;
- c. termination from the Medicaid Program; or
- d. withholding of Medicaid reimbursement as authorized by the department's surveillance and utilization review (SURS) Rule (LAC 50:I.Chapter 41);

2. the service provider fails to timely renew its home and community-based services license as required by the home and community-based services providers licensing standards Rule (LAC 48:I.Chapter 50); or

3. the Louisiana Attorney General's Office has seized the assets of the service provider.

B. The department may offer recipients the freedom to choose another provider if/when the owner(s), operator(s), or member(s) of the governing body of the provider agency is/are under investigation related to:

1. bribery or extortion;
2. tax evasion or tax fraud;
3. money laundering;
4. securities or exchange fraud;
5. wire or mail fraud;
6. violence against a person;
7. act(s) against the aged, children or infirmed; or
8. any crime involving public funds

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 Aging and Adult Services, LR 40:1098 (June 2014), amended by the Department of Health, Bureau of Health Services Financing, the Office of Aging and Adult Services and the Office

for Citizens with Developmental Disabilities, LR 43:1978 (October 2017).

Chapter 3. Eligibility

§301. Termination of Coverage for Displaced Recipients

A. When a declared disaster occurs and recipients relocate out of state due to the declared disaster, Medicaid coverage of the services they are receiving in home and community-based waivers, shall be terminated under either of the following circumstances:

1. the participant fails to return to Louisiana within 90 days following the initial identified date of the declared disaster; or

EXCEPTION: The department may extend this timeframe due to extenuating circumstances.

2. the participant relocates with no intention of returning to Louisiana.

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 Community Supports and Services, LR 29:1829 (September 2003), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities and the Division of Long Term Supports and Services, LR 34:1627 (August 2008), amended by the Department of Health, Bureau of Health Services Financing, the Office of Aging and Adult Services and the Office for Citizens with Developmental Disabilities, LR 43:1978 (October 2017).

§303. Active Duty Military Families

A. Any active duty member of the armed forces who has been temporarily assigned to work outside of Louisiana, and any member of his/her immediate family who has qualified for and received home and community-based waiver services provided under the Medicaid Program for persons with developmental disabilities, shall be eligible to receive the next available opportunity for waiver services upon the member's resumed residence in Louisiana.

1. For purposes of these provisions, immediate family shall be defined as the spouse, child, or other person for whom the member of the armed services has guardianship.

B. After the individual returns to live in Louisiana, he/she must contact the department to report his/her address and to request that the waiver services be restarted.

C. The individual's name will be placed on a preferred registry with other active duty persons who have returned to

live in Louisiana and requested that their waiver services be restarted.

D. Waiver opportunities shall be offered to individuals on the preferred registry on a first come, first serve basis.

1. The first available waiver opportunity shall be offered to an individual on this registry based on the date that the request to restart services was received.

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 for Citizens with Developmental Disabilities, LR 37:3516 (December 2011).

§305. Continued Eligibility

A. Home and community-based providers shall report to the operating agency when/if it becomes known to the agency that a participant's status has changed such that the participant no longer meets programmatic or financial eligibility requirements.

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, the Office of Aging and Adult Services and the Office for Citizens with Developmental Disabilities, LR 43:1978 (October 2017).

Chapter 5. Support Coordination Standards for Participation for Office of Aging and Adult Services Waiver Programs

Subchapter A. General Provisions

§501. Introduction

A. The Department of Health (LDH) establishes these minimum standards for participation which provides the core requirements for support coordination services provided under home and community-based services waiver programs administered by the Office of Aging and Adult Services (OAAS). OAAS must determine the adequacy of quality and protection of waiver participants in accordance with the provisions of these standards.

B. OAAS, or its designee, is responsible for setting the standards for support coordination, monitoring the provisions of this Rule, and applying administrative sanctions for failures by support coordinators to meet the minimum standards for participation in serving participants of OAAS-administered waiver programs.

C. Support coordination are services that will assist participants in gaining access to needed waiver and other state plan services, as well as needed medical, social, educational, housing, and other services, regardless of the funding source for these services.

D. If, in the judgement of OAAS, application of the requirements stated in these standards would be impractical in a specified case; such requirements may be modified by

the OAAS assistant secretary to allow alternative arrangements that will secure as nearly equivalent provision of services as is practical. In no case will the modification afford less quality or protection, in the judgement of OAAS, than that which would be provided with compliance of the provisions contained in these standards.

1. Requirement modifications may be reviewed by the OAAS assistant secretary and either continued or canceled.

E. If a support coordination agency fails to comply with their requirements as a certified support coordination agency and/or requests assistance from OAAS, OAAS may temporarily perform the mandatory duties of the support coordination agency to ensure the continuity of the participants' services and the participants' health and welfare. The support coordination agency shall not be reimbursed for support coordination duties performed by OAAS.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3086 (November 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 47:886 (July 2021).

§503. Certification Requirements

A. All agencies that provide support coordination to OAAS-administered home- and community-based waivers must be certified by the Department of Health and Hospitals. It shall be unlawful to operate as a support coordination agency for OAAS-administered waivers without being certified by the department.

B. In order to provide support coordination services for OAAS-administered home- and community-based waiver programs, the agency must:

1. be certified and meet the standards for participation requirements as set forth in this Rule;
2. sign a performance agreement with OAAS;
3. assure staff attends all training mandated by OAAS;
4. enroll as a Medicaid support coordination agency in all regions in which it intends to provide services for OAAS-administered home- and community-based services; and
5. comply with all DHH and OAAS policies and procedures.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3087 (November 2013).

§505. Certification Issuance

A. A certification shall:

1. be issued only to the entity named in the certification application;

2. be valid only for the support coordination agency to which it is issued after all applicable requirements are met;

3. enable the support coordination agency to provide support coordination for OAAS-administered home- and community-based waivers within the specified DHH region; and

4. be valid for the time specified on the certification, unless revoked, suspended, modified or terminated prior to that date.

B. Provisional certification may be granted when the agency has deficiencies which are not a danger to the health and welfare of clients. Provisional certification shall be issued for a period not to exceed 90 days.

C. Initial certification shall be issued by OAAS based on the survey report of DHH, or its designee.

D. Unless granted a waiver by OAAS, a support coordination agency shall provide such services only to waiver participants residing in the agency's designated DHH region.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3087 (November 2013).

§507. Certification Refusal or Revocation and Fair Hearing

A. A certification may be revoked or refused if applicable certification requirements, as determined by OAAS or its designee, have not been met. Certification decisions are subject to appeal and fair hearing, in accordance with R.S. 46:107(A)(3).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3087 (November 2013).

§509. Certification Review

A. Compliance with certification requirements is determined by OAAS through its agency review and support coordination monitoring processes. This review is usually annual but may be conducted at any time and may be conducted without advance notice. Monitors must be given access to all areas of the agency and all relevant files and records.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3087 (November 2013), amended LR 40:1936 (October 2014).

Subchapter B. Administration and Organization

§513. Governing Body

A. A support coordination agency shall have an identifiable governing body with responsibility for and authority over the policies and activities of the agency.

1. An agency shall have documents identifying all members of the governing body, their addresses, their terms of membership, and officers of the governing body.

2. The governing body shall hold formal meetings at least twice a year.

3. There shall be written minutes of all formal meetings of the governing body.

4. There shall be governing body by-laws which specify the frequency of meetings and quorum requirements.

B. The governing body of a support coordination agency shall:

1. ensure the agency's continual compliance and conformity with all relevant federal, state, local and municipal laws and regulations;

2. ensure that the agency is adequately funded and fiscally sound;

3. review and approve the agency's annual budget; and

4. designate a person to act as administrator and delegate sufficient authority to this person to manage the agency.

C. A support coordination agency shall maintain an administrative file that includes:

1. documents identifying the governing body;

2. a list of members and officers of the governing body, along with their addresses and terms of membership;

3. minutes of formal meetings and by-laws of the governing body, if applicable;

4. documentation of the agency's authority to operate under state law;

5. an organizational chart of the agency which clearly delineates the line of authority;

6. all leases, contracts and purchases-of-service agreements to which the agency is a party;

7. insurance policies;

8. annual budgets and, if performed, audit reports;

9. the agency's policies and procedures; and

10. documentation of any corrective action taken as a result of external or internal reviews.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3087 (November 2013), amended LR 40:1936 (October 2014).

§515. Business Location and Operations

A. Each support coordination agency shall have a business location which shall not be in an occupied personal residence. The business location shall be in the DHH region for which the certification is issued and shall be where the agency:

1. maintains staff to perform administrative functions;
2. maintains the agency's personnel records; and
3. maintains the agency's participant service records.

B. The business location shall have:

1. a published nationwide toll-free telephone number answered by a person which is available and accessible 24 hours a day, 7 days a week, including holidays;
2. a published local business number answered by agency staff during the posted business hours;
3. a business fax number that is operational 24 hours a day, 7 days a week, including holidays;
4. internet access and a working e-mail address;
5. hours of operation, which must be at least 40 hours a week, Monday-Friday, posted in a location outside of the business that is easily visible to persons receiving services and the general public; and
6. at least one staff person on the premises during posted hours of operation.

C. Records and other confidential information shall be secure and protected from unauthorized access.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3088 (November 2013), amended LR 40:1936 (October 2014).

§517. Financial Management

A. The agency must establish a system of financial management and staffing to assure maintenance of complete and accurate accounts, books and records in keeping with generally accepted accounting principles.

B. The agency must not permit public funds to be paid or committed to be paid, to any person who is a member of the governing board or administrative personnel who may have any direct or indirect financial interest, or in which any of these persons serve as an officer or employee, unless the services or goods involved are provided at a competitive cost or under terms favorable to the agency. The agency shall have a written disclosure of any financial transaction with the agency in which a member of the governing board, administrative personnel, or his/her immediate family is involved.

C. For the protection of its participants, staff, facilities, and the general public, the agency must have at least \$150,000 in general liability and at least \$150,000 in professional liability insurance coverage.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3088 (November 2013), amended LR 40:1936 (October 2014).

§519. Policy and Procedures

A. The support coordination agency shall have written policies and procedures approved by the owner or governing body which must be implemented and followed that address at a minimum the following:

1. confidentiality and confidentiality agreements;
2. security of files;
3. publicity and marketing, including the prohibition of illegal or coercive inducement, solicitation and kickbacks;
4. personnel;
5. participant rights;
6. grievance procedures;
7. emergency preparedness;
8. abuse and neglect reporting;
9. critical incident reporting;
10. worker safety;
11. documentation; and
12. admission and discharge procedures.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3088 (November 2013).

§521. Organizational Communication

A. The agency must establish procedures to assure adequate communication among staff to provide continuity of services to the participant and to facilitate feedback from staff, participants, families, and when appropriate, the community.

B. The agency must have brochures and make them available to OAAS or its designee. The brochures must include the following information:

1. that each participant has the freedom to choose their providers and that their choice of provider does not affect their eligibility for waiver, state plan, or support coordination services;
2. that a participant receiving support coordination through OAAS may contact the OAAS help line for information, assistance with, or questions about OAAS programs;

3. the OAAS help line number along with the appropriate OAAS regional office telephone numbers;

4. information, including the Health Standards Section complaint line, on where to make complaints against support coordinators, support coordination agencies, and providers; and

5. a description of the agency, services provided, current address, and the agency's local and nationwide toll-free number.

C. The brochure may also include the agency's experience delivering support coordination services.

D. The support coordination agency shall be responsible for:

1. obtaining written approval of the brochure from OAAS prior to distributing to applicants/participants of OAAS-administered waiver programs;

2. providing OAAS staff or its designee with adequate supplies of the OAAS-approved brochure; and

3. timely completing revisions to the brochure, as requested by OAAS, to accurately reflect all program changes as well as other revisions OAAS deems necessary.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3089 (November 2013), amended LR 40:1936 (October 2014).

Subchapter C. Provider Responsibilities

§525. General Provisions

A. Any entity wishing to provide support coordination services for any OAAS-administered home- and community-based waiver program shall meet all of the standards for participation contained in this Rule, unless otherwise specifically noted within these provisions.

B. The support coordination agency shall also abide by and adhere to any federal, state law, Rule, policy, procedure, performance agreement, manual or memorandum pertaining to the provision of support coordination services for OAAS-administered home- and community-based waiver programs.

C. Failure to comply with the requirements of these standards for participation may result in sanctions including, but not limited to:

1. recoupment of funds;
2. cessation of linkages;
3. citation of deficient practice and plan of correction submission;
4. removal from the freedom of choice list; or
5. decertification as a support coordination agency for OAAS-administered home- and community-based waiver services.

D. A support coordination agency shall make any required information or records, and any information reasonably related to assessment of compliance with these requirements, available to the department.

E. Designated representatives of the department, in the performance of their mandated duties, shall be allowed by a support coordination agency to:

1. inspect all aspects of a support coordination agency operations which directly or indirectly impact participants; and

2. conduct interviews with any staff member or participant of the agency.

F. A support coordination agency shall, upon request by the department, make available the legal ownership documents of the agency.

G. Support coordination agencies must comply with all of the department's systems/software requirements.

H. Support coordination agencies shall, at a minimum:

1. maintain and/or have access to a comprehensive resource directory containing all of the current inventory of existing formal and informal resources that identifies services within the geographic area which shall address the unique needs of participants of OAAS-administered home- and community-based waiver programs;

2. establish linkages with those resources;

3. demonstrate knowledge of the eligibility requirements and application procedures for federal, state and local government assistance programs, which are applicable to participants of OAAS-administered home- and community-based waiver programs;

4. employ a sufficient number of support coordinators and supervisory staff to comply with OAAS staffing, continuous quality improvement (CQI), timeline, workload, and performance requirements;

5. demonstrate administrative capacity and the financial resources to provide all core elements of support coordination services and ensure effective service delivery in accordance with programmatic requirements;

6. assure that all agency staff is employed in accordance with Internal Revenue Service (IRS) and Department of Labor regulations (subcontracting of individual support coordinators and/or supervisors is prohibited);

7. have appropriate agency staff attend trainings, as mandated by DHH and OAAS;

8. have a documented CQI process;

9. document and maintain records in accordance with federal and state regulations governing confidentiality and program requirements;

10. assure each participant has freedom of choice in the selection of available qualified providers and the right to

change providers in accordance with program guidelines; and

11. assure that the agency and support coordinators will not provide both support coordination and Medicaid-reimbursed direct services to the same participant(s).

I. Abuse and Neglect. Support coordination agencies shall establish policies and procedures relative to the reporting of abuse and neglect of participants, pursuant to the provisions of R.S. 15:1504-1505, R.S. 40:2009.20 and any subsequently enacted laws. Providers shall ensure that staff complies with these regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3089 (November 2013).

§527. Support Coordination Services

A. Support coordination is services that will assist participants in gaining access to needed waiver and other state plan services, as well as needed medical, social, educational, housing and other services, regardless of the funding source for these services. Support coordination agencies shall be required to perform the following core elements of support coordination services:

1. intake;
2. assessment;
3. plan of care development and revision;
4. linkage to direct services and other resources;
5. coordination of multiple services among multiple providers;
6. monitoring/follow-up;
7. reassessment;
8. evaluation and re-evaluation of level of care and need for waiver services;
9. ongoing assessment and mitigation of health, behavioral and personal safety risk;
10. responding to participant crisis;
11. critical incident management; and
12. transition/discharge and closure.

B. The support coordination agency shall also be responsible for assessing, addressing and documenting delivery of services, including remediation of difficulties encountered by participants in receiving direct services.

C. A support coordination agency shall not refuse to serve, or refuse to continue to serve, any individual who chooses/has chosen its agency unless there is documentation to support an inability to meet the individual's health and welfare needs, or all previous efforts to provide service and supports have failed and there is no option but to refuse services.

1. Before an agency can refuse to provide or to continue to provide services to an individual, OAAS must be immediately notified of the circumstances surrounding a refusal by a support coordination agency to provide/continue to provide services along with supporting documentation.

2. This requirement can only be waived by OAAS.

D. Support coordination agencies must establish and maintain effective communication and good working relationships with providers of services to participants served by the agency.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3090 (November 2013).

§529. Transfers and Discharges

A. All participants of OAAS-administered waiver programs must receive support coordination services. However, a participant has the right to choose a support coordination agency. This right includes the right to be discharged from his/her current support coordination agency and be transferred to another support coordination agency.

B. Upon notice by the participant or his/her authorized representative that the participant has selected another support coordination agency or the participant has decided to discontinue participation in the waiver program, the agency shall have the responsibility of planning for the participant's transfer or discharge.

C. The support coordination agency shall also have the responsibility of planning for a participant's transfer when the support coordination agency ceases to operate or when the participant moves from the geographical region serviced by the support coordination agency.

D. The transfer or discharge responsibilities of the support coordinator shall include:

1. holding a transfer or discharge planning conference with the participant, his/her family, providers, legal representative and advocate, if such are known, in order to facilitate a smooth transfer or discharge, unless the participant declines such a meeting;

2. providing a current plan of care to the receiving support coordination agency (if applicable); and

3. preparing a written discharge summary. The discharge summary shall include, at a minimum, a summary on the health, behavioral, and social issues of the participant and shall be provided to the receiving support coordination agency (if applicable).

E. The written discharge summary, along with the current plan of care, shall be completed and provided to the receiving support coordination agency and OAAS regional office, within five working days of any of the following:

1. notice by the participant or authorized representative that the participant has selected another support coordination agency;

2. notice by the participant or authorized representative that the participant has decided to discontinue participation in the waiver program;

3. notice by the participant or authorized representative that the participant will be transferring to a DHH geographic region not serviced by his/her current support coordination agency; or

4. notice from OAAS or its designee that “good cause” has been established by the support coordination agency to discontinue services.

F. The support coordination agency shall not coerce the participant to stay with the support coordination agency or interfere in any way with the participant’s decision to transfer. Failure to cooperate with the participant’s decision to transfer to another support coordination agency will result in adverse action by the department.

G. If a support coordination agency ceases to operate, the agency must give OAAS at least 60 days written notice of its intent to close. Where transfer of participants is necessary due to the support coordination agency closing, the written discharge summary for all participants served by the agency shall be completed within 10 working days of the notice to OAAS of the agency’s intent to close.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3090 (November 2013), amended LR 40:1936 (October 2014).

§531. Staffing Requirements

A. Agencies must maintain sufficient staff to comply with OAAS staffing, timeline, workload, and performance requirements. This includes, but is not limited to, including sufficient support coordinators and support coordinator supervisors that have passed all of the OAAS training and certification requirements. At all times, an agency must have at least one certified support coordination supervisor and at least one certified support coordinator, both employed full time. Agencies may employ staff who are not certified to perform services or requirements other than assessment and care planning.

B. Agencies must maintain sufficient supervisory staff to comply with OAAS supervision and CQI requirements. Support coordination supervisors must be continuously available to support coordinators by telephone.

1. Each support coordination agency must have and implement a written plan for supervision of all support coordination staff.

2. Each supervisor must maintain a file on each support coordinator supervised and hold documented supervisory sessions and evaluate each support coordinator at least annually.

C. Agencies shall employ or contract a licensed registered nurse to serve as a consultant. The nurse

consultant shall be available a minimum of 16 hours per month.

D. Agencies shall ensure that staff is available at times which are convenient and responsive to the needs of participants and their families.

E. Support coordinators may only carry caseloads that are composed exclusively of OAAS participants. Support coordination supervisors may only supervise support coordinators that carry caseloads that are composed exclusively of OAAS participants.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3091 (November 2013), amended LR 40:1937 (October 2014).

§533. Personnel Standards

A. Support coordinators must meet one of the following requirements:

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

2. a diploma, associate’s bachelor’s or master’s degree in nursing (RN) currently licensed in Louisiana;

3. a bachelor’s or master’s degree in a human service related field which includes:

- a. psychology;
- b. education;
- c. counseling;
- d. social services;
- e. sociology;
- f. philosophy;
- g. family and participant sciences;
- h. criminal justice;
- i. rehabilitation services;
- j. substance abuse treatment;
- k. gerontology;
- l. 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 in §533.A.3.a-1 of this Section.

B. Support coordination supervisors must meet the following requirements:

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;

2. a diploma, associate's, bachelor's or master's degree in nursing (RN), currently licensed in Louisiana, and two years of paid post degree experience in providing support coordination services;

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 participant 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 following fields: psychology, education, counseling, social services, sociology, philosophy, family and participant sciences, criminal justice, rehab services, child development, substance abuse, gerontology, or vocational rehabilitation and two years of paid post degree experience in providing support coordination services.

C. Documentation showing that personnel standards have been met must be placed in the individual's personnel file.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3091 (November 2013), amended LR 40:1937 (October 2014).

§535. Employment and Recruitment Practices

A. A support coordination agency shall have written personnel policies, which must be implemented and followed, that include:

1. a plan for recruitment, screening, orientation, ongoing training, development, supervision and performance evaluation of staff members;

2. a policy to prevent discrimination and comply with all state and federal employment practices and laws;

3. a policy to recruit, wherever possible, qualified persons of both sexes representative of cultural and racial groups served by the agency, including the hiring of qualified persons with disabilities;

4. written job descriptions for each staff position, including volunteers;

5. an employee grievance procedure that allows employees to make complaints without fear of retaliation; and

6. abuse reporting procedures that require all employees to report any incidents of abuse or mistreatment, whether that abuse or mistreatment is done by another staff member, a family member, a participant or any other person.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3091 (November 2013).

§537. Orientation and Training

A. Support coordinators must receive necessary orientation and periodic training on the provision of support coordination services arranged or provided through their agency at the agency's expense.

B. Orientation shall be provided by the agency to all staff, volunteers and students within five working days of begin/employment date.

C. Orientation and training of at least 32 hours shall be provided by the agency to all newly hired support coordinators within five working days of employment. The topics shall be agency/OAAS specific and shall include, at a minimum:

1. core OAAS support coordination requirements;
2. agency policies and procedures;
3. confidentiality;
4. case record documentation;
5. participant rights protection and reporting of violations;
6. professional ethics;
7. emergency and safety procedures;
8. infection control, including universal precautions;
9. overview of all OAAS waivers and services;
10. fundamentals of support coordination (e.g. person centered planning, emergency planning, back-up staff planning, critical incident reporting, risk assessment and mitigation, etc.);
11. interviewing techniques;
12. data management;
13. communication skills;
14. community resources;
15. continuous quality improvement; and
16. abuse and neglect policies and procedures.

D. Upon completion of the agency-provided training requirements set forth above, support coordinators and support coordination supervisors must successfully complete all OAAS assessment and care planning training.

E. No support coordinator shall be given sole responsibility for a participant until all of the required training is satisfactorily completed and the employee possesses adequate abilities, skills, and knowledge of support coordination.

F. All support coordinators and support coordination supervisors must complete a minimum of 16 hours of training per year. For new employees, the orientation cannot

be counted toward the 16 hour minimum annual training requirement. The 16 hours of initial training for support coordinators required in the first 90 days of employment may be counted toward the 16 hour minimum annual training requirement. Routine supervision shall not be considered training.

G. A newly hired or promoted support coordination supervisor must, in addition to satisfactorily completing the orientation and training set forth above, also complete a minimum of 24 hours on all of the following topics prior to assuming support coordination supervisory responsibilities:

1. orientation/in-service training of staff;
2. evaluating staff;
3. approaches to supervision;
4. managing workload and performance requirements;
5. conflict resolution;
6. documentation;
7. population specific service needs and resources; and
8. the support coordination supervisor's role in continuous quality improvement (CQI) systems.

H. Documentation of all orientation and training must be placed in the individual's personnel file. Documentation must include a training agenda, name of presenter(s), title, agency affiliation and/or other sources of training (e.g. web/on-line trainings, etc.).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3092 (November 2013), amended LR 40:1937 (October 2014).

§539. Participant Rights

A. Unless adjudicated by a court of competent jurisdiction, participants served by a support coordination agency shall have the same rights, benefits, and privileges guaranteed by the constitution and the laws of the United States and Louisiana.

B. There shall be written policies and procedures that protect the participant's welfare, including the means by which the protections will be implemented and enforced.

C. Each support coordination agency's written policies and procedures, at a minimum, shall ensure the participant's right to:

1. confidentiality;
2. privacy;
3. impartial access to treatment regardless of race, religion, sex, ethnicity, age or disability;
4. access to the interpretive services, translated material and similar accommodations as appropriate;

5. access to his/her records upon the participant's written consent for release of information;

6. an explanation of the nature of services to be received;

7. actively participate in services;

8. refuse services or participate in any activity against their will;

9. obtain copies of the support coordination agency's complaint or grievance procedures;

10. file a complaint or grievance without retribution, retaliation or discharge;

11. be informed of the financial aspect of services;

12. give informed written consent prior to being involved in research projects;

13. refuse to participate in any research project without compromising access to services;

14. be free from mental, emotional and physical abuse and neglect;

15. be free from chemical or physical restraints;

16. receive services that are delivered in a professional manner and are respectful of the participant's wishes concerning their home environment;

17. receive services in the least intrusive manner appropriate to their needs;

18. contact any advocacy resources as needed, especially during grievance procedures; and

19. discontinue services with one provider and choose the services of another provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3092 (November 2013), amended LR 40:1937 (October 2014).

§541. Grievances

A. The support coordination agency shall establish and follow a written grievance procedure to be used to process complaints by participants, their family member(s), or a legal representative that is designed to allow participants to make complaints without fear of retaliation. The written grievance procedure shall be provided to the participant.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3093 (November 2013), amended LR 40:1938 (October 2014).

§543. Critical Incident Reporting

A. Support coordination agencies shall report critical incidents according to established OAS policy including

timely entries into the designated DHH critical incident database.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3093 (November 2013), amended LR 40:1938 (October 2014).

§545. Participant Records

A. Participant records shall be maintained in the support coordinator's office. The support coordinator shall have a current written record for each participant.

B. Support coordination agencies shall maintain participant records in readily accessible form for a period of six years.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3093 (November 2013), amended LR 40:1938 (October 2014).

§547. Emergency Preparedness

A. Support coordination agencies shall ensure that each participant has an individual plan for dealing with emergencies and disasters and shall assist participants in identifying the specific resources available through family, friends, the neighborhood, and the community. The support coordinator shall assess monthly whether the emergency plan information is current and effective and shall make changes accordingly.

B. Continuity of Operations. The support coordination agency shall have an emergency preparedness plan to maintain continuity of the agency's operations in preparation for, during, and after an emergency or disaster. The plan shall be designed to manage the consequences of all hazards, declared disasters or other emergencies that disrupt the agency's ability to render services.

C. The support coordination agency shall follow and execute its emergency preparedness plan in the event of the occurrence of a declared disaster or other emergency.

D. The support coordinator shall cooperate with the department and with the local or parish Office of Homeland Security and Emergency Preparedness in the event of an emergency or disaster and shall provide information as requested.

E. The support coordinator shall monitor weather warnings and watches as well as evacuation orders from local and state emergency preparedness officials.

F. All agency employees shall be trained in emergency or disaster preparedness. Training shall include orientation, ongoing training, and participation in planned drills for all personnel.

G. Upon request by the department, the support coordination agency shall submit a copy of its emergency

preparedness plan and a written summary attesting to how the plan was followed and executed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3094 (November 2013), amended LR 40:1938 (October 2014).

§549. Continuous Quality Improvement Plan

A. Support coordination agencies shall have a continuous quality improvement (CQI) plan which governs the agency's internal quality management activities.

B. The CQI plan shall demonstrate a process of continuous cyclical improvement and include the following:

1. *design*—continuous quality improvement approach detailing how the agency monitors its operations and makes improvements when problems are detected;

2. *discovery*—the methods used to uncover problems and deviations from plan design and programmatic processes in a timely fashion;

3. *remediation*—the process of addressing and resolving problems uncovered in the course of discovery; and

4. *improvement*—the actions taken to make adjustments to the system's processes or procedures to prevent or minimize future problems.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3094 (November 2013), amended LR 40:1938 (October 2014).

§551. Support Coordination Monitoring

A. Support coordination agencies shall be monitored annually as outlined in the OAAS policies and procedures.

B. Support coordination agencies shall offer full cooperation with the OAAS during the monitoring process. Responsibilities of the support coordination agency in the monitoring process include, but are not limited to:

1. providing policy and procedure manuals, personnel records, case records, and other documentation;

2. providing space for documentation review and support coordinator interviews; and

3. coordinating agency support coordinator interviews.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:3095 (November 2013), amended LR 40:1939 (October 2014).

§553. Workforce Retention Bonus Payments**A. Establishment of Support Coordination Workforce Bonus Payments**

1. Support coordination agencies (SCAs) who provided services from April 1, 2021 to October 31, 2022 shall receive bonus payments of \$300 per month for each SCA staff member that worked directly with participants for those months.

2. The SCA staff member who worked directly with 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 SCA staff members of any working status, whether full-time or part-time.

B. Audit Procedures for Support Coordination Workforce Bonus Payments

1. The bonus payments reimbursed to support coordination agencies shall be subject to audit by LDH.

2. Support coordination agencies shall provide to LDH or its representative all requested documentation to verify that they are in compliance with the SCA staff member bonus payments.

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

4. Support coordination agencies shall produce the requested documentation upon request and within the timeframe provided by LDH.

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

- a. sanctions; or
- b. disenrollment from the Medicaid program.

C. Sanctions for Support Coordination Workforce Bonus Payments

1. The support coordination agencies will be subject to sanctions or penalties for failure to comply with this Rule. The severity of such action shall depend upon the following:

- a. failure to pay SCA staff members the \$250 monthly bonus payments;
- b. the number of employees identified as having been paid less than the \$250 monthly bonus payments; or
- 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 and the Office of Aging and Adult Services, LR 49:685 (April 2023).

Chapter 7. Reimbursement Methodology**§701. General Provisions**

A. The Department of Health (LDH) establishes reimbursement methodologies and cost reporting requirements for providers of home and community-based services waiver programs who provide personal care services (including personal care services, personal care attendant services, community living supports services, attendant care services, personal assistance services, in-home respite, and individual and family support services).

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:509 (March 2013), amended LR 42:898 (June 2016), amended by the Department of Health, Bureau of Health Services Financing, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:1112 (August 2021).

§703. Cost Reporting Requirements

A. Effective July 1, 2012, the department implemented mandatory cost reporting requirements for providers of home and community-based waiver services listed above in §701.A. The cost reports will be used to verify expenditures and to support rate setting for the services rendered to waiver participants.

B. Providers of services in the following waiver programs shall be required to submit cost reports:

1. Adult Day Health Care Waiver;
2. Children's Choice Waiver;
3. Community Choices Waiver;
4. New Opportunities Waiver;
5. Residential Options Waiver; and
6. Supports Waiver.

C. Each provider shall complete the LDH approved cost report and submit the cost report(s) to the department no later than five months after the state's fiscal year ends (June 30).

D. When a provider fails to submit a cost report by the last day of November, which is five months after the state fiscal year ends (June 30), a penalty of 5 percent of the total monthly payment for the first month and a progressive penalty of 5 percent of the total monthly payment for each succeeding month may be levied and withheld from the provider's payment for each month that the cost report is due, not extended and not received. The penalty is non-refundable and not subject to an administrative appeal.

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 Aging and Adult Services, LR 42:899 (June 2016),

amended by the Department of Health, Bureau of Health Services Financing, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:1112 (August 2021).

§705. Rate Methodology

EDITOR'S NOTE: This Section was previously numbered LAC 50:XXI.703 and complies with Act 299 of the 2011 Regular Session of the Louisiana Legislature.

A. Reimbursement for the following services shall be a prospective flat rate for each approved unit of service that is provided to the participant:

1. personal care services;
2. personal care attendant services;
3. community living supports services;
4. attendant care services;
5. personal assistance services;
6. in-home respite; and
7. individual and family support services, collectively referred to as reimbursable assistance services.

B. One quarter hour (15 minutes) shall be the standard unit of service. Reimbursement shall not be paid for the provision of less than one quarter hour (15 minutes) of service.

C. Effective July 1, 2016, a rate validation process occurred to determine the sufficiency of reimbursement rates. This process will be repeated at a minimum of every two years thereafter. The rate validation process will involve the comparison of current provider reimbursement rates to reimbursement rates established using the department's reimbursement methodology.

1. The department's reimbursement methodology will establish an estimated reimbursement rate through the summation of the following two rate component totals:

- a. adjusted staff cost rate component; and
- b. other operational cost rate component.

2. The adjusted staff cost rate component will be determined in the following manner.

a. Direct service worker wage expense, contract labor expense, and hours worked for reimbursable assistance services will be collected from provider cost reports.

i. Collected wage and contract labor expense will be divided by collected hours worked, on an individual cost report basis, to determine a per hour labor rate for direct service workers.

ii. The individual cost report hourly labor rates will be aggregated for all applicable filed cost reports, outliers will be removed, and a simple average statewide labor rate will be determined.

b. A blended direct service worker labor rate will be calculated by comparing the simple average statewide labor rate to the most recently available, as of the calculation of

the department's rate validation process, average personal care aide wage rate from the *Louisiana Occupational Employment and Wages* report for all Louisiana parishes published by the Louisiana Workforce Commission (or its successor).

i. If the simple average statewide labor rate is less than the wage rate from the *Louisiana Occupational Employment and Wages* report, a blended wage rate will be calculated using 50 percent of both wage rates.

ii. If the simple average statewide labor rate is equal to or greater than the wage rate from the *Louisiana Occupational Employment and Wages* report, the simple average statewide labor rate will be utilized.

c. An employee benefit factor will be added to the blended direct service worker wage rate to determine the unadjusted hourly staff cost.

i. Employee benefit expense allocated to reimbursable assistance services will be collected from provider cost reports.

ii. Employee benefit expense, on an individual cost report basis, will be divided by the cost report direct service wage and contract labor expense for reimbursable assistance services to calculate employee benefits as a percentage of labor costs.

iii. The individual cost report employee benefit percentages will be aggregated for all applicable filed cost reports, outliers will be removed, and a simple average statewide employee benefit percentage will be determined.

iv. The simple average statewide employee benefit percentage will be multiplied by the blended direct service worker labor rate to calculate the employee benefit factor.

d. The department will be solely responsible for determining if adjustments to the unadjusted hourly staff cost for items that are underrepresented or not represented in provider cost reports is considered appropriate.

e. The unadjusted hourly staff cost will be multiplied by a productive hours' adjustment to calculate the hourly adjusted staff cost rate component total. The productive hours' adjustment allows the reimbursement rate to reflect the cost associated with direct service worker time spent performing required non-billable activities. The productive hours' adjustment will be calculated as follows.

i. The department will determine estimates for the amount of time a direct service worker spends performing required non-billable activities during an eight-hour period. Examples of non-billable time include, but are not limited to: meetings, substitute staff, training, wait-time, supervising, etc.

ii. The total time associated with direct service worker non-billable activities will be subtracted from eight hours to determine direct service worker total billable time.

iii. Eight hours will be divided by the direct service worker total billable time to calculate the productive hours' adjustment.

3. The other operational cost rate component will be calculated in the following manner.

a. Capital expense, transportation expense, other direct non-labor expense, and other overhead expense allocated to reimbursable assistance services will be collected from provider cost reports.

b. Capital expense, transportation expense, supplies, and other direct non-labor expense, and other overhead expense, on an individual cost report basis, will be divided by the cost report direct service wage and contract labor expense for reimbursable assistance services to calculate other operational costs as a percentage of labor costs.

c. The individual cost report other operational cost percentages will be aggregated for all applicable filed cost reports, outliers will be removed, and a simple average statewide other operational cost percentage will be determined.

d. The simple average other operational cost percentage will be multiplied by the blended direct service worker labor rate to calculate the other operational cost rate component.

4. The calculated department reimbursement rates will be adjusted to a one quarter hour unit of service by dividing the hourly adjusted staff cost rate component and the hourly other operational cost rate component totals by four.

5. The department will be solely responsible for determining the sufficiency of the current reimbursement rates during the rate validation process. Any reimbursement rate change deemed necessary due to rate validation process will be subject to legislative budgetary appropriation restrictions prior to implementation.

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, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:1112 (August 2021).

Subchapter B. Adult Day Health Care Providers

§707. General Provisions

A. The Department of Health (LDH) establishes reimbursement methodologies and cost reporting requirements for Adult Day Health Care (ADHC) providers of home and community-based waiver programs.

B. ADHC providers in the following waiver programs shall be required to submit cost reports:

1. Adult Day Health Care (ADHC) Waiver;
2. Community Choices Waiver; and
3. Residential Options Waiver (ROW).

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, the Office for

Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:1113 (August 2021).

§709. Rate Methodology

A. Adult day health care providers shall be reimbursed a per quarter hour rate for services provided under a prospective payment system (PPS). The system shall be designed in a manner that recognizes and reflects the cost of direct care services provided. The reimbursement methodology is designed to improve the quality of care for all waiver participants by ensuring that direct care services are provided at an acceptable level while fairly reimbursing the providers.

B. Reimbursement shall not be made for ADHC waiver services provided under the waivers prior to the department's approval of the POC.

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, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:1114 (August 2021).

§711. Cost Reporting

A. Cost Centers Components

1. **Direct Care Costs.** This component reimburses for in-house and contractual direct care staffing, social services, and activities (excluding the activities director) and fringe benefits and direct care supplies.

2. **Care Related Costs.** This component reimburses for in-house and contractual salaries and fringe benefits for supervisory and dietary staff, raw food costs, and care related supplies.

3. **Administrative and Operating Costs.** This component reimburses for in-house or contractual salaries and related benefits for administrative, housekeeping, laundry, and maintenance staff. Also included are:

- a. utilities;
- b. accounting;
- c. dietary supplies;
- d. housekeeping and maintenance supplies; and
- e. all other administrative and operating type expenditures.

4. **Property.** This component reimburses for depreciation, interest on capital assets, lease expenses, property taxes, and other expenses related to capital assets, excluding property costs related to participant transportation.

5. **Transportation.** This component reimburses for in-house and contractual driver salaries and related benefits, non-emergency medical transportation, vehicle maintenance, and supply expense, motor vehicle depreciation, interest expense related to vehicles, vehicle insurance, and auto leases.

B. Providers of ADHC services are required to file acceptable annual cost reports of all reasonable and allowable costs. An acceptable cost report is one that is prepared in accordance with the requirements of this Section and for which the provider has supporting documentation necessary for completion of a desk review or audit. The annual cost reports are the basis for determining reimbursement rates. A copy of all reports and statistical data must be retained by the center for no less than five years following the date cost reports are submitted to the bureau. A chart of accounts and an accounting system on the accrual basis or converted to the accrual basis at year end are required in the cost report preparation process. The bureau or its designee will perform desk reviews of the cost reports. In addition to the desk review, a representative number of the centers shall be subject to a full-scope, annual on-site audit. All ADHC cost reports shall be filed with a fiscal year from July 1 through June 30.

1. When a provider ceases to participate as an ADHC provider the provider must file a cost report covering a period under this program up to the effective date of cessation of participation in the program. Depending on the circumstances involved in the preparation of the provider's final cost report, the provider may file the cost report for a period of not less than one month or not more than 13 months.

C. The cost reporting forms and instructions developed by the Bureau must be used by all ADHC centers participating in the Louisiana Medicaid Program. Hospital based and other provider based ADHC which use Medicare forms for step down in completing their ADHC Medicaid cost reports must submit copies of the applicable Medicare cost report forms also. All amounts must be rounded to the nearest dollar and must foot and cross foot. Only per diem cost amounts will not be rounded. Cost reports submitted that have not been rounded in accordance with this policy will be returned and will not be considered as received until they are resubmitted.

D. Annual Reporting. Cost reports are to be filed on or before the last day of September following the close of the cost reporting period. Should the due date fall on a Saturday, Sunday, or an official state or federal holiday, the due date shall be the following business day. The cost report forms and schedules must be filed with one copy of the following documents:

1. a cost report grouping schedule. This schedule should include all trial balance accounts grouped by cost report line item. All subtotals should agree to a specific line item on the cost report. This grouping schedule should be done for the balance sheet, income statement, and expenses;

2. a depreciation schedule. The depreciation schedule which reconciles to the depreciation expense reported on the cost report must be submitted. If the center files a home office cost report, copies of the home office depreciation schedules must also be submitted with the home office cost report. All hospital based centers must submit a copy of a

depreciation schedule that clearly shows and totals assets that are hospital only, ADHC only and shared assets;

3. an amortization schedule(s), if applicable;

4. a schedule of adjustment and reclassification entries;

5. a narrative description of purchased management services and a copy of contracts for managed services, if applicable;

6. for management services provided by a related party or home office, a description of the basis used to allocate the costs to providers in the group and to non-provider activities and copies of the cost allocation worksheet, if applicable. Costs of related management/home offices must be reported on a separate cost report that includes an allocation schedule; and

7. all allocation worksheets must be submitted by hospital-based centers. The Medicare worksheets that must be attached by centers using the Medicare forms for allocation are:

- a. A;
- b. A-6;
- c. A-7 parts I, II and III;
- d. A-8;
- e. A-8-1;
- f. B part 1; and
- g. B-1.

E. Each copy of the cost report must have the original signatures of an officer or center administrator on the certification. The cost report and related documents must be submitted to the address indicated on the cost report instruction form. In order to avoid a penalty for delinquency, cost reports must be postmarked on or before the due date.

F. When it is determined, upon initial review for completeness, that an incomplete or improperly completed cost report has been submitted, the provider will be notified. The provider will be allowed a specified amount of time to submit the requested information without incurring the penalty for a delinquent cost report. For cost reports that are submitted by the due date, 10 working days from the date of the provider's receipt of the request for additional information will be allowed for the submission of the additional information. For cost reports that are submitted after the due date, five working days from the date of the provider's receipt of the request for additional information will be allowed for the submission of the additional information. An exception exists in the event that the due date comes after the specified number of days for submission of the requested information. In these cases, the provider will be allowed to submit the additional requested information on or before the due date of the cost report. If requested additional information has not been submitted by the specified date, a second request for the information will be made. Requested information not received after the

second request may not be subsequently submitted and shall not be considered for reimbursement purposes. An appeal of the disallowance of the costs associated with the requested information may not be made. Allowable costs will be adjusted to disallow any expenses for which requested information is not submitted.

G. Accounting Basis. The cost report must be prepared on the accrual basis of accounting. If a center is on a cash basis, it will be necessary to convert from a cash basis to an accrual basis for cost reporting purposes. Particular attention must be given to an accurate accrual of all costs at the year-end for appropriate recordation of costs in the applicable cost reporting period. Care must be given to the proper allocation of costs for contracts to the period covered by such contracts. Amounts earned although not actually received and amounts owed to creditors but not paid must be included in the appropriate cost reporting period.

H. Supporting Information. Providers are required to maintain adequate financial records and statistical data for proper determination of reimbursable costs. Financial and statistical records must be maintained by the center for five years from the date the cost report is submitted to the Bureau. Cost information must be current, accurate and in sufficient detail to support amounts reported in the cost report. This includes all ledgers, journals, records, and original evidences of cost (canceled checks, purchase orders, invoices, vouchers, inventories, time cards, payrolls, bases for apportioning costs, etc.) that pertain to the reported costs. Census data reported on the cost report must be supportable by daily census records. Such information must be adequate and available for auditing.

I. Attendance Records

1. Attendance data reported on the cost report must be supportable by daily attendance records. Such information must be adequate and available for auditing.

2. Daily attendance records should include the time of each participant's arrival and departure from the center. The attendance records should document the presence or absence of each participant on each day the center is open. The center's attendance records should document all admissions and discharges on the attendance records. Attendance records should be kept for all participants that attend the adult day center. This includes Medicaid, Veteran's Administration, insurance, private, waiver, and other participants. The attendance of all participants should be documented regardless of whether a payment is received on behalf of the participant. Supporting documentation such as admission documents, discharge summaries, nurse's progress notes, sign-in/out logs, etc. should be maintained to support services provided to each participant.

J. Employee Record

1. the provider shall retain written verification of hours worked by individual employees:

a. records may be sign-in sheets or time cards, but shall indicate the date and hours worked;

b. records shall include all employees even on a contractual or consultant basis;

2. verification of employee orientation and in-service training; and

3. verification of the employee's communicable disease screening.

K. Billing Records

1. The provider shall maintain billing records in accordance with recognized fiscal and accounting procedures. Individual records shall be maintained for each participant. These records shall meet the following criteria.

a. Records shall clearly detail each charge and each payment made on behalf of the participant.

b. Records shall be current and shall clearly reveal to whom charges were made and for whom payments were received.

c. Records shall itemize each billing entry.

d. Records shall show the amount of each payment received and the date received.

2. The provider shall maintain supporting fiscal documents and other records necessary to ensure that claims are made in accordance with federal and state requirements.

L. Non-Acceptable Descriptions. Miscellaneous, other, and various, without further detailed explanation, are not acceptable descriptions for cost reporting purposes. If any of these are used as descriptions in the cost report, a request for information will not be made and the related line item expense will be automatically disallowed. The provider will not be allowed to submit the proper detail of the expense at a later date, and an appeal of the disallowance of the costs may not be made.

M. Exceptions. Limited exceptions to the cost report filing requirements will be considered on an individual provider basis upon written request from the provider to the Bureau of Health Services Financing, Rate and Audit Review Section. If an exception is allowed, the provider must attach a statement describing fully the nature of the exception for which prior written permission was requested and granted. Exceptions which may be allowed with written approval are as follows.

1. If the center has been purchased or established during the reporting period, a partial year cost report may be filed in lieu of the required 12-month report.

2. If the center experiences unavoidable difficulties in preparing the cost report by the prescribed due date, an extension may be requested prior to the due date. Requests for exception must contain a full statement of the cause of the difficulties that rendered timely preparation of the cost report impossible.

N. Delinquent Cost Report. When an ADHC provider fails to submit a cost report by the last day of September following the close of the cost reporting period, a penalty of 5 percent of the monthly payment for the first month and a

progressive penalty of 5 percent of the monthly payment for each succeeding month may be levied and withheld from the ADHC provider's payment for each month that the cost report is due, not extended and not received. The penalty is non-refundable and not subject to an administrative appeal.

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, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:1114 (August 2021).

§713. Cost Categories Included in the Cost Report

A. Direct Care (DC) Costs

1. Salaries, Aides-gross salaries of certified nurse aides and nurse aides in training.
2. Salaries, LPNs-gross salaries of nonsupervisory licensed practical nurses and graduate practical nurses.
3. Salaries, RNs-gross salaries of nonsupervisory registered nurses and graduate nurses (excluding director of nursing and participant assessment instrument coordinator).
4. Salaries, Social Services-gross salaries of nonsupervisory licensed social services personnel providing medically needed social services to attain or maintain the highest practicable physical, mental, or psychosocial well-being of the participants.
5. Salaries, Activities—gross salaries of nonsupervisory activities/recreational personnel providing an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interest and the physical, mental, and psychosocial well-being of the participants.
6. Payroll Taxes—cost of employer's portion of Federal Insurance Contribution Act (FICA), Federal Unemployment Tax Act (FUTA), State Unemployment Tax Act (SUTA), and Medicare tax for direct care employees.
7. Group Insurance, DC—cost of employer's contribution to employee health, life, accident and disability insurance for direct care employees.
8. Pensions, DC—cost of employer's contribution to employee pensions for direct care employees.
9. Uniform Allowance, DC—employer's cost of uniform allowance and/or uniforms for direct care employees.
10. Worker's Comp, DC—cost of worker's compensation insurance for direct care employees.
11. Contract, Aides—cost of aides through contract that are not center employees.
12. Contract, LPNs—cost of LPNs and graduate practical nurses hired through contract that are not center employees.
13. Contract, RNs—cost of RNs and graduate nurses hired through contract that are not center employees.

14. Drugs, Over-the-Counter and Non-Legend—cost of over-the-counter and non-legend drugs provided by the center to its participants. This is for drugs not covered by Medicaid.

15. Medical Supplies—cost of participant-specific items of medical supplies such as catheters, syringes and sterile dressings.

16. Medical Waste Disposal—cost of medical waste disposal including storage containers and disposal costs.

17. Recreational Supplies, DC—cost of items used in the recreational activities of the center.

18. Other Supplies, DC—cost of items used in the direct care of participants which are not participant-specific such as prep supplies, alcohol pads, betadine solution in bulk, tongue depressors, cotton balls, thermometers, blood pressure cuffs and under-pads and diapers (reusable and disposable).

19. Allocated Costs, Hospital Based—the amount of costs that have been allocated through the step-down process from a hospital or state institution as direct care costs when those costs include allocated overhead.

20. Miscellaneous, DC—costs incurred in providing direct care services that cannot be assigned to any other direct care line item on the cost report.

21. Total Direct Care Costs—sum of the above line items.

B. Care Related (CR) Costs

1. Salaries—gross salaries for care related supervisory staff including supervisors or directors over nursing, social service, and activities/recreation.
2. Salaries, Dietary—gross salaries of kitchen personnel including dietary supervisors, cooks, helpers, and dishwashers.
3. Payroll Taxes—cost of employer's portion of Federal Insurance Contribution Act (FICA), Federal Unemployment Tax Act (FUTA), State Unemployment Tax Act (SUTA), and Medicare tax for care related employees.
4. Group Insurance, CR—cost of employer's contribution to employee health, life, accident, and disability insurance for care related employees.
5. Pensions, CR—cost of employer's contribution to employee pensions for care related employees.
6. Uniform Allowance, CR—employer's cost of uniform allowance and/or uniforms for care related employees.
7. Worker's Comp, CR—cost of worker's compensation insurance for care related employees.
8. Contract, Dietary—cost of dietary services, and personnel hired through contract that are not employees of the center.

9. Consultant Fees, Activities—fees paid to activities personnel, not on the center's payroll, for providing advisory, and educational services to the center.

10. Consultant Fees, Nursing—fees paid to nursing personnel, not on the center's payroll, for providing advisory, and educational services to the center.

11. Consultant Fees, Pharmacy—fees paid to a registered pharmacist, not on the center's payroll, for providing advisory, and educational services to the center.

12. Consultant Fees, Social Worker—fees paid to a social worker, not on the center's payroll, for providing advisory, and educational services to the center.

13. Consultant Fees, Therapists—fees paid to a licensed therapist, not on the center's payroll, for providing advisory, and educational services to the center.

14. Food, Raw—cost of food products used to provide meals and snacks to participants. Hospital based facilities must allocate food based on the number of meals served.

15. Food, Supplements—cost of food products given in addition to normal meals and snacks under a doctor's orders. Hospital based facilities must allocate food-supplements based on the number of meals served.

16. Supplies, CR—the costs of supplies used for rendering care related services to the participants of the center. All personal care related items such as shampoo and soap administered by all staff must be included on this line.

17. Allocated Costs, Hospital Based—the amount of costs that have been allocated through the step-down process from a hospital or state institution as care related costs when those costs include allocated overhead.

18. Miscellaneous, CR—costs incurred in providing care related care services that cannot be assigned to any other care related line item on the cost report.

19. Total Care Related Costs—the sum of the care related cost line items.

C. Administrative and Operating Costs (AOC)

1. Salaries, Administrator—gross salary of administrators excluding owners. Hospital based centers must attach a schedule of the administrator's salary before allocation, the allocation method, and the amount allocated to the nursing center.

2. Salaries, Assistant Administrator—gross salary of assistant administrators excluding owners.

3. Salaries, Housekeeping—gross salaries of housekeeping personnel including housekeeping supervisors, maids, and janitors.

4. Salaries, Laundry—gross salaries of laundry personnel.

5. Salaries, Maintenance—gross salaries of personnel involved in operating and maintaining the physical plant, including maintenance personnel or plant engineers.

6. Salaries, Other Administrative—gross salaries of other administrative personnel including bookkeepers, receptionists, administrative assistants, and other office and clerical personnel.

7. Salaries, Owner or Owner/Administrator—gross salaries of all owners of the center that are paid through the center.

8. Payroll Taxes—cost of employer's portion of Federal Insurance Contribution Act (FICA), Federal Unemployment Tax Act (FUTA), State Unemployment Tax Act (SUTA), and Medicare tax for administrative and operating employees.

9. Group Insurance, AOC—cost of employer's contribution to employee health, life, accident, and disability insurance for administrative, and operating employees.

10. Pensions, AOC—cost of employer's contribution to employee pensions for administration, and operating employees.

11. Uniform Allowance, AOC—employer's cost of uniform allowance and/or uniforms for administration and operating employees.

12. Worker's Compensation, AOC—cost of worker's compensation insurance for administration and operating employees.

13. Contract, Housekeeping—cost of housekeeping services and personnel hired through contract that are not employees of the center.

14. Contract, Laundry—cost of laundry services and personnel hired through contract that are not employees of the center.

15. Contract, Maintenance—cost of maintenance services and persons hired through contract that are not employees of the center.

16. Consultant Fees, Dietician—fees paid to consulting registered dietitians.

17. Accounting Fees—fees incurred for the preparation of the cost report, audits of financial records, bookkeeping, tax return preparation of the adult day health care center and other related services excluding personal tax planning and personal tax return preparation.

18. Amortization Expense, Non-Capital—costs incurred for legal and other expenses when organizing a corporation must be amortized over a period of 60 months. Amortization of costs attributable to the negotiation or settlement of the sale or purchase of any capital asset on or after July 18, 1984, whether by acquisition or merger, for which any payment has previously been made are non-allowable costs. If allowable cost is reported on this line, an amortization schedule must be submitted with the cost report.

19. Bank Service Charges—fees paid to banks for service charges, excluding penalties and insufficient funds charges.

PUBLIC HEALTH—MEDICAL ASSISTANCE

20. Dietary Supplies—costs of consumable items such as soap, detergent, napkins, paper cups, straws, etc., used in the dietary department.

21. Dues—dues to one organization are allowable.

22. Educational Seminars and Training—the registration cost for attending educational seminars and training by employees of the center and costs incurred in the provision of in-house training for center staff, excluding owners or administrative personnel.

23. Housekeeping Supplies—cost of consumable housekeeping items including waxes, cleaners, soap, brooms and lavatory supplies.

24. Insurance, Professional Liability and Other—includes the costs of insuring the center against injury and malpractice claims.

25. Interest expense, non-capital interest paid on short term borrowing for center operations.

26. Laundry Supplies—cost of consumable goods used in the laundry including soap, detergent, starch and bleach.

27. Legal Fees—only actual and reasonable attorney fees incurred for non-litigation legal services related to participant care are allowed.

28. Linen Supplies—cost of sheets, blankets, pillows, and gowns.

29. Management Fees and Home Office Costs—the cost of purchased management services or home office costs incurred that are allocable to the provider. Costs for related management/home office must also be reported on a separate cost report that includes an allocation schedule.

30. Office Supplies and Subscriptions—cost of consumable goods used in the business office such as:

- a. pencils, paper and computer supplies;
- b. cost of printing forms and stationery including, but not limited to, nursing and medical forms, accounting and census forms, charge tickets, center letterhead and billing forms;
- c. cost of subscribing to newspapers, magazines and periodicals.

31. Postage—cost of postage, including stamps, metered postage, freight charges, and courier services.

32. Repairs and Maintenance—supplies and services, including electricians, plumbers, extended service agreements, etc., used to repair and maintain the center building, furniture and equipment except vehicles. This includes computer software maintenance.

33. Taxes and Licenses—the cost of taxes and licenses paid that are not included on any other line of the cost report. This includes tags for vehicles, licenses for center staff (including nurse aide re-certifications) and buildings.

34. Telephone and Communications—cost of telephone services, internet and fax services.

35. Travel—cost of travel (airfare, lodging, meals, etc.) by the administrator and other authorized personnel to attend professional and continuing educational seminars and meetings or to conduct center business. Commuting expenses and travel allowances are not allowable.

36. Utilities—cost of water, sewer, gas, electric, cable TV and garbage collection services.

37. Allocated Costs, Hospital Based—costs that have been allocated through the step-down process from a hospital as administrative and operating costs.

38. Advertising—costs of employment advertising and soliciting bids. Costs related to promotional advertising are not allowable.

39. Maintenance Supplies—supplies used to repair and maintain the center building, furniture and equipment except vehicles.

40. Miscellaneous—costs incurred in providing center services that cannot be assigned to any other line item on the cost report. Examples of miscellaneous expenses are small equipment purchases, all employees' physicals and shots, nominal gifts to all employees, such as a turkey or ham at Christmas, and flowers purchased for the enjoyment of the participants. Items reported on this line must be specifically identified.

41. Total administrative and operating costs.

D. Property and Equipment

1. Amortization Expense, Capital—legal and other costs incurred when financing the center must be amortized over the life of the mortgage. Amortization of goodwill is not an allowable cost. Amortization of costs attributable to the negotiation or settlement of the sale or purchase of any capital asset on or after July 18, 1984, whether by acquisition or merger, for which any payment has previously been made are non-allowable costs. If allowable cost is reported on this line, an amortization schedule must be submitted with the cost report.

2. Depreciation—depreciation on the center's buildings, furniture, equipment, leasehold improvements, and land improvements.

3. Interest Expense, Capital—interest paid or accrued on notes, mortgages, and other loans, the proceeds of which were used to purchase the center's land, buildings and/or furniture, and equipment, excluding vehicles.

4. Property Insurance—cost of fire and casualty insurance on center buildings, and equipment, excluding vehicles. HCBS providers that share owned or leased space with other programs, Medicaid or private, should allocate building costs such as property insurance, property taxes, depreciation, etc. based on documented square footage used by each program.

5. Property Taxes—taxes levied on the center's buildings and equipment. HCBS providers that share owned or leased space with other programs, Medicaid or private, should allocate building costs such as property insurance,

property taxes, depreciation, etc. based on documented square footage used by each program.

6. Rent, Building—cost of leasing the center’s real property.

7. Rent, Furniture and Equipment—cost of leasing the center’s furniture and equipment, excluding vehicles.

8. Allocated Costs, Hospital Based—costs that have been allocated through the step-down process from a hospital or state institution as property costs when those costs include allocated overhead.

9. Miscellaneous, Property—any capital costs related to the center that cannot be assigned to any other property and equipment line item on the cost report.

10. Total property and equipment.

E. Transportation Costs

1. Salaries, Drivers—gross salaries of personnel involved in transporting participants to and from the center.

2. Payroll Taxes, Transportation—the cost of the employer’s portion of Federal Insurance Contribution Act (FICA), Federal Unemployment Tax Act (FUTA), State Unemployment Tax Act (SUTA), and Medicare tax for drivers.

3. Employee Benefits, Transportation—the cost of group insurance, pensions, uniform allowances, and other employee benefits related to drivers.

4. Workers’ Compensation, Transportation—the cost of workers’ compensation insurance for drivers.

5. Non-Emergency Medical Transportation—the cost of purchased non-emergency medical transportation services including, but not limited to:

a. payments to employees for use of their personal vehicle(s);

b. ambulance companies; and

c. other transportation companies for transporting participants of the center.

6. Interest Expenses, Vehicles—interest paid or accrued on loans used to purchase vehicles.

7. Property Insurance, Vehicles—the cost of vehicle insurance.

8. Vehicle Expenses—vehicle maintenance and supplies, including gas and oil.

9. Lease, Automotive—the cost of leasing vehicles used for participant care. A mileage log must be maintained. If a leased vehicle is used for both participant care and personal purposes, cost must be allocated based on the mileage log.

10. Total Transportation Costs.

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, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:1116 (August 2021).

§715. Allowable Costs

EDITOR’S NOTE: The provisions of this Section were previously located in LAC 50:XXI.2907.

A. Allowable costs include those costs incurred by providers to conform to state licensure and federal certification standards. General cost principles are applied during the desk review and audit process to determine allowable costs.

1. These general cost principles include determining whether the cost is:

a. ordinary, necessary, and related to the delivery of care;

b. what a prudent and cost conscious business person would pay for the specific goods or services in the open market or in an arm’s length transaction; and

c. for goods or services actually provided to the center.

B. Through the desk review and/or audit process, adjustments and/or disallowances may be made to a provider’s reported costs. The Medicare Provider Reimbursement Manual is the final authority for allowable costs unless the Department has set a more restrictive policy.

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, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:1119 (August 2021).

§717. Non-allowable Costs

EDITOR’S NOTE: The provisions of this Section were previously located in LAC 50:XXI.2909.

A. Costs that are not based on the reasonable cost of services covered under Medicare and are not related to the care of participants are considered non-allowable costs.

B. Reasonable cost does not include the following:

1. costs not related to participant care;

2. costs specifically not reimbursed under the program;

3. costs that flow from the provision of luxury items or services (items or services substantially in excess or more expensive than those generally considered necessary for the provision of the care);

4. costs that are found to be substantially out of line with other centers that are similar in size, scope of services, and other relevant factors;

5. costs exceeding what a prudent and cost-conscious buyer would incur to purchase the goods or services.

C. General non-allowable costs:

PUBLIC HEALTH—MEDICAL ASSISTANCE

1. services for which Medicaid participants are charged a fee;
 2. depreciation of non-participant care assets;
 3. services that are reimbursable by other state or federally funded programs;
 4. goods or services unrelated to participant care;
 5. unreasonable costs.
- D. Specific non-allowable costs (this is not an all-inclusive listing):
1. advertising—costs of advertising to the general public that seeks to increase participant utilization of the ADHC center;
 2. bad debts—accounts receivable that are written off as not collectible;
 3. contributions—amounts donated to charitable or other organizations;
 4. courtesy allowances;
 5. director’s fees;
 6. educational costs for participants;
 7. gifts;
 8. goodwill or interest (debt service) on goodwill;
 9. costs of income producing items such as fund raising costs, promotional advertising, or public relations costs, and other income producing items;
 10. income taxes, state, and federal taxes on net income levied or expected to be levied by the federal or state government;
 11. insurance, officers—cost of insurance on officers, and key employees of the center when the insurance is not provided to all employees;
 12. judgments or settlements of any kind;
 13. lobbying costs or political contributions, either directly or through a trade organization;
 14. non-participant entertainment;
 15. non-Medicaid related care costs—costs allocated to portions of a center that are not licensed as the reporting ADHC or are not certified to participate in Title XIX;
 16. officers’ life insurance with the center or owner as beneficiary;
 17. payments to the parent organization or other related party;
 18. penalties and sanctions—penalties and sanctions assessed by the Centers for Medicare and Medicaid Services, LDH, the Internal Revenue Service or the state Tax Commission;
 19. insufficient funds charges;
 20. personal comfort items; and

21. personal use of vehicles.

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, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:1119 (August 2021).

§719. Audits

EDITOR’S NOTE: The provisions of this Section were previously located in LAC 50:XXI.2911.

A. Each provider shall file an annual center cost report and, if applicable, a central office cost report.

B. The provider shall be subject to financial and compliance audits.

C. All providers who elect to participate in the Medicaid program shall be subject to audit by state or federal regulators or their designees. Audit selection shall be at the discretion of the department.

1. The department conducts desk reviews of all of the cost reports received and also conducts on-site audits of provider cost reports.

2. The records necessary to verify information submitted to the department on Medicaid cost reports, including related-party transactions, and other business activities engaged in by the provider, must be accessible to the department’s audit staff.

D. In addition to the adjustments made during desk reviews and on-site audits, the department may exclude or adjust certain expenses in the cost report data base in order to base rates on the reasonable and necessary costs that an economical and efficient provider must incur.

E. The center shall retain such records or files as required by the department and shall have them available for inspection for five years from the date of service or until all audit exceptions are resolved, whichever period is longer.

F. If a center’s audit results in repeat findings and adjustments, the department may:

1. withhold provider’s payments until the center submits documentation that the non-compliance has been resolved;

2. exclude the provider’s cost from the database used for rate setting purposes; and

3. impose civil monetary penalties until the center submits documentation that the non-compliance has been resolved.

G. If the department’s auditors determine that a center’s financial and/or census records are unauditible, the provider’s payments may be withheld until the center submits auditible records. The provider shall be responsible for costs incurred by the department’s auditors when additional services or procedures are performed to complete the audit.

H. Provider payments may also be withheld under the following conditions:

1. a center fails to submit corrective action plans in response to financial and compliance audit findings within 15 days after receiving the notification letter from the department; or

2. a center fails to respond satisfactorily to the department's request for information within 15 days after receiving the department's notification letter.

I. The provider shall cooperate with the audit process by:

1. promptly providing all documents needed for review;

2. providing adequate space for uninterrupted review of records;

3. making persons responsible for center records and cost report preparation available during the audit;

4. arranging for all pertinent personnel to attend the closing conference;

5. insuring that complete information is maintained in participant's records;

6. developing a plan of correction for areas of noncompliance with state and federal regulations immediately after the exit conference time limit of 30 calendar days.

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, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:1120 (August 2021).

§721. Exclusions from the Database

EDITOR'S NOTE: The provisions of this Section were previously located in LAC 50:XXI.2913.

A. The following providers shall be excluded from the database used to calculate the rates:

1. providers with disclaimed audits; and

2. providers with cost reports for periods other than a 12-month period.

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, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:1120 (August 2021).

§723. Provider Reimbursement

A. Cost Determination Definitions

Base Rate—calculated in accordance with §723.B.5, plus any base rate adjustments granted in accordance with §723.B.7 which are in effect at the time of calculation of new rates or adjustments.

Index Factor—computed by dividing the value of the index for December of the year preceding the rate year by the value of the index one year earlier (December of the second preceding year).

Indices—

a. *CPI, All Items*—the Consumer Price Index for All Urban Consumers-South Region (all items line) as published by the United States Department of Labor.

b. *CPI, Medical Services*—the Consumer Price Index for All Urban Consumers-South Region (medical services line) as published by the United States Department of Labor.

Rate Component—the rate is the summation of the following:

- a. direct care;
- b. care related costs;
- c. administrative and operating costs;
- d. property costs; and
- e. transportation costs.

B. Rate Determination

1. The base rate is calculated based on the most recent audited or desk reviewed cost for all ADHC providers filing acceptable full year cost reports. The rates are based on cost components appropriate for an economic and efficient ADHC providing quality service. The participant per quarter hour rates represent the best judgment of the state to provide reasonable and adequate reimbursement required to cover the costs of economic and efficient ADHC.

2. For rate periods between rebasing, the rates will be trended forward using the index factor contingent upon appropriation by the legislature.

3. The median costs for each component are multiplied in accordance with §723.B.4 then by the appropriate index factors for each successive year to determine base rate components. For subsequent years, the components thus computed become the base rate components to be multiplied by the appropriate index factors, unless they are adjusted as provided in §723.B.6 below. Application of an inflationary adjustment to reimbursement rates in non-rebasing years shall apply only when the state legislature allocates funds for this purpose. The inflationary adjustment shall be made prorating allocated funds based on the weight of the rate components.

4. The inflated median shall be increased to establish the base rate median component as follows.

a. The inflated direct care median shall be multiplied times 115 percent to establish the direct care base rate component.

b. The inflated care related median shall be multiplied times 105 percent to establish the care related base rate component.

c. The administrative and operating median shall be multiplied times 105 percent to establish the administrative and operating base rate component.

5. At least every three years, audited and desk reviewed cost report items will be compared to the rate components calculated for the cost report year to insure that the rates remain reasonably related to costs.

6. Formulae. Each median cost component shall be calculated as follows.

a. Direct Care Cost Component. Direct care allowable quarter hour costs from all acceptable full year cost reports, except those for which an audit disclaimer has been issued, shall be arrayed from lowest to highest. The cost at the midpoint of the array shall be the median cost. Should there be an even number of arrayed cost, an average of the two midpoint centers shall be the median cost. The median cost shall be trended forward by dividing the value of the consumer price index-medical services (south region) index for December of the year preceding the rate year by the value of the index for the December of the year preceding the cost report year. The direct care rate component shall be set at 115 percent of the inflated median.

b. Care Related Cost Component. Care related allowable quarter hour costs from all acceptable full year cost reports, except those for which an audit disclaimer has been issued, shall be arrayed from lowest to highest. The cost of the center at the midpoint of the array shall be the median cost. Should there be an even number of arrayed cost, an average of the two midpoint centers shall be the median cost. The median cost shall be trended forward by the value of the consumer price index-all items (south region) index for December of the year preceding the rate year by the value of the index for the December of the year preceding the cost report year. The care related rate component shall be set at 105 percent of the inflated median.

c. Administrative and Operating Cost Component. Administrative and operating allowable quarter hour cost from all acceptable full year cost reports, except those for which an audit disclaimer has been issued, shall be arrayed from lowest to highest. The cost of the midpoint of the array shall be the median cost. Should there be an even number of arrayed cost, an average of the two midpoint centers shall be the median cost. The median cost shall be trended forward by dividing the value of the CPI-all items (south region) index for December of the year preceding the base rate year by the value of the index for the December of the year preceding the cost report year. The administrative and operating rate component shall be set at 105 percent of the inflated median.

d. Property Cost Component. The property allowable quarter hour costs from all acceptable full year cost reports, except those for which an audit disclaimer has been issued, shall be arrayed from lowest to highest. The cost at the midpoint of the array shall be the median cost. Should there be an even number of arrayed cost, an average of the two midpoint centers shall be the median cost. This

will be the rate component. Inflation will not be added to property costs.

e. Transportation Cost Component. The transportation allowable quarter hour costs from all acceptable full year cost reports, except those for which an audit disclaimer has been issued, will be calculated on a provider by provider basis. Should a provider not have filed an acceptable full year cost report, the provider's transportation cost will be reimbursed as follows.

i. New provider, as described in §723.E.1, will be reimbursed in an amount equal to the statewide allowable quarter hour median transportation costs.

(a). In order to calculate the statewide allowable quarter hour median transportation costs, all acceptable full year cost reports, except those for which an audit disclaimer has been issued, shall be arrayed from lowest to highest. The cost at the midpoint of the array shall be the median cost. Should there be an even number of arrayed cost, an average of the two midpoint centers shall be the median cost. This will be the rate component. Inflation will not be added to transportation costs.

ii. Providers that have gone through a change of ownership (CHOW), as described in §723.E.2, will be reimbursed for transportation costs based upon the previous owner's specific allowable quarter hour transportation costs for the period of time between the effective date of the CHOW and the first succeeding base year in which the new owner could possibly file an allowable 12-month cost report. Thereafter, the new owner's data will be used to determine the provider's rate following the procedures specified in this Rule.

iii. Providers that have been issued an audit disclaimer, or have a non-filer status, as described in §723.E.3, will be reimbursed for transportation costs at a rate equal to the lowest allowable quarter hour transportation cost (excluding providers with no transportation costs) in the state as of the most recent audited and/or desk reviewed rate database.

iv. For rate periods between rebasing years, if a provider discontinues transportation services and reported no transportation costs on the most recently audited or desk reviewed cost report, no center specific transportation rate will be added to the center's total rate for the rate year.

7. Budgetary Constraint Rate Adjustment. Effective for the rate period July 1, 2011 to July 1, 2012, the allowable quarter hour rate components for direct care, care related, administrative and operating, property, and transportation shall be reduced by 10.8563 percent.

8. Interim Adjustments to Rates. If an unanticipated change in conditions occurs that affects the cost of at least 50 percent of the enrolled ADHC providers by an average of 5 percent or more, the rate may be changed. The department will determine whether or not the rates should be changed when requested to do so by 25 percent or more of the enrolled providers, or an organization representing at least 25 percent of the enrolled providers. The burden of proof as

to the extent and cost effect of the unanticipated change will rest with the entities requesting the change. The department may initiate a rate change without a request to do so. Changes to the rates may be temporary adjustments or base rate adjustments as described below.

a. **Temporary Adjustments.** Temporary adjustments do not affect the base rate used to calculate new rates.

i. **Changes Reflected in the Economic Indices.** Temporary adjustments may be made when changes which will eventually be reflected in the economic indices, such as a change in the minimum wage, a change in FICA or a utility rate change, occur after the end of the period covered by the indices (i.e., after the December preceding the rate calculation). Temporary adjustments are effective only until the next annual base rate calculation.

ii. **Lump Sum Adjustments.** Lump sum adjustments may be made when the event causing the adjustment requires a substantial financial outlay, such as a change in certification standards mandating additional equipment or furnishings. Such adjustments shall be subject to the bureau's review and approval of costs prior to reimbursement.

b. **Base Rate Adjustment.** A base rate adjustment will result in a new base rate component value that will be used to calculate the new rate for the next fiscal year. A base rate adjustment may be made when the event causing the adjustment is not one that would be reflected in the indices.

9. **Provider Specific Adjustment.** When services required by these provisions are not made available to the participant by the provider, the department may adjust the prospective payment rate of that specific provider by an amount that is proportional to the cost of providing the service. This adjustment to the rate will be retroactive to the date that is determined by the department that the provider last provided the service and shall remain in effect until the department validates, and accepts in writing, an affidavit that the provider is then providing the service and will continue to provide that service.

C. **Cost Settlement.** The direct care cost component shall be subject to cost settlement. The direct care floor shall be equal to 70 percent of the median direct care rate component trended forward for direct care services (plus 70 percent of any direct care incentive added to the rate). The Medicaid Program will recover the difference between the direct care floor and the actual direct care amount expended. If a provider receives an audit disclaimer, the cost settlement for that year will be based on the difference between the direct care floor and the lowest direct care per diem of all centers in the most recent audited and/or desk reviewed database. If the lowest direct care per diem of all centers in the most recent audited and/or desk reviewed database is lower than 50 percent of the direct care rate paid for that year, 50 percent of the direct care rate paid will be used as the provider's direct care per diem for settlement purposes.

D. **Support Coordination Services Reimbursement.** Support coordination services previously provided by

ADHC providers and included in the rate, including the interRAI Home Care assessment, the social assessment, the nursing assessment, the plan of care (POC) and home visits are no longer the responsibility of the ADHC provider. Support coordination services shall be provided as a separate service covered in the waiver programs. As a result of the change in responsibilities, the rate paid to ADHC providers was adjusted accordingly.

E. **New Centers, Changes of Ownership of Existing Centers, and Existing Centers with Disclaimer or Non-Filer Status.**

1. New centers are those entities whose beds have not previously been certified to participate, or otherwise have participated, in the Medicaid program. New centers will be reimbursed in accordance with this Rule and receiving the direct care, care related, administrative and operating, property rate components as determined in §723.B.1-6. These new centers will also receive the state-wide average transportation rate component, as calculated in §723.B.6.e.i.(a), effective the preceding July 1.

2. A change of ownership exists if the beds of the new owner have previously been certified to participate, or otherwise have participated, in the Medicaid program under the previous owner's provider agreement. Rates paid to centers that have undergone a change in ownership will be based upon the rate paid to the previous owner for all rate components. Thereafter, the new owner's data will be used to determine the center's rate following the procedures in this Rule.

3. Existing providers that have been issued an audit disclaimer, or are a provider who has failed to file a complete cost report in accordance with §711, will be reimbursed based upon the statewide allowable quarter hour median costs for the direct care, care related, administrative and operating, and property rate components as determined in §723.B.1-7. No inflation or median adjustment factor will be included in these components. The transportation component will be reimbursed as described in §723.B.6.e.iii.

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, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:1120 (August 2021).

Chapter 9. Provider Requirements

Subchapter A. General Provisions

§901. Settings Requirements for Service Delivery

A. All home and community-based services (HCBS) delivered through a 1915(c) waiver must be provided in settings with the following qualities:

1. the setting is integrated in and supports full access of waiver participants to the greater community, including opportunities to:

- a. seek employment and work in competitive integrated settings;
- b. control personal resources;
- c. engage in community life; and
- d. receive services in the community to the same degree of access as individuals not receiving Medicaid home and community-based services;

2. the setting is selected by the participant from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the participant's needs, preferences, and, for residential settings, resources available for room and board;

3. the setting ensures a participant's rights of privacy, dignity and respect, and freedom from coercion and restraint;

4. the setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact; and

5. the setting facilitates individual choice regarding services and supports, and who provides them.

B. In a provider-owned or controlled non-residential setting, in addition to the qualities listed in Subsection A above, the following additional conditions must be met:

1. participants shall have the freedom and support to control their own schedules and activities, and have access to food at any time to the same extent as participants not receiving Medicaid home and community-based waiver services;

2. participants shall be able to have visitors of their choosing at any time to the same extent as participants not receiving Medicaid home and community-based waiver services; and

3. the setting shall be physically accessible to the participant.

C. In a provider-owned or controlled residential setting, in addition to the qualities listed in Subsections A and B above, the following additional conditions must be met.

1. The unit or dwelling shall be a specific physical place that can be owned, rented or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant laws of the state, parish, city, or other designated entity. For settings in which landlord/tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord/tenant law.

2. Each participant shall have privacy in their sleeping or living unit.

a. Units shall have entrance doors lockable by the participant, with only appropriate staff having keys to doors.

b. Participants sharing units shall have a choice of roommates in that setting.

c. Participants shall have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

D. Providers shall work with the department to timely address and remediate any identified instances of non-compliance.

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, the Office of Aging and Adult Services and the Office for Citizens with Developmental Disabilities, LR 43:1978 (October 2017), amended LR 45:1080 (August 2019).

§903. Electronic Visit Verification

A. An electronic visit verification (EVV) system must be used for time and attendance tracking and post-authorization for home and community-based services.

1. Home and community-based waiver providers identified by the department shall use:

- a. the EVV system designated by the department, or
- b. an alternate system that:
 - i. has successfully passed the data integration process to connect to the designated EVV system, and
 - ii. is approved 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 a 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 Medicaid provider manual.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, the Office of Aging and Adult Services and the Office for Citizens with Developmental Disabilities, LR 43:1979 (October 2017), amended LR 45:1081 (August 2019).

§904. Social Security Verification

A. Home and community-based waiver providers shall verify all currently employed and all new employees' Social Security numbers either by obtaining a copy of the employee's Social Security card or through a Social Security number verification service.

B. A copy of the employee's Social Security card or proof of verification shall be kept in the employee's record.

1. The department or its designee reserves the right to request verification of an employee's Social Security number at any time.

2. Should the provider be unable to provide proof of verification, payments associated with that employee's previously billed time may be recouped and/or future reimbursement withheld until proper verification is submitted.

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 of Aging and Adult Services and the Office for Citizens with Developmental Disabilities, LR 45:1081 (August 2019).

§905. Critical Incident Reporting

A. Support coordination and direct service provider types are responsible for documenting the occurrence of incidents or accidents that affect the health and welfare of the participant, and for completing an incident report.

B. The incident report shall be submitted to the department, or its designee, with the specified requirements and within specified time lines.

C. Specific requirements and timelines are outlined in each program office's *Critical Incident Reporting Policy and Procedures* document.

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, the Office of Aging and Adult Services and the Office for Citizens with Developmental Disabilities, LR 43:1979 (October 2017).

Chapter 11. Fiscal Employer Agent Standards for Participation in Home and Community-Based Services Waiver Programs

Subchapter A. General Provisions

§1101. Introduction

A. The Department of Health (LDH) establishes these minimum standards for participation as a fiscal employer agent (F/EA). These standards provide the core requirements for financial management services provided under home and community-based services waiver programs administered by the Office of Aging and Adult Services (OAAS), the Office for Citizens with Developmental Disabilities (OCDD), and the Bureau of Health Services Financing (BHSF).

B. LDH is responsible for setting the standards for F/EAs, monitoring the provisions of this Rule, and applying administrative sanctions for failures to meet the minimum

standards for participation in serving employers/participants of the OAAS and OCDD-administered waiver programs.

C. The F/EA provides financial management services for participants who are eligible for self-directed waiver services. Under this service model, the F/EA assists individuals with management of fiscal employment and/or budget responsibilities and will provide the employer/participant with current utilization information to ensure self-directed services are not exceeded beyond the prior authorization cap; processes employer-related payroll and necessary taxes on behalf of self-direction participants. The F/EA also verifies qualifications (e.g., background checks, exclusion checks, etc.) for employees hired by the employers.

D. Medicaid-enrolled F/EAs providing financial management services at the time of OCDD and OAAS-administered waiver programs shall be required to meet the requirements of this Chapter.

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, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1559 (September 2023).

§1103. Certification Requirements

A. All F/EAs that provide financial management services must be certified through completion of a readiness review by LDH. It shall be unlawful to operate as an F/EA without being certified by LDH.

B. In order to provide financial management services, the F/EA must:

1. be certified through completion of a readiness review and meet the standards for participation requirements as set forth in this Rule;

2. sign a performance agreement with LDH;

3. enroll as an F/EA with the Louisiana Medicaid program to provide services for OCDD and OAAS-administered home and community-based services; and

4. comply with all policies and procedures set forth by LDH.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1560 (September 2023).

§1105. Certification Issuance

A. A certification shall:

1. be issued only to the F/EA named in the certification application;

2. be valid only for the F/EA to which it is issued after all applicable requirements are met;

3. enable the F/EA to provide financial management services for OCDD and OAAS-administered home and community-based services waivers statewide;

4. be valid indefinitely, unless revoked, suspended, modified, or terminated; and

5. be issued by LDH.

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, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1560 (September 2023).

§1107. Certification Refusal or Revocation and Fair Hearing

A. A certification may be revoked or refused if applicable certification requirements, as determined by LDH, have not been met. Certification decisions are subject to appeal and fair hearing, in accordance with R.S. 46:107(A)(3).

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1560 (September 2023).

§1109. Certification Review

A. Compliance with certification requirements is determined by LDH through its F/EA monitoring processes. Monitors must be given access to data upon request by LDH to ensure the F/EA continues to meet certification requirements.

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, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1560 (September 2023).

Subchapter B. Administration and Organization

§1115. Governing Body

A. The F/EA shall have an identifiable governing body with responsibility for and authority over its policies and activities.

B. The F/EA shall have documents identifying all members of the governing body, their addresses, their terms of membership, and officers of the governing body.

C. The governing body of the F/EA shall:

1. ensure continual compliance and conformity with all relevant federal, state, local, and municipal laws and regulations;

2. ensure the F/EA is adequately funded and fiscally sound;

3. review and approve the F/EA's annual budget; and

4. designate a person to act as administrator and delegate sufficient authority to this person to manage the F/EA.

D. The F/EA shall maintain an administrative file that includes:

1. documents identifying the governing body;

2. a list of members and officers of the governing body, along with their addresses and terms of membership;

3. minutes of formal meetings and by-laws of the governing body, if applicable;

4. documentation of the F/EA's authority to operate under state law;

5. an organizational chart of the F/EA which clearly delineates the line of authority;

6. all leases, contracts and purchases-of-service agreements to which the F/EA is a party;

7. insurance policies;

8. annual budgets and, if performed, audit reports;

9. the F/EA's policies and procedures; and

10. documentation of any corrective action taken as a result of external or internal reviews.

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, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1560 (September 2023).

§1117. Business Location and Operations

A. The F/EA shall have a business location which shall not be in an occupied personal residence. The F/EA must maintain the following at the business location:

1. staff to perform administrative functions;

2. direct service worker/employee personnel records; and

3. participant service records.

B. The F/EA shall have the following for the business location:

1. a published nationwide toll-free telephone number that is available during business hours and capable of receiving messages 24 hours a day, seven days a week, including holidays;

2. a published business telephone number answered by staff during business hours;

3. a business fax number that is operational 24 hours a day, seven days a week, including holidays;

4. internet access;

5. a designated e-mail mailbox to receive inquiries from Medicaid beneficiaries and LDH; and

6. business hours shall be at least 8 a.m. to 5 p.m. CT, Monday through Friday, excluding official state holidays.

C. Records and other confidential information shall be secure and protected from unauthorized access.

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, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1561 (September 2023).

§1119. Financial Management

A. The F/EA must establish a system of financial management and staffing to assure maintenance of complete and accurate accounts, books, and records in keeping with generally accepted accounting principles.

B. The F/EA must not permit public funds to be paid, or committed to be paid, to any person who is a member of the governing board or administrative personnel who may have any direct or indirect financial interest, or in which any of these persons serve as an officer or employee, unless the services or goods involved are provided at a competitive cost or under terms favorable to the F/EA.

1. The F/EA shall have a written disclosure of any financial transaction with the F/EA in which a member of the governing board, administrative personnel, or his/her immediate family is involved.

C. To ensure the F/EA's ability to pay direct service workers for waiver services delivered, the F/EA shall have and maintain documented evidence of an available line of credit of at least \$1,000,000 or a cash reserve sufficient to cover the cost of two payroll cycles.

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, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1561 (September 2023).

§1121. Policy and Procedures

A. The F/EA shall have written policies and procedures approved by the owner or governing body which must be implemented and followed that address at a minimum the following:

1. confidentiality and confidentiality agreements;
2. security of files;
3. publicity and marketing, including the prohibition of illegal or coercive inducement, solicitation, and kickbacks;
4. personnel;
5. grievance procedures;
6. emergency preparedness;
7. procedures for reporting suspected abuse, neglect, exploitation, and extortion;

8. procedures for reporting suspected fraud;

9. documentation; and

10. enrollment/disenrollment procedures.

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, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1561 (September 2023).

§1123. Organizational Communication

A. The F/EA must establish procedures to assure adequate communication among staff to provide continuity of services to the participant and to facilitate feedback from staff, participants, families, and when appropriate, the community.

B. The F/EA must have brochures and make them available to LDH or its designee. The brochures must include the following information:

1. a toll-free number and email address to direct customer service questions or to receive assistance;
2. information on how to make a complaint if they are dissatisfied with F/EA services; and
3. a description of the F/EA, services provided, current mailing and physical addresses, website information, and the F/EA's toll-free number.

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, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1561 (September 2023).

Subchapter C. Provider Responsibilities

§1129. General Provisions

A. Any entity wishing to provide F/EA services shall meet all of the standards for participation contained in this Rule, unless otherwise specifically noted within these provisions.

B. The F/EA shall also abide by and adhere to any federal and state law, Rule, policy, procedure, performance agreement, or other state or federal requirements pertaining to the provision of F/EA services.

C. Failure to comply with the requirements of these standards for participation may result in the following actions including, but not limited to:

1. recoupment of funds;
2. sanctions for violations/non-performance as outlined in the performance agreement;
3. citation of deficient practice and plan of correction submission;
4. removal from the F/EA freedom of choice list; or

5. decertification as an F/EA and termination of the F/EA's Medicaid provider enrollment.

D. The F/EA shall make any required information or records, and any information reasonably related to assessment of compliance with these requirements, available to LDH.

E. The F/EA shall, upon request by LDH, make available the legal ownership documents of the F/EA.

F. The F/EA must comply with all of LDH's systems/software requirements, including the following:

1. The F/EA is required to transmit all non-proprietary data which is relevant for analytical purposes to LDH on a regular schedule in XML format.

a. Final determination of relevant data will be made by LDH based on collaboration between all parties;

b. The schedule for transmission of the data will be established by LDH and dependent on the needs of LDH related to the data being transmitted;

c. XML files for this purpose will be transmitted via secure file transfer protocol (SFTP) to LDH; and

d. Any other data or method of transmission used for this purpose must be approved via written agreement by all parties.

2. The F/EA is responsible for procuring and maintaining hardware and software resources which are sufficient for it to successfully perform the services detailed in this Rule.

3. The F/EA shall adhere to state and federal regulations and guidelines as well as industry standards and best practices for systems or functions required to support the requirements of this Rule.

4. Unless explicitly stated to the contrary, the F/EA is responsible for all expenses required to obtain access to LDH systems or resources which are relevant to successful completion of the requirements of this agreement. The F/EA is also responsible for expenses required for LDH to obtain access to the F/EA's systems or resources which are relevant to the successful completion of the requirements of this agreement. Such expenses are inclusive of hardware, software, network infrastructure, and any licensing costs.

5. The F/EA, for all confidential or protected health information, must be encrypted to federal information processing standards (FIPS) 140-2 standards when at rest or in transit.

6. The F/EA shall ensure appropriate protections of shared personally identifiable information (PII), in accordance with 45 CFR §155.260.

7. The F/EA shall ensure that its system is operated in compliance with the Centers for Medicare and Medicaid Services' (CMS) latest version of the minimum acceptable risk standards for exchanges (MARS-E) document suite.

8. Multi-factor authentication is a CMS requirement for all remote users, privileged accounts, and non-privileged accounts. In this context, remote user refers to staff accessing the network from offsite, normally with a client virtual private network (VPN) with the ability to access Medicaid and PII data.

9. A site-to-site tunnel is an extension of LDH's network. If the agent utilizes a VPN site-to-site tunnel and also has remote users who access CMS data, the agent is responsible for providing and enforcing multi-factor authentication.

10. The F/EA owned resources must be compliant with industry standard physical and procedural safeguards (NIST SP 800-114, NIST SP 800-66, NIST 800-53A, ISO 17788, etc.) for confidential information (i.e., health information technology for economic and clinical health (HITECH), health insurance portability and accountability act (HIPAA) part 164).

11. Any F/EA use of flash drives or external hard drives for storage of LDH data must first receive written approval from LDH and upon such approval shall adhere to FIPS 140-2 hardware level encryption standards.

12. All F/EA utilized computers and devices must:

a. be protected by industry standard virus protection software that is automatically updated on a regular schedule;

b. have installed all security patches which are relevant to the applicable operating system and any other system software; and

c. have encryption protection enabled at the operating system level.

G. F/EAs shall, at a minimum:

1. demonstrate administrative capacity and the financial resources to provide all core elements of financial management services and ensure effective service delivery in accordance with state and federal requirements;

2. have appropriate F/EA staff attend trainings, as mandated by LDH;

3. document and maintain records in accordance with federal and state regulations governing confidentiality and program requirements; and

4. assure that the F/EA will not provide both financial management services and support coordination or personal care services in Louisiana.

H. Abuse and Neglect. Fiscal employer agencies shall establish policies and procedures relative to the reporting of abuse, neglect, exploitation, and extortion of participants, pursuant to the provisions of R.S. 15:1504-1505, R.S. 40:2009.20 and any subsequently enacted laws. The F/EA shall ensure that staff complies with these regulations.

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, the Office of Aging

and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1561 (September 2023).

§1131. Fiscal Employer Agent Requirements

A. The F/EA must comply with requirements for financial management services in self-direction including, but not limited to:

1. verifying qualifications of employers and support workers;
2. processing payroll, including applying applicable withholds and filing/paying all required state and federal income taxes;
3. disbursing payment to direct support workers;
4. setting up accounting records to track expenses;
5. setting up procedures for processing payroll and non-labor items;
6. maintaining all records related to the direct support worker's payroll, taxes, and benefits;
7. producing and sending required reports to LDH;
8. providing support to self-direction employers;
9. billing the LDH fiscal intermediary for Medicaid service claims and making refunds to LDH as appropriate;
10. resolving all billing discrepancies timely;
11. utilizing an LDH approved payroll calendar that addresses tax obligations; and
12. utilizing a system capable of capturing, recording, and tracking service, payroll, and tax information.

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, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1562 (September 2023).

§1133. Transfers and Discharges

A. Participant has the right to choose among the F/EAs certified by LDH and enrolled in the Louisiana Medicaid Program. This includes the right to transition to another F/EA.

B. Upon notice by the participant or his/her authorized representative that the participant has selected another F/EA or the participant has decided to discontinue participation in the self-direction program, the F/EA is responsible for planning and facilitating the participant's transfer or discharge.

C. The F/EA shall facilitate transfer to another F/EA when it ceases to operate or its Medicaid enrollment is terminated.

D. The transfer or transition responsibilities of the F/EA shall include:

1. working with the F/EA selected by the participant to transition by ensuring the following

documents/information are submitted to the new provider: participant/employer wages, federal employment identification number (FEIN), and state unemployment tax act (SUTA) account information including username and password;

2. ensuring that there is only one F/EA for a given employer at any time;

3. adhering to specific processes and procedures when transitioning a participant to a new F/EA in accordance with all federal, state, and local laws; and

4. documenting the activities that are required to transition the participant to the receiving F/EA.

E. The F/EA shall not coerce or attempt to influence the participant's choice of F/EA. Failure to cooperate with the participant's decision to transfer to another F/EA will result in adverse action by LDH.

F. If the F/EA ceases to operate, the F/EA must give LDH at least 60 days written notice of its intent to close.

1. The transition plan for all participants served by the F/EA shall be completed within 10 working days of the notice to LDH of the F/EA's intent to close to minimize disruption of payroll services provided for employers.

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, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1563 (September 2023).

§1135. Staffing Requirements

A. F/EAs must maintain sufficient staff to comply with LDH regulations and policies for the self-direction program. The F/EA shall:

1. employ at least one staff member with a bachelor's degree in accounting and five years of applicable experience, or a master's degree in accounting and two years of applicable experience, or a master's degree in accounting and two years of applicable experience;

2. must have on staff a database administrator and sufficient programmers to ensure that systems comply with program requirements and are flexible enough to accommodate changes to those requirements; and

3. must designate a project director who will have day-to-day authority to manage the overall operations.

- a. The project director will be available to LDH by telephone, e-mail, and video conferencing during regular business hours.

B. In the event LDH determines that the F/EA staffing levels do not conform to the above requirements, LDH shall advise the F/EA in writing and the F/EA shall submit a corrective action plan within five business days. This plan shall describe how the deficiency(ies) will be remedied and is subject to LDH approval.

C. The F/EA shall ensure all staff supporting the self-direction program are not excluded from participating in the Medicaid program by confirming each staff's name and social security number are not included on the Louisiana adverse actions list and Office of Inspector General (OIG) exclusions list.

D. Each F/EA shall ensure that staff is available at times which are convenient and responsive to the needs of participants and their families.

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, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1563 (September 2023).

§1137. Employer Rights

A. Each F/EA's written policies and procedures, at a minimum, shall ensure the employer's right to:

1. confidentiality;
2. privacy;
3. impartial access to F/EA services regardless of race, religion, sex, ethnicity, or disability;
4. access to the interpretive services, translated material and similar accommodations as appropriate;
5. access to his/her records upon the participant's written consent for release of information;
6. an explanation of the nature of services to be received;
7. file a complaint or grievance without retribution, retaliation, or discharge;
8. have access to information related to tracking their budget and service balance; and
9. discontinue services with their F/EA and choose another F/EA.

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, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1563 (September 2023).

§1139. Grievances

A. The F/EA shall establish and follow a written grievance procedure to be used to process complaints by employers, their family member(s), or a legal representative that is designed to allow employers to make complaints without fear of retaliation. The written grievance procedure shall be provided to the employer.

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, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1564 (September 2023).

§1141. Electronic Visit Verification (EVV) Requirements

A. The F/EA must have an electronic visit verification (EVV) system in place that complies with the 21st Century Cures Act. The F/EA's EVV system must verify the type of service provided, the individual receiving the service, the individual providing the service, date of service, location of the service (geolocation), and time the service begins and ends.

B. Services may be verified via smart phone, telephony (landline from participant's home), or a fixed visit verification device in the participant's home. Other methods of verification may be submitted to LDH for consideration and approval.

C. The F/EA is responsible for ensuring the system used meets the requirements specified in the LDH attestation for third party EVV systems.

1. The system shall have the capability to interface with LDH's EVV system.

2. The F/EA's system and its interface shall pass testing required by the data integration process prior to go-live.

3. The F/EA will be required to collect electronic check in/check out information including geolocation data in accordance with state requirements.

D. The F/EA must provide a user-friendly EVV system, including an alternate method of collecting time should the EVV system becomes unavailable.

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, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1564 (September 2023).

§1143. Employer Records

A. The F/EA shall store employer/employee records securely and protected in accordance with HIPAA requirements at the F/EA's place of business.

B. F/EAs shall maintain employer and employee records for at least six years or longer when required by state or federal law.

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, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1564 (September 2023).

§1145. Emergency Preparedness

A. The F/EA, regardless of the architecture of its systems, shall develop and be continually ready to invoke an all hazards plan to protect the availability, integrity, and security of data during unexpected failures or disasters (either natural or man-made) to continue essential

application or system functions during or immediately following failures or disasters.

B. The all hazards plan shall include a disaster recovery plan (DRP) and a business continuity plan (BCP). A DRP is designed to recover systems, networks, workstations, applications, etc., in the event of a disaster. A BCP shall focus on restoring the operational function of the organization in the event of a disaster and includes items related to information technology (IT), as well as operational items such as employee notification processes and the procurement of office supplies needed to do business in the emergency mode operation environment. The practice of including both the DRP and the BCP in the all hazards planning process is a best practice. At a minimum, the all hazards plan shall address the following scenarios:

1. the central computer installation and resident software are destroyed or damaged;

2. the system interruption or failure resulting from network, operating hardware, software, or operations errors that compromise the integrity of transaction that are active in a live system at the time of the outage; and

3. system interruption or failure resulting from network, operating hardware, software or operations errors that compromise the integrity of data maintained in a live or archival system.

C. The all hazards plan shall specify projected recovery times and data loss for mission-critical systems in the event of a declared disaster. The following minimum criteria are required:

1. system restoration within 24 hours;
2. two physical locations for maintaining data; and
3. backups of all system data every 24 hours.

D. The F/EA shall annually test its plan through simulated disasters and lower level failures in order to demonstrate to LDH that it can restore system functions. In the event the F/EA fails to demonstrate through these tests that it can restore system functions, the F/EA shall be required to submit a corrective action plan to LDH describing how the failure shall be resolved within 10 business days of the conclusion of the test.

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, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1564 (September 2023).

§1147. Fiscal Employer Agent Monitoring

A. F/EAs shall be monitored on an on-going basis as outlined in the performance agreement.

B. F/EAs shall offer full cooperation with LDH during the monitoring process.

C. Responsibilities of the F/EA in the monitoring process include, but are not limited to, providing policy and

procedure manuals, employer/employee records, and other documentation as requested.

D. F/EAs shall cooperate with any audit requests from state or federal agencies.

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, the Office of Aging and Adult Services, and the Office for Citizens with Developmental Disabilities, LR 49:1564 (September 2023).

Subpart 3. Adult Day Health Care

Chapter 21. General Provisions

§2101. Introduction

A. These standards for participation specify the requirements of the Adult Day Health Care (ADHC) Waiver Program. The program is funded as a waived service under the provisions of Title XIX of the Social Security Act and is administered by the Department of Health (LDH).

B. Waiver services are provided under the provisions of the approved waiver agreement between the Centers for Medicare and Medicaid Services (CMS) and the Louisiana Medicaid Program.

C. Any provider of services under the ADHC waiver shall abide by and adhere to any federal or state laws, rules, policy, procedures, or manuals issued by the department. Failure to do so may result in sanctions.

D. Each individual who requests ADHC waiver services has the option to designate a responsible representative. For purposes of these provisions, a responsible representative shall be defined as the person designated by the individual to act on his/her behalf in the process of accessing and/or maintaining ADHC waiver services.

1. The appropriate form authorized by the Office of Aging and Adult Services (OAAS) shall be used to designate a responsible representative.

a. The written designation of a responsible representative does not take away the right of the individual to continue to transact business on his/her own behalf nor does it give the representative any legal authority other than as specified in the designation form.

b. The written designation is valid until revoked by the individual granting the designation.

i. To revoke the written designation, the revocation must be submitted in writing to OAAS or its designee.

2. The functions of a responsible representative are to:

a. assist and represent the individual in the assessment, care plan development and service delivery processes; and

b. aid the participant in obtaining all of the necessary documentation for these processes.

3. No individual, unless granted an exception by OAAS, may concurrently serve as a responsible representative for more than two participants in OAAS-operated Medicaid home and community-based service programs including:

- a. the Program of All-Inclusive Care for the Elderly (PACE);
- b. long-term personal care services (LT-PCS);
- c. the Community Choices Waiver; and
- d. the Adult Day Health Care 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 Human Resources, Office of Family Security, LR 11:623 (June 1985), repromulgated LR 13:181 (March 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 23:1149 (September 1997), repromulgated LR 30:2034 (September 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2161 (October 2008), repromulgated LR 34:2565 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2494 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:2162 (December 2018), LR 50:382 (March 2024).

§2103. Program Description

A. An Adult Day Health Care Waiver Program expands the array of services available to individuals with functional impairments, and helps to bridge the gap between independence and institutional care by allowing them to remain in their own homes and communities. This program provides direct care for individuals who have physical, mental or functional impairments. ADHC waiver participants must attend a minimum of 36 days per calendar quarter, absent extenuating circumstances. Exceptions for extenuating circumstances must be approved by the assigned support coordinator based upon guidance provided by OAAS.

B. The target population for the ADHC Waiver Program includes individuals who:

1. are 65 years old or older; or
2. are 22 to 64 years old and with a physical disability; and
3. meet nursing facility level of care requirements.

C. The long-range goal for all adult day health care participants is the delay or prevention of long-term care facility placement. The more immediate goals of the Adult Day Health Care Waiver are to:

1. promote the individual's maximum level of independence;
2. maintain the individual's present level of functioning as long as possible, preventing or delaying further deterioration;

3. restore and rehabilitate the individual to the highest possible level of functioning as may be practicable under the circumstances;

4. provide support and education for families and other caregivers;

5. foster socialization and peer interaction; and

6. serve as an integral part of the community services network and the long-term care continuum of 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 8:145 (March 1982), amended LR 11:623 (June 1985), repromulgated LR 13:181 (March 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 14:793 (November 1988), amended by the Bureau of Health Services Financing, LR 23:1149 (September 1997), repromulgated LR 30:2034 (September 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2161 (October 2008), repromulgated LR 34:2566 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2624 (September 2011), LR 39:2495 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:382 (March 2024).

§2105. Request for Services Registry [Formerly §2107]

A. The Department of Health is responsible for the Request for Services Registry, hereafter referred to as "the registry", for the ADHC Waiver. An individual who wishes to have his or her name placed on the registry shall contact a toll free telephone number, which shall be maintained by LDH.

B. Individuals who desire their name to be placed on the ADHC waiver registry shall be screened to determine whether they:

1. meet nursing facility level of care; and
2. are members of the target population as identified in the federally-approved waiver document.

C. Only individuals who pass the screening in §2105.B shall be added to the registry.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and pursuant to 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 30:2035 (September 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office of Aging and Adult Services, LR 32:2256 (December 2006), LR 34:2161 (October 2008), repromulgated LR 34:2566 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2495 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:2163 (December 2018).

§2107. Programmatic Allocation of Waiver Opportunities

A. When funding is appropriated for a new ADHC waiver opportunity or an existing opportunity is vacated, the department shall send a written notice to an individual on the registry indicating that a waiver opportunity is available. That individual shall be evaluated for a possible ADHC waiver opportunity assignment.

B. Adult day health care waiver opportunities shall be offered to individuals on the registry according to priority groups. The following groups shall have priority for ADHC waiver opportunities in the order listed:

1. individuals with substantiated cases of abuse or neglect referred by protective services who, without ADHC waiver services, would require institutional placement to prevent further abuse and neglect;

2. individuals who have been discharged after a hospitalization within the past 30 calendar days that involved a stay of at least one night;

3. individuals admitted to, or residing in, a nursing facility who have Medicaid as the sole payer source for the nursing facility stay; and

4. all other eligible individuals on the Request for Services Registry (RFSR), by date of first request for services.

C. If an applicant is determined to be ineligible for any reason, the next individual on the registry is notified and the process continues until an individual is determined eligible. An ADHC waiver opportunity is assigned to an individual when eligibility is established and the individual is certified.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2162 (October 2008), repromulgated LR 34:2566 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2624 (September 2011), LR 39:2495 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:2163 (December 2018).

Chapter 23. Services

§2301. Covered Services

A. The following services are available to participants in the ADHC Waiver. All services must be provided in accordance with the approved plan of care (POC). No services shall be provided until the POC has been approved.

1. Adult Day Health Care. Services furnished as specified in the POC at a licensed ADHC center, in a non-institutional, community-based setting encompassing both health/medical and social services needed to ensure the optimal functioning of the participant. Services are furnished on a regularly scheduled basis, not to exceed 10 hours a day, 50 hours a week. ADHC services include those core service

requirements identified in the ADHC licensing standards (LAC 48:I.4243) in addition to:

- a. medical care management; and

- b. transportation to and from medical and social activities (if the participant is accompanied by the ADHC center staff).

2. Support Coordination. These services assist participants in gaining access to necessary waiver and other state plan services, as well as needed medical, social, educational, housing, and other services, regardless of the funding source for these services. Support coordination agencies shall be required to perform the following core elements of support coordination services:

- a. intake;

- b. assessment and reassessment;

- c. plan of care development and revision;

- d. follow-up/monitoring;

- e. critical incident management; and

- f. transition/discharge and closure.

3. Transition Intensive Support Coordination. These services will assist participants currently residing in nursing facilities in gaining access to needed waiver and other state plan services, as well as needed medical, social, housing, educational and other services regardless of the funding source for these services. Support coordinators shall initiate and oversee the process for assessment and reassessment, as well as be responsible for ongoing monitoring of the provision of services included in the participants approved POC.

- a. This service is paid up to six months prior to transitioning from the nursing facility when adequate pre-transition supports and activities are provided and documented.

- b. The scope of transition intensive support coordination shall not overlap with the scope of support coordination.

- c. Support coordinators may assist participants to transition for up to six months while the participants still reside in the facility.

4. Transition Services. These services are time limited, non-recurring set-up expenses available for individuals who have been offered and approved for an ADHC waiver opportunity and are transitioning from a nursing facility to a living arrangement in a private residence where the individual is directly responsible for his/her own expenses.

- a. Allowable expenses are those necessary to enable the individual to establish a basic household (excluding expenses for room and board) including, but not limited to:

- i. security deposits that are required to obtain a lease on an apartment or house;

- ii. specific set up fees or deposits;
- iii. activities to assess need, arrange for and procure needed resources;
- iv. essential furnishings to establish basic living arrangements; and
- v. health, safety, and welfare assurances.

b. These services must be prior approved in the participant's plan of care.

c. These services do not include monthly rental charges, mortgage expenses, food, recurring monthly utilities charges, household appliances, and/or items intended for purely diversional/recreational purposes.

d. These services may not be used to pay for furnishings or set-up living arrangements that are owned or leased by a waiver provider.

e. Support coordinators shall exhaust all other resources to obtain these items prior to utilizing the waiver.

f. Funds are available for specific items up to the lifetime maximum amount identified in the federally-approved waiver document.

5. Assistive Technology. These services include the following:

a. an item, piece of equipment, or product system, acquired commercially, that is used to increase, maintain, or improve functional capabilities of participants; and

b. the assistance provided to the participant in the acquisition, set up, and use of an assistive technology device:

i. evaluating to determine if an assistive technology device is appropriate for the participant;

ii. purchasing the most appropriate assistive technology device for the participant; and

iii. costs associated with the delivery, set up, and training.

6. ADHC Health Status Monitoring (HSM). This service monitors the status of participants that are unable to attend the ADHC on their scheduled day as outlined in the approved plan of care.

a. The ADHC provider may utilize this service and contact the participant via telephone to check in on the participant and provide follow-up on any need identified during the telephone contact.

7. Home Delivered Meals (HDMs). These services assist in meeting the nutritional needs of a participant in support of the maintenance of self-sufficiency and enhancing the quality of life.

a. Up to two nutritionally balanced meals per day may be delivered to the home of an eligible participant who is unable to prepare their own meals, and/or has no responsible caregiver in the home on days that the participant is not scheduled to attend the ADHC center.

b. Each meal shall provide a minimum of one-third of the current recommended dietary allowance (RDA) for the participant as adopted by the United States Department of Agriculture. The provision of HDMs does not provide a full nutritional regimen.

8. Activity and Sensor Monitoring (ASM). This is a computerized system that monitors the participant's in-home movement and activity for health, welfare, and safety purposes.

a. The provider agency is responsible for monitoring electronically-generated information, for responding as needed, and for equipment maintenance.

b. ASM must meet applicable manufacturing, design and installation standards.

c. ASM must be prior authorized and no experimental items shall be authorized.

9. Personal Emergency Response System (PERS). This is an electronic device which enables participants to secure help in an emergency. PERS is appropriate for participants who are cognitively and/or physically able to operate the system and who are alone for significant periods of time.

a. PERS must meet applicable manufacturing, design, and installation standards.

b. PERS must be prior authorized and no experimental items shall be authorized.

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 11:623 (June 1985), amended LR 13:181 (March 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 23:1149 (September 1997), amended LR 25:1100 (June 1999), repromulgated LR 30:2036 (September 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2162 (October 2008), repromulgated LR 34:2566 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2625 (September 2011), LR 39:2495 (September 2013), LR 40:791 (April 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:2163 (December 2018), LR 49:486 (March 2023), LR 50:382 (March 2024).

§2303. Individualized Service Plan

A. All participants shall have an ADHC individualized service plan (ISP) written in accordance with ADHC licensing standards (LAC 48:I.4281).

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 11:623 (June 1985), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 13:181 (March 1987), LR 23:1150, 1156 and 1163 (September 1997), LR 28:2356 (November 2002), repromulgated LR 30:2036 (September 2004), amended by the Department of

Health and Hospitals, Office of Aging and Adult Services, LR 34:2162 (October 2008), repromulgated LR 34:2567 (December 2008), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:2164 (December 2018).

§2305. Plan of Care

A. The applicant and support coordinator have the flexibility to construct a plan of care (POC) that serves the participant's health, safety and welfare needs. The service package provided under the POC shall include services covered under the Adult Day Health Care Waiver, Medicaid State Plan services, and any other services, regardless of the funding source.

1. All services approved pursuant to the POC shall be medically necessary and provided in a cost-effective manner.

2. The POC shall be developed using a person-centered process coordinated by the support coordinator.

B. Reimbursement shall not be made for adult day health care waiver services provided prior to the department's, or its designee's, approval of the POC.

C. The POC shall contain the:

1. types and number of services (including waiver and all other services) necessary to reasonably assure health and welfare and to maintain the individual in the community;

2. individual cost of each waiver service; and

3. total cost of waiver services covered by the POC.

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 Aging and Adult Services, LR 39:2496 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:2164 (December 2018).

Chapter 25. Admission and Discharge Criteria

§2501. Admission Criteria

A. Admission to the ADHC Waiver Program shall be determined in accordance with the following criteria:

1. meets the target population criteria as specified in the approved waiver document;

2. initial and continued Medicaid eligibility;

3. initial and continued eligibility for nursing facility level of care;

4. justification, as documented in the approved POC, that the ADHC waiver services are appropriate, cost-effective and represent the least restrictive environment for the individual; and

5. reasonable assurance that the health, safety and welfare of the individual can be maintained in the community with the provision of ADHC waiver services.

B. Failure of the individual to cooperate in the eligibility determination process, POC development, or to meet any of the criteria above shall result in denial of admission to the ADHC 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 Human Resources, Office of Family Security, LR 11:626 (June 1985), amended LR 13:181 (March 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 23:1153 (September 1997), repromulgated LR 30:2040 (September 2004), amended by the Department Of Hospitals, Office of Aging and Adult Services, LR 34:2163 (October 2008), repromulgated LR 34:2568 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2625 (September 2011), LR 39:2496 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:2164 (December 2018).

§2503. Admission Denial or Discharge Criteria

A. Admission shall be denied or the participant shall be discharged from the ADHC Waiver Program if any of the following conditions are determined.

1. The individual does not meet the target population criteria as specified in the federally approved waiver document.

2. The individual does not meet the criteria for Medicaid eligibility.

3. The individual does not meet the criteria for nursing facility level of care.

4. The individual resides in another state or the participant has a change of residence to another state.

5. Continuity of services is interrupted as a result of the participant not receiving and/or refusing ADHC waiver services (exclusive of support coordination services) for a period of 30 consecutive days.

a. Exceptions may be granted by OAAS to delay discharge if interruption is due to an acute care hospital, rehabilitation hospital, or nursing facility admission.

6. The health, safety and welfare of the individual cannot be assured through the provision of ADHC waiver services.

7. The individual/participant fails to cooperate in the eligibility determination process, POC development, or in the performance of the POC.

8. It is not cost effective or appropriate to serve the individual in the ADHC Waiver.

9. The participant fails to attend the ADHC center for a minimum of 36 days per calendar quarter.

10. The participant fails to maintain a safe and legal home environment.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2163 (October 2008), repromulgated LR 34:2568 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2625 (September 2011), LR 39:2496 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:2165 (December 2018).

Chapter 27. Provider Responsibilities

§2701. General Provisions

A. Each ADHC center shall:

1. be licensed by the Department of Health, Health Standards Section, in accordance with LAC 48:I.Chapter 42;
2. enroll as an ADHC Medicaid provider;
3. enter into a provider agreement with the department to provide services; and
4. agree to comply with the provisions of this Rule.

B. The provider shall not request payment unless the participant for whom payment is requested is receiving services in accordance with the ADHC Waiver program provisions and the services have been prior authorized and delivered.

C. Adult day health care waiver providers shall not refuse to serve any participant who chooses their agency unless there is documentation to support an inability to meet the participant's health, safety and welfare needs, or all previous efforts to provide service and supports have failed and there is no option but to refuse services.

1. OAAS, or its designee, must be immediately notified of the circumstances surrounding a refusal by a provider to render services.

2. This requirement can only be waived by OAAS or its designee.

D. Providers must maintain adequate documentation to support service delivery and compliance with the approved POC and will provide said documentation at the request of the department, or its designee.

E. Adult day health care providers shall not interfere with the eligibility, assessment, care plan development or care plan monitoring processes with use of methods including, but not limited to:

1. harassment;
2. intimidation; or
3. threats against program participants, members of the participant's informal support network, LDH staff, or support coordination staff.

F. Adult day health care providers shall have the capacity and resources to provide all aspects of the services they are enrolled to provide in the specified licensed service area.

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 11:627 (June 1985), amended LR 13:181 (March 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 23:1155 (September 1997), LR 24:457 (March 1998), repromulgated LR 30:2041 (September 2004), amended by the Department of Health and Hospitals, Office for Aging and Adult Services, LR 34:2164 (October 2008), repromulgated LR 34:2568 (December 2008),), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2625 (September 2011), LR 39:2497 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:2165 (December 2018).

§2703. Reporting Requirements

A. Support coordinators and direct service providers, including ADHC providers, are obligated to immediately report any changes to the department that could affect the waiver participant's eligibility including, but not limited to, those changes cited in the denial or discharge criteria listed in §2503.

B. Support coordinators and direct service providers, including ADHC providers, are responsible for documenting the occurrence of incidents or accidents that affect the health, safety and welfare of the participant and completing an incident report. The incident report shall be submitted to the department or its designee with the specified requirements within specified time lines.

C. Support coordinators shall provide the participant's approved POC to the providers listed on the POC in a timely manner.

D. Adult day health care providers shall provide the participant's approved individualized service plan to the support coordinator in a timely manner.

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, Office of Aging and Adult Services, LR 34:2164 (October 2008), repromulgated LR 34:2568 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2497 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:2165 (December 2018), LR 50:383 (March 2024).

Chapter 29. Reimbursement

§2901. Reimbursement and Rate Requirements

A. Adult day health care services shall be reimbursed according to LAC 50:XXI.709.

B. The following services shall be reimbursed at the authorized rate or approved amount of the installation, device/equipment, and when the service has been prior approved by the plan of care:

1. home delivered meals (not to exceed the maximum limit set by OAAS);
2. activity and sensor monitoring;
3. transition services (not to exceed the maximum lifetime limit set by OAAS);
4. personal emergency response system; and
5. assistive technology.

C. ADHC health status monitoring services shall be reimbursed as a per diem rate.

D. The following services shall be reimbursed at an established monthly rate:

1. support coordination;
2. transition intensive support coordination; and
3. monthly monitoring/maintenance for PERS and/or ASM services.

E. Reimbursement shall not be made for ADHC Waiver services provided prior to the department's approval of the POC and release of prior authorization for the services.

F. The state has the authority to set and change provider rates and/or provide lump sum payments to providers based upon funds allocated by the legislature.

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 of Aging and Adult Services, LR 49:683 (April 2023), amended LR 50:383 (March 2024).

**§2903. Adult Day Health Care (ADHC) Direct Support Worker Wages, Other Benefits, and Workforce Retention Bonus Payments
[Formerly LAC 50:XXI.2901]**

A. Establishment of ADHC Direct Support Worker Wage Floor and Other Benefits

1. ADHC providers that were providing ADHC services on or after October 1, 2021 and employing ADHC direct support workers will receive a rate increase. The ADHC reimbursement rates shall be rebased resulting in an average increase of \$4.31 per hour (rates differ based on facility specific transportation rate).

2. For direct support workers employed at the ADHC centers on or after October 1, 2021, 70 percent of the ADHC provider rate increases shall be passed directly to the ADHC direct support workers in the form of a minimum wage floor of \$9 per hour and in other wage and non-wage benefits.

3. All ADHC providers affected by this rate increase shall be subject to passing 70 percent of their rate increases directly to the ADHC direct support worker in various forms. These forms include a minimum wage floor of \$9 per hour and wage and non-wage benefits. This wage floor and wage and non-wage benefits are effective for all affected ADHC direct support workers of any working status, whether full-time or part-time.

4. The ADHC provider rate increases, wage floor, and/or wage and non-wage benefits will end March 31, 2025 or when the state's funding authorized under section 9817 of the American Rescue Plan Act of 2021 (Pub. L. No. 117-002) is exhausted.

5. The Department of Health (LDH) reserves the right to adjust the ADHC direct support worker wage floor and/or wage and non-wage benefits as needed through appropriate rulemaking promulgation consistent with the Administrative Procedure Act.

B. Establishment of Direct Support Worker Workforce Bonus Payments

1. ADHC providers who provided services from April 1, 2021 to October 31, 2022 shall receive bonus payments of \$300 per month for each ADHC direct support worker that worked with participants for those months.

2. The ADHC direct support worker who provided services from April 1, 2021 to October 31, 2022 to participants must receive at least \$250 of this \$300 monthly bonus payment paid to the provider. This bonus payment is effective for all affected ADHC direct support workers of any working status, whether full-time or part-time.

C. Audit Procedures for ADHC Direct Support Worker Wage Floor, Other Benefits, and Workforce Bonus Payments

1. The wage enhancements, wage and non-wage benefits and bonus payments reimbursed to ADHC providers shall be subject to audit by LDH.

2. ADHC providers shall provide to LDH or its representative all requested documentation to verify that they are in compliance with the ADHC direct support worker wage floor, wage and non-wage benefits and/or bonus payments.

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

4. ADHC providers shall produce the requested documentation upon request and within the timeframe provided by LDH.

5. Non-compliance or failure to demonstrate that the wage enhancement, wage and non-wage benefits and bonus payments were paid directly to ADHC direct support workers may result in the following:

- a. sanctions; or
- b. disenrollment from the Medicaid Program.

D. Sanctions for ADHC Direct Support Worker Wage Floor, Other Benefits and Workforce Bonus Payments

1. The ADHC provider will be subject to sanctions or penalties for failure to comply with this Rule or with requests issued by LDH pursuant to this Rule. The severity of such action will depend on the following factors:

- a. failure to pass 70 percent of the ADHC provider rate increases directly to the ADHC direct support workers

in the form of a floor minimum of \$9 per hour and in other wage and non-wage benefits and/or the \$250 monthly bonus payments;

b. the number of employees identified that the ADHC provider has not passed 70 percent of the ADHC provider rate increases directly to the ADHC direct support workers in the form of a floor minimum of \$9 per hour and in other wage and non-wage benefits and/or the \$250 monthly bonus payments;

c. the persistent failure to not pass 70 percent of the ADHC provider rate increases directly to the ADHC direct support workers in the form of a floor minimum of \$9 per hour and in other wage and non-wage benefits and/or 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 and the Office of Aging and Adult Services, LR 50:383 (March 2024).

Subpart 5. Supports Waiver

Chapter 53. General Provisions

§5301. Purpose

A. The mission of this waiver is to create options and provide meaningful opportunities that enhance the lives of individuals with intellectual and/or developmental disabilities through employment and day service supports in the community. The goals of the supports waiver are as follows:

1. promote independence for beneficiaries with a developmental disability who are aged 18 years or older while ensuring health and safety through a system of beneficiary safeguards;

2. provide an alternative to institutionalization and costly comprehensive services through the provision of an array of services and supports that promote community inclusion and independence by enhancing and not replacing existing informal networks; and

3. increase high school to community transition resources by offering supports and services to those 18 years and older.

B. Allocation of Waiver Opportunities. The Office for Citizens with Developmental Disabilities (OCDD) maintains the developmental disabilities request for services registry (DDRSR), hereafter referred to as “the registry,” which identifies persons with intellectual and/or developmental disabilities who are found eligible for developmental disabilities services using standardized tools, and who request waiver services.

1. Services are accessed through a single point of entry in the local governing entity (LGE). When criteria are

met, individuals’ names are placed on the registry and a screening of urgency of need (SUN) is completed.

2. Individuals determined to have current unmet needs as defined as a SUN score of urgent [three] or emergent [four] are offered a waiver opportunity.

3. The registry is arranged by the urgency of need and date of application for developmentally disabled (DD) waiver services.

4. OCDD waiver opportunities shall be offered based on the following priority groups:

a. Individuals living at publicly operated intermediate care facilities for the developmentally disabled (ICF/IIDs) or who lived at a publically operated ICF/IID when it was transitioned to a private ICF/IID through a cooperative endeavor agreement (CEA facility), or their alternates. Alternates are defined as individuals living in a private ICF/IID who will give up the private ICF/IID bed to an individual living at a publicly operated ICF/IID or to an individual who was living in a publicly operated ICF/IID when it was transitioned to a private ICF/IID through a cooperative endeavor agreement. Individuals requesting to transition from a publicly operated ICF/IID are awarded a slot when one is requested, and their health and safety can be assured in an OCDD waiver. This also applies to individuals who were residing in a publicly operated facility at the time the facility was privatized and became a CEA facility.

b. Individuals on the registry who have a current unmet need as defined by a SUN score of urgent [three] or emergent [four] and the earliest registry date shall be notified in writing when a funded OCDD waiver opportunity is available and a waiver offer is available.

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, Office for Citizens with Developmental Disabilities, LR 32:1604 (September 2006), amended LR 40:2583 (December 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2531 (December 2017), LR 48:1574 (June 2022), LR 50:211 (February 2024).

§5303. Settings for Home and Community-Based Services

A. Supports Waiver beneficiaries are expected to be integrated in and have full access to the greater community while receiving services, to the same extent as individuals without disabilities. Providers shall meet the requirements of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services’ (CMS) home and community-based setting requirements for home and community-based services (HCBS) waivers as delineated in LAC 50:XXI.901.

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 48:1574 (June 2022).

Chapter 55. Target Population

§5501. Participant Qualifications and Admissions Criteria

A. In order to qualify for the supports waiver, an individual must be 18 years of age or older, offered a waiver opportunity (slot), and meet all of the following criteria:

1. have a developmental disability as specified in R.S. 28:451.2;
2. be on the registry, unless otherwise specified through programmatic allocation in §5501;
3. meet the financial eligibility requirements for the Medicaid Program;
4. meet the requirements for an intermediate care facility for persons with intellectual disabilities (ICF/ID) level of care which requires active treatment of a developmental disability under the supervision of a qualified developmental disability professional;
5. have assurance that the health and welfare of the beneficiary can be maintained in the community with the provision of supports waiver services;
6. have justification, as documentation in the approved plan of care, that supports waiver services are appropriate, cost effective and represent the least restrictive environment for the beneficiary;
7. be a resident of Louisiana; and
8. be a citizen of the United States or a qualified alien.

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, Office for Citizens with Developmental Disabilities, LR 32:1604 (September 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:2583 (December 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2532 (December 2017), LR 48:1574 (June 2022).

§5503. Denial of Admission or Discharge Criteria

A. Beneficiaries shall be denied admission to, or discharged from, the supports waiver if one of the following criteria is met:

1. the beneficiary does not meet the financial eligibility requirements for the Medicaid Program;
2. the beneficiary does not meet the requirement for an ICF/IID level of care;
3. the beneficiary is incarcerated or placed under the jurisdiction of penal authorities, courts or state juvenile authorities;
4. the beneficiary resides in another state or has a change of residence to another state;

5. the beneficiary is admitted to an ICF/IID or nursing facility with the intent to stay and not to return to waiver services:

a. the waiver beneficiary may return to waiver services when documentation is received from the treating physician that the admission is temporary and shall not exceed 90 days;

b. the beneficiary will be discharged from the waiver on the ninety-first day if the participant is still in the ICF/IID or nursing facility;

6. the health and welfare of the beneficiary cannot be assured through the provision of supports waiver services within the beneficiary's approved plan of care;

7. the beneficiary fails to cooperate in the eligibility determination/re-determination process and in the development or implementation of the approved plan of care; and/or

8. continuity of services is interrupted as a result of the beneficiary not receiving a supports waiver service during a period of 30 or more consecutive days. This does not include interruptions in supports waiver services because of hospitalization, institutionalization (such as ICFs/DD or nursing facilities), or non-routine lapses in services where the family agrees to provide all needed or paid natural supports. There must be documentation from the treating physician that this interruption will not exceed 90 days. During this 90-day period, the OCDD will not authorize payment for supports waiver services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:2584 (December 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:1575 (June 2022), LR 50:212 (February 2024).

§5505. Needs-Based Assessment

A. The Office for Citizens with Developmental Disabilities (OCDD) has developed a framework for all activities related to planning for individualized supports and services. Discovery activities include:

1. a review of the beneficiary's records relevant to service planning (i.e. school, vocational, medical, and psychological records);
2. completing person-centered tools and worksheets, which may include a personal outcomes assessment, which assists the planning team in determining what is important to the beneficiary and his/her satisfaction or dissatisfaction with different life domain areas;
3. completion and review of the needs-based assessment within 30 days of a person being linked to a waiver opportunity and support coordination agency; and
4. review and/or completion of any additional interviews, observations, or other needed professional

assessments (i.e. occupational therapist, physical therapist, or speech therapist assessments).

B. A needs-based assessment is completed within the discovery process for all applicants aged 21 years and over who have received an OCDD waiver offer in order to identify the individual's service needs. The needs-based assessment instrument(s) is designed to evaluate the practical support requirements of individuals with developmental disabilities in daily living, medical areas, and behavioral areas as well as to identify living arrangements, existing relationships, and preferences and the levels of satisfaction in various life areas.

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 43:2532 (December 2017), amended LR 48:1575 (June 2022).

Chapter 57. Covered Services

§5701. Supported Employment Services

A. Supported employment services consists of intensive, ongoing supports and services necessary for a beneficiary to achieve the desired outcome of employment in a community setting where a majority of the persons employed are without disabilities. Beneficiaries utilizing these services may need ongoing supports for the life of their employment due to the nature of their disability, and natural supports may not meet this need.

B. Supported employment services provide supports in the following areas:

1. individual job, group employment, or self-employment;
2. job assessment, discovery and development, placement; and
3. initial job support and job retention, which may include assistance in personal care with activities of daily living in the supported employment setting and follow-along.

C. When supported employment services are provided at a work site where a majority of the persons employed are without disabilities, payment is only made for the adaptations, supervision and training required by beneficiaries receiving the service as a result of their disabilities. It does not include payment for the supervisory activities rendered as a normal part of the business setting.

D. Transportation is a separate billable component for supported employment services, both individual and group. Transportation may be billed on the same day as a supported employment service is delivered.

E. These services are also available to those beneficiaries who are self-employed. Funds for self-employment may not be used to defray any expenses associated with setting up or operating a business.

F. Supported employment services may be furnished by a coworker or other job-site personnel under the following circumstances:

1. the services furnished are not part of the normal duties of the coworker or other job-site personnel; and
2. these coworkers meet the pertinent qualifications for the providers of the service.

G. Service Limitations

1. Services for job assessment, discovery and development in individual jobs and self-employment shall not exceed the number of units as defined in a plan of care year and must have a prior authorization.

2. Services for job assessment, discovery and development in group employment shall not exceed the number of units as defined in a plan of care year and must have a prior authorization.

3. Services for individual initial job support, job retention and follow-along shall not exceed the number of units of service as defined in a plan of care year and must have prior authorization. Individual job follow-along services may be delivered virtually.

4. Services for initial job support, job retention and follow-along in group employment shall not exceed the number of units of service as defined in a plan of care year and must have prior authorization.

H. Restrictions

1. Beneficiaries receiving individual and/or group supported employment services may also receive other services in the same service day. However, these services cannot be provided at the same time of the day.

2. All virtual individual supported employment services must be documented and included in the plan of care. Virtual delivery of group supported employment is not allowed.

I. Choice of this service and staff ratio needed to support the beneficiary must be documented on the plan of care.

J. Supported employment services are not available to individuals who are eligible to participate in services that are available from programs funded under section 110 of the Rehabilitation Act of 1973 or sections 602 (16) or (17) of the Individuals with Disabilities Education Act [20 U.S.C. 1401 (26 and 29)], as amended, and those covered under the state plan, if applicable.

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, Office for Citizens with Developmental Disabilities, LR 32:1605 (September 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:2585 (December 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental

Disabilities, LR 43:2532 (December 2017), LR 48: LR 48:1575 (June 2022), LR 50:212 (February 2024).

§5703. Day Habilitation

A. Day habilitation is services that assist the beneficiary to gain desired community living experience, including the acquisition, retention or improvement in self-help, socialization and adaptive skills, and/or to provide the beneficiary an opportunity to contribute to his or her community. These services may be coordinated with any physical, occupational, or speech therapies identified in the individualized plan of care. Volunteer activities may be a part of this service and should follow the state guidelines for volunteering.

B. Day habilitation is the overarching service and may be delivered in a combination of these two service types:

1. onsite day habilitation; and
2. community life engagement.

NOTE: Day habilitation services may be delivered virtually and be included in the approved plan of care.

C. Day habilitation services are provided on a regularly scheduled basis for one or more days per week in a variety of community settings that are separate from the beneficiary's private residence, with the exception of virtual day habilitation. Day habilitation services should not be limited to a fixed site facility. Activities and environments are designed to foster personal choice in developing the beneficiary's meaningful day, including community activities alongside people who do not receive HCBS.

D. Day habilitation services may include assistance in personal care with activities of daily living.

E. Transportation is a separate billable component for day habilitation services. A day habilitation service must be billed on the same day that transportation is billed. Transportation cannot be billed if the service is delivered virtually.

F. Service Limitations. Services shall not exceed the number of units of service as defined in a plan of care year and must have a prior authorization.

G. Restrictions

1. Beneficiaries receiving day habilitation services may also receive other services on the same day but not at the same time of the day.

2. All virtual delivery of day habilitation services must be on an approved plan of care.

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, Office for Citizens with Developmental Disabilities, LR 32:1605 (September 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:2585 (December 2014), amended by Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:1576 (June 2022), LR 50:212 (February 2024).

§5705. Prevocational Services

A. Prevocational services are individualized, person centered services that assist the beneficiaries in establishing their path to obtain individualized community employment. This service is time limited and targeted for people who have an interest in becoming employed in individual jobs in the community, but who may need additional skills, information, and experiences to determine their employment goal and become successfully employed. Beneficiaries receiving prevocational services may choose to leave this service at any time or pursue employment opportunities at any time. Career planning must be a major component of prevocational services and should include activities focused on beneficiaries becoming employed to their highest ability.

B. Prevocational services is the overarching service and may be delivered in a combination of these two service types:

1. onsite prevocational; and
2. community career planning.

NOTE: Prevocational services may be delivered virtually.

C. Prevocational services are to be provided in a variety of locations in the community and are not to be limited to a fixed site facility. Activities associated with prevocational services should focus on preparing the beneficiary for integrated individual employment in the community. These services are operated through a provider agency that is licensed by the appropriate state licensing agency. Services are furnished on a regularly scheduled basis for one or more days per week.

D. Beneficiaries receiving prevocational services must participate in activities designed to establish an employment goal. Prevocational services are designed to help create a path to integrated community-based employment for which a beneficiary is compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

E. Prevocational services may also include assistance in personal care with activities of daily living.

F. Transportation is a separate billable component for prevocational services. A prevocational service must be billed on the same day that transportation is billed. Transportation cannot be billed if the prevocational service is delivered virtually.

G. Service Limitations. Services shall not exceed the number of units of service as defined in a plan of care year and must have a prior authorization.

H. Restrictions

1. Beneficiaries receiving prevocational services may also receive other services on the same day but cannot be provided during the same time of the day.

2. All virtual prevocational services must be included on the approved plan of care.

I. Prevocational services are not available to individuals who are eligible to participate in programs that are available and funded under section 110 of the Rehabilitation Act of 1973 or sections 602 (16) or (17) of the Individuals with Disabilities Education Act [20 U.S.C. 1401 (26 and 29)], as amended, and those covered under the state plan, if applicable.

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, Office for Citizens with Developmental Disabilities, LR 32:1605 (September 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:2585 (December 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:1577 (June 2022), LR 50:213 (February 2024).

§5707. Respite

A. Respite care is a service provided on a short-term basis to a beneficiary who is unable to care for himself/herself due to the absence or need for relief of those unpaid persons normally providing care for the beneficiary.

B. Respite may be provided in a licensed respite care facility that is determined to be appropriate by the beneficiary or other responsible party, or may be provided in the beneficiary's home or private place of residence.

C. Service Limitations. Services shall not exceed 428 units of service in a plan of care year.

D. Choice and need for this service must be documented on the plan of care.

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, Office for Citizens with Developmental Disabilities, LR 32:1606 (September 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:2586 (December 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:1577 (June 2022), LR 50:213 (February 2024).

§5709. Habilitation

A. Habilitation offers services designed to assist the beneficiary in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community settings.

B. Habilitation is provided in the home or community, includes necessary transportation, and is included on the plan of care as determined to be appropriate.

C. Habilitation services may include, but are not limited to:

1. acquisition of skills needed to do household tasks which include, but are not limited to laundry, dishwashing, housekeeping, grocery shopping in the community, and other

tasks to promote independence in the home and community; and

2. travel training activities in the community that promote community independence, to include but not limited to, place of individual employment, church, or other community activity. This does not include group supported employment, day habilitation, or prevocational sites.

D. Service Limitations. Services shall not exceed 285 units of service in a plan of care year.

E. Choice and need for this service must be documented on the plan of care.

F. Beneficiaries receiving habilitation may use this service in conjunction with other supports waiver services as long as other services are not provided during the same period in a day.

NOTE: Beneficiaries who are age 18 through 21 may also receive available services as outlined on their plan of care through the Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program, if applicable. Beneficiaries who are age 21 and older may receive available services as outlined on their plan of care through the Long-Term Personal Care Services (LT-PCS) Program, if applicable.

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, Office for Citizens with Developmental Disabilities, LR 32:1606 (September 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:2586 (December 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:1577 (June 2022), LR 50:213 (February 2024).

§5713. Personal Emergency Response System

A. A personal emergency response system (PERS) is an electronic device connected to the beneficiary's phone which enables a beneficiary to secure help in the community. The system is programmed to signal a response center staffed by trained professionals when a "help" button is activated.

B. This service must be prior authorized and be in accordance with the plan of care.

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, Office for Citizens with Developmental Disabilities, LR 32:1607 (September 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:2587 (December 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:1578 (June 2022), LR 50:214 (February 2024).

§5715. Support Coordination

A. Support coordination is a service that will assist beneficiaries in gaining access to all of their necessary services, as well as medical, social, educational, and other services, regardless of the funding source for the services. Support coordinators shall be responsible for on-going

monitoring of the provision of services included in the beneficiary's approved plan of care.

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, Office for Citizens with Developmental Disabilities, LR 34:662 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, Office for Citizens with Developmental Disabilities, LR 40:2587 (December 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:1578 (June 2022), LR 50:214 (February 2024).

§5717. Housing Stabilization Transition Services

A. Housing stabilization transition services enable beneficiaries who are transitioning into a permanent supportive housing unit, including those transitioning from institutions, to secure their own housing. The service is provided while the beneficiary is in an institution and preparing to exit the institution using the waiver. The service includes the following components:

1. conducting a housing assessment to identify the beneficiary's preferences related to housing (i.e., type, location, living alone or with someone else, need for accommodations, and other important preferences), and his/her needs for support to maintain housing, including:

- a. access to housing;
- b. meeting the terms of a lease;
- c. eviction prevention;
- d. budgeting for housing/living expenses;
- e. obtaining/accessing sources of income necessary for rent;
- f. home management;
- g. establishing credit; and
- h. understanding and meeting the obligations of tenancy as defined in the lease terms;

2. assisting the beneficiary to view and secure housing as needed, which may include arranging and providing transportation;

3. assisting the beneficiary to secure supporting documents/records, completing/submitting applications, securing deposits, and locating furnishings;

4. developing an individualized housing support plan based upon the housing assessment that:

- a. includes short- and long-term measurable goals for each issue;
- b. establishes the beneficiary's approach to meeting the goal; and
- c. identifies where other provider(s) or services may be required to meet the goal;

5. participating in the development of the plan of care and incorporating elements of the housing support plan; and

6. exploring alternatives to housing if permanent supportive housing is unavailable to support completion of transition.

B. Housing stabilization transition services are only available upon referral from the support coordinator. This service is not duplicative of other waiver services, including support coordination. This service is only available to persons who are residing in a state of Louisiana permanent supportive housing unit or who are linked for the state of Louisiana permanent supportive housing selection process.

C. Beneficiaries may not exceed 165 combined units of this service and the housing stabilization service.

1. Exceptions to exceed the 165 unit limit may be made only with written approval from the OCDD.

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 for Citizens with Developmental Disabilities, LR 40:81 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:1578 (June 2022), LR 50:214 (February 2024).

§5719. Housing Stabilization Services

A. Housing stabilization services enable waiver beneficiaries to maintain their own housing as set forth in a beneficiary's approved plan of care. Services must be provided in the home or a community setting. This service includes the following components:

1. conducting a housing assessment to identify the beneficiary's preferences related to housing (i.e., type, location, living alone or with someone else, accommodations needed, and other important preferences), and his/her needs for support to maintain housing, including:

- a. access to housing;
- b. meeting the terms of a lease;
- c. eviction prevention;
- d. budgeting for housing/living expenses;
- e. obtaining/accessing sources of income necessary for rent;
- f. home management;
- g. establishing credit; and
- h. understanding and meeting the obligations of tenancy as defined in the lease terms;

2. participating in the development of the plan of care, incorporating elements of the housing support plan;

3. developing an individualized housing stabilization service provider plan based upon the housing assessment that includes short- and long-term measurable goals for each issue, establishes the beneficiary's approach to meeting the

goal, and identifies where other provider(s) or services may be required to meet the goal;

4. providing supports and interventions according to the individualized housing support plan;

a. if additional supports or services are identified as needed outside the scope of housing stabilization service, the needs must be communicated to the support coordinator;

5. providing ongoing communication with the landlord or property manager regarding the beneficiary's disability, accommodations needed, and components of emergency procedures involving the landlord or property manager;

6. updating the housing support plan annually or as needed due to changes in the beneficiary's situation or status; and

7. if at any time the beneficiary's housing is placed at risk (e.g., eviction, loss of roommate or income), providing supports to retain housing or locate and secure housing to continue community-based supports, including locating new housing, sources of income, etc.

B. Housing stabilization services are only available upon referral from the support coordinator. This service is not duplicative of other waiver services including support coordination. It is only available to persons who are residing in a state of Louisiana permanent supportive housing unit.

C. Beneficiaries may not exceed 165 combined units of this service and the housing stabilization transition service.

1. Exceptions to exceed the 165 unit limit may be made only with written approval from the OCDD.

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 for Citizens with Developmental Disabilities, LR 40:81 (January 2014), amended LR 40:2587 (December 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:1578 (June 2022).

§5721. Dental Services

A. Dental services are available to adult beneficiaries over the age of 21. Covered dental services include:

1. adult diagnostic services;
2. preventative services;
3. restorative services;
4. endodontics;
5. periodontics;
6. prosthodontics;
7. oral and maxillofacial surgery;
8. orthodontics;
9. emergency care; and

10. adjunctive general services.

B. Dental Service Exclusions

1. Dental services are not available to beneficiaries who are 18 to 21 years of age as this group accesses dental services through the EPSDT benefit.

2. Non-covered services include but are not limited to the following:

a. services that are not medically necessary to the beneficiary's dental health;

b. dental care for cosmetic reasons;

c. experimental procedures;

d. plaque control;

e. any periapical radiographic images, occlusal radiographic images, complete series, or panoramic radiographic images taken annually or routinely at the time of a dental examination for screening purposes;

f. routine post-operative services—these services are covered as part of the fee for initial treatment provided;

g. treatment of incipient or non-carious lesions (other than covered sealants and fluoride);

h. services that are eligible for reimbursement by insurance or covered under any other insurance or medical health plan;

i. dental expenses related to any dental services:

i. started after the beneficiary's coverage ended; or

ii. received before the beneficiary became eligible for these services; and

j. administration of in-office pre-medication.

C. Provider Qualifications. Providers are enrolled through the LA Dental Benefit Program, which is responsible for maintaining provider lists.

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 48:1579 (June 2022), LR 50:214 (February 2024).

§5723. Community Life Engagement Development

A. Community life engagement development (CLED) facilitates the development of opportunities to assist beneficiaries in becoming involved in the community. The purpose of CLED is to find the opportunities that encourage and foster the development of meaningful relationships in the community reflecting the beneficiary's choices and values. Objectives outlined in the comprehensive plan of care will afford opportunities to increase community inclusion, participation in leisure/recreational activities, and encourage participation in volunteer and civic activities. To utilize this service, the beneficiary may or may not be present. CLED services may be performed by a staff person

for up to three waiver beneficiaries who have a common provider agency for day services and supports. Rates shall be adjusted accordingly.

B. Transportation costs are included in the reimbursement for CLED services.

C. Service Limitations. Services shall not exceed the number of units as defined in the beneficiary's plan of care and must have a prior authorization.

D. Provider Qualifications. Providers must be licensed by the Department of Health as a home and community-based services provider and must meet the module specific requirements for the service being provided.

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 50:214 (February 2024).

§5725. Specialized Medical Equipment and Supplies

A. Incontinence briefs and supplies are available for a beneficiary, 21 years or older, who has a physician's order and requires the use of incontinence briefs and supplies.

B. Service Restrictions

1. This service is for those who are 21 years of age or older.

2. This service requires a physician's order.

C. Service Limitations

1. The cost cannot exceed \$2,500 in a single plan of care 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, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 50:214 (February 2024).

Chapter 59. Provider Participation

§5901. General Provisions

A. In order to participate in the Medicaid Program as a provider of Supports Waiver services, a provider must meet all qualifications outlined in LAC 50.XXI, Subpart 1, Chapter 1 and all applicable amendments.

B. If the transportation component for supported employment, day habilitation, and/or prevocational services is provided by the provider, the provider must have insurance coverage that meets current home and community-based services providers licensing standards on any vehicles used in transporting a beneficiary.

C. In addition to meeting the requirements cited in this §5901.A and B, providers must meet the following requirements for the provision of designated services.

1. Day Habilitation and Prevocational Services. The provider must possess a current, valid license as an adult day care center in order to provide these services.

2. Supported Employment Services. The provider must possess a valid certificate of compliance as a community rehabilitation provider (CRP) from an approved program or the certification and training as required per OCDD.

3. Respite Services. The provider must possess a current, valid license as a personal care attendant agency or a respite care center in order to provide these services.

4. Habilitation Services. The provider must possess a valid license as a personal care attendant agency in order to provide this service.

5. Personal Emergency Response System. The provider must be enrolled to participate in the Medicaid Program as a provider of personal emergency response systems.

6. Support Coordination. Providers must be licensed as support coordination agencies and enrolled in the Medicaid Program to deliver these services.

7. Dental Services. Providers of this service are managed through the LA Dental Benefit Program and must have a current, valid license from the state Board of Dentistry.

8. Specialized Medical Equipment and Supplies. Providers of this service must be enrolled to participate in the Medicaid Program as a provider of assistive technology, specialized medical equipment, and supplies.

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, Office for Citizens with Developmental Disabilities, LR 32:1607 (September 2006), LR 34:662 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, Office for Citizens with Developmental Disabilities, LR 40:2587 (December 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2532 (December 2017), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2532 (December 2017), LR 48:1579 (June 2022), LR 50:215 (February 2024).

§5903. Electronic Visit Verification

A. Effective for dates of service on or after August 1, 2015, Supports Waiver providers shall use the electronic visit verification (EVV) system designated by the department for automated scheduling, time and attendance tracking, and billing for certain home and community-based services.

B. Reimbursement shall only be made to providers with use of the EVV system. The services that require use of the EVV system include the following: in home respite, center-based respite, habilitation, day habilitation, prevocational services, and supported employment services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:1288 (July 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:1579 (June 2022), LR 50:215 (February 2024).

Chapter 61. Reimbursement

§6101. Unit of Reimbursement

A. The reimbursement for all services will be paid on a per claim basis. The reimbursement rate covers both service provision and administration. Services which utilize a prospective flat rate of one-quarter hour (15 minutes) will not be paid for the provision of less than one-quarter hour of service.

B. Supported Employment Services. Reimbursement shall be a prospective flat rate for each approved unit of service provided to the beneficiary. A standard unit of service in both individual and group supported employment services is one-quarter hour (15 minutes). A standard unit for individual ongoing follow along and job assessment is a fee for service rate.

C. Day Habilitation. Reimbursement shall be a prospective flat rate for each approved unit of service provided to the beneficiary. A standard unit of service is one-quarter hour (15 minutes).

D. Prevocational Services. Reimbursement shall be a prospective flat rate for each approved unit of service provided to the beneficiary. A standard unit of service is one-quarter hour (15 minutes).

E. Respite, housing stabilization transition services and housing stabilization services shall be reimbursed at a prospective flat rate for each approved unit of service provided to the beneficiary. One-quarter hour (15 minutes) is the standard unit of service.

F. Habilitation. Reimbursement shall be a prospective flat rate for each approved unit of service provided to the beneficiary. One-quarter hour (15 minutes) is the standard unit of service.

G. Personal Emergency Response System (PERS). Reimbursement for the maintenance of the PERS is paid through a monthly rate. Installation of the device is paid through a one-time fixed cost.

H. Direct Service Worker Wages and Bonus Payments

1. Establishment of Direct Service Worker Wage Floor for Medicaid Home and Community-Based Services for Intellectual and Developmental Disabilities

a. Effective October 1, 2021, providers of Medicaid home and community-based waiver services operated through the Office for Citizens with Developmental Disabilities employing direct service workers will receive the equivalent of a \$2.50 per hour rate increase.

b. Effective October 1, 2021, this increase or its equivalent will be applied to all service units provided by direct service workers with an effective date of service for the identified home and community-based waiver services provided beginning October 1, 2021.

c. The minimum hourly wage floor paid to direct service workers shall be \$9 per hour.

d. All providers of services affected by this rate increase shall be subject to a direct service worker wage floor of \$9 per hour. This wage floor is effective for all affected direct service workers of any work status whether full-time or part-time.

e. The Department of Health (LDH) reserves the right to adjust the direct service worker wage floor as needed through appropriate rulemaking promulgation consistent with the Administrative Procedure Act.

2. Establishment of Direct Service Worker Workforce Bonus Payments

a. Providers who provided services from April 1, 2021 to October 31, 2022 shall receive bonus payments of \$300 per month for each direct service worker that worked with participants for those months.

b. The direct service worker 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 provider. This bonus payment is effective for all eligible direct service workers of any working status, whether full-time or part-time.

c. Bonus payments will end October 31, 2022.

d. LDH reserves the right to adjust the amount of the bonus payments paid to the direct service worker as needed through appropriate rulemaking promulgation consistent with the Administrative Procedure Act.

3. Audit Procedures for Direct Service Worker Wage Floor and Workforce Bonus Payments

a. The wage enhancement and bonus payments reimbursed to providers shall be subject to audit by LDH.

b. Providers shall provide to LDH or its representative all requested documentation to verify that they are in compliance with the direct service worker wage floor and bonus payments.

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

d. Providers shall produce the requested documentation upon request and within the timeframe provided by LDH.

e. Non-compliance or failure to demonstrate that the wage enhancement and/or bonus payment were paid directly to direct service workers may result in the following:

i. sanctions; or

- ii. disenrollment from the Medicaid program.

4. Sanctions for Direct Service Worker Wage Floor and Workforce Bonus Payments

a. The provider will be subject to sanctions or penalties for failure to comply with this Rule or with requests issued by LDH pursuant to this Rule. The severity of such an action will depend upon the following factors:

- i. Direct Service Worker Wage Floor

(a). failure to pay I/DD HCBS direct service workers the wage floor minimum of \$9 per hour;

(b). the number of I/DD HCBS direct service workers identified as having been paid less than the wage floor minimum of \$9 per hour; or

(c). the persistent failure to pay I/DD HCBS direct service workers the wage floor minimum of \$9 per hour;

- ii. Direct Service Worker Workforce Bonus Payments

(a). failure to pay eligible I/DD HCBS direct service workers the \$250 monthly workforce bonus payments;

(b). the number of eligible I/DD HCBS direct service workers identified as having not been paid the \$250 monthly workforce bonus payments; or

(c). the persistent failure to pay eligible I/DD HCBS direct service workers the \$250 monthly workforce bonus payments; or

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

I. Support Coordination. Support coordination shall be reimbursed at a fixed monthly rate in accordance with the terms of the established contract.

1. Establishment of Support Coordination Workforce Bonus Payments

a. Support coordination providers who provided services from April 1, 2021 to October 31, 2022 shall receive bonus payments of \$300 per month for each support coordination worker that worked with participants for those months.

b. The support coordination worker 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 provider. This bonus payment is effective for all eligible support coordination workers of any working status, whether full-time or part-time.

2. Audit Procedures for Support Coordination Workforce Bonus Payments

a. The bonus payments reimbursed to support coordination providers shall be subject to audit by LDH.

b. Support coordination providers shall provide to LDH or its representative all requested documentation to verify that they are in compliance with the support coordination bonus payments.

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

d. Support coordination providers shall produce the requested documentation upon request and within the timeframe provided by LDH.

e. Noncompliance or failure to demonstrate that the bonus payments were paid directly to support coordination workers may result in the following:

- i. sanctions; or
- ii. disenrollment from the Medicaid Program.

3. Sanctions for Support Coordination Workforce Bonus Payments

a. The support coordination provider will be subject to sanctions or penalties for failure to comply with this Rule or with requests issued by LDH pursuant to this Rule. The severity of such action will depend upon the following factors:

i. failure to pay support coordination workers the \$250 monthly workforce bonus payments;

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

iii. the persistent failure to pay the \$250 monthly workforce bonus payments; or

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

J. Dental Services. Dental services are reimbursed according to the LA Dental Benefit Program.

K. Community Life Engagement Development. Reimbursement shall be a prospective flat rate for each approved unit of service provided to the beneficiary. One-quarter hour (15 minutes) is the standard unit of service.

L. Transportation. Reimbursement shall be a prospective flat rate for each approved unit of service provided to the beneficiary. A standard unit is a daily rate.

M. Specialized Medical Equipment and Supplies. Reimbursement shall be a prospective flat rate for each approved unit of service provided to the beneficiary.

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, Office for Citizens with Developmental Disabilities, LR 32:1607 (September 2006), amended LR 34:662 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 36:2281

(October 2010), LR 37:2158 (July 2011), LR 39:1050 (April 2013), LR 40:82 (January 2014), LR 40:2587 (December 2014), LR 42:900 (June 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:43 (January 2022), LR 48:1579 (June 2022), LR 49:1072 (June 2023), LR 50:215 (February 2024).

Subpart 7. Community Choices Waiver

Chapter 81. General Provisions

§8101. Introduction

A. The target population for the Community Choices Waiver (CCW) includes individuals who:

1. are 65 years of age or older; or
2. are 21-64 years of age with a physical disability; and
3. meet nursing facility level of care requirements.

B. Services are provided under the provisions of the approved waiver agreement between the Centers for Medicare and Medicaid Services (CMS) and the Louisiana Medicaid Program.

C. Requests for Community Choices Waiver services shall be accepted from the following:

1. an individual requestor/applicant;
2. an individual who is legally responsible for a requestor/applicant; or
3. a responsible representative designated by the requestor/applicant to act on his/her behalf.

D. Each individual who requests Community Choices Waiver services has the option to designate a responsible representative. For purposes of these provisions, a responsible representative shall be defined as the person designated by the individual to act on his/her behalf in the process of accessing and/or maintaining Community Choices Waiver services.

1. The appropriate form authorized by the Office of Aging and Adult Services (OAAS) shall be used to designate a responsible representative.

a. The written designation of a responsible representative does not take away the right of the individual to continue to transact business on his/her own behalf nor does it give the representative any legal authority other than as specified in the designation form.

b. The written designation is valid until it is revoked by the individual granting the designation. To revoke the written designation, the revocation must be submitted in writing to OAAS or its designee.

2. The functions of a responsible representative are to:

a. assist and represent the individual in the assessment, care plan development and service delivery processes; and

b. to aid the participant in obtaining all of the necessary documentation for these processes.

3. No individual, unless granted an exception by OAAS, may concurrently serve as a responsible representative for more than two participants in OAAS-operated Medicaid home and community-based service programs. This includes but is not limited to:

- a. the Program of All-Inclusive Care for the Elderly (PACE);
- b. long term-personal care services (LT-PCS);
- c. the Community Choices Waiver; and
- d. the Adult Day Health Care (ADHC) 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, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3517 (December 2011), amended LR 40:791 (April 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1896 (October 2018), repromulgated LR 44:2005 (November 2018), amended LR 50:784 (June 2024).

§8103. Request for Services Registry

A. The Department of Health (LDH) is responsible for the request for services registry, hereafter referred to as “the registry,” for the Community Choices Waiver. An individual who wishes to have his or her name placed on the registry must contact a toll-free telephone number which shall be maintained by the department.

B. Individuals who desire their name to be placed on the community choices waiver registry shall be screened to determine whether they meet:

1. nursing facility level of care; and
2. are members of the target population as identified in the federally-approved waiver document.

C. Only individuals who pass the screen required in §8103.B.1-2 shall be added to the registry.

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 Aging and Adult Services, LR 37:3517 (December 2011), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1896 (October 2018), LR 50:785 (June 2024).

§8105. Programmatic Allocation of Waiver Opportunities

A. When funding is available for a new Community Choices Waiver opportunity or an existing opportunity is vacated, the department shall send a written notice to an individual on the registry indicating that a waiver opportunity is available. If the individual accepts the opportunity, that individual shall be evaluated for a possible Community Choices Waiver opportunity assignment.

B. Community Choices Waiver opportunities shall be offered to individuals on the registry according to priority groups. The following groups shall have priority for Community Choices Waiver opportunities, in the order listed:

1. individuals with substantiated cases of abuse or neglect referred by protective services who, without Community Choices Waiver services, would require institutional placement to prevent further abuse or neglect;

2. individuals diagnosed with Amyotrophic Lateral Sclerosis (ALS), also known as Lou Gehrig's disease;

3. individuals who are residing in a state of Louisiana permanent supportive housing unit or who are linked for the state of Louisiana permanent supportive housing process;

4. individuals admitted to or residing in a nursing facility who have Medicaid as the sole payer source for the nursing facility stay;

5. individuals who are not presently receiving home and community-based services (HCBS) under another Medicaid program, including, but not limited to:

a. Program of All-Inclusive Care for the Elderly (PACE);

b. long term—personal care services (LT-PCS); and/or

c. any other 1915(c) waiver; and

6. all other eligible individuals on the CCW registry, by date of first request for services.

C. If an applicant is determined to be ineligible for any reason, the next individual on the CCW registry is notified as stated above and the process shall continue until an individual is determined eligible. A Community Choices Waiver opportunity is assigned to an individual when eligibility is established and the individual is certified.

D. Notwithstanding the priority group provisions, 75 Community Choices Waiver opportunities are reserved for qualifying individuals who have been diagnosed with amyotrophic lateral sclerosis (ALS). Qualifying individuals who have been diagnosed with ALS shall be offered an opportunity on a first-come, first-serve basis.

E. Notwithstanding the priority group provisions, up to 300 Community Choices Waiver opportunities may be granted to qualified individuals who require emergency expedited waiver services. These individuals shall be offered an opportunity on a first-come, first-serve basis.

1. To be considered for an emergency expedited waiver opportunity, the individual must, at the time of the request for the expedited opportunity, be approved for the maximum amount of services allowable under the LT-PCS and require institutional placement, unless offered an expedited waiver opportunity.

2. The following criteria shall be considered in determining whether to grant an emergency expedited waiver opportunity:

a. support through other programs is either unavailable or inadequate to prevent nursing facility placement;

b. the death or incapacitation of an informal caregiver leaves the person without other supports;

c. the support from an informal caregiver is not available due to a family crisis;

d. the person lives alone and has no access to informal support; or

e. for other reasons, the person lacks access to adequate informal support to prevent nursing facility placement.

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 Aging and Adult Services, LR 37:3517 (December 2011), amended LR 39:319 (February 2013), LR 39:1778 (July 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1896 (October 2018), LR 45:756 (June 2019), LR 50:785 (June 2024).

§8107. Resource Assessment and Allocation Process

A. Each Community Choices Waiver applicant/participant shall be assessed using the uniform international resident assessment instrument (interRAI). This assessment provides researched and validated measures of an individual's functional status. The assessment is used to verify if an individual meets nursing facility level of care and generates a resource utilization group (RUG) score. This score is used to establish an individual's services and supports budget.

B. The RUG score assigns an individual to one of 23 distinct groups in seven major groupings. Individuals are assigned to a group based on a hierarchy and are assigned to the highest group for which they qualify. The following seven major groupings will be utilized to determine the waiver assistance needed to complete various activities of daily living (ADLs) and instrumental activities of daily living (IADLs).

1. Special Rehabilitation. Individuals in this group had at least 120 minutes of rehabilitation therapy (physical, occupational and/or speech) within the seven days prior to the interRAI assessment.

2. Extensive Services. Individuals in this group received one or more of the following services and have an ADL index of 7 or more:

a. tracheostomy;

b. ventilator or respirator;

c. suctioning;

d. parenteral/IV feeding only;

e. combined oral and parenteral/tube feeding; or

f. IV medications.

3. Special Care. Individuals in this group must meet one of the following criteria:

a. have one of the following conditions or treatments and have an ADL index of 7 or greater:

i. stage 3 or 4 pressure ulcers and turning/positioning program;

ii. combined oral and parenteral/tube feeding or nasogastric feeding only and aphasia;

iii. fever with either vomiting, weight loss, dehydration, nasogastric tube or parenteral feeding, or pneumonia; or

iv. radiation therapy; or

b. have one of the following conditions and have an ADL index of 10 or greater:

i. cerebral palsy;

ii. multiple sclerosis;

iii. quadriplegia; or

c. are receiving one of the extensive care services (as listed in B.2 above) and have an ADL index of 6 or less.

4. Clinically Complex. Individuals in this group have one of the following conditions or treatments:

a. septicemia;

b. dehydration;

c. hemiplegia and an ADL index of 10 or greater;

d. pneumonia;

e. end-stage disease;

f. comatose (confirmed by totally dependent in the four ADLs used in the ADL index);

g. foot problems that limit/prevent walking;

h. gastrointestinal (GI) or genitourinary (GU) bleeding;

i. diabetes;

j. combined oral and parenteral/tube feeding or nasogastric tube feeding only;

k. chemotherapy;

l. dialysis;

m. transfusions;

n. oxygen therapy; or

o. one of the special care conditions or treatments listed in 3.a above and an ADL index of 6 or less.

5. Impaired Cognition. Individuals in this group have a cognitive performance scale of 3 or more and an ADL index of 10 or less.

6. Behavior Problems. Individuals in this group have one or more of the following behavior problems and an ADL index of 10 or less:

a. wandering;

b. verbally abusive;

c. physically abusive;

d. socially inappropriate/disruptive;

e. resists care;

f. sexually inappropriate;

g. hallucinations; or

h. delusions.

7. Physical Function. Individuals who did not meet the criteria for any of the previous categories.

C. Based on the RUG score, the applicant/participant is assigned to one of the distinct groups and is eligible for a set annual services budget associated with that group.

1. If the applicant/participant disagrees with their annual services budget, they or their responsible representative may request a fair hearing to appeal the decision.

2. The applicant/participant may qualify for an increase in the annual services budget amount upon showing that:

a. one or more responses on the assessment are recorded incorrectly (except for the responses in the identification information, personal intake and initial history, assessment date and reason, and/or signature sections); or

b. they need an increase in the annual services budget to avoid entering into a nursing facility.

D. Each Community Choices Waiver participant shall be re-assessed at least annually.

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 Aging and Adult Services, LR 37:3518 (December 2011), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1896 (October 2018), LR 49:1068 (June 2023).

Chapter 83. Covered Services

§8301. Support Coordination

A. Support coordination services assist participants in gaining access to needed waiver and other state plan services, as well as needed medical, social, educational, housing, and other services, regardless of the funding source for these services. Support coordination agencies shall be required to perform the following core elements of support coordination services:

1. intake;

2. assessment and re-assessment;

3. plan of care development and revision;
4. follow-up/monitoring;
5. critical incident management; and
6. transition/discharge and closure.

B. Support coordinators shall provide information and assistance to waiver participants in directing and managing their services.

1. When participants choose to self-direct their waiver services, the support coordinators are responsible for informing participants about:

- a. their responsibilities as an employer;
- b. how their activities as an employer are coordinated with the fiscal agent; and
- c. their responsibility to comply with all applicable state and federal laws, rules, policies, and procedures.

2. Support coordinators shall be available to participants for on-going support and assistance in these decision-making areas and with employer responsibilities.

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 Aging and Adult Services, LR 37:3519 (December 2011), amended LR 39:319 (February 2013), LR 39:1778 (July 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1897 (October 2018).

§8302. Long-Term Personal Care Services

A. Community Choices Waiver participants cannot also receive long term-personal care services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:320 (February 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1897 (October 2018), LR 50:785 (June 2024).

§8303. Transition Intensive Support Coordination

A. Transition intensive support coordination services assist participants who are currently residing in nursing facilities in gaining access to needed waiver and other state plan services, as well as needed medical, social, housing, educational and other services, regardless of the funding source for these services. Support coordinators shall initiate and oversee the process for assessment and reassessment, as well as be responsible for ongoing monitoring of the provision of services included in the participant's approved POC.

1. This service is paid for up to six months prior to transition from the nursing facility when adequate pre-transition supports and activities are provided and documented.

2. The scope of transition intensive support coordination shall not overlap with the scope of support coordination.

B. Support coordinators may assist persons to transition for up to six months while the individual still resides in the facility.

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 Aging and Adult Services, LR 37:3519 (December 2011), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1897 (October 2018).

§8305. Environmental Accessibility Adaptations

A. Environmental accessibility adaptations are necessary physical adaptations that will be made to the home to reasonably assure the health and welfare of the participant, or enable the participant to function with greater independence in the home.

1. There must be an identified need for environmental accessibility adaptations as indicated by:

- a. the interRAI assessment; or
- b. supporting documentation of the need.

2. A credentialed environmental accessibility adaptation assessor must complete a written report that includes:

- a. verification of the need for the adaptation(s);
- b. draft job specifications; and
- c. cost estimates for completion of the environmental accessibility adaptation(s).

3. The work must be completed by an enrolled, licensed contractor.

4. Environmental accessibility adaptation(s) shall meet all job specifications as outlined in the written report before payment is made to the contractor that performed the environmental accessibility adaptation(s).

a. If final inspection, conducted either by OAAS staff or the assessor, reveals that the adaptation(s) is substandard, the costs of correcting the work will be the responsibility of the party in error.

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 Aging and Adult Services, LR 37:3519 (December 2011), amended LR 39:320 (February 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1897 (October 2018), LR 50:785 (June 2024).

§8307. Personal Assistance Services

A. Personal assistance services (PAS) provide assistance and/or supervision necessary for the participant with

functional impairments to remain safely in the community. PAS include the following services and supports based on the approved POC:

1. supervision or assistance in performing activities of daily living (ADL);

2. supervision or assistance in performing instrumental activities of daily living (IADL);

3. protective supervision provided solely to assure the health and welfare of a participant;

4. supervision or assistance with health related tasks (any health related procedures governed under the Nurse Practice Act) where the direct service worker has received proper training pursuant to R.S. 37:1031-1034;

5. supervision or assistance while escorting/accompanying the participant outside of the home to perform tasks, including instrumental activities of daily living, health maintenance or other needs as identified in the POC and to provide the same supervision or assistance as would be rendered in the home; and

6. extension of therapy services, defined as follows:

a. Licensed therapists may choose to instruct the attendants on the proper way to assist the participant in follow-up therapy sessions. This assistance and support provides reinforcement of instruction and aids in the rehabilitative process.

b. In addition, a registered nurse may instruct an attendant to perform basic interventions with a participant that would increase and optimize functional abilities for maximum independence in performing activities of daily living such as range of motion exercises.

B. PAS is provided in the participant's home or in another location outside of the home if the provision of these services allows the participant to participate in normal life activities pertaining to the ADLs and IADLs cited in the POC. IADLs may not be performed in the participant's home when the participant is absent from the home unless it is approved by OAAS or its designee on a case-by-case basis. There shall be no duplication of services. PAS may not be provided while the participant is admitted to or attending a program which provides in-home assistance with ADLs or IADLs or while attending or admitted to a program or setting where such assistance is provided.

C. The provision of PAS services outside of the participant's home does not include trips outside of the borders of the state without prior written approval by OAAS or its designee.

D. PAS may be provided through the "a.m." and "p.m." delivery option defined as follows:

1. a minimum of one hour and a maximum of two hours of PAS provided to assist the participant at the beginning of his/her day, referred to as the "a.m." portion of this PAS delivery method; and

2. a minimum of one hour and a maximum of two hours of PAS provided to assist the participant at the end of his/her day, referred to as the "p.m." portion of this PAS delivery method; and

3. a minimum four hours break between the "a.m." and the "p.m." portions of this PAS delivery method;

4. not to exceed a maximum of four hours of PAS being provided within a calendar day;

5. "a.m. and p.m." PAS cannot be "shared";

6. it is permissible to receive only the "a.m." or "p.m." portion of PAS within a calendar day;

7. "a.m." and/or "p.m." PAS may not be provided on the same calendar day as other PAS delivery methods;

8. PAS providers must be able to provide both regular and "a.m." and "p.m." PAS and cannot refuse to accept a Community Choices Waiver participant solely due to the type of PAS delivery method that is listed on the POC.

E. PAS may be provided by one worker for up to three waiver participants who live together and who have a common direct service provider. Waiver participants may share PAS staff when agreed to by the participants and as long as the health and welfare of each participant can be reasonably assured. Shared PAS is to be reflected in the POC of each participant. Reimbursement rates shall be adjusted accordingly.

F. A home health agency direct service worker who renders PAS must be a qualified home health aide as specified in Louisiana's minimum licensing standards for home health agencies.

G. Every PAS provider shall ensure that each waiver participant who receives PAS has a written individualized back-up staffing plan and agreement for use in the event that the assigned PAS worker is unable to provide support due to unplanned circumstances, including emergencies which arise during a shift.

H. Every PAS provider shall ensure timely completion of the emergency plan for each waiver participant they serve.

I. The following individuals are allowed to provide PAS to a participant:

1. the participant's spouse;

a. when it is determined that the spouse may be the worker due to the participant needing extraordinary care.

2. the participant's curator;

3. the participant's tutor;

4. the participant's legal guardian;

5. the person to whom the participant has given representative and mandate authority (also known as power of attorney).

J. The participant's responsible representative is prohibited from being a PAS worker for a participant.

K. Participants are not permitted to receive PAS while living in a home or property owned, operated, or controlled by an owner, operator, agent, or employee of a licensed provider of long term care services and providers are prohibited from providing and billing for services under these circumstances. Participants may not live in the home of their direct support worker unless the direct support worker is related to, and it is the choice of, the participant.

1. The provisions of §8307.K may be waived with prior written approval by OAAS or its designee.

L. It is permissible for the PAS allotment to be used flexibly within a prior authorized week in accordance with the participant's preferences and personal schedule, and with proper documentation.

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 Aging and Adult Services, LR 37:3519 (December 2011), amended LR 39:320 (February 2013), LR 39:1778 (July 2013), LR 40:791 (April 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1898 (October 2018), LR 47:885 (July 2021), LR 49:486 (March 2023), LR 50:785 (June 2024).

§8309. Transition Services

A. Transition Services are time limited, non-recurring set-up expenses available for individuals who have been offered and approved for a Community Choices Waiver opportunity and are transitioning from a nursing facility to a living arrangement in a private residence where the individual is directly responsible for his/her own living expenses.

B. Allowable expenses are those necessary to enable the individual to establish a basic household (excluding expenses for room and board) including, but not limited to:

1. security deposits that are required to obtain a lease on an apartment or house;
2. specific set up fees or deposits;
3. activities to assess need, arrange for and procure needed resources;
4. essential furnishings to establish basic living arrangements; and
5. health and welfare assurances.

C. These services must be prior approved in the participant's POC.

D. These services do not include monthly rental payments, mortgage expenses, food, recurring monthly utility charges, and household appliances and/or items intended for purely diversional/recreational purposes. These services may not be used to pay for furnishing or to set-up living arrangements that are owned or leased by a waiver provider.

E. Support coordinators shall exhaust all other resources to obtain these items prior to utilizing the waiver.

F. Funds are available up to the lifetime maximum amount identified in the federally-approved waiver document.

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 Aging and Adult Services, LR 37:3520 (December 2011), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1898 (October 2018), LR 50:786 (June 2024).

§8311. Adult Day Health Care Services

A. Adult day health care (ADHC) services are furnished as specified in the POC at an ADHC center, in a non-institutional, community-based setting encompassing both health/medical and social services needed to ensure the optimal functioning of the participant.

B. ADHC services include those core service requirements identified in the ADHC licensing standards (LAC 48.I.4243), in addition to:

1. medical care management; and
2. transportation to and from medical and social activities (if the participant is accompanied by the ADHC center staff).

C. ADHC services may be provided no more than 10 hours per day and no more than 50 hours per week.

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 Aging and Adult Services, LR 37:3521 (December 2011), amended LR 39:321 (February 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1898 (October 2018).

§8313. Caregiver Temporary Support Services

A. Caregiver temporary support services are furnished on a short-term basis because of the absence or need for relief of caregivers during the time they are normally providing unpaid care for the participant.

B. Federal financial participation is not claimed for the cost of room and board except when provided as part of caregiver temporary support services furnished in a facility approved by the state that is not a private residence.

C. The intent of caregiver temporary support services is to provide relief to unpaid caregivers to maintain the informal support system.

D. Caregiver temporary support services are provided in the following locations:

1. the participant's home or place of residence;
2. nursing facilities;
3. assisted living facilities;
4. respite centers; or
5. adult day health care centers.

E. Caregiver temporary support services provided by nursing facilities, assisted living facilities and respite centers must include an overnight stay.

F. When caregiver temporary support services are provided by an ADHC center, services may be provided no more than 10 hours per day.

G. Caregiver temporary support services may be utilized no more than 30 calendar days or 29 overnight stays per plan of care year for no more than 14 consecutive calendar days or 13 consecutive overnight stays. The service limit may be increased based on documented need and prior approval by OAAS.

H. Caregiver temporary support services may not be delivered at the same time as adult day health care or personal assistance services.

I. Caregiver temporary support services may be provided for the relief of the principal caregiver for participants who receive monitored in-home caregiving (MIHC) services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3521 (December 2011), amended LR 39:321 (February 2013), LR 40:792 (April 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1898 (October 2018), LR 50:786 (June 2024).

§8315. Assistive Devices and Medical Supplies

A. Assistive devices and medical supplies are specialized medical equipment and supplies which include:

1. devices, controls, appliances or nutritional supplements that enable participants to increase their ability to perform activities of daily living; or

2. devices, controls, appliances or nutritional supplements that enable participants to perceive, control, or communicate with the environment in which they live or provide emergency response;

3. items, supplies and services necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items;

4. supplies and services necessary to assure health and welfare;

5. other durable and non-durable medical equipment and medical supplies that are necessary, but not available under the state plan;

6. personal emergency response systems (PERS);

7. other in-home monitoring and medication management devices and technology;

8. routine maintenance or repair of specialized equipment; and

9. batteries, extended warranties, and service contracts that are cost effective and assure health and welfare.

B. This service includes medical equipment, not available under the state plan, that is necessary to address participant functional limitations and necessary medical supplies not available under the state plan.

C. Where applicable, participant must use Medicaid State Plan, Medicare, or other available payers first. The participant's preference for a certain brand or supplier is not grounds for declining another payer in order to access waiver services.

D. All services must be based on a verified need of the participant and the service must have a direct or remedial benefit to the participant with specific goals and outcomes. This benefit must be determined by an independent assessment on any items whose cost exceeds the amount identified in the federally-approved waiver document and on all communication devices, mobility devices, and environmental controls. Independent assessments are done by individuals who have no fiduciary relationship with the manufacturer, supplier, or vendor of the item.

E. All items must reduce reliance on other Medicaid State Plan or waiver services.

F. All items must meet applicable standards of manufacture, design, and installation.

G. All items must be prior authorized and no experimental items shall be authorized.

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 Aging and Adult Services, LR 37:3521 (December 2011), amended LR 39:321 (February 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1899 (October 2018).

§8317. Home Delivered Meals

A. The purpose of home delivered meals is to assist in meeting the nutritional needs of an individual in support of the maintenance of self-sufficiency and enhancing the quality of life.

B. Up to two nutritionally balanced meals per day may be delivered to the home of an eligible participant who is unable to leave his/her home without assistance, unable to prepare his/her own meals, and/or has no responsible caregiver in the home.

C. Each meal shall provide a minimum of one-third of the current recommended dietary allowance (RDA) for the participant as adopted by the United States Department of Agriculture. The provision of home delivered meals does not provide a full nutritional regimen.

D. Medically tailored meals (MTMs) may be delivered to participants with chronic conditions when discharging from the hospital and/or nursing facility. In addition, participants will receive nutritional guidance to support healthy food choices for their third meal and snacks.

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 Aging and Adult Services, LR 37:3522 (December 2011), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 49:487 (March 2023).

§8321. Nursing Services

A. Nursing services are services that are medically necessary and may only be provided efficiently and effectively by a registered nurse or a licensed practical nurse working under the supervision of a registered nurse. These nursing services provided must be within the scope of the Louisiana statutes governing the practice of nursing.

B. Nursing services may include periodic assessment of the participant's medical condition when the condition requires a skilled nurse to identify and evaluate the need for medical intervention or to monitor and/or modify the medical treatment services provided by non-professional care providers.

C. Services may also include regular, ongoing monitoring of a participant's fragile or complex medical condition as well as the monitoring of a participant with a history of noncompliance with medication or other medical treatment needs.

D. Nursing may also be used to assess a participant's need for assistive devices or home modifications, training the participant and family members in the use of the purchased devices, and training of direct service workers in tasks necessary to carry out the POC.

E. Where applicable, a participant must use Medicare, Medicaid State Plan services, or other available payers first. The participant's preference for a certain staff or agencies is not grounds for declining another payer in order to access waiver services.

F. All services must be based on a verified need of the participant. The service must have a direct or remedial benefit to the participant with specific goals and outcomes.

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 Aging and Adult Services, LR 37:3522 (December 2011), amended LR 39:321 (February 2013).

§8323. Skilled Maintenance Therapy

A. Skilled maintenance therapy is therapy services that may be received by participants in the home or rehabilitation center.

B. Skilled maintenance therapy services include physical therapy, occupational therapy, and speech and language therapy.

C. Therapy services provided to participants are not necessarily tied to an episode of illness or injury and instead focus primarily on the participant's functional need for maintenance of, or reducing the decline in, the participant's ability to carry out activities of daily living.

D. Skilled maintenance therapies may also be used to assess a participant's need for assistive devices or home modifications, training the participant and family members in the use of the purchased devices, performance of in-home fall prevention assessments, and participation on the POC planning team.

E. Services may be provided in a variety of locations including the participant's home or as approved by the POC planning team.

F. Skilled maintenance therapy services specifically include:

1. physical therapy services which promote the maintenance of, or the reduction in, the loss of gross/fine motor skills, and facilitate independent functioning and/or prevent progressive disabilities including:

a. professional assessment(s), evaluation(s) and monitoring for therapeutic purposes;

b. physical therapy treatments and interventions;

c. training regarding physical therapy activities, use of equipment and technologies;

d. designing, modifying or monitoring the use of related environmental modifications;

e. designing, modifying, and monitoring the use of related activities supportive to the POC goals and objectives; or

f. consulting or collaborating with other service providers or family members, as specified in the POC;

2. occupational therapy (OT) services which promote the maintenance of, or reduction in, the loss of fine motor skills, coordination, sensory integration, and/or facilitate the use of adaptive equipment or other assistive technology including:

a. teaching of daily living skills;

b. development of perceptual motor skills and sensory integrative functioning;

c. design, fabrication, or modification of assistive technology or adaptive devices;

d. provision of assistive technology services;

e. design, fabrication, or applying selected orthotic or prosthetic devices or selecting adaptive equipment;

f. use of specifically designed crafts and exercise to enhance function;

g. training regarding OT activities; and

h. consulting or collaborating with other service providers or family members, as specified in the POC;

3. speech language therapy (SLT) services which preserve abilities for independent function in communication, facilitate oral motor and swallowing function, facilitate use of assistive technology, and/or prevent progressive disabilities including:

- a. identification of communicative or oropharyngeal disorders;
- b. prevention of communicative or oropharyngeal disorders;
- c. development of eating or swallowing plans and monitoring their effectiveness;
- d. use of specifically designed equipment, tools, and exercises to enhance function;
- e. design, fabrication, or modification of assistive technology or adaptive devices;
- f. provision of assistive technology services;
- g. adaptation of the participant's environment to meet his/her needs;
- h. training regarding SLT activities; and
- i. consulting or collaborating with other service providers or family members, as specified in the POC.

G. Where applicable, the participant must use Medicaid State Plan, Medicare, or other available payers first. The participant's preference for a certain therapist or agency is not grounds for declining another payer in order to access waiver services.

H. All services must be based on a verified need of the participant and the service must have a direct or remedial benefit to the participant with specific goals and outcomes. The authorized service will be reviewed/monitored by the support coordinator to verify the continued need for the service and that the service meets the participant's needs in the most cost effective manner.

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 Aging and Adult Services, LR 37:3522 (December 2011), amended LR 39:321 (February 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1899 (October 2018), LR 47:885 (July 2021), LR 50:786 (June 2024).

§8325. Housing Transition or Crisis Intervention Services

A. Housing transition or crisis intervention services enable participants who are transitioning into a permanent supportive housing (PSH) unit, including those transitioning from institutions, to secure their own housing or provide assistance at any time the participant's housing is placed at risk (e.g., eviction, loss of roommate or income). The service includes the following components:

- 1. conducting a housing assessment identifying the participant's preferences related to housing (type, location, living alone or with someone else, accommodations needed, and other important preferences), and identifying his/her needs for support to maintain housing, including:
 - a. access to housing;

- b. becoming familiar with neighborhood, resources, and neighbors;
- c. meeting the terms of a lease;
- d. eviction prevention;
- e. budgeting for housing/living expenses;
- f. obtaining/accessing sources of income necessary for rent;
- g. home management; and
- h. understanding and meeting the obligations of tenancy as defined in the lease terms;

2. assisting the participant to view and secure housing as needed. This may include arranging or providing transportation. The participant shall be assisted in securing supporting documents/records, completing/submitting applications, securing/seeking waiver of deposits, and locating furnishings;

3. developing an individualized housing support plan based upon the housing assessment that:

- a. includes short- and long-term measurable goals for each issue;
- b. establishes the participant's approach to meeting the goal; and
- c. identifies where other provider(s) or services may be required to meet the goal;

4. participating in the development of the plan of care and incorporating elements of the housing support plan;

5. looking for alternatives to housing if permanent supportive housing is unavailable to support completion of transition; and

6. communicating with the landlord or property manager regarding:

- a. accommodations needed by the participant;
- b. components of emergency procedures involving the landlord or property manager; and
- c. needs to assist with issues that may place the participant's ability to access or remain in housing at risk.

B. If at any time the participant's housing is placed at risk (e.g. eviction, loss of roommate or income), housing transition or crisis intervention services will provide supports to retain housing or locate and secure housing to continue community based supports including locating new housing, sources of income, etc.

C. This service is only available upon referral from the support coordinator. This service is not duplicative of other waiver services, including support coordination. It is only available to persons who are residing in a State of Louisiana permanent supportive housing unit or who are linked for the State of Louisiana permanent supportive housing selection process.

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 Aging and Adult Services, LR 39:1779 (July 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1899 (October 2018).

§8327. Housing Stabilization Services

A. Housing stabilization services enable waiver participants to, once housed, successfully maintain tenancy and residence in their own housing as set forth in the participant's approved plan of care. Services must be provided in the home or a community setting. This service includes the following components:

1. participation in the plan of care renewal and updates as needed, incorporating elements of the housing support plan;

2. providing supports and interventions designed to maintain ongoing successful and stable tenancy and residence;

3. serving as point of contact for the landlord or property manager regarding any accommodations needed by the participant, any components of emergency procedures involving the landlord or property manager and to assist with issues that may place the participant's housing at risk; and

4. updating the housing support plan annually or as needed due to changes in the participant's situation or status.

B. This service is only available upon referral from the support coordinator. This service is not duplicative of other waiver services including support coordination. It is only available to persons who are residing in a state of Louisiana permanent supportive housing unit.

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 Aging and Adult Services, LR 39:1779 (July 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1900 (October 2018).

§8329. Monitored In-Home Caregiving Services

A. Monitored in-home caregiving (MIHC) services are provided by a principal caregiver to a participant who lives in a private unlicensed residence. The principal caregiver shall be contracted by the licensed HCBS provider having a MIHC service module. The principal caregiver shall reside with the participant. Professional staff employed by the HCBS provider shall provide oversight, support and monitoring of the principal caregiver, service delivery, and participant outcomes through on-site visits, training, and daily, web-based electronic information exchange.

B. The principal caregiver is responsible for supporting the participant to maximize the highest level of independence possible by providing necessary care and supports that may include:

1. supervision or assistance in performing activities of daily living;

2. supervision or assistance in performing instrumental activities of daily living;

3. protective supervision provided solely to assure the health and welfare of a participant;

4. supervision or assistance with health related tasks (any health related procedures governed under the Nurse Practice Act) in accordance with applicable laws governing the delegation of medical tasks/medication administration;

5. supervision or assistance while escorting/accompanying the participant outside of the home to perform services indicated in the plan of care and to provide the same level of supervision or assistance as would be rendered in the home; and

6. extension of therapy services to maximize independence when the caregiver has been instructed in the performance of the activities by a licensed therapist or registered nurse.

C. The following individuals are allowed to be the MIHC principal caregiver:

1. the participant's spouse;

2. the participant's curator;

3. the participant's tutor;

4. the participant's legal guardian; or

5. the person to whom the participant has given representative and mandate authority (also known as power of attorney).

D. The participant's responsible representative is prohibited from being a MIHC principal caregiver for a participant.

E. Participants electing monitored in-home caregiving services shall not receive the following Community Choices Waiver services during the period of time that the participant is receiving monitored in-home caregiving services:

1. personal assistance services; or

2. home delivered meal services.

F. Monitored in-home caregiving providers must be licensed HCBS providers with a monitored in-home caregiving module who employ professional staff, including a registered nurse and a care manager, to support principal caregivers to perform the direct care activities performed in the home. The provider must assess and approve the home in which services will be provided, and shall enter into contractual agreements with caregivers who the agency has approved and trained. The provider will pay per diem stipends to caregivers.

G. The MIHC provider must use secure, web-based information collection from principal caregivers for the purposes of monitoring participant health and caregiver performance. All protected health information (PHI) must be

transferred, stored, and otherwise utilized in compliance with applicable federal and state privacy laws. Providers must sign, maintain on file, and comply with the LDH HIPAA business associate addendum.

H. The department shall reimburse for monitored in-home caregiving services based upon a tiered model which is designed to address the participant's acuity.

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 Aging and Adult Services, LR 40:792 (April 2014), amended LR 41:2642 (December 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1900 (October 2018), LR 50:786 (June 2024).

§8331. Assistive Technology

A. Assistive technology services include the following:

1. an item, piece of equipment or product system, acquired commercially, that is used to increase, maintain or improve functional capabilities of participants; and

2. the assistance provided to the participant in the acquisition, set up and use of an assistive technology device:

a. evaluating to determine if an assistive technology device is appropriate for the participant;

b. purchasing the most appropriate assistive technology device for the participant; and

c. costs associated with the delivery, set up, and training.

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 of Aging and Adult Services, LR 49:487 (March 2023).

§8335. Financial Management Services

A. Financial management services (FMS) assist the participant to live independently in the community while controlling their services by choosing the staff who work with them.

B. FMS are provided to participants who have chosen and are capable of self-directing their Community Choices Waiver services.

C. FMS are provided by a Medicaid enrolled fiscal employer agent (F/EA) and the F/EA's responsibilities and standards for participation are identified in LAC 50:XXI.Chapter 11, Subchapters A-C.

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 of Aging and Adult Services, LR 50:787 (June 2024).

Chapter 85. Self-Direction Initiative

§8501. Self-Direction Service Option

A. The self-direction initiative is a voluntary, self-determination option which allows the participant to coordinate the delivery of personal assistance services through an individual direct support professional rather than through a licensed, enrolled provider. Selection of this option requires that the participant utilize a payment mechanism approved by the department to manage the required fiscal functions that are usually handled by a traditional direct service provider.

B. Participant Responsibilities. Waiver participants choosing the self-directed services option must understand the rights, risks, and responsibilities of managing their own care and individual budget. If the participant is unable to make decisions independently, he/she must have a responsible representative who understands the rights, risks, and responsibilities of managing his/her care and supports within his/her individual budget.

C. Termination of the Self-Direction Service Option. Termination of participation in the self-direction service option requires a revision of the POC, the elimination of the fiscal agent and the selection of the Medicaid-enrolled waiver service provider(s) of choice.

1. Voluntary Termination. A waiver participant may choose at any time to withdraw from the self-direction service option and return to the traditional direct service provider.

2. Involuntary Termination. The department may terminate the self-direction service option for a participant and require him/her to receive provider-managed services under the following circumstances:

a. the health or welfare of the participant is compromised by continued participation in the self-directed option;

b. the participant is no longer able to direct his/her own care and there is no responsible representative to direct the care;

c. there is misuse of public funds by the participant or the responsible representative; or

d. the participant or responsible representative:

i. places barriers to the payment of the salaries and related state and federal payroll taxes of direct support staff;

ii. fails to follow the POC;

iii. fails to provide required documentation;

iv. fails to cooperate with the department, fiscal agent or support coordinator;

v. violates Medicaid Program rules or guidelines of the self-direction option; or

vi. fails to receive self-directed services for 90 calendar days or more.

D. Employee Qualifications. All employees under the self-direction option must:

1. meet the minimum age requirement per LAC 48:I.Chapter 92;
2. pass required criminal background checks; and
3. be able to complete the tasks identified in the plan of care.

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 Aging and Adult Services, LR 37:3523 (December 2011), amended LR 39:321 (February 2013), LR 39:1779 (July 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1900 (October 2018), LR: 49:1726 (October 2023), LR 50:787 (June 2024).

Chapter 86. Organized Health Care Delivery System

§8601. General Provisions

A. An organized health care delivery system (OHCDS) is an entity with an identifiable component within its mission to provide services to individuals receiving Community Choices Waiver services. The entity must be a qualified and enrolled Medicaid provider and must directly render at least one service offered in the Community Choices Waiver. As long as the entity furnishes at least one waiver service itself, it may contract with other qualified providers to furnish the other required waiver services.

B. Entities that function as an OHCDS must ensure that subcontracted entities meet all of the applicable provider qualification standards for the services they are rendering.

C. The OHCDS must attest that all applicable provider qualifications are met.

D. Prior to enrollment, an OHCDS must show the ability to provide all of the following Community Choices Waiver services:

1. personal assistance services (PAS);
2. home delivered meals;
3. skilled maintenance therapy;
4. nursing;
5. caregiver temporary support services;
6. assistive devices and medical supplies;
7. environmental accessibility adaptations (EAA); and
8. adult day health care (only if there is a licensed ADHC provider in the service area).

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 Aging and Adult Services, LR 40:792 (April 2014), amended LR 41:2643 (December 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1901 (October 2018), LR 50:787 (June 2024).

Chapter 87. Plan of Care

§8701. Plan of Care

A. The applicant and support coordinator have the flexibility to construct a plan of care that serves the participant's health and welfare needs. The service package provided under the POC shall include services covered under the Community Choices Waiver in addition to services covered under the Medicaid state plan (not to exceed the established service limits for either waiver or state plan services) as well as other services, regardless of the funding source for these services. All services approved pursuant to the POC shall be medically necessary and provided in a cost-effective manner. The POC shall be developed using a person-centered process coordinated by the support coordinator.

B. Reimbursement shall not be made for services provided prior to the department's, or its designee's, approval of the POC.

C. The support coordinator shall complete a POC which shall contain the:

1. types and number of services (including waiver and all other services) necessary to reasonably assure health and welfare and to maintain the person in the community;
2. individual cost of each waiver service; and
3. total cost of waiver services covered by the POC.

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 Aging and Adult Services, LR 37:3524 (December 2011), amended LR 39:321 (February 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1901 (October 2018), LR 50:787 (June 2024).

Chapter 89. Admission and Discharge Criteria

§8901. Admission Criteria

A. Admission to the Community Choices Waiver program shall be determined in accordance with the following criteria:

1. meets the target population criteria as specified in the approved waiver document;
2. initial and continued Medicaid eligibility;
3. initial and continued eligibility for a nursing facility level of care;

4. justification, as documented in the approved POC, that the Community Choices Waiver services are appropriate, cost effective and represent the least restrictive environment for the individual; and

5. reasonable assurance that the health and welfare of the participant can be maintained in the community with the provision of Community Choices Waiver services.

B. Failure of the individual to cooperate in the eligibility determination, plan of care development process or to meet any of the criteria above shall result in denial of admission to the Community Choices 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, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3524 (December 2011), amended LR 39:322 (February 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1901 (October 2018), LR 50:787 (June 2024).

§8903. Admission Denial or Discharge Criteria

A. Admission shall be denied or the participant shall be discharged from the Community Choices Waiver program if any of the following conditions are determined.

1. The individual does not meet the target population criteria as specified in the federally approved waiver document.

2. The individual does not meet the criteria for Medicaid financial eligibility.

3. The individual does not meet the criteria for nursing facility level of care.

4. The participant resides in another state or has a change of residence to another state.

5. Continuity of services is interrupted as a result of the participant not receiving and/or refusing Community Choices Waiver services (exclusive of support coordination services) for a period of 30 consecutive days.

EXCEPTION: An exception may be granted by OAAS to delay discharge if interruption is due to an acute care hospital, rehabilitation hospital, or nursing facility admission.

6. The health and welfare of the individual cannot be reasonably assured through the provision of Community Choices Waiver services.

7. The individual fails to cooperate in the eligibility determination or plan of care development processes or in the performance of the POC.

8. Failure on behalf of the individual to maintain a safe and legal environment.

9. It is not cost effective or appropriate to serve the individual in the Community Choices 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, Bureau of Health Services Financing and the

Office of Aging and Adult Services, LR 37:3524 (December 2011), amended LR 39:322 (February 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1901 (October 2018), LR 50:788 (June 2024).

Chapter 91. Waiver Cost Neutrality

§9101. Waiver Costs Limit

A. The annual service budget for each of the RUG-III/HC groups shall be reviewed to ensure that the costs of the Community Choices Waiver remain within applicable federal rules regarding the cost-effectiveness of the waiver. To ensure cost-effectiveness, the mean expenditures across all RUG-III/HC categories must be less than or equal to the average cost to the state of providing care in a nursing facility. If the waiver is not cost-effective, the annual service budgets for some or all RUG-III/HC groups shall be reduced to bring the waiver into compliance.

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 Aging and Adult Services, LR 37:3524 (December 2011).

Chapter 93. Provider Responsibilities

§9301. General Provisions

A. Any provider of services under the Community Choices Waiver shall abide by and adhere to any federal or state laws, rules, policy, procedures, or manuals issued by the department. Failure to do so may result in sanctions.

B. The provider shall not request payment unless the participant for whom payment is requested is receiving services in accordance with the Community Choices Waiver program provisions and the services have been prior authorized and actually provided.

C. Any provider of services under the Community Choices Waiver shall not refuse to serve any individual who chooses their agency unless there is documentation to support an inability to meet the individual's health and welfare needs, or all previous efforts to provide service and supports have failed and there is no option but to refuse services.

1. OAAS or its designee must be immediately notified of the circumstances surrounding a refusal by a provider to render services.

2. This requirement can only be waived by OAAS or its designee.

D. Providers must maintain adequate documentation to support service delivery and compliance with the approved POC and will provide said documentation at the request of the department, or its designee.

E. Any provider of services under the Community Choices Waiver shall not interfere with the eligibility, assessment, care plan development, or care plan monitoring processes with use of methods including, but not limited to:

1. harassment;
2. intimidation; or
3. threats against program participants, members of their informal support network, LDH staff or support coordination staff.

F. Any provider of services under the Community Choices Waiver shall have the capacity and resources to provide all aspects of any service they are enrolled to provide in the specified service area.

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 Aging and Adult Services, LR 37:3524 (December 2011), amended LR 39:322 (February 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1901 (October 2018), LR 50:788 (June 2024).

§9303. Reporting Requirements

A. Support coordinators and direct service providers are obligated to immediately report any changes to the department that could affect the waiver participant's eligibility including, but not limited to, those changes cited in the denial or discharge criteria.

B. Support coordinators and direct service providers are responsible for documenting the occurrence of incidents or accidents that affect the health and welfare of the participant and for completing an incident report. The incident report shall be submitted to the department or its designee with the specified requirements within specified timelines.

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 Aging and Adult Services, LR 37:3525 (December 2011), amended LR 39:322 (February 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1902 (October 2018), LR 50:788 (June 2024).

Chapter 95. Reimbursement

§9501. Reimbursement and Rate Requirements

A. Reimbursement for the following services shall be a prospective flat rate for each approved unit of service provided to the participant. One quarter hour (15 minutes) is the standard unit of service, which covers both the service provision and administrative costs for the following services, and reimbursement shall not be made for less than one quarter hour (15 minutes) of service:

1. personal assistance services (except for the “a.m. and p.m.” service delivery model);

- a. up to three participants may share personal assistance services if they live together and share a common provider of these services; and

- b. there is a separate reimbursement rate for shared personal assistance services;

2. in-home caregiver temporary support services when provided by a personal care services or home health agency;

3. caregiver temporary support services when provided by an adult day health care center;

4. adult day health care services;

5. housing transition or crisis intervention services; and

6. housing stabilization services.

B. The following services shall be reimbursed at the authorized rate or approved amount of the assessment, inspection, installation/fitting, maintenance, repairs, adaptation, device, equipment, or supply item and when the service has been prior authorized by the plan of care:

1. environmental accessibility adaptations;

2. environmental accessibility adaption assessment and inspections;

3. assistive devices and medical supplies;

4. home delivered meals (not to exceed the maximum limit set by OAAS);

5. transition services (not to exceed the maximum lifetime limit set by OAAS);

6. monitored in-home caregiving (MIHC) assessment;

7. certain nursing, and skilled maintenance therapy procedures; and

8. assistive technology.

C. The following services shall be reimbursed at a per diem rate:

1. caregiver temporary support services when rendered by the following providers:

- a. assisted living providers;

- b. nursing facility; or

- c. respite center; and

2. monitored in-home caregiving services.

- a. The per diem rate for monitored in-home caregiving services does not include payment for room and board, and federal financial participation is not claimed for room and board.

D. The following services shall be reimbursed at an established monthly rate:

1. support coordination;

2. transition intensive support coordination;

3. monthly monitoring/maintenance for certain assistive devices/technology and medical supplies procedures; and

4. financial management services.

E. The following services shall be reimbursed on a per-visit basis:

1. certain nursing and skilled maintenance therapy procedures; and

2. personal assistance services furnished via “a.m. and p.m.” delivery method.

F. Reimbursement shall not be made for Community Choices Waiver services provided prior to the department’s, or its designee’s, approval of the POC and release of prior authorization for the services.

G. The minimum hourly rate paid to direct support professionals shall be at least the current federal or state minimum hourly rate.

H. The state has the authority to set and change provider rates and/or provide lump sum payments to providers based upon funds allocated by the legislature.

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 Aging and Adult Services, LR 37:3525 (December 2011), amended LR 39:322 (February 2013), LR 39:508, 508 (March 2013), repromulgated LR 39:1048 (April 2013), amended LR 39:1779 (July 2013), LR 40:793 (April 2014), LR 42:897 (June 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1902 (October 2018), LR 47:886 (July 2021), LR 49:487 (March 2023), LR 50:788 (June 2024).

§9503. Direct Support/Service Worker Wages, Other Benefits, and Workforce Retention Bonus Payments

A. Establishment of Direct Support/Service Worker Wage Floor and Other Benefits

1. Personal assistance service (PAS) providers that were providing services on or after October 1, 2021 and employing direct service workers (DSWs) will receive the equivalent of a \$5.50 per hour rate increase.

2. DSWs providing self-direction PAS on or after July 31, 2022 shall be paid a minimum wage floor of \$9 per hour.

3. Adult day health care (ADHC) providers that were providing ADHC services on or after October 1, 2021 and employing ADHC direct support workers will receive a rate increase. The ADHC reimbursement rates shall be rebased resulting in an average increase of \$4.31 per hour (rates differ based on facility specific transportation rate).

4. All PAS and ADHC providers affected by this rate increase shall be subject to passing 70 percent of their rate increases directly to the direct support/service worker in various forms. These forms include a minimum wage floor of \$9 per hour and other wage and non-wage benefits. This wage floor and wage and non-wage benefits are effective for all affected direct support/service workers of any working status, whether full-time or part-time.

5. The rate increase, wage floor and/or wage and non-wage benefits will end March 31, 2025 or when the state’s funding authorized under section 9817 of the American Rescue Plan Act of 2021 (Pub. L. No. 117-002) is exhausted.

6. The Department of Health (LDH) reserves the right to adjust the direct support/service worker wage floor and/or wage and non-wage benefits as needed through appropriate rulemaking promulgation consistent with the Administrative Procedure Act.

B. Establishment of Direct Support/Service Worker Workforce Bonus Payments

1. PAS and ADHC providers who provided services from April 1, 2021 to October 31, 2022 shall receive bonus payments of \$300 per month for each direct support/service worker that worked with participants for those months.

2. The PAS and ADHC direct support/service worker who provided services from April 1, 2021 to October 31, 2022 to participants must receive at least \$250 of this \$300 monthly bonus payment paid to the provider. This bonus payment is effective for all affected direct support/service workers of any working status, whether full-time or part-time.

C. Audit Procedures for Direct Support/Service Worker Wage Floor, Other Benefits, and Workforce Bonus Payments

1. The wage enhancements, wage and non-wage benefits and bonus payments reimbursed to providers shall be subject to audit by LDH.

2. Providers shall provide to LDH or its representative all requested documentation to verify that they are in compliance with the direct support/service worker wage floor, wage and non-wage benefits and/or bonus payments.

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

4. Providers shall produce the requested documentation upon request and within the timeframe provided by LDH.

5. Non-compliance or failure to demonstrate that the wage enhancements, wage and non-wage benefits and/or bonus payments were paid directly to direct support/service workers may result in the following:

a. sanctions; or

b. disenrollment from the Medicaid Program.

D. Sanctions for Direct Support/Service Worker Wages, Other Benefits, and Workforce Payments

1. Providers will be subject to sanctions or penalties for failure to comply with this Rule or with requests issued by LDH pursuant to this Rule. The severity of such action will depend on the following factors:

a. failure to pass 70 percent of the PAS and ADHC provider rate increases directly to the direct support/service workers in the form of a floor minimum of \$9 per hour and

in other wage and non-wage benefits and/or the \$250 monthly bonus payments;

b. the number of employees identified that the PAS and ADHC provider has not passed 70 percent of the provider rate increases directly to the direct support/service workers in the form of a floor minimum of \$9 per hour and in other wage and non-wage benefits and/or the \$250 monthly bonus payments;

c. the persistent failure to not pass 70 percent of the PAS and ADHC provider rate increases directly to the direct support/service workers in the form of a floor minimum of \$9 per hour and in other wage and non-wage benefits and/or 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 and the Office of Aging and Adult Services, LR 49:684 (April 2023).

Subpart 9. Children's Choice

Chapter 111. General Provisions

§11101. Introduction

A. The Children's Choice (CC) Waiver is a home and community-based services (HCBS) program that offers supplemental support to individuals with intellectual/developmental disabilities (IDD) who currently live in the community or who will leave an institution to return to the community.

B. The Children's Choice Waiver is an option offered to individuals who have been determined eligible for developmental disability services and are on the intellectual/developmental disabilities request for services registry (IDDRFSR) hereafter referred to as "the registry" or as identified in §11105 or §11107.

C. Children's Choice Waiver participants are eligible for all medically necessary Medicaid services in addition to Children's Choice Waiver services.

D. The number of participants in the Children's Choice Waiver is contingent upon available funding.

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 26:2793 (December 2000), repromulgated for LAC, LR 28:1983 (September 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 35:1891 (September 2009), LR 39:2497 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2523 (December 2017).

§11103. Participant Qualifications and Admissions Criteria

A. The Children's Choice Waiver is available to individuals who:

1. are from birth through age 20;
2. have a developmental disability as specified in R.S. 28:451.2;
3. are on the registry unless otherwise specified in §11105 and §11107;
4. meet all of the financial and non-financial Medicaid eligibility criteria for a home and community-based services (HCBS) waiver;
5. meet the requirements for an intermediate care facility for persons with intellectual/developmental disabilities (ICF/ID) level of care, which requires active treatment of a developmental disability under the supervision of a qualified developmental disability professional;
6. meet the assurance requirements that the health and welfare of the individual can be maintained in the community with the provision of children's choice services;
7. have justification, as documented in the approved plan of care, that the children's choice services are appropriate, cost effective and represent the least restrictive environment for the individual;
8. are residents of Louisiana; and
9. are citizens of the United States or a qualified alien.

B. The plan of care must be sufficient to assure the health and welfare of the waiver applicant/participant in order to be approved for waiver participation or continued participation.

C. Participants who are currently receiving Children's Choice Waiver services who reach their eighteenth birthday and remain enrolled in school may continue receiving Children's Choice Waiver services until their twenty-first birthday at which time they will transition to the most appropriate OCDD adult waiver as long as they remain eligible for waiver services.

D. Participants who are currently receiving Children's Choice Waiver services and reach their eighteenth birthday and choose to no longer attend school may transition to a Supports Waiver anytime between their eighteenth birthday and their twenty-first birthday based on a person-centered planning process.

1. Participants who transition to a Supports Waiver will continue receiving Supports Waiver services after their twenty-first birthday as long as they remain eligible for waiver services.

2. Children's Choice Waiver recipients who reach their twenty-first birthday will transfer into the most appropriate OCDD adult waiver as long as they remain eligible for waiver services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 35:1892 (September 2009), amended LR 39:2498 (September 2013), amended by the Department of Health, Bureaus of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2524 (December 2017).

§11104. Admission Denial or Discharge Criteria

A. Individuals shall be denied admission to or discharged from the Children's Choice Waiver if one of the following criteria is met:

1. the individual does not meet the financial eligibility requirements for the Medicaid Program;
2. the individual does not meet the requirements for ICF/ID level of care;
3. the individual is incarcerated or placed under the jurisdiction of penal authorities, courts or state juvenile authorities;
4. the individual resides in another state or has a change of residence to another state;
5. the participant is admitted to an ICF/ID or nursing facility with the intent to stay and not to return to waiver services:
 - a. The waiver participant may return to waiver services when documentation is received from the treating physician that the admission is temporary and shall not exceed 90 days.
 - b. the participant will be discharged from the waiver on the ninety-first day if the participant is still in the ICF/ID or nursing facility;
6. the health and welfare of the individual cannot be assured through the provision of children's choice services within the individual's approved plan of care;
7. the individual fails to cooperate in the eligibility determination/re-determination process and in the development or implementation of the approved plan of care.

B. Recipients of the Children's Choice Waiver who reach their twenty-first birthday will transfer to the most appropriate OCDD adult waiver as long as they remain eligible for waiver services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:2498 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2524 (December 2017).

§11105. Money Follows the Person Rebalancing Demonstration

A. The Money Follows the Person (MFP) Rebalancing Demonstration is a federal demonstration program awarded by the Centers for Medicare and Medicaid Services to the department. The demonstration is a transition program that targets individuals using qualified institutional services and moves them to home and community-based long-term care services. The MFP rebalancing demonstration will stop allocation of opportunities when the demonstration expires.

1. For purposes of these provisions, a qualified institution is a hospital, nursing facility, or intermediate care facility for people with developmental disabilities.

B. Individuals must meet the following criteria for participation in the MFP Rebalancing demonstration.

1. Individuals with a developmental disability must:
 - a. be from birth through 20 years of age;
 - b. occupy a licensed, approved and enrolled Medicaid nursing facility bed for at least 60 days or have been hospitalized in an acute care hospital for 60 days with referral for nursing facility placement; and
 - c. be Medicaid eligible, eligible for state developmental disability services and meet ICF/DD level of care.
2. The participant or his/her authorized representative must provide informed consent for both transition and participation in the demonstration.

C. Individuals who participate in the demonstration are not required to have a protected request date on the registry.

D. Children's choice waiver opportunities created using the MFP methodology do not create a permanent funding shift. These opportunities shall be funded on an individual basis for the purpose of this demonstration program only.

E. All other children's choice waiver provisions apply to the money follows the person rebalancing demonstration.

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 for Citizens with Developmental Disabilities, LR 35:1892 (September 2009), amended by Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2524 (December 2017), amended by the Department of Health, Bureau of Health Services Financing, and the Office for the Citizens with Developmental Disabilities, LR 48:1543 (June 2022).

§11107. Allocation of Waiver Opportunities

A. The intellectual/developmental disabilities (I/DD) request for services registry, hereafter referred to as "the registry," shall be used to identify individuals with intellectual and/or developmental disabilities who are waiting for an OCDD waiver opportunity.

B. Individuals who are found eligible for developmental disabilities services according to the *OCDD System Entry Policy*, and who request waiver services will be added to the registry. The request for services registry is arranged by the urgency of need and date of application for developmentally disabled (DD) waiver services.

C. Children's Choice Waiver opportunities shall be offered to individuals under the age of 21 who are on the registry, have the highest level of need and the earliest registry date. These individuals shall be notified in writing when a funded Children's Choice Waiver opportunity is available and that he/she is next in line for a Children's Choice Waiver slot except for allocations to the specific targeted groups cited as follows.

1. Money Follows the Person Rebalancing Demonstration Waiver opportunities which are allocated to demonstration participants only. The MFP Rebalancing demonstration will stop allocation of opportunities when the Demonstration expires. An additional 20 Children's Choice Waiver opportunities shall be created for the MFP Rebalancing Demonstration program and must only be filled by a demonstration participant. No alternate may utilize an MFP Rebalancing Demonstration opportunity.

a. In the event that an MFP Rebalancing Demonstration opportunity is vacated or closed, the opportunity will be returned to the MFP Rebalancing Demonstration pool and an offer will be made based upon the approved program guidelines until such time as the demonstration expires.

D. The Office for Citizens with Developmental Disabilities (OCDD) has the responsibility to monitor the utilization of Children's Choice Waiver opportunities. At the discretion of the OCDD, specifically allocated waiver opportunities may be reallocated to better meet the needs of individuals with developmental disabilities.

E. Funded opportunities will only be allocated to individuals who successfully complete the financial eligibility and medical certification process required for waiver certification.

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 for Citizens with Developmental Disabilities, LR 35:1892 (September 2009), amended LR 40:539, 540 (March 2014), LR 41:125 (January 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2524 (December 2017).

Chapter 113. Service

§11301. Service Cap

A. Effective May 20, 2007, children's choice services are capped at \$17,000 per individual per plan of care year.

B. Participants are eligible to receive all medically necessary Medicaid State Plan services, including early

periodic screening, diagnosis, and treatment (EPSDT) services.

C. Effective September 1, 2010, children's choice waiver services are capped at \$16,660 per individual per plan of care year.

D. Effective August 1, 2012, children's choice services are capped at \$16,410 per individual per plan of care year.

E. Children's choice services are capped at \$20,200 per individual per plan of care year.

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§11303. Service Definitions

A. The services in this §11303 are included in the service package for the Children's Choice Waiver. All services must be included on the approved plan of care which prior authorizes all services.

1. Children's choice services may be utilized to supplement EPSDT State Plan services that are prior approved as medically necessary.

2. Children's choice family supports services cannot be provided on the same day at the same time as EPSDT's personal care services.

3. Children's choice family supports services cannot be provided on the same day at the same time as any other children's choice waiver service except for the following:

- a. environmental accessibility adaptations;
- b. family training;
- c. specialized medical equipment and supplies; or
- d. support coordination.

4. Children's choice services cannot be provided in a school setting.

5. Services provided through a program funded under the Individuals with Disabilities Education Act (IDEA) must be utilized before accessing children's choice therapy services.

B. Support coordination consists of the coordination of services which will assist participants who receive children's choice services in gaining access to needed waiver and other Medicaid services, as well as needed medical, social, educational and other services, regardless of the funding

source. The support coordinator is responsible for convening the person-centered planning team comprised of the participant, participant's family, direct service providers, medical and social work professionals, as necessary, and advocates who assist in determining the appropriate supports and strategies to meet the participant's needs and preferences. The support coordinator shall be responsible for the ongoing coordination of supports and services included in the participant's plan of care. Support coordinators shall initiate the process of assessment and reassessment of the participant's level of care and the review of plans of care as required.

1. Support coordination services are provided to all children's choice participants to assist them in gaining access to needed waiver services, Medicaid State Plan services, as well as needed medical, social, educational and other services regardless of the funding source for the services. Support coordinators provide information and assistance to waiver participants by directing and managing their services in compliance with the rules and regulations governing support coordination.

a. Support coordinators shall be responsible for ongoing monitoring of the provision of services included in the participant's approved plan of care.

b. Support coordinators shall also participate in the evaluation and re-evaluation of the participant's plan of care.

c. Support coordinators will have limited annual plan of care approval authority as authorized by OCDD as indicated in policy and procedures.

2. Support coordinators are responsible for providing assistance to participants who choose self-direction option with their review of the Self-Direction Employer Handbook and for being available to these participants for on-going support and help with carrying out their employer responsibilities.

3. Provider Qualifications. Providers must have a current, valid support coordination license and meet all other requirements for targeted case management services as set forth in LAC 50:XV.Chapter 105 and the Medicaid Targeted Case Management Manual.

C. Center-based respite is service provided in a licensed respite care facility to participants unable to care for themselves. These services are furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

D. Environmental accessibility adaptations are physical adaptations to the home or vehicle provided when required by the participant's plan of care as necessary to ensure the health, welfare and safety of the participant, or which enable the participant to function with greater independence in the community, and without which the participant would require additional supports or institutionalization.

1. Such adaptations to the home may include:

a. the installation of ramps and/or grab-bars;

b. widening of doorways;

c. modification of bathroom facilities; or

d. installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the participant.

2. Adaptations which add to the total square footage of the home are excluded from this benefit.

3. Home modification funds are not intended to cover basic construction cost. For example, in a new home, a bathroom is already part of the building cost. Waiver funds can be used to cover the difference between constructing a bathroom and building an accessible or modified bathroom.

4. All services shall be in accordance with applicable state and local building codes.

5. An example of adaptation to the vehicle is a van lift.

6. Excluded is the purchase or lease of a vehicle and regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

7. Excluded are those adaptations or improvements to the home or vehicle, which are of general utility, and are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, central air conditioning, whole home generators, a fence, etc.

8. Fire alarms, smoke detectors, and fire extinguishers are not considered environmental adaptations and are excluded.

9. Any services covered by Title XIX (Medicaid State Plan Services) are excluded.

E. Family training consists of formal instruction offered through training and education designed to assist the families of children's choice waiver participants in meeting the needs of their children.

1. The training and education must be conducted by professional organizations or practitioners who offer education or training appropriate to the needs of the child as identified in the plan of care.

2. Family training must be prior approved by the LGE and incorporated into the approved plan of care.

3. For purposes of this service only, *family* is defined as persons who live with or provide care to a participant in the children's choice waiver and may include a parent, spouse, stepparent, grandparent, child, sibling, relative, foster family, legal guardian, or in-law.

4. Payment for family training services includes coverage of registration and training fees associated with formal instruction in areas relevant to the participant's needs as identified in the plan of care. Payment is not available for the costs of travel, meals and overnight lodging to attend a training event or conference.

F. Family support services are services that enable a family to keep their child or family member at home, thereby enhancing family functioning. Services may be provided in the home or outside of the home in settings such as after school programs, summer camps, or other places as specified in the approved plan of care.

1. Family support includes:

a. assistance and prompting with eating, bathing, dressing, personal hygiene, and essential housekeeping incidental to the care of the child, rather than the child's family. The preparation of meals is included, but not the cost of the meals themselves; and

b. assistance with participating in the community, including activities to maintain and strengthen existing informal networks and natural supports. Providing transportation to these activities is also included.

2. Family members who provide family support services must meet the same standards of service, training requirements, and documentation requirements as caregivers who are unrelated to the participant. Service hours shall be capped at 40 hours per week, Sunday to Saturday, for services delivered by family members living in the home.

3. Legally responsible individuals (such as a parent or spouse) and legal guardians may provide family support services for their own child, provided that the care is extraordinary in comparison to that of a child of the same age without a disability and the care is in the best interest of the child. Legally responsible individuals and legal guardians may not provide family support services delivered through self-direction.

G. Specialized Medical Equipment and Supplies

1. Specialized medical equipment and supplies are devices, controls, or appliances, as specified in the plan of care, which enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

2. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the participant.

3. All items shall meet applicable standards of manufacture, design and installation.

4. This service may also be used for routine maintenance or repair of specialized equipment. Some examples would include sip and puffer switches; other specialized switches; and voice-activated, light-activated, or motion-activated devices to access the participant's environment.

5. Routine maintenance or repair of specialized medical equipment is funded under this service.

6. Excluded are those durable and non-durable items that are available under the Medicaid State Plan. The Support Coordinator shall pursue and document all alternate funding sources that are available to the participant before submitting a request for approval to purchase or lease specialized medical equipment and supplies.

7. Excluded are those specialized equipment and supplies that are not of direct medical or remedial benefit to the participant such as, but not limited to:

- a. appliances;
- b. personal computers and software;
- c. daily hygiene products;
- d. rent subsidy;
- e. food;
- f. bed linens;
- g. exercise equipment;
- h. taxi fares, bus passes, etc;
- i. pagers and telephones; and
- j. home security systems.

H. Aquatic Therapy

1. Aquatic therapy uses the resistance of water to rehabilitate a participant with a chronic illness, poor or lack of muscle tone or a physical injury/disability.

2. Aquatic therapy is not for participants who have fever, infections and are bowel/ bladder incontinent.

I. Art Therapy

1. Art therapy is used to increase awareness of self and others; cope with symptoms, stress and traumatic experiences; enhance cognitive abilities; and as a mode of communication and enjoyment of the life-affirming pleasure of making art.

2. Art therapy is the therapeutic use of art by people who experience illness, trauma, emotional/behavioral or mental health problems; by those who have learning or physical disabilities, life-limiting conditions, brain injuries or neurological conditions and/or challenges in living; and by people who strive to improve personal development.

J. Music Therapy

1. Music therapy services help participants improve their cognitive functioning, motor skills, emotional and affective development, behavior and social skills and quality of life.

K. Sensory Integration

1. Sensory integration is used to improve the way the brain processes and adapts to sensory information, as opposed to teaching specific skills. Sensory integration involves activities that provide vestibular, proprioceptive and tactile stimuli which are selected to match specific sensory processing deficits of the child.

L. Hippotherapy/Therapeutic Horseback Riding

1. Hippotherapy/therapeutic horseback riding are services used to promote the use of the movement of the horse as a treatment strategy in physical, occupational and speech-language therapy sessions for people living with disabilities.

2. Hippotherapy improves muscle tone, balance, posture, coordination, motor development as well as motor planning that can be used to improve sensory integration skills and attention skills.

a. Specially trained therapy professionals evaluate each potential participant on an individual basis to determine the appropriateness of including hippotherapy as a treatment strategy.

b. Hippotherapy requires therapy sessions that are one-on-one with a licensed physical therapist, speech therapist or occupational therapist who works closely with the horse professional in developing treatment strategies. The licensed therapist must be present during the hippotherapy sessions.

c. Hippotherapy must be ordered by a physician with implementation of service, treatment strategies and goals developed by a licensed therapist. Services must be included in the participant's plan of care.

3. Therapeutic horseback riding teaches riding skills and improves neurological function and sensory processing.

a. Therapeutic horseback riding must be ordered by a physician with implementation of service, treatment strategies and goals developed by a licensed therapist. Services must be included in the participant's plan of care.

M. Housing Stabilization Transition Services

1. Housing stabilization transition services enable participants who are transitioning into a permanent supportive housing unit, including those transitioning from institutions, to secure their own housing. The service is provided while the participant is in an institution and preparing to exit the institution using the waiver.

2. Housing stabilization transition services include the following components:

a. conducting a housing assessment to identify the participant's preferences related to housing (i.e., type, location, living alone or with someone else, accommodations needed, and other important preferences), and his/her needs for support to maintain housing, including:

- i. access to housing;
- ii. meeting the terms of a lease;
- iii. eviction prevention;
- iv. budgeting for housing/living expenses;
- v. obtaining/accessing sources of income necessary for rent;
- vi. home management;

vii. establishing credit; and

viii. understanding and meeting the obligations of tenancy as defined in the lease terms;

b. assisting the participant to view and secure housing as needed, which may include arranging for and providing transportation;

c. assisting the participant to secure supporting documents/records, completing/submitting applications, securing deposits, and locating furnishings;

d. developing an individualized housing support plan based upon the housing assessment that:

i. includes short and long term measurable goals for each issue;

ii. establishes the participant's approach to meeting the goal; and

iii. identifies where other provider(s) or services may be required to meet the goal;

e. participating in the development of the plan of care and incorporating elements of the housing support plan; and

f. exploring alternatives to housing if permanent supportive housing is unavailable to support completion of the transition.

3. Housing stabilization transition services are only available upon referral from the support coordinator. This service is not duplicative of other waiver services, including support coordination. This service is only available to persons who are residing in a state of Louisiana permanent supportive housing unit, or who are linked for the state of Louisiana permanent supportive housing selection process.

4. Participants may not exceed 165 combined units of this service and housing stabilization services.

a. Exceptions to exceed the 165 unit limit may be made only with written approval from the Office for Citizens with Developmental Disabilities.

N. Housing Stabilization Services

1. Housing stabilization services enable waiver participants to maintain their own housing as set forth in the participant's approved plan of care. Services must be provided in the home or a community setting.

2. Housing stabilization services include the following components:

a. conducting a housing assessment to identify the participant's preferences related to housing (i.e., type, location, living alone or with someone else, accommodations needed, and other important preferences), and his/her needs for support to maintain housing, including:

- i. access to housing;
- ii. meeting the terms of a lease;
- iii. eviction prevention;

- iv. budgeting for housing/living expenses;
 - v. obtaining/accessing sources of income necessary for rent;
 - vi. home management;
 - vii. establishing credit; and
- b. participating in the development of the plan of care and incorporating elements of the housing support plan;
 - c. developing an individualized housing stabilization service provider plan based upon the housing assessment that includes short and long term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies where other provider(s) or services may be required to meet the goal;
 - d. providing supports and interventions according to the individualized housing support plan (If additional supports or services are identified as needed outside the scope of housing stabilization service, the needs must be communicated to the support coordinator.);
 - e. providing ongoing communication with the landlord or property manager regarding the participant's disability, accommodations needed, and components of emergency procedures involving the landlord or property manager;
 - f. updating the housing support plan annually or as needed due to changes in the participant's situation or status; and
 - g. providing supports to retain housing or locate and secure housing to continue community-based supports if the participant's housing is placed at risk (e.g., eviction, loss of roommate or income); this includes locating new housing, sources of income, etc.

3. Housing stabilization services are only available upon referral from the support coordinator. This service is not duplicative of other waiver services, including support coordination. This service is only available to persons who are residing in a state of Louisiana permanent supportive housing unit.

4. Participants may not exceed 165 combined units of this service and housing stabilization transition services.

a. Exceptions to exceed the 165 unit limit may be made only with written approval from the Office for Citizens with Developmental Disabilities.

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

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LR 41:126 (January 2015), amended by Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2525 (December 2017), LR 48:1543 (June 2022).

Chapter 115. Provider Participation Requirements

Subchapter A. Provider Qualifications

§11501. Support Coordination Providers and Service Providers

A. Support Coordination Providers. Families of waiver participants shall choose one support coordination agency from those available in their region to provide developmental disabilities support coordination services.

B. Service Providers. Agencies licensed to provide personal care attendant services may enroll as a provider of children's choice services with the exception of support coordination services and therapy services. Agencies that enroll to be a children's choice service provider shall provide family support services, and shall either provide or subcontract for center-based respite, environmental accessibility adaptations, family training, and specialized medical equipment and supplies. Families of participants shall choose one service provider agency from those available in their region that will provide all waiver services, except support coordination.

1. Family members who provide family support services must meet the same standards of service, training requirements, and documentation requirements as caregivers who are unrelated to the participant.

2. Legally responsible individuals (such as a parent or spouse) and legal guardians who provide family support services for their own child must meet the same standards of service, training requirements, and documentation requirements as caregivers who are unrelated to the participant. Monitoring shall be conducted to ensure proper documentation and that the services are delivered in accordance with the child's plan of care. Payments to legally responsible individuals, legal guardians and family members living in the home shall be audited on a semi-annual basis to ensure payment for services rendered.

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 26:2793 (December 2000), repromulgated for LAC, LR 28:1984 (September 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:2501 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:1544 (June 2022).

Subchapter B. Provider Requirements

§11521. General Requirements for Medicaid Enrollment

A. In order to participate in the Medicaid Program, a provider must meet all of the following requirements.

1. The provider must meet all the requirements for licensure as established by state laws and rules promulgated by the Department of Health (LDH) or have a current, valid license or certification from the appropriate governing board for that profession.

2. The provider must agree to comply with all the terms and conditions for Medicaid enrollment as contained in:

- a. the provider enrollment packet;
- b. the Medical Assistance Program Integrity Law (MAPIL), R.S. 46:437.1 - 440.3;
- c. the provider agreement;
- d. the standards for participation contained in the Children's Choice and Case Management Services provider manuals; and
- e. all other applicable federal and state laws, regulations and policies.

3. All services must be appropriately documented in the provider's records.

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 27: 310 (March 2001), repromulgated for LAC, LR 28:1984 (September 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:2501 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2525 (December 2017).

§11523. Enrollment

A. Both support coordination and direct services providers must comply with the requirements of this §11523 in order to participate as Children Choice providers. Agencies will not be added to the Freedom of Choice (FOC) list of available providers maintained by OCDD until they have received a Medicaid provider number.

B. Providers shall attend all mandated meetings and training sessions as directed by OCDD as a condition of enrollment and continued participation as waiver providers. Attendance at a provider enrollment orientation shall be required prior to enrollment as a Medicaid provider of services. The frequency of the provider enrollment orientations shall be determined by LDH Health Standards Section.

C. A separate provider enrollment packet must be completed for each site in each LDH administrative region where the agency will provide services.

D. Participant case records and billing records shall be housed at the site in LDH administrative region where the participant resides.

E. Providers may not refuse to serve any waiver participant that chooses their agency to provide services.

F. Providers shall have available computer equipment and software necessary to participate in prior authorization and data collection as described in the Children's Choice Provider Manual.

G. Providers shall participate in initial training for prior authorization and data collection. This initial training and any LDH scheduled subsequent training addressing program changes is to be provided at no cost to the agency. Repeat training must be paid for by the requesting agency.

H. Providers shall develop a quality improvement plan which must be submitted for approval within 60 days after LDH training. Self-assessments are due six months after approval of the plan and yearly thereafter.

I. The agency must not have been terminated or actively sanctioned by Medicaid, Medicare or other health-related programs in Louisiana or any other state.

J. The agency must not have an outstanding Medicaid program audit exception or other unresolved financial liability owed to the state.

K. Providers shall be certified for a period of one year. Re-certification must be completed no less than 60 days prior to the expiration of the certification period.

L. Waiver services are to be provided only to persons who are waiver participants, and strictly in accordance with the provisions of the approved plan of care.

M. Changes in the following areas are to be reported to both OCDD and the Provider Enrollment Section in writing at least 10 days prior to any change:

1. ownership;
2. physical location;
3. mailing address;
4. telephone number; and
5. account information affecting electronic funds transfer.

N. The provider must complete a new provider enrollment packet when a change in ownership of 5 percent to 50 percent of the controlling interest occurs, but may continue serving participants. When 51 percent or more of the controlling interest is transferred, a complete re-certification process must occur and the agency shall not continue serving participants until the re-certification process is complete.

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 Community Supports and Services, LR 27:310 (March 2001),

repromulgated for LAC by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1984 (September 2002), amended LR 28:2533 (December 2002), repromulgated LR 29:38 (January 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:2501 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2525 (December 2017).

§11525. Case Management Providers

A. Case management providers must also comply with Paragraphs 1 and 2 of this Subsection A in order to participate as children choice providers.

1. Providers of case management services for the Children's Choice program must have a contract with LDH to provide services to waiver participants.

2. Case management agencies must meet all requirements of their contract in addition to the requirements contained in the Children's Choice and Case Management Services Provider Manuals.

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 27:310 (March 2001), repromulgated for LAC, LR 28:1985 (September 2002), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2526 (December 2017).

§11527. Direct Service Providers

A. Direct service providers, except those listed in §11529, must also comply with §11527 in order to participate as children's choice providers.

1. The provider must be licensed by LDH as a home and community-based services provider and meet the module specific requirements for the services being provided.

2. Direct service providers must provide, at a minimum, family support services, crisis support services and subcontract services for center-based respite, family training, environmental adaptations and specialized medical equipment and supplies.

3. The following services may either be provided directly by the direct service provider or by written agreement (subcontract) with other agents; and the actual provider of the service, whether it is the direct service provider or a subcontracted agent, shall meet the following licensure or other qualifications.

a. Center-based respite must be provided by a facility licensed by LDH and meet all module specific requirements for the service.

b. Family training must be provided at approved events.

c. Environmental adaptations must be provided by an individual/agency deemed capable to perform the service by the participant's family and the direct service provider agency. When required by state law, the person performing the service must meet applicable requirements for a professional license. When building code standards are applicable, modifications to the home shall meet such standards.

d. Specialized Medical Equipment and Supplies agencies who are vendors of technological equipment and supplies must be enrolled in the Medicaid Program as a durable medical equipment provider and must meet all applicable vendor standards and requirements for manufacturing, design and installation of technological equipment and supplies.

e. All services must be performed and completed during the current approved plan of care year. Services that are not completed by the end of the current approved plan of care year will be voided and deemed as non-billable. Services cannot carry over into the next plan of care year.

4. Providers shall maintain a 24-hour toll-free telephone number manned by a person and shall provide a written plan to the participants, families and support coordinators that explains how workers can be contacted and the expected response time.

5. Providers shall develop and provide brochures to interested parties that document the agency's experience, toll-free telephone number, OCDD information, and other pertinent information. All brochures are subject to OCDD approval prior to distribution.

6. Agencies must provide services consistent with the personal outcomes identified by the participant and his/her family.

7. All personnel who are at a supervisory level must have a minimum of one year verifiable work experience in planning and providing direct services to people with intellectual/developmental disabilities.

8. The agency shall document that its employees and the employees of subcontractors do not have a criminal record as defined in 42 CFR 441.404(b). Providers of community supported living arrangement services must:

a. not use individuals who have been convicted of child abuse, neglect, or mistreatment, or of a felony involving physical harm to an individual; and

b. take all reasonable steps to determine whether applications for employment by the provider have histories indicating involvement in child or client abuse, neglect, or mistreatment, or a criminal record involving physical harm to an individual.

9. Direct service providers who contract with other agencies to provide waiver services shall maintain copies of such contracts signed by both agencies. Such contracts must state that the subcontractor may not refuse to serve any waiver participant referred to them by the enrolled direct service provider agency.

10. Direct service providers and subcontractors shall maintain written internal policy and procedure manuals that comply with the requirements contained in the children's choice provider manual.

11. Enrollment of direct service providers is contingent on the submission of a complete application packet.

12. Service delivery shall be documented with progress notes on participant status, supports provided that address personal outcomes, participant responses, etc. Progress notes shall be dated and signed in ink. Whiteout is not to be used in making corrections.

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 27: 310 (March 2001), repromulgated for LAC, LR 28:1985 (September 2002), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1872 (September 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:2501 (September 2013), LR 41:127 (January 2015), repromulgated LR 41:538 (March 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2526 (December 2017).

§11529. Professional Services Providers

A. Professional services are direct services to participants, based on need, that may be utilized to increase the participant's independence, participation and productivity in the home and community. Service intensity, frequency and duration will be determined by individual need. Professional services include the following:

1. aquatic therapy;
2. art therapy;
3. music therapy;
4. sensory integration; and
5. hippotherapy/therapeutic horseback riding.

B. Professional services must be delivered with the participant present and in accordance with the plan of care.

C. Children's choice services cannot be provided on the same day at the same time as any other waiver or State Plan service except for the following services:

1. environmental accessibility adaptations;
2. family training;
3. specialized medical equipment and supplies;
4. support coordination; and
5. therapy

D. Children's choice services cannot be provided in a school setting.

E. Provider Qualifications

1. Individual practitioners must enroll as a Medicaid provider;

2. Have a current, valid license or certification from the appropriate governing board for that profession; and

3. Possess one year of post licensure or certification experience.

a. In addition, the specific service delivered must be consistent with the scope of the license or certification held by the professional.

F. All services rendered shall be prior approved and in accordance with the plan of care.

G. All services must be documented in service notes which describe the services rendered and progress towards the participant's personal outcomes and his/her plan of care.

H. Providers of professional services must maintain adequate documentation to support service delivery and compliance with the approved plan of care and provide said documentation upon the LDH's 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 Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:2501 (September 2013), amended LR 41:128 (January 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:1544 (June 2022).

§11531. Electronic Visit Verification

A. Effective for dates of service on or after August 1, 2015, Children's Choice Waiver providers shall use the electronic visit verification (EVV) system designated by the department for automated scheduling, time and attendance tracking, and billing for certain home and community-based services.

B. Reimbursement shall only be made to providers with documented use of the EVV system. The services that require use of the EVV system will be published in the Children's Choice Waiver provider manual.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:1286 (July 2015).

Chapter 117. Crisis Provisions

§11701. Participation in Children's Choice

A. Children's Choice Waiver participants who experience a crisis that increases the need for paid supports to a level that cannot be accommodated within the service cap specified in §11301.A on waiver expenditures, may request consideration for a crisis designation. A *crisis* is defined as a catastrophic change in circumstances rendering the natural and community support system unable to provide for the health and welfare of the participant at the level of

benefits offered under Children's Choice. The procedure in this Chapter has been developed to address these situations.

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 27:1015 (July 2001), repromulgated for LAC, LR 28:1986 (September 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:2502 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2526 (December 2017).

§11703. Crisis Designation Criteria

A. In order to be considered a crisis, one of the following circumstances must exist:

1. death of the caregiver with no other supports (i.e., other family) available; or
2. the caregiver is incapacitated with no other supports (i.e., other family) available; or
3. the participant is committed to the custody of LDH by the court; or
4. other family crisis with no caregiver support available, such as abuse/neglect, or a second person in the household becomes disabled and must be cared for by same caregiver, causing inability of the natural caregiver to continue necessary supports to assure health and safety; or
5. the participant's condition deteriorates to the point when the plan of care is inadequate.

B. Exhausting available funds through the use of therapies, environmental accessibility adaptations, and specialized medical equipment and supplies does not qualify as justification for crisis designation.

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 27:1015 (July 2001), repromulgated for LAC, LR 28:1986 (September 2002), amended LR 29:704 (May 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:2503 (September 2013), LR 41:128 (January 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2526 (December 2017).

§11705. Crisis Extension Provisions

A. Additional services (crisis support) outside of the waiver cap amount shall be approved by the OCDD state office. Crisis designation is time-limited, depending on the anticipated duration of the causative event. Each request for crisis designation may be approved for a maximum of three months.

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 27:1015 (July 2001), repromulgated for LAC, LR 28:1986 (September 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:2503 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2526 (December 2017).

Chapter 119. Noncrisis Provisions

§11905. Determination Responsibilities and Appeals

A. The LGE shall have the responsibility for making the determinations as to the matters set forth in this Chapter 119. Persons who have elected or whose legal representatives have elected that they receive services under the Children's Choice Waiver have the right to appeal any determination of the department as to matters set forth in this Chapter 119, under the regulations and procedures applicable to Medicaid fair hearings.

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 28:1465 (June 2002), repromulgated for LAC, LR 28:1987 (September 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:2504 (September 2013), LR 41:128 (January 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2527 (December 2017).

Chapter 121. Reimbursement Methodology

§12101. Unit of Reimbursement

A. Case management services shall be reimbursed at a flat monthly rate billed for each waiver participant served in accordance with the conditions and procedures contained in the Case Management Services provider manual.

1. Establishment of Support Coordination Workforce Bonus Payments

a. Support coordination providers who provided services from April 1, 2021 to October 31, 2022 shall receive bonus payments of \$300 per month for each support coordination worker that worked with participants for those months.

b. The support coordination worker 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 provider. This bonus payment is effective for all eligible support coordination workers of any working status, whether full-time or part-time.

2. Audit Procedures for Support Coordination Workforce Bonus Payments

a. The bonus payments reimbursed to support coordination providers shall be subject to audit by LDH.

b. Support coordination providers shall provide to LDH or its representative all requested documentation to verify that they are in compliance with the support coordination bonus payments.

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

d. Support coordination providers shall produce the requested documentation upon request and within the time frame provided by LDH.

e. Noncompliance or failure to demonstrate that the bonus payments were paid directly to support coordination workers may result in the following:

- i. sanctions; or
- ii. disenrollment from the Medicaid Program.

3. Sanctions for Support Coordination Workforce Bonus Payments

a. The support coordination provider will be subject to sanctions or penalties for failure to comply with this Rule or with requests issued by LDH pursuant to this Rule. The severity of such action will depend upon the following factors:

- i. failure to pay support coordination workers the \$250 monthly workforce payments;
- ii. the number of employees identified as having been paid less than the \$250 monthly workforce retention bonus payments;
- iii. the persistent failure to pay the \$250 monthly workforce bonus payments; or
- iv. failure to provide LDH with any requested documentation or information related to or for the purpose of verifying compliance with this Rule.

B. Direct service providers shall be reimbursed according to the following unit of reimbursement approach. Actual rates will be published in the Children's Choice Waiver provider manual, and will be subsequently amended by direct notification to the affected providers. For services provided by a subcontractor agency, the enrolled direct service provider shall coordinate and reimburse the subcontractor according to the terms of the contract and retain the administrative costs.

1. Family support, crisis support, center-based respite, aquatic therapy, art therapy, music therapy, sensory integration and hippotherapy/therapeutic horseback riding services shall be reimbursed at a flat rate per 15-minute unit of service and reimbursement shall not be made for less than 15-minute (one quarter-hour) of service. This covers both service provision and administrative costs.

a. Up to two participants may choose to share family support services if they share a common provider of this service. Family support services may share a direct support worker (DSW) across two waivers: the Residential Options Waiver (community living supports) and/or New

Opportunities Waiver (individual and family supports). However, sharing a DSW at the same time across all three waivers is not allowed.

b. Up to two participants may choose to share crisis support services if they share a common provider of this service.

c. There is a separate reimbursement rate when these services are shared.

2. Family training shall be reimbursed at cost.

3. Environmental accessibility adaptations and specialized medical equipment and supplies shall be reimbursed at cost plus a set administrative add-on per project.

4. Direct Service Worker Wages and Workforce Bonus Payments

a. Establishment of Direct Service Worker Wage Floor for Medicaid Home and Community-Based Services for Intellectual and Developmental Disabilities

i. Effective October 1, 2021, providers of Medicaid home and community-based waiver services operated through the Office for Citizens with Developmental Disabilities employing direct service workers will receive the equivalent of a \$2.50 per hour rate increase.

ii. Effective October 1, 2021, this increase or its equivalent will be applied to all service units provided by direct service workers with an effective date of service for the identified home and community-based waiver services provided beginning October 1, 2021.

iii. The minimum hourly wage floor paid to direct service workers shall be \$9 per hour.

iv. All providers of services affected by this rate increase shall be subject to a direct service worker wage floor of \$9 per hour. This wage floor is effective for all affected direct service workers of any work status, whether full-time or part-time.

v. The Department of Health reserves the right to adjust the direct service worker wage floor as needed through appropriate rulemaking promulgation consistent with the Administrative Procedure Act.

b. Establishment of Direct Service Worker Workforce Bonus Payments.

i. Providers who provided services from April 1, 2021 to October 31, 2022 shall receive bonus payments of \$300 per month for each direct service worker that worked with participants for those months.

ii. Direct service workers who provided services from April 1, 2021 to October 31, 2022 that worked with participants must receive at least \$250 of this \$300 bonus payment paid to providers. This bonus payment is effective for all eligible direct service workers of any working status, whether full-time or part-time.

iii. Bonus payments will end October 31, 2022.

iv. LDH reserves the right to adjust the amount of the bonus payments paid to the direct service worker as needed through appropriate rulemaking promulgation consistent with the Administrative Procedure Act.

c. Audit Procedures for Direct Service Worker Wage Floor and Workforce Bonus Payments

i. The wage enhancement and bonus payments reimbursed to providers shall be subject to audit by LDH.

ii. Providers shall provide to the LDH or its representative all requested documentation to verify that they are in compliance with the direct service wage floor and bonus payments.

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

iv. Providers shall produce the requested documentation upon request and within the timeframe provided by the LDH.

v. Non-compliance or failure to demonstrate that the wage enhancement and/or bonus payments were paid directly to the direct service workers may result in the following:

- (a). sanctions; or
- (b). disenrollment from the Medicaid Program.

d. Sanctions for Direct Service Worker Wage Floor and Workforce Bonus Payments

i. The provider will be subject to sanctions or penalties for failure to comply with this Rule or with requests issued by LDH pursuant to this Rule. The severity of such action will depend upon the following factors:

(a). Direct Service Worker Wage Floor;

(i). the failure to pay I/DD HCBS direct service workers the wage floor minimum of \$9 per hour;

(ii). the number of I/DD HCBS direct service workers identified as having been paid less than the wage floor minimum of \$9 per hour; or

(iii). the persistent failure to pay I/DD HCBS direct service workers the wage floor minimum of \$9 per hour;

(b). Direct Service Worker Workforce Bonus Payments;

(i). the failure to pay eligible I/DD HCBS direct service workers the \$250 monthly workforce bonus payments;

(ii). the number of eligible I/DD HCBS direct service workers who are identified as having not been paid the \$250 monthly workforce bonus payments; or

(iii). the persistent failure to pay eligible I/DD HCBS direct service workers the monthly \$250 monthly workforce bonus payments; or

(c). 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 and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1987 (September 2002), LR 33:1872 (September 2007), amended by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 34:250 (February 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 36:324 (February 2010), LR 36:2280 (October 2010), LR 37:2157 (July 2011), LR 39:2504 (September 2013), LR 40:68 (January 2014), LR 41:128 (January 2015), LR 42:896 (June 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:40 (January 2022), LR 48:1544 (June 2022), LR 49:1067 (June 2023).

Chapter 123. Self-Direction Initiative

§12301. Self-Direction Service Delivery Option

A. The self-direction initiative is a voluntary, self-determination option which allows the participant to coordinate the delivery of children's choice services, as designated by OCDD, through an individual direct support professional rather than through a licensed, enrolled provider agency. Selection of this option requires that the participant utilize a payment mechanism approved by the department to manage the required fiscal functions that are usually handled by a provider agency.

B. Participant Responsibilities. Waiver participants choosing the self-directed service delivery option must understand the rights, risks and responsibilities of managing their own care and individual budget. If the participant is under 18 years of age or is unable to make decisions independently, the participant must have an authorized representative who understands the rights, risks and responsibilities of managing his/her care and supports within the participant's individual budget. The employer must be at least 18 years of age. Responsibilities of the participant or authorized representative include:

1. completion of mandatory trainings, including the rights and responsibilities of managing services, supports and individual budgets;

2. participation in the self-direction service delivery option without a lapse in or decline in quality of care or an increased risk to health and welfare;

a. adhering to the health and welfare safeguards identified by the team, including the application of a comprehensive monitoring strategy and risk assessment and management systems;

3. participation in the development and management of the approved budget:

a. this annual budget is determined by the recommended service hours listed in the participant's plan of care to meet his/her needs; and

b. the participant's individual budget includes a potential amount of dollars within which the participant or his/her authorized representative exercises decision-making responsibility concerning the selection of services and service providers;

4. all services rendered shall be prior approved and in accordance with the plan of care;

5. all services must be documented in service notes, which describes the services rendered and progress towards the participant's personal outcomes plan of care; and

6. authorized representatives may be the employer of the self-directed option, but may not also be the employee.

C. Termination of the Self-Direction Service Option. Termination of participation in the self-direction service delivery option requires a revision of the plan of care, the elimination of the fiscal agent and the selection of the Medicaid-enrolled waiver service provider(s) of choice.

1. Voluntary Termination. The waiver participant may choose at any time to withdraw from the self-direction service delivery option and return to the traditional provider agency management of services.

2. Involuntary termination. The department may terminate the self-direction service delivery option for a participant and require him/her to receive provider-managed services under the following circumstances:

a. the health or welfare of the participant is compromised by continued participation in the self-direction service delivery option;

b. the participant is no longer able to direct his/her own care and there is no authorized representative to direct the care;

c. there is misuse of public funds by the participant or the authorized representative; or

d. over three payment cycles in a one year period, the participant or authorized representative:

i. places barriers to the payment of the salaries and related state and federal payroll taxes of direct support staff;

ii. fails to follow the approved budget;

iii. fails to provide required documentation of expenditures and related items; or

iv. fails to cooperate with the fiscal agent or support coordinator in preparing any additional documentation of expenditures.

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, Office for Citizens with Developmental Disabilities, LR 39:2504 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2527 (December 2017), LR 48:1544 (June 2022).

Subpart 11. New Opportunities Waiver

Chapter 137. General Provisions

§13701. Introduction

A. The New Opportunities Waiver (NOW), hereafter referred to as the NOW, is designed to enhance the home and community-based services and supports available to individuals with developmental disabilities, who would otherwise require an intermediate care facility for persons with developmental disabilities (ICF-IDD) level of care. The mission of the NOW is to utilize the principle of self-determination and supplement the family and/or community supports while supporting the dignity, quality of life and security in the everyday life of an individual, and maintaining that individual in the community. Services provided in the NOW are community-based, and are designed to allow an individual experience that mirrors the experiences of individuals without disabilities. These services are not to be restrictive, but liberating, by empowering individuals to experience life in the most fulfilling manner as defined by the individual while still assuring health and safety. In keeping with the principles of self-determination, NOW includes a self-direction service delivery option. This allows for greater flexibility in hiring, training, and general service delivery issues.

B. All NOW services are accessed through the case management agency of the beneficiary's choice. All services must be prior authorized and delivered in accordance with the approved comprehensive plan of care (CPOC). The CPOC shall be developed using a person-centered process coordinated by the beneficiary's case manager

C. Providers must maintain adequate documentation to support service delivery and compliance with the approved plan of care and provide said documentation at the request of the department.

D. In order for the NOW provider to bill for services, the beneficiary and the direct service provider, professional or other practitioner rendering service, must be present at the time the service is rendered unless otherwise allowed in rule. The service must be documented in service notes describing the service rendered and progress towards the beneficiary's personal outcomes and CPOC.

E. Only the following NOW services shall be provided for, or billed for, during the same hours on the same day as any other NOW service:

1. substitute family care;
2. supported independent living; and
3. skilled nursing services.

a. Skilled nursing services may only be provided with:

- i. substitute family care;
- ii. supported independent living;
- iii. day habilitation;

- iv. supported employment (all three modules); and/or
- v. prevocational services

F. The average beneficiary expenditures for all waiver services shall not exceed the average Medicaid expenditures for ICF-IDD services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1201 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1647 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:68 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:50 (January 2018), LR 45:42 (January 2019), LR 46:1680 (December 2020), LR 48:1545 (June 2022).

§13702. Settings for Home and Community-Based Services

A. NOW beneficiaries are expected to be integrated in and have full access to the greater community while receiving services, to the same extent as individuals without disabilities. Providers shall meet the requirements of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services' (CMS) home and community-based setting requirements for Home and Community-Based Services (HCBS) Waivers as delineated in LAC 50:XXI.901.

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 44:51 (January 2018), LR 48:1545 (June 2022).

§13703. Beneficiary Qualifications and Admissions Criteria

A. In order to qualify for the New Opportunities Waiver (NOW), an individual must be three years of age or older and meet all of the following criteria:

1. have an intellectual and/or developmental disability as specified in R.S. 28:451.2;
2. be deemed eligible for developmental disability services and be on the intellectual/developmental disabilities (IDD) request for services registry (RFSR), unless otherwise specified through programmatic allocation in §13707;
3. meet the financial eligibility requirements for the Medicaid Program;
4. meet the requirements for an ICF-IDD level of care which requires active treatment of a developmental disability under the supervision of a qualified developmental disability professional;

5. have assurance that health and welfare of the individual can be maintained in the community with the provision of NOW services;

6. have justification, based on a uniform needs-based assessment and a person-centered planning discussion that the NOW is the only OCDD waiver that will meet the needs of the individual;

7. be a resident of Louisiana; and

8. be a citizen of the United States or a qualified immigrant.

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 Community Supports and Services, LR 30:1201 (June 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:96 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2528 (December 2017), LR 45:43 (January 2019), LR 48:1545 (June 2022).

§13704. Needs-Based Assessment

A. A uniform needs-based assessment in conjunction with person-centered planning is utilized in the service planning process for the individuals receiving or participating in an OCDD waiver. The results of this assessment activity shall be utilized to determine which OCDD waiver will be offered to the individual during the initial plan of care process.

1. The beneficiary or his/her representative may request a reconsideration and present supporting documentation if he/she disagrees with the specific OCDD waiver offered as a result of the needs based assessment and person-centered planning process. If the beneficiary disagrees with the reconsideration decision, he/she may request a fair hearing through the formal appeals process.

B. The needs-based assessment instrument(s) is designed to evaluate the practical support requirements of individuals with developmental disabilities in daily living, medical and behavioral areas, including:

1. home living;
2. community living;
3. lifelong learning;
4. employment;
5. health and safety;
6. social activities; and
7. protection and advocacy.

C. The needs-based assessment instrument(s) is also used to evaluate the individual's support needs based on information and data obtained from four areas of the person's life, which includes:

1. support needs measurements including:
 - a. material support;
 - b. vision related supports;
 - c. hearing related supports;
 - d. supports for communicating needs;
 - e. positive behavior supports;
 - f. physicians supports;
 - g. professional supports (e.g., registered nurse, physical therapist, occupational therapist, etc.); and
 - h. stress and risk factors;
2. living arrangements and program participation including:
 - a. people living in the home;
 - b. natural supports in the home;
 - c. living environments; and
 - d. supports and service providers;
3. medical and diagnostic information findings including:
 - a. diagnoses;
 - b. medications and dosages; and
 - c. need for relief from pain or illness; and
4. personal satisfaction reports including:
 - a. agency supports provided at home;
 - b. work or day programs;
 - c. living environment;
 - d. family relationships; and
 - e. social relationships.

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 Service Financing and the Office for Citizens with Developmental Disabilities, LR 36:65 (January 2010), amended LR 40:69 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2528 (December 2017), LR 48:1546 (June 2022).

§13705. Denial of Admission or Discharge Criteria

A. Individuals shall be denied admission to or discharged from the NOW if one of the following criteria is met:

1. the individual does not meet the financial eligibility requirements for the Medicaid Program;
2. the individual does not meet the requirement for an ICF-IDD level of care;
3. the individual is incarcerated or placed under the jurisdiction of penal authorities, courts or state juvenile authorities;

4. the individual resides in another state or has a change of residence to another state;

5. the beneficiary is admitted to an ICF-IDD facility or nursing facility with the intent to stay and not to return to waiver services. The waiver beneficiary may return to waiver services when documentation is received from the treating physician that the admission is temporary and shall not exceed 90 days. The beneficiary will be discharged from the waiver on the ninety-first day if the beneficiary is still in the ICF-IDD or nursing facility;

6. the health and welfare of the beneficiary cannot be assured through the provision of NOW services within the beneficiary's approved comprehensive plan of care;

7. the individual fails to cooperate in the eligibility determination/re-determination process and in the development or implementation of the approved POC;

8. continuity of services is interrupted as a result of the individual not receiving a NOW service during a period of 30 or more consecutive days. This does not include interruptions in NOW services because of hospitalization, temporary admission to rehabilitation or nursing facilities, or non-routine lapses in services where the family agrees to provide all needed or paid natural supports. There must be documentation from the treating physician that this interruption will not exceed 90 days in the case of the admission to a rehabilitation or nursing facility. During this 90-day period, the Office for Citizens with Developmental Disabilities (OCDD) will not authorize payment for NOW services; and/or

9. there is no justification, based on a uniform needs-based assessment and a person-centered planning discussion, that the NOW is the only OCDD waiver that will meet the beneficiary's needs.

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 Community Supports and Services, LR 30:1202 (June 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities LR 40:69 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:51 (January 2018), LR 45:43 (January 2019), LR 48:1546 (June 2022).

§13706. Resource Allocation

A. The resource allocation model shall be used to assign service units based on the findings of the needs-based assessment and person-centered planning discussion for individuals who will be offered or are currently receiving New Opportunities Waiver services. Within the resource allocation model, there is a determination of an acuity level for individual and family support (IFS) services.

1. The beneficiary or his/her representative may request a reconsideration and present supporting documentation if he/she disagrees with the amount of assigned IFS service units. If the beneficiary disagrees with

the reconsideration decision, he/she may request a fair hearing through the formal appeals process.

2. Implementation of the resource allocation model was phased-in for the allocation of new NOW opportunities and renewal of existing NOW opportunities beginning July 1, 2009.

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 Service Financing and the Office for Citizens with Developmental Disabilities, LR 43:2528 (December 2017), LR 48:1546 (June 2022).

§13707. Programmatic Allocation of Waiver Opportunities

A. The intellectual/developmental disabilities request for services registry, hereafter referred to as “the registry,” is the list that documents and maintains the person’s name and protected request date for waiver services. A person’s protected request date for any OCDD waiver is the date of the first face-to-face interview in which he/she applied for waiver services and is determined eligible for developmental disabilities services by the entry unit. The order of entry into an OCDD waiver is needs based from the registry arranged by an urgency of need assessment and date of application for developmentally disabled (DD) waiver services.

B. Funded OCDD waiver opportunities shall be offered based on the following priority groups:

1. individuals living at a publicly operated ICF-IDD or who lived at a publicly operated ICF-IDD when it transitioned to a private ICF-IDD through a cooperative endeavor agreement (CEA facility), or their alternates. Alternates are defined as individuals living in a private ICF-IDD who will give up the private ICF-IDD bed to an individual living at a publicly operated ICF-IDD when it transitioned to a private ICF-IDD through a cooperative endeavor agreement (CEA Facility). Individuals requesting to transition from a publicly operated ICF-IDD are awarded a slot when one is requested, and their health and safety can be assured in an OCDD waiver. This also applies to individuals who were residing in a publicly operated facility at the time the facility was privatized and became a CEA facility. The funded waiver opportunity will be reserved for a period not to exceed 120 days; however, this 120-day period may be extended as needed;

2. individuals on the registry who have a current unmet need as defined by a screening for urgency of need (SUN) score of (three) urgent or (four) emergent and the earliest registry date shall be notified in writing when a funded OCDD waiver opportunity is available.

C. The Office for Citizens with Developmental Disabilities has the responsibility to monitor the utilization of NOW opportunities. At the discretion of the OCDD, specifically allocated waiver opportunities may be reallocated, to better meet the needs of citizens with developmental disabilities in the state of Louisiana.

D. Funded waiver opportunities will only be allocated to individuals who successfully complete the financial and medical eligibility process required for waiver certification.

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, Office for Citizens with Developmental Disabilities, LR 31:2900 (November 2005), amended LR 33:2440 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 37:3526 (December 2011), LR 40:70 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2529 (December 2017), LR 48:1546 (June 2022).

Chapter 139. Covered Services

§13901. Individual and Family Support Services

A. Individual family support (IFS) services are direct support and assistance services, provided in the beneficiary’s home or in the community, that allow the beneficiary to achieve and/or maintain increased independence, productivity, enhanced family functioning and inclusion in the community to the same degree as individuals without disabilities. IFS services are also used to provide relief to the primary caregiver. Transportation is included in the reimbursement for these services. Reimbursement for these services includes the development of a service plan for the provision of these services, based on the approved CPOC.

1. Individual and family support day (IFS-D) services will be authorized during waking hours for up to 16 hours when natural supports are unavailable in order to provide continuity of services to the beneficiary. Waking hours are the period of time when the beneficiary is awake and not limited to traditional daytime hours as outlined in the CPOC.

a. Additional hours of IFS-D services beyond the 16 hours can be approved based on documented need, which can include medical or behavioral need, and specified in the approved CPOC.

2. Individual family support-night (IFS-N) service is direct support and assistance provided during the beneficiary’s sleeping “night” hours. Night hours are considered to be the period of time when the beneficiary is asleep and there is a reduced frequency and intensity of required assistance. IFS-N services are not limited to traditional nighttime hours and are outlined in the CPOC. The IFS-N worker must be immediately available and in the same residence as the beneficiary to be able to respond to the beneficiary’s immediate needs. Documentation of the level of support needed, based on the frequency and intensity of needs, shall be included in the CPOC with supporting documentation in the provider’s services plan. Supporting documentation shall outline the beneficiary’s safety, communication, and response methodology planned for and agreed to by the beneficiary and/or his/her authorized representative identified in his/her circle of support. The

IFS-N worker is expected to remain awake and alert unless otherwise authorized under the procedures noted below.

a. Beneficiaries who are able during sleeping hours to notify direct support workers of his/her need for assistance may choose the option of IFS-N services where staff is not required to remain awake.

b. The beneficiary's support team shall assess the beneficiary's ability to awaken staff. If it is determined that the beneficiary is able to awaken staff and requests that the IFS-N worker be allowed to sleep, the CPOC shall reflect the beneficiary's request.

c. Support teams should consider the use of technological devices that would enable the beneficiary to notify/awaken IFS-N staff. (Examples of devices include wireless pagers, alerting devices such as a buzzer, a bell or a monitoring system.) If the method of awakening the IFS-N worker utilizes technological device(s), the service provider will document competency in use of devices by both the beneficiary and IFS-N staff prior to implementation. The support coordinator will require a demonstration of effectiveness of this service no less than quarterly.

d. A review shall include review of log notes indicating instances when IFS-N staff was awakened to attend to the beneficiary. Also included in the review is acknowledgement by the beneficiary that IFS-N staff responded to his/her need for assistance timely and appropriately. Instances when staff did not respond appropriately will immediately be brought to the support team for discontinuation of allowance of the staff to sleep. The service will continue to be provided by awake and alert staff.

e. Any allegation of abuse/neglect during sleeping hours will result in the discontinuation of allowance of the staff to sleep until investigation is complete. Valid findings of abuse/neglect during night hours will require immediate revision to the CPOC.

B. IFS services may be shared by up to three waiver beneficiaries who may or may not live together and who have a common direct service provider agency. Waiver beneficiaries may share IFS services staff when agreed to by the beneficiaries and health and welfare can be assured for each beneficiary. The decision to share staff must be reflected on the CPOC and based on an individual-by-individual determination and choice. Reimbursement rates are adjusted accordingly. Shared IFS services, hereafter referred to as shared support services, may be either day or night services. In addition, IFS direct support may be shared across the Children's Choice Waiver or the Residential Options Waiver at the same time.

C. IFS (day or night) services include:

1. assisting and prompting with the following activities of daily living (ADL):

- a. personal hygiene;
- b. dressing;

- c. bathing;
- d. grooming;
- e. eating;
- f. toileting;
- g. ambulation or transfers;
- h. other personal care and behavioral support needs;

and

- i. any medical task which can be delegated;
2. assisting and/or training in the performance of tasks related to maintaining a safe, healthy and stable home, such as:
 - a. housekeeping;
 - b. laundry;
 - c. cooking;
 - d. evacuating the home in emergency situations;
 - e. shopping; and
 - f. money management;
 3. personal support and assistance in participating in community, employment, health and leisure activities;
 4. support and assistance in developing relationships with neighbors and others in the community and in strengthening existing informal social networks and natural supports;
 5. enabling and promoting individualized community supports targeted toward inclusion into meaningful integrated experiences; and
 6. accompanying the beneficiary to the hospital and remaining until admission or a responsible representative arrives, whichever occurs first. IFS services may resume at the time of discharge.

D. Exclusions. The following exclusions apply to IFS services.

1. IFS-D services and IFS-N services will not be authorized or provided to the beneficiary while the beneficiary is in a center-based respite facility.
2. IFS-D and IFS-N services will not be authorized or provided to the beneficiary while the beneficiary is receiving monitored in-home caregiving services.
3. Beneficiaries receiving adult companion care services are not eligible to receive individual family support services.

E. Staffing Criteria and Limitations

1. Family members who provide IFS services must meet the same standards as providers or direct care staff who are unrelated to the beneficiary. Service hours shall be capped at 40 hours per week, Sunday to Saturday, for services delivered by family members living in the home.

2. Legally responsible individuals (such as a parent or spouse) and legal guardians may provide individual and family support services for a beneficiary provided that the care is extraordinary in comparison to that of a beneficiary of the same age without a disability and the care is in the best interest of the beneficiary.

F. Place of Service

1. IFS services shall be provided in the state of Louisiana. IFS services may be performed outside the state for a time-limited period or for emergencies. The provision of services outside of the state must be prior-approved by the department.

2. Provision of IFS services shall not be authorized outside of the United States or the Territories of the United States.

3. The provision of IFS services in licensed congregated settings shall be excluded from coverage.

G. Provider Requirements. Providers must be licensed by the Department of Health as a home and community-based services provider and must meet the module-specific requirements for the service being provided.

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§13902 Individual and Family Support Supplemental Payments

A. Supplemental payments will be made to licensed HCBS providers with a PCA module who support individuals currently receiving qualified waiver services who have complex medical and/or behavioral needs and are at a higher risk of institutionalization.

1. The integration of the supplemental payment provides additional funding to licensed HCBS providers with a PCA module who provide supports that focus on the prevention of deteriorating or worsening medical or behavioral conditions for individuals with complex needs.

2. The provider will be required to complete a screening tool and submit initial documentation as outlined in the program manual prior to qualifying for any supplemental payment. The supplemental payment will be re-evaluated annually to determine ongoing need per program requirements.

3. The PCA providers must be licensed home and community-based services (HCBS) providers with a personal care attendant module in order to receive the

supplemental payment, in addition to the criteria listed in §13902 B.

B. Determination Process: A PCA provider can qualify for a supplemental payment if the individual currently receiving qualified waiver services has a complex medical and/or behavioral need.

1. Complex Medical

a. Individuals must require at least two of the following non-complex tasks delegated by a registered nurse to a non-licensed direct service worker:

i. suctioning of a clean, well-healed, uncomplicated mature tracheostomy in an individual who has no cardiopulmonary problems and is able to cooperate with the person performing the suctioning (excludes deep suctioning);

ii. care of a mature tracheostomy site;

iii. removing/cleaning/replacing inner tracheostomy cannula for mature tracheostomy;

iv. providing routine nutrition, hydration or medication through an established gastrostomy or jejunostomy tube (excludes nasogastric tube);

v. clean intermittent urinary catheterization;

vi. obtaining a urinary specimen from a port of an indwelling urinary catheter;

vii. changing a colostomy appliance;

viii. ensuring proper placement of nasal cannula (excludes initiation/changing of flow rate);

ix. capillary blood glucose testing;

x. simple wound care (including non-sterile/clean dressing removal/application); or

xi. other delegable non-complex tasks as approved by OCDD in accordance with LAC 48:1 Chapter 92 Subchapter D.

2. Behavioral

a. The individual meets two of the following items:

i. specific behavioral programming/procedures are required, or the individual receives behavioral health treatment/therapy and needs staff assistance on a daily basis to complete therapeutic homework or use skills/coping mechanisms being addressed in therapy;

ii. staff must sometimes intervene physically with the individual beyond a simple touch prompt or redirect, or the individual's environment must be carefully structured based on professionally driven guidance/assessment to avoid behavior problems or minimize symptoms; or

iii. a supervised period of time away, outside of the individual's weekly routine, such as work, school or participation in his/her community, is needed at least once per week; and

b. the individual requires one of the following due to the items listed in Subparagraph a.-a.iii above:

i. higher credentialed staff (college degree, specialized licensing, such as registered behavior technician [RBT], applied behavior analysis [ABA], etc.), who have advanced behavioral training for working with individuals with severe behavioral health symptoms or significant experience working with this population; or

ii. the need for higher qualified supervision of the direct support of staff (master's degree, additional certification, such as board certified behavior analyst [BCBA], etc.).

C. The supplemental payment is not allowed for waiver beneficiaries who do not receive individual and family support (IFS) services.

D. The supplemental payment may not be approved for waiver beneficiaries receiving IFS hours in addition to 12 or more hours of skilled nursing per day.

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 46:1681 (December 2020), LR 48:1548 (June 2022).

§13903. Center-Based Respite Care

A. Center-based respite (CBR) care is temporary, short-term care provided to a beneficiary with developmental disabilities who requires support and/or supervision in his/her day-to-day life due to the absence or relief of the primary caregiver. While receiving center-based respite care, the beneficiary's routine is maintained in order to attend school, work or other community activities/outings. The respite center is responsible for providing transportation for community outings, as that is included as part of its reimbursement.

B. Exclusions

1. Individual family support services (both day and night) may not be provided and will not be reimbursed while the beneficiary is in a center-based respite facility.

2. Monitored in home caregiving, adult companion care, and supported independent living services cannot be reimbursed while the beneficiary is in a center-based respite facility.

3. The cost of room and board cannot be claimed except when provided as part of respite care furnished in a facility approved by the state that is not a private residence.

C. **Service Limits.** CBR services shall not exceed 720 hours per beneficiary, per CPOC year.

1. Beneficiaries may request approval of hours in excess of 720 hours. The request must be submitted to the OCDD central office with proper justification and documentation for prior approval.

D. **Provider Requirements.** Providers must be licensed by the Department of Health as a home and community-based services provider and must meet the module specific requirements for the service being provided.

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 Community Supports and Services, LR 30:1203 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1648 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:72 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:51 (January 2018), LR 48:1548 (June 2022).

§13905. Community Life Engagement Development

A. Community life engagement development (CLE) facilitates the development of opportunities to assist beneficiaries in becoming involved in the community through the creation of natural supports. The purpose of CLE is to encourage and foster the development of meaningful relationships in the community reflecting the beneficiary's choices and values. Objectives outlined in the comprehensive plan of care will afford opportunities to increase community inclusion, participation in leisure/recreational activities, and encourage participation in volunteer and civic activities. Reimbursement for this service includes the development of a service plan. To utilize this service, the beneficiary may or may not be present as identified in the approved CLE service plan. CLE services may be performed by a shared supports worker for up to three waiver beneficiaries who have a common direct service provider agency. Rates shall be adjusted accordingly.

B. Transportation costs are included in the reimbursement for CLE services.

C. **Service Limitations.** Services shall not exceed 60 hours per beneficiary per CPOC year which includes the combination of shared and non-shared community integration development.

D. **Provider Qualifications.** Providers must be licensed by the Department of Health as a home and community-based services provider and must meet the module specific requirements for the service being provided.

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 Community Supports and Services, LR 30:1203 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1648 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:72 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:52 (January 2018), LR 48:1548 (June 2022).

§13907. Supported Independent Living

A. Supported independent living (SIL) assists the beneficiary to acquire, improve or maintain those social and adaptive skills necessary to enable a beneficiary to reside in the community and to participate as independently as possible. SIL services include assistance and/or training in the performance of tasks such as personal grooming, housekeeping and money management. Payment for this service includes oversight and administration and the development of service plans for the enhancement of socialization with age-appropriate activities that provide enrichment and may promote wellness. The service plan should include initial, introduction, and exploration for positive outcomes for the beneficiary for community integration and development. These services also assist the beneficiary in obtaining financial aid, housing, advocacy and self-advocacy training as appropriate, emergency support, trained staff and assisting the beneficiary in accessing other programs for which he/she qualifies. SIL beneficiaries must be 18 years or older.

B. Place of Service. Services are provided in the beneficiary's residence and/or in the community. The beneficiary's residence includes his/her apartment or house, provided that he/she does not live in the residence of any legally responsible relative. An exception will be considered when the beneficiary lives in the residence of a spouse or disabled parent, or a parent aged 70 years or older. Family members who are not legally responsible relatives can be SIL workers provided they meet the same qualifications as any other SIL worker. A legally responsible relative is defined as a parent of a minor child, foster parent, curator, tutor, legal guardian, or the beneficiary's spouse.

C. Exclusions

1. Legally responsible persons may not be SIL providers for the individual whom they are legally responsible.

2. SIL shall not include the cost of:

- a. meals or the supplies needed for preparation;
- b. room and board;
- c. home maintenance, or upkeep, improvement, modifications, or adaption to a home, or to meet the requirements of the applicable life safety code;
- d. routine care and supervision which could be expected to be provided by a family member; or
- e. activities or supervision for which a payment is made by a source other than Medicaid, e.g., Office for Citizens with Developmental Disabilities, etc.

3. SIL services cannot be provided in a substitute family care setting.

4. Beneficiaries receiving adult companion care services are not eligible to receive supported independent living services.

5. Monitored in-home-caregiving services cannot be provided at the same time or on the same day as supported independent living.

D. Service Limit. SIL services are limited to one service per day, per CPOC year, except when the beneficiary is in center-based respite. When a beneficiary living in an SIL setting is admitted to a center-based respite facility, the SIL provider shall not bill the SIL per diem beginning with the date of admission to the center-based respite facility and through the date of discharge from the center-based respite facility.

E. Provider Qualifications. Providers must be licensed by the Department of Health as a home and community-based services provider and meet the module specific requirements for the service being provided.

F. Provider Responsibilities

1. Minimum direct services by the SIL agency include two documented contacts per week and one documented face-to-face contact per month by the SIL provider agency in addition to the approved direct support hours. These required contacts must be completed by the SIL agency supervisor so designated by the provider agency due to the experience and expertise relating to the beneficiary's needs or a licensed/certified professional qualified in the state of Louisiana who meets requirements as defined by 42 CFR §483.430 or any subsequent regulation.

2. The provider must furnish back-up staff that is available on a 24-hour basis.

3. Supported independent living services shall be coordinated with any services listed in the approved CPOC, and may serve to reinforce skills or lessons taught in school, therapy or other settings.

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 Community Supports and Services, LR 30:1204 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1648 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:73 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:52 (January 2018), LR 48:1549 (June 2022).

§13909. Substitute Family Care

A. Substitute family care (SFC) provides for day programming, transportation, independent living training, community integration, homemaker, chore, attendant care and companion services, and medication oversight (to the extent permitted under state law) to beneficiaries residing in a substitute family care home that meets all licensing requirements for the substitute family care module. The service is a stand-alone family living arrangement for beneficiaries aged 18 years and older. The SFC house parents assume the direct responsibility for the beneficiary's physical, social, and emotional well-being and growth,

including family ties. Only two SFC beneficiaries may reside in a single SFC setting at the same time. There shall be no more than three persons living in a substitute family care setting who are unrelated to the SFC provider. Immediate family members (mother, father, brother and/or sister) cannot be substitute family care parents. Reimbursement for this service includes the development of a service plan based on the approved CPOC. Beneficiaries living in an SFC home may receive IFS services.

B. Service Limits. SFC services are limited to one service per day.

C. Exclusions

1. Beneficiaries receiving adult companion care services are not eligible to receive substitute family care services.

2. Payments may not be made for room and board, items of comfort or convenience, or the cost of facility maintenance, upkeep, or improvement.

3. Payments may not be made directly or indirectly to members of the beneficiary's immediate family.

D. Provider Qualifications. Providers must be licensed by the Department of Health as a home and community-based services provider and must meet the module specific requirements for the service being provided.

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 Community Supports and Services, LR 30:1204 (June 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:73 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:52 (January 2018), LR 48:1549 (June 2022).

§13911. Day Habilitation

A. Day habilitation is provided in a community-based setting and provides the beneficiary assistance with social and adaptive skills necessary to enable the beneficiary to participate as independently as possible in the community. These services focus on socialization with meaningful age-appropriate activities which provide enrichment and promote wellness, as indicated in the beneficiary's CPOC. Day habilitation services are provided in a variety of community settings, (i.e. local recreation department, garden clubs, libraries, etc.) other than the person's residence, except for virtual habilitation services, and are not limited to a fixed-site facility.

1. Day habilitation services must be directed by a person-centered service plan and provide the beneficiary choice in how they spend their day. The activities should assist the beneficiary to gain their desired community living experience, including the acquisition, retention or improvement in self-help, socialization and adaptive skills, and/or to provide the individual an opportunity to contribute to and be a part of his or her community.

2. Day habilitation services shall be coordinated with any therapy, prevocational service, or supported employment models that the beneficiary may be receiving. The beneficiary does not receive payment for the activities in which he/she are engaged. The beneficiary must be 18 years of age or older in order to receive day habilitation services.

3. Career planning activities may be a component of the beneficiary's plan and may be used to develop learning opportunities and career options consistent with the person's skills and interests.

B. Day Habilitation may be delivered in a combination of these three service types:

1. onsite day habilitation;
2. community life engagement;
3. virtual day habilitation.

C. Day Habilitation is provided on a regularly scheduled basis and may be scheduled on a plan of care for one or more days per week and may be prior authorized for up to 8,320 units of service in a plan of care year. A standard unit of service is a 15-minute increment.

D. Licensing Requirements. Providers must be licensed by the Department of Health and as a home and community-based services provider and must meet the module specific requirements for the service being provided.

E. Service Limitations

1. Beneficiaries receiving day habilitation services may also receive prevocational or supported employment services, but these services cannot be provided the same time period.

2. All virtual day habilitation services must be approved by the local governing entity or the OCDD state office.

3. Community life engagement cannot be delivered at the same time as any other service.

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 Community Supports and Services, LR 30:1204 (June 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:73 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:53 (January 2018), LR 48:1550 (June 2022).

§13913. Supported Employment

A. Supported employment is competitive work in an integrated work setting, or employment in an integrated work setting in which the beneficiaries are working toward competitive work that is consistent with the strengths, resources, priorities, interests, and informed choice of beneficiaries for whom competitive employment has not traditionally occurred. The beneficiary must be eligible and assessed to need the service in order to receive supported

employment services. The outcome of this service is sustained paid employment and work experience leading to further career development and individual integrated community-based employment for which an individual is compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

B. Individuals eligible for Louisiana Rehabilitation Services (LRS) must access those services prior to utilizing home and community based waiver supported employment services.

C. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment cannot be provided at worksites that are facility based, or other similar types of vocational services furnished in specialized facilities that are not part of the general workplace. Supported employment includes activities needed by waiver beneficiaries to sustain paid work, including supervision and training and is based on an individualized service plan. Supported employment may include assistance and prompting with:

1. personal hygiene;
 2. dressing;
 3. grooming;
 4. eating;
 5. toileting;
 6. ambulation or transfers;
 7. other personal care and behavioral support needs;
- and
8. any medical task which can be delegated.

D. Supported Employment Models. Reimbursement for supported employment includes an individualized service plan for each model.

1. Individual supported employment one-to-one services include all aspects of the supported employment, process including assessments, development, placement, job retention, and stabilization that are necessary to get an individual to work in an individual competitive job in the community.

2. Follow-along support services provide ongoing supports to individuals and their employers who need the support to maintain their job in integrated work settings in the general workforce. The amount of support is determined for each individual based on the individual's ability to be independent in the job. Follow-along services may be delivered virtually.

3. Group employment is an employment setting in which a group of two to eight beneficiaries work to complete jobs in a variety of locations in the community under the supervision of an employment specialist in a manner that promotes integration into the workplace and interaction

between beneficiaries and people without disabilities in those workplaces that are in the community.

E. Service Exclusions

1. Supported employment services shall not be used in conjunction or simultaneously with any other waiver service, except substitute family care, supported independent living, and skilled nursing services. Virtual follow-along supported employment services cannot be utilized at the same time as any other service.

2. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by beneficiaries receiving waiver services as a result of his/her disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

3. Supported employment services are not available to beneficiaries who are eligible to participate in programs funded under section 110 of the Rehabilitation Act of 1973 or sections 602(16) and (17) of the Individuals with Disabilities Education Act [20 U.S.C. 1401(26) and (29)], as amended, and those covered under the Medicaid State Plan, if applicable.

F. Service Limits

1. Individual supported employment one-to-one services shall not exceed 2,880 one-quarter hour units (15 minute increments) per CPOC year.

2. Both individual and virtual supported employment follow-along services shall not exceed 960 one-quarter hour units (15 minute increments) per CPOC year.

3. Group supported employment services shall not exceed 8,320 one-quarter hour units of service per CPOC year, without additional documentation and approval.

4. All virtual supported employment services must be approved by the local governing entity or the OCDD state office.

G. Licensing Requirements. The provider must possess a valid certificate of compliance as a community rehabilitation provider (CRP) from Louisiana Rehabilitation Services or be licensed by the Department of Health as a home and community-based services provider and must meet the module specific requirements for the service being provided.

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 Community Supports and Services, LR 30:1205 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1649 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:74 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:53 (January 2018), LR 48:1550 (June 2022).

§13915. Transportation for Day Habilitation and Supported Employment Models

A. Transportation provided for the beneficiary to the site of the day habilitation or supported employment model, or between the day habilitation and supported employment model site (if the beneficiary receives services in more than one place) is reimbursable when day habilitation or supported employment model has been provided. Reimbursement may be made for a one-way trip. There is a maximum fee per day that can be charged for transportation regardless of the number of trips per day.

1. Transportation is included in the group supported employment service rate when traveling between job sites.

2. Transportation is a separate billable service if criteria is met. One rate covers regular transportation, and a separate rate covers wheelchair transportation.

3. Transportation may be provided to and/or from the beneficiary's residence or a location agreed upon by the beneficiary or authorized representative to the onsite location or community location and a separate return trip.

B. Licensing Requirements. Providers must be licensed by the Department of Health as a home and community-based services provider and meet the module specific requirements for the service being provided. The provider must have insurance coverage on any vehicles used in transporting a beneficiary that meets current home and community-based services providers licensing standards.

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 Community Supports and Services, LR 30:1205 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 32:2064 (November 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:74 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:54 (January 2018), LR 48:1551 (June 2022).

§13917. Prevocational Services

A. Prevocational services are individualized, person centered services that assist the beneficiary in establishing their path to obtain individualized community employment. This service is time limited and targeted for people who have an interest in becoming employed in an individual job in the community but may need additional skills, information and experiences to determine their employment goal and to become successfully employed. Beneficiaries receiving prevocational services may choose to leave this service at any time or pursue employment opportunities at any time.

B. Prevocational services may be delivered in a combination of these three service types:

1. onsite prevocational services;
2. community career planning; and

3. virtual prevocational services.

C. Prevocational services are to be provided in a variety of locations in the community and are not to be limited to a fixed site facility. Activities associated with prevocational services should focus on preparing the beneficiary for integrated individual employment in the community. These services are operated through a provider agency that is licensed by the appropriate state licensing agency. Beneficiaries receiving prevocational services must participate in activities designed to establish an employment related goal as part their CPOC. Prevocational services are designed to help create a path to integrated community-based employment for which a beneficiary is compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

D. Prevocational services are provided on a regularly scheduled basis and may be scheduled on a comprehensive plan of care for one or more days per week and may be prior authorized for up to 8,320 units of service in a plan year with appropriate documentation. A standard unit is one-quarter hour (15 minute increment).

E. Exclusions. The following service exclusions apply to prevocational services.

1. Prevocational services are not available to beneficiaries who are eligible to participate in programs funded under section 110 of the Rehabilitation Act of 1973 or sections 602(16) and (17) of the Individuals with Disabilities Education Act, [20 U.S.C. 1401(26) and (29)], as amended, and covered under the Medicaid State Plan, if applicable.

2. Prevocational services cannot be provided or billed during the same hours on the same day as other services.

3. All virtual prevocational services must be approved by the local governing entity or the OCDD state office.

4. Transportation is billed as a separate service.

F. Service Limits

1. Prevocational services cannot exceed 8,320 one-quarter hour units of service per CPOC year.

2. On-site prevocational and community career planning services are time limited and individually based with employment at the individual's highest level of work in the most integrated setting in the community while following applicable federal wage guidelines. Beneficiaries may choose to leave this service at any time or seek employment at any time.

3. Through permission from the local governing entity, a person may complete this service more than once.

G. Licensing Requirements. Providers must be licensed by the Department of Health as a home and community-based services provider and must meet the module specific requirements for the service being provided.

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 Community Supports and Services, LR 30:1205 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1649 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:75 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:55 (January 2018), LR 48:1551 (June 2022).

§13919. Environmental Accessibility Adaptations

A. Environmental accessibility adaptations are physical adaptations to the home or a vehicle that are necessary to ensure the health, welfare, and safety of the beneficiary or that enable him/her to function with greater independence in the home and/or community. Without these services, the beneficiary would require additional supports or institutionalization.

B. Such adaptations may include:

1. installation of ramps and/or grab-bars;
2. widening of doorways;
3. modification of bathroom facilities;
4. installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies for the welfare of the beneficiary; or
5. adaptations to the vehicle, which may include a lift or other adaptations, to make the vehicle accessible to the beneficiary or for the beneficiary to drive.

C. Requirements for Authorization. Items reimbursed through NOW funds shall be supplemental to any adaptations furnished under the Medicaid state plan.

1. Any service covered under the Medicaid state plan shall not be authorized by NOW. The environmental accessibility adaptation(s) must be delivered, installed, operational and accepted by the beneficiary/authorized representative in the CPOC year for which it was approved. The environmental accessibility adaptation(s) must be billed and reimbursed according to the Medicaid billing guidelines established by LDH policy. A written itemized detailed bid, including drawings with the dimensions of the existing and proposed floor plans relating to the modification, must be obtained and submitted for prior authorization. Modifications may be applied to rental or leased property with the written approval of the landlord and approval of the human services authority or district. Reimbursement shall not be paid until receipt of written documentation that the job has been completed to the satisfaction of the beneficiary.

2. Upon completion of the work and prior to payment, the provider shall give the beneficiary a certificate of warranty for all labor and installation and all warranty certificates from manufacturers.

3. Excluded are those adaptations or improvements to the residence that are of general utility or maintenance and are not of direct medical or remedial benefit to the beneficiary, including, but not limited to:

- a. air conditioning or heating;
- b. flooring;
- c. roofing, installation or repairs;
- d. smoke and carbon monoxide detectors, sprinklers, fire extinguishers, or hose; or
- e. furniture or appliances; or
- f. whole home generators.

4. Adaptations which add to the total square footage or add to the total living area under the roof of the residence are excluded from this benefit.

5. Home modification funds are not intended to cover basic construction cost. For example, funds may be used to cover the difference between constructing a bathroom and building an accessible or modified bathroom, but in any situation funds must be used to pay for a specific approved adaptation.

6. Excluded are those vehicle adaptations which are of general utility or for maintenance of the vehicle. Car seats are not considered a vehicle adaptation.

D. Service Limits. There is a cap of \$7,000 per three-year period for a beneficiary for environmental accessibility adaptations. On a case-by-case basis, with supporting documentation and based on need, a beneficiary may be able to exceed this cap with the prior approval of OCDD central office.

E. Provider Qualifications. The provider must be an enrolled Medicaid provider and comply with applicable state and local laws governing licensure and/or certification.

1. All providers of environmental accessibility adaptations must be registered through the Louisiana State Licensing Board for Contractors as a home improvement contractor, with the exception of providers of vehicle adaptations.

2. Providers of environmental accessibility adaptations to vehicles must be licensed by the Louisiana Motor Vehicle Commission as a specialty vehicle dealer and accredited by the National Mobility Equipment Dealers Association under the Structural Vehicle Modifier category.

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 Community Supports and Services, LR 30:1206 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1649 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:75 (January 2014), amended by the Department of Health, Bureau of Health

Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:55 (January 2018), LR 48:1552 (June 2022).

§13921. Specialized Medical Equipment and Supplies

A. Specialized medical equipment and supplies (SMES) are devices, controls, or appliances which enable the beneficiary to:

1. increase his/her ability to perform the activities of daily living;
2. ensure safety; or
3. perceive, control and communicate with the environment in which he/she lives.

B. The service includes medically necessary durable and nondurable medical equipment not covered under the Medicaid state plan. NOW does not cover non-medically necessary items. All items shall meet applicable standards of manufacture, design and installation. Routine maintenance or repair of specialized medical equipment is funded under this service.

C. All alternate funding sources that are available to the beneficiary shall be pursued before a request for the purchase or lease of specialized equipment and supplies will be considered.

D. Exclusion. Excluded are specialized equipment and supplies that are of general utility or maintenance, but are not of direct medical or remedial benefit to the beneficiary. Excluded also are those durable and non-durable items that are available under the Medicaid State Plan.

E. Service Limitations. There is a cap of \$1,000 per three year period for a beneficiary for specialized equipment and supplies. On a case-by-case basis, with supporting documentation and based on need, a beneficiary may be able to exceed this cap with the prior approval of OCDD central office.

F. Provider Qualifications. All agencies who are vendors of technological equipment and supplies must be enrolled in the Medicaid Program as a durable medical equipment provider and must meet all applicable vendor standards and requirements for manufacturing, design and installation of technological equipment and supplies.

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 Community Supports and Services, LR 30:1207 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1649 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:75 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:56 (January 2018), LR 48:1552 (June 2022).

§13923. Personal Emergency Response Systems

A. Personal emergency response systems (PERS) is a rented electronic device connected to the person's phone and

programmed to signal a response center which enables a beneficiary to secure help in an emergency.

B. Beneficiary Qualifications. Personal emergency response systems (PERS) services are available to those persons who:

1. have a demonstrated need for quick emergency back-up;
2. are unable to use other communication systems as they are not adequate to summon emergency assistance; or
3. do not have 24 hour direct supervision.

C. Coverage of the PERS is limited to the rental of the electronic device. PERS services shall include the cost of maintenance and training the beneficiary to use the equipment.

D. Reimbursement will be made for a one-time installation fee for the PERS unit. A monthly fee will be paid for the maintenance of the PERS.

E. Provider Qualifications. The provider must be an enrolled Medicaid provider of the PERS. The provider shall install and support PERS equipment in compliance with all applicable federal, state, parish and local laws and meet manufacturer's specifications, response requirements, maintenance records and beneficiary education.

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 Community Supports and Services, LR 30:1207 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1650 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:76 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:1553 (June 2022).

§13925. Professional Services

A. Professional services are services designed to increase the beneficiary's independence, participation and productivity in the home, work and community. Beneficiaries, up to the age of 21, who participate in NOW must access these services through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Professional services may only be furnished and reimbursed through NOW when the services are not covered under the Medicaid State Plan. Professional services must be delivered with the beneficiary present and be provided based on the approved CPOC and an individualized service plan. Service intensity, frequency and duration will be determined by individual need. Professional services may be utilized to:

1. perform assessments and/or re-assessments and recommendations;
2. provide consultative services and recommendations;

3. provide training or therapy to a beneficiary and/or his/her natural and formal supports necessary to either develop critical skills that may be self-managed by the beneficiary or maintained according to the beneficiary's needs;

4. intervene in and stabilize a crisis situation, behavioral or medical, that could result in the loss of home and community-based services; or

5. provide necessary information to the beneficiary, family, caregivers and/or team to assist in the implementation of plans according to the approved CPOC.

B. Professional services are limited to the following services.

1. Psychological services are direct services performed by a licensed psychologist, as specified by state law and licensure. These services are for the treatment of a behavioral or mental condition that addresses personal outcomes and goals desired by the beneficiary and his/her team. Services must be reasonable and necessary to preserve and improve or maintain adaptive behaviors or decrease maladaptive behaviors of a person with developmental disabilities. Service intensity, frequency, and duration will be determined by individual need.

2. Social work services are highly specialized direct counseling services furnished by a licensed clinical social worker and designed to meet the unique counseling needs of individuals with development disabilities. Counseling may address areas such as human sexuality, depression, anxiety disorders, and social skills. Services must only address those personnel outcomes and goals listed in the approved CPOC.

3. Nutritional/Dietary services are medically necessary direct services provided by a licensed registered dietician or licensed nutritionist. Services must be ordered by a physician. Direct services may address health care and nutritional needs related to prevention and primary care activities, treatment and diet. Reimbursement is only available for the direct service performed by a dietitian or nutritionist, and not for the supervision of a dietician or nutritionist performing the hands-on direct service.

C. Service Limits. There shall be a \$2,250 cap per beneficiary per CPOC year for the combined range of professional services in the same day but not at the same time. Additional services may be prior authorized if the beneficiary reaches the cap before the expiration of the comprehensive plan of care and the beneficiary's health and safety are at risk. One or more professional services may be utilized in the same day, but not at the same time.

D. Provider Qualifications. The provider of professional services must be a Medicaid-enrolled provider. Each professional must possess a current valid Louisiana license to practice in his/her field and have at least one year of experience post licensure in his/her area of expertise.

E. Non-reimbursable Activities. The following activities are not reimbursable:

1. friendly visiting, attending meetings;

2. time spent on paperwork or travel;

3. time spent writing reports and progress notes;

4. time spent on the billing of services; and

5. other non-Medicaid reimbursable activities.

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 Community Supports and Services, LR 30:1207 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1650 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:76 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:56 (January 2018), LR 48:1553 (June 2022).

§13927. Skilled Nursing Services

A. Skilled nursing services are medically necessary nursing services ordered by a physician and provided by a licensed registered nurse, nurse practitioner, or a licensed practical nurse working under the supervision of a registered nurse. Skilled nursing services shall be provided by a licensed, enrolled home health agency and require an individual nursing service plan. These services must be included in the beneficiary's approved CPOC. All available Medicaid State Plan skilled nursing services must be exhausted before accessing this service. Beneficiaries, up to the age of 21, must access these services as outlined on the CPOC through the Home Health Program in the Medicaid State Plan pursuant to the EPSDT benefit.

B. When there is more than one beneficiary in the home receiving skilled nursing services, services may be shared and payment must be coordinated with the service authorization system and each beneficiary approved CPOC. Nursing consultations are offered on an individual basis only.

C. Provider Qualifications. The provider must be licensed by the Department of Health as a home health agency.

D. Monitored in-home caregiving services cannot be provided at the same time or on the same day as skilled nursing services.

E. All requests for over 12 hours of skilled nursing per day must be reviewed and approved by the LDH medical director and medical evaluation team.

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 Community Supports and Services, LR 30:1208 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1651 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:77 (January 2014), amended by the Department of Health, Bureau of Health

Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:56 (January 2018), LR 46:1681 (December 2020), LR 48:1553 (June 2022).

§13929. One-Time Transitional Expenses

A. One-time transitional expenses are those allowable one-time, set-up expenses incurred by beneficiaries who are being transitioned from an ICF-DD to his/her own home or apartment of their choice in the community of their choice. *Own home* shall mean the beneficiary's own place of residence and does not include any family members' home or substitute family care homes. The beneficiaries must be allowed choice in the items purchased.

B. Allowable transitional expenses include:

1. the purchase of essential furnishings, such as:
 - a. bedroom and living room furniture;
 - b. dining table and chairs;
 - c. window blinds;
 - d. eating utensils; and
 - e. food preparation items;
2. moving expenses required to occupy and use a community domicile;
3. health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy; and
4. non-refundable security deposits required to obtain a lease on an apartment or home and set-up fees for utilities.

C. Service Limits. Set-up expenses are capped at \$3,000 over a beneficiary's lifetime.

D. Service Exclusion. Transitional expenses shall not constitute payment for housing, rent, or refundable security deposits.

E. Provider Qualifications. This service shall only be provided by the Department of Health, Office for Citizens with Developmental Disabilities (OCDD) with coordination of appropriate entities.

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 Community Supports and Services, LR 30:1208 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1651 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:77 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:56 (January 2018), LR 48:1554 (June 2022).

§13931. Adult Companion Care

A. Adult companion care services assist the beneficiary to achieve and/or maintain the outcomes of increased independence, productivity and inclusion in the community. These services are designed for an individual who lives

independently and can manage his/her own household with limited supports. The companion is a principal care provider chosen by the beneficiary, who provides services in the beneficiary's home. The companion must be at least 18 years of age and lives with the beneficiary as a roommate. Adult companion care services are furnished through a licensed provider organization as outlined in the beneficiary's CPOC. This service includes:

1. providing assistance with all of the activities of daily living as indicated in the beneficiary's CPOC;
2. providing community integration and coordination of transportation services, including medical appointments; and
3. providing medical and physical health care that can be delivered by unlicensed persons in accordance with Louisiana's Nurse Practice Act.

B. Adult companion care services are arranged by provider organizations that are subject to licensure. The setting is the beneficiary's home which should have been freely chosen by the beneficiary from among non-disability specific settings and not owned or controlled by the provider. The companion is an employee or contractor of the provider organization and is responsible for providing limited, daily direct services to the beneficiary.

1. The companion shall be available in accordance with a pre-arranged time schedule and available by telephone for crisis support on short notice.
2. Services may not be provided by a family member who is a legally responsible individual, such as the beneficiary's spouse, or a legal guardian.

C. Provider Responsibilities

1. The provider organization shall develop a written agreement as part of the beneficiary CPOC which defines all of the shared responsibilities between the companion and the beneficiary. The written agreement shall include, but is not limited to:

- a. types of support provided by the companion;
- b. activities provided by the companion; and
- c. a typical weekly schedule.

2. The provider organization is responsible for performing the following functions which are included in the daily rate:

- a. arranging the delivery of services and providing emergency services;
- b. making an initial home visit to the beneficiary home, as well as periodic home visits as required by the department;
- c. contacting the companion a minimum of once per week or as specified in the beneficiary's comprehensive plan of care; and

d. providing 24-hour oversight and supervision of the adult companion care services, including back-up for the scheduled and unscheduled absences of the companion.

3. The provider shall facilitate a signed written agreement between the companion and the beneficiary which assures that:

a. the companion's portion of expenses must be at least \$200 per month, but shall not exceed 50 percent of the combined monthly costs which includes rent, utilities and primary telephone expenses; and

b. inclusion of any other expenses must be negotiated between the beneficiary and the companion. These negotiations must be facilitated by the provider and the resulting agreement must be included in the written agreement and in the beneficiary's CPOC.

D. Companion Responsibilities

1. The companion is responsible for:

- a. participating in, and abiding by, the CPOC;
- b. maintaining records in accordance with state and provider requirements; and
- c. purchasing his/her own food and personal care items.

2. The companion is an employee of the provider agency and is paid a flat daily rate to provide adult companion care services as included in the approved CPOC.

3. The companion is responsible for meeting all financial obligations as agreed upon in the agreement between the provider agency, the beneficiary, and the companion.

E. Service Limits

1. Adult companion care services may be authorized for up to 365 days per year as documented in the beneficiary's CPOC.

F. Service Exclusions

1. Adult companion care services cannot be provided or billed for at the same time as center-based respite care services.

2. Beneficiaries receiving adult companion care services are not eligible for receiving the following services:

- a. supported independent living;
- b. individual and family support;
- c. substitute family care;
- d. skilled nursing; or
- e. monitored in-home caregiving (MIHC).

G. Provider Qualifications. Providers must be licensed by the Department of Health as a home and community-based services provider and must meet the module specific requirements for the service being provided.

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 for Citizens with Developmental Disabilities, LR 40:77 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:57 (January 2018), repromulgated LR 44:282 (February 2018), LR 48:1554 (June 2022).

§13935. Housing Stabilization Transition Service

A. Housing stabilization transition service enables beneficiaries who are transitioning into a permanent supportive housing unit, including those transitioning from institutions, to secure their own housing. The service is provided while the beneficiary is in an institution and preparing to exit the institution using the waiver. The setting for the permanent supportive housing must be integrated in the greater community, and support full access to the greater community by the beneficiary. The service includes the following components:

1. conducting a housing assessment to identify the beneficiary's preferences related to housing (i.e., type, location, living alone or with someone else, accommodations needed, and other important preferences), and his/her needs for support to maintain housing, including:

- a. access to housing of the beneficiary's choice, including non-disability specific settings;
- b. meeting the terms of a lease;
- c. eviction prevention;
- d. budgeting for housing/living expenses;
- e. obtaining/accessing sources of income necessary for rent;
- f. home management;
- g. establishing credit; and
- h. understanding and meeting the obligations of tenancy as defined in the lease terms;

2. assisting the beneficiary to view and secure housing as needed. This may include arranging or providing transportation. The beneficiary shall be assisted in securing supporting documents/records, completing/submitting applications, securing deposits, and locating furnishings;

3. developing an individualized housing support plan based upon the housing assessment that:

- a. includes short- and long-term measurable goals for each issue;
- b. establishes the beneficiary's approach to meeting the goal; and
- c. identifies where other provider(s) or services may be required to meet the goal;

4. participating in the development of the comprehensive plan of care and incorporating elements of the housing support plan; and

5. exploring alternatives to housing if permanent supportive housing is unavailable to support completion of transition.

B. This service is only available upon referral from the support coordinator and is not duplicative of other waiver services, including support coordination. It is only available to persons who are residing in a state of Louisiana permanent supportive housing unit or who are linked for the state of Louisiana permanent supportive housing selection process.

C. Beneficiaries may not exceed 165 combined units of this service and the housing stabilization service.

1. Exceptions to the 165 unit limit can only be made with written approval from the OCDD.

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 for Citizens with Developmental Disabilities, LR 40:78 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:57 (January 2018), LR 48:1555 (June 2022).

§13937. Housing Stabilization Service

A. Housing stabilization service enables waiver beneficiaries to maintain their own housing as set forth in the beneficiary's approved CPOC. Services must be provided in the home or a community setting. This service includes the following components:

1. conducting a housing assessment to identify the beneficiary's preferences related to housing (i.e., type, location, living alone or with someone else, accommodations needed, and other important preferences), and his/her needs for support to maintain housing, including:

- a. access to housing;
- b. meeting the terms of a lease;
- c. eviction prevention;
- d. budgeting for housing/living expenses;
- e. obtaining/accessing sources of income necessary for rent;
- f. home management;
- g. establishing credit; and
- h. understanding and meeting the obligations of tenancy as defined in the lease terms;

2. assisting the beneficiary to view and secure housing as needed. This may include arranging or providing transportation. The beneficiary shall be assisted in securing supporting documents/records, completing/submitting applications, securing deposits, and locating furnishings;

3. developing an individualized housing stabilization service provider plan based upon the housing assessment that includes short and long-term measurable goals for each issue, establishes the beneficiary's approach to meeting the goal, and identifies where other provider(s) or services may be required to meet the goal. This includes updating the housing support plan annually or as needed due to changes in the beneficiary's situation or status;

4. participating in the development of the CPOC, incorporating elements of the housing stabilization service provider plan. This includes participation in plan of care renewals and updates as needed;

5. providing supports and interventions according to the individualized stabilization service provider plan. If additional supports or services are identified as needed outside the scope of housing stabilization service, the needs must be communicated to the support coordinator;

6. providing ongoing communication with the landlord or property manager regarding the beneficiary's disability, accommodations needed, and components of emergency procedures involving the landlord or property manager; and

7. if at any time the beneficiary's housing is placed at risk (e.g., eviction, loss of roommate or income), housing stabilization service will provide supports to retain housing or locate and secure housing to continue community-based supports, including locating new housing, sources of income, etc.

B. This service is only available upon referral from the support coordinator and the service is not duplicative of other waiver services including support coordination. It is only available to persons who are residing in a state of Louisiana permanent supportive housing unit or who are linked for a state of Louisiana permanent supportive housing unit.

C. Beneficiaries may not exceed 165 combined units of this service and the housing stabilization transition service.

1. Exceptions to the 165 unit limit can only be made with written approval from the OCDD.

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 for Citizens with Developmental Disabilities, LR 40:79 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:57 (January 2018), LR 48:1555 (June 2022).

§13939. Monitored In-Home Caregiving Services

A. Monitored in-home caregiving (MIHC) services are provided by a principal caregiver to a beneficiary who lives in a private unlicensed residence.

1. The goal of this service is to provide a community-based option that provides continuous care, supports, and professional oversight.

2. This goal is achieved by promoting a cooperative relationship between a beneficiary, a principal caregiver, the professional staff of a monitored in-home caregiver agency provider, and the beneficiary's support coordinator.

B. The principal caregiver is responsible for supporting the beneficiary to maximize the highest level of independence possible by providing necessary care and supports that may include:

1. supervision or assistance in performing activities of daily living;
2. supervision or assistance in performing instrumental activities of daily living;
3. protective supervision provided solely to assure the health and welfare of a beneficiary;
4. supervision or assistance with health related tasks, meaning any health related procedures governed under the Nurse Practice Act, in accordance with applicable laws governing the delegation of medical tasks/medication administration.
5. supervision or assistance while escorting/accompanying the individual outside of the home to perform tasks, including instrumental activities of daily living, health maintenance, or other needs as identified in the plan of care, and to provide the same supervision or assistance as would be rendered in the home; and
6. extension of therapy services to maximize independence when the caregiver has been instructed in the performance of the activities by a licensed therapist or registered nurse.

C. Service Exclusions and Restrictions

1. Beneficiaries electing monitored in-home caregiving are not eligible to receive the following New Opportunities Waiver services during the period of time that the beneficiary is receiving monitored in-home caregiving services:

- a. individual family support;
- b. center-based respite;
- c. supported independent living;
- d. adult companion care; or
- e. skilled nursing care;

D. Monitored in-home caregiving providers must be agency providers who employ professional nursing staff, including a registered nurse and a care manager, and other professionals to train and support principal caregivers to perform the direct care activities performed in the home.

1. The agency provider must assess and approve the home in which services will be provided, and enter into contractual agreements with caregivers whom that agency has approved and trained.

2. The agency provider will pay per diem stipends to caregivers. The per diem for monitored in-home caregiving services does not include payments for room and board.

3. The agency provider must capture daily notes electronically and use the information collected to monitor beneficiary health and caregiver performance.

4. The agency provider must take such notes available to support coordinators and the state, upon request.

E. The MIHC provider must use secure, web-based information collection from principal caregivers for the purposes of monitoring beneficiary health and caregiver performance. All protected health information must be transferred, stored, and otherwise utilized in compliance with applicable federal and state privacy laws. Providers must sign, maintain on file, and comply with the LDH HIPAA business associate addendum.

F. The department shall reimburse for monitored in-home caregiving services based on a two-tiered model which is designed to address the beneficiary's acuity. Reimbursement will not be made for room and board of the principal caregiver, and federal financial participation is not available for room and board.

G. Provider Qualifications

1. MIHC providers must be licensed according to the home and community based service provider licensing requirements contained in the R.S. 40:2120.2-2121.9 and their implementing regulations.

2. MIHC providers must enroll as a Medicaid monitored in-home caregiving provider.

3. MIHC providers must comply with LDH rules and regulations.

4. The principal caregiver must:

- a. be at least 18 years of age;
- b. live in the home with the beneficiary; and
- c. be available 24 hours a day, 7 days a week.

H. The assessment performed by the monitored in-home caregiving provider shall be reimbursed when the service has been approved by the plan of care.

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 48:1556 (June 2022).

§13941. Dental Services

A. Dental services are available to adult beneficiaries over the age of 21 as of component of the NOW. Covered dental services include:

1. adult diagnostic services;
2. preventative services;
3. restorative services;

4. endodontics;
5. periodontics;
6. prosthodontics;
7. oral and maxillofacial surgery;
8. orthodontics;
9. emergency care; and
10. adjunctive general services.

B. Dental Service Exclusions

1. NOW dental services are not available to children (up to 21 years of age). Children access dental services through the EPSDT benefit.

2. Non-covered services include but are not limited to the following:

- a. services that are not medically necessary to the beneficiary's dental health;
- b. dental care for cosmetic reasons;
- c. experimental procedures;
- d. plaque control;
- e. any periapical radiographic images, occlusal radiographic images, complete series, or panoramic radiographic images taken annually or routinely at the time of a dental examination for screening purposes;
- f. routine post-operative services – these services are covered as part of the fee for the initial treatment provided;
- g. treatment of incipient or non-carious lesions (other than covered sealants and fluoride);
- h. services that are eligible for reimbursement by insurance or covered under any other insurance or medical health plan;
- i. dental expenses related to any dental services:
 - i. started after the beneficiary's coverage ended,
 - or
 - ii. received before the beneficiary became eligible for these service; and
- j. administration of in-office pre-medication.

C. Providers are enrolled through the LA Dental Benefit Program, which is responsible for maintaining provider lists.

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 48:1556 (June 2022).

Chapter 141. Self-Direction Initiative

§14101. Self-Direction Service Delivery Option

A. The self-direction initiative is a voluntary, self-determination option which allows the beneficiary to

coordinate the delivery of NOW services, as designated by OCDD, through an individual direct support professional rather than through a licensed, enrolled provider agency. Selection of this option requires that the beneficiary utilize a payment mechanism approved by the department to manage the required fiscal functions that are usually handled by a provider agency.

B. **Beneficiary Responsibilities.** Waiver beneficiaries choosing the self-directed service delivery option must understand the rights, risks and responsibilities of managing his/her own care and individual budget. If the beneficiary is unable to make decisions independently, he/she must have an authorized representative who understands the rights, risks and responsibilities of managing his/her care and supports within his/her individual budget. Responsibilities of the beneficiary or authorized representative include:

1. completion of mandatory trainings, including the rights and responsibilities of managing his/her own services and supports and individual budget;
2. participation in the self-direction service delivery option without a lapse in or decline in quality of care or an increased risk to health and welfare; and
3. participation in the development and management of the approved personal purchasing plan:
 - a. this annual budget is determined by the recommended service hours listed in the beneficiary's CPOC to meet his/her needs;
 - b. the beneficiary's individual budget includes a potential amount of dollars within which the beneficiary or his/her authorized representative exercises decision-making responsibility concerning the selection of services and service providers.

C. **Termination of the Self-Direction Service Delivery Option.** Termination of participation in the self-direction service delivery option requires a revision of the CPOC, the elimination of the fiscal agent and the selection of the Medicaid-enrolled waiver service provider(s) of choice.

1. **Voluntary Termination.** The waiver beneficiary may choose at any time to withdraw from the self-direction service delivery option and return to the traditional provider agency management of services.

2. **Involuntary Termination.** The department may terminate the self-direction service delivery option for a beneficiary and require him/her to receive provider-managed services under the following circumstances:

- a. the health or welfare of the beneficiary is compromised by continued participation in the self-direction service delivery option;
- b. the beneficiary is no longer able to direct his/her own care and there is no responsible representative to direct the care;
- c. there is misuse of public funds by the beneficiary or the authorized representative; or

d. over three consecutive payment cycles, the beneficiary or authorized representative:

i. places barriers to the payment of the salaries and related state and federal payroll taxes of direct support staff;

ii. fails to follow the Personal Purchasing Plan;

iii. fails to provide required documentation of expenditures and related items; or

iv. fails to cooperate with the fiscal agent or support coordinator in preparing any additional documentation of expenditures.

D. All services rendered shall be prior approved and in accordance with the comprehensive plan of care.

E. All services must be documented in service notes, which describes the services rendered and progress towards the beneficiary's personal outcomes and his/her comprehensive plan of care.

F. Service Limits

1. Authorized representatives, legally responsible individuals, and legal guardians may be the employers in the self-directed option but may not also be the employees.

2. Legally responsible individuals may only be paid for services when the care is extraordinary care in comparison to that of a beneficiary of the same age without a disability and the care is in the best interest of the beneficiary.

3. Family members who are employed in the self-directed option must meet the same standards as direct support staff that are not related to the beneficiary.

4. Family members who live in the home with the beneficiary cannot exceed a total of 40 hours per week when employed in the self-directed option.

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 Community Supports and Services, LR 30:1209 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1651 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:79 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:58 (January 2018), LR 48:1557 (June 2022).

Chapter 142. Provider Participation Requirements

§14201. Electronic Visit Verification

A. Effective for dates of service on or after August 1, 2015, New Opportunities Waiver providers shall use the electronic visit verification (EVV) system designated by the department for automated scheduling, time and attendance

tracking, and billing for certain home and community-based services.

B. Reimbursement shall only be made to providers with documented use of the EVV system. The services that require use of the EVV system will be published in the NOW provider manual.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:1287 (July 2015).

§14202. Incident Reporting, Tracking and Follow-Up

A. The direct service provider is responsible for responding to, reviewing, and remediating incidents that occur to the beneficiaries they support. Direct service providers must comply with any other rules promulgated by the LDH regarding incident reporting and response.

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 44:58 (January 2018), amended LR 48:1558 (June 2022).

Chapter 143. Reimbursement

§14301. Unit of Reimbursement

A. Reimbursement for services shall be a prospective flat rate for each approved unit of service provided to the beneficiary. One-quarter hour (15 minutes) is the standard unit of service and reimbursement shall not be made for less than 15 minutes (one-quarter hour) of service. This covers both service provision and administrative costs for the following services:

1. center-based respite;
2. community integration development:

a. up to three beneficiaries may choose to share community integration development if they share a common provider of this service;

b. there is a separate reimbursement rate for community integration development when these services are shared;

3. day habilitation;
4. prevocational services;
5. individual and family support-day and night:

a. up to three beneficiaries may choose to share individualized and family support services if they share a common provider;

b. there is a separate reimbursement rate for individualized and family support when these services are shared;

6. professional services;

7. skilled nursing services:
 - a. up to three beneficiaries may choose to share skilled nursing services if they share a common provider;
 - b. there is a separate reimbursement rate for skilled nursing services when these services are shared;
 - c. nursing consultations are offered on an individual basis only.

8. supported employment,
9. housing stabilization transition; and
10. housing stabilization.

B. The following services are to be paid at cost, based on the need of the beneficiary and when the service has been prior authorized and on the CPOC:

1. environmental accessibility adaptations;
2. specialized medical equipment and supplies; and
3. transitional expenses.

C. The following services are paid through a per diem:

1. substitute family care;
2. supported independent living;
3. adult companion care;
4. individual and family support supplemental payments; and
5. monitored in-home caregiving services.

D. Maintenance of the personal emergency response system is paid through a monthly rate.

E. Installation of the personal emergency response system is paid through a one-time fixed cost.

F. Direct Service Worker Wages and Workforce Bonus Payments

1. Establishment of Direct Service Worker Wage Floor for Medicaid Home and Community-Based Services for Intellectual and Developmental Disabilities

a. Effective October 1, 2021, providers of Medicaid home and community-based waiver services operated through the Office for Citizens with Developmental Disabilities employing direct service workers will receive the equivalent of a \$2.50 per hour rate increase.

b. Effective October 1, 2021, this increase or its equivalent will be applied to all service units provided by direct service workers with an effective date of service for the identified home and community based waiver services provided beginning October 1, 2021.

c. The minimum hourly wage floor paid to direct service workers shall be \$9 per hour.

d. All providers of services affected by this rate increase shall be subject to a direct service worker wage floor of \$9 per hour. This wage floor is effective for all

affected direct service workers of any work status, whether full-time, or part-time etc.

e. The Department of Health reserves the right to adjust the direct service worker wage floor as needed through appropriate rulemaking promulgation consistent with the Administrative Procedure Act.

2. Establishment of Direct Service Worker Workforce Bonus Payments

a. Providers who provided services from April 1, 2021 to October 31, 2022 shall receive bonus payments of \$300 per month for each direct service worker that worked with participants for those months.

b. The direct service worker 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 provider. This bonus payment is effective for all eligible direct service workers of any working status, whether full-time or part-time.

c. Bonus payments will end October 31, 2022.

d. LDH reserves the right to adjust the amount of the bonus payments paid to the direct service worker as needed through appropriate rulemaking promulgation consistent with the Administrative Procedure Act.

3. Audit Procedures for Direct Service Worker Wage Floor and Workforce Bonus Payments

a. The wage enhancement and bonus payments reimbursed to providers shall be subject to audit by LDH.

b. Providers shall provide to the LDH or its representative all requested documentation to verify that they are in compliance with the direct service worker wage floor and bonus payments.

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

d. Providers shall produce the requested documentation upon request and within the timeframe provided by LDH.

e. Non-compliance or failure to demonstrate that the wage enhancement and/or bonus payments were paid directly to direct service workers may result in:

- i. sanctions; or
- ii. disenrollment from the Medicaid Program.

4. Sanctions for Direct Service Worker Wage Floor and Workforce Bonus Payments

a. The provider will be subject to sanctions or penalties for failure to comply with this Rule or with requests issued by LDH pursuant to this Rule. The severity of such action will depend upon the following factors:

- i. Direct Service Worker Wage Floor

(a). failure to pay I/DD HCBS direct service workers the wage floor minimum of \$9 per hour;

(b). the number of I/DD HCBS direct service workers identified as having been paid less than the wage floor minimum of \$9 per hour; or

(c). the persistent failure to pay I/DD HCBS direct service workers the wage floor minimum of \$9 per hour;

ii. Direct Service Worker Workforce Bonus Payments

(a). failure to pay eligible I/DD HCBS direct service workers the \$250 monthly workforce bonus payments;

(b). the number of I/DD HCBS direct service workers identified as having not been paid the \$250 monthly workforce bonus payments; or

(c). the persistent failure to pay eligible I/DD HCBS direct service workers the \$250 monthly workforce bonus payments; or

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

G. Payments to legally responsible individuals, legal guardians, and family members living in the home shall be audited on a semi-annual basis to ensure payment for services rendered.

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 Community Supports and Services, LR 30:1209 (June 2004), amended by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 34:252 (February 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 35:1851 (September 2009), LR 36:1247 (June 2010), LR 37:2158 (July 2011), LR 39:1049 (April 2013), LR 40:80 (January 2014), LR 42:898 (June 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:58 (January 2018), LR 45:44 (January 2019), LR 46:1682 (December 2020), LR 48:41 (January 2022), LR 48:1558 (June 2022), LR 49:1070 (June 2023).

Subpart 13. Residential Options Waiver

Chapter 161. General Provisions

§16101. Introduction

A. The Residential Options Waiver (ROW), a 1915(c) home and community-based services (HCBS) waiver, is designed to assist beneficiaries in leading healthy, independent and productive lives to the fullest extent possible and promote the full exercise of their rights as citizens of the state of Louisiana. The ROW is person-centered incorporating the beneficiary's support needs and preferences with a goal of integrating the beneficiary into their community. The ROW provides opportunities for eligible individuals with developmental disabilities to receive HCBS services that allow them to transition to

and/or remain in the community. These individuals would otherwise require an intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care.

B. The Residential Options Waiver services are provided with the goal of promoting independence through strengthening the beneficiary's capacity for self-care, self-sufficiency and community integration utilizing a wide array of services, supports and residential options. The ROW is person-centered incorporating the beneficiary's support needs and preferences, while supporting the dignity, quality of life, and security with the goal of integrating the participant into the community.

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 for Citizens with Developmental Disabilities, LR 33:2441 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2154 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1764 (December 2019), LR 47:1507 (October 2021), LR 48:1558 (June 2022).

§16103. Program Description

A. The ROW is designed to utilize the principles of self-determination and to supplement the family and/or community supports that are available to maintain the individual in the community and are designed to allow an individual experience that mirrors the experiences of individuals without disabilities. These services are not to be restrictive, but liberating, by empowering individuals to experience life in the most fulfilling manner as defined by the individual while still assuring health and safety. In keeping with the principles of self-determination, ROW includes a self-direction option, which allows for greater flexibility in hiring, training and general service delivery issues. ROW services are meant to enhance, not replace existing informal networks.

B. The ROW offers an alternative to institutional care with the objectives to:

1. promote independence for beneficiaries through the provision of services meeting the highest standards of quality and national best practices, while ensuring health and safety through a comprehensive system of beneficiary safeguards;

2. offer an alternative to institutionalization and costly comprehensive services through the provision of an array of services and supports that promote community inclusion and independence by enhancing and not replacing existing informal networks; and

3. offer access to services which would protect the health and safety of the beneficiary.

C. ROW services are accessed through a single point of entry in the human services district or authority. All waiver beneficiaries choose their support coordination and direct

service provider agencies through the freedom of choice process.

1. The plan of care (POC) shall be developed using a person-centered process coordinated by the beneficiary's support coordinator. The initial POC is developed during this person-centered planning process and approved by the human services district or authority. Annual reassessments may be approved by the support coordination agency supervisor as allowed by Office for Citizens with Developmental Disabilities (OCDD) policy.

D. All services must be prior authorized and delivered in accordance with the approved POC.

E. The total expenditures available for each waiver beneficiary is established through an assessment of individual support needs and may not exceed the approved ICF/IID Inventory for Client and Agency Planning (ICAP) rate/ROW budget level established for that individual except as approved by the OCDD assistant secretary, deputy assistant secretary, or his/her designee to prevent institutionalization. ROW acuity/budget cap level(s) are based upon each beneficiary's ICAP assessment tool results and may change as the beneficiary's needs change.

1. When the department determines that it is necessary to adjust the ICF/IID ICAP rate, each waiver beneficiary's annual service budget may be adjusted to ensure that the beneficiary's total available expenditures do not exceed the approved ICAP rate. A reassessment of the beneficiary's ICAP level will be conducted to determine the most appropriate support level.

2. The average beneficiary's expenditures for all waiver services shall not exceed the average Medicaid expenditures for ICF/IID services.

3. Beneficiaries may exceed assigned ROW acuity/budget cap level(s) to access defined additional support needs to prevent institutionalization on a case by case basis according to policy and as approved by the OCDD assistant secretary or his/her designee.

4. If it is determined that the ROW can no longer meet the beneficiary's health and safety needs and/or support the beneficiary, the case management agency will conduct person centered discovery activities.

5. All Medicaid service options will be explored, including ICF/IID placement, based upon the assessed need.

F. No reimbursement for ROW services shall be made for a beneficiary who is admitted to an inpatient setting.

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 for Citizens with Developmental Disabilities, LR 33:2441 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2154 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1764

(December 2019), LR 47:1507 (October 2021), LR 48:1559 (June 2022).

§16104. Settings for Home and Community Based Services

A. ROW beneficiaries are expected to be integrated in and have full access to the greater community while receiving services, to the same extent as individuals without disabilities. Providers shall meet the requirements of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) home and community-based setting requirements for home and community-based services (HCBS) waivers as delineated in LAC 50:XXI.901 or any superseding 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 and the Office for Citizens with Developmental Disabilities, LR 45:1764 (December 2019), amended LR 47:1508 (October 2021), LR 48:1559 (June 2022).

§16105. Beneficiary Qualifications

A. In order to qualify for Residential Options Waiver (ROW), individuals of all ages must meet all of the following criteria:

1. have an intellectual and/or developmental disability as specified in R.S. 28:451.2;
2. be determined eligible through the developmental disabilities entry process;
3. be on the intellectual/developmental disabilities (IDD) request for services registry (RFSR), unless otherwise specified through programmatic allocation in §16107 of this Chapter;
4. meet the requirements for an ICF/IID level of care which requires active treatment for developmental disabilities under the supervision of a qualified developmental disabilities professional;
5. meet the financial eligibility requirements for the Louisiana Medicaid Program;
6. have justification based on a uniform needs-based assessment and a person-centered planning discussion that the ROW is the OCDD waiver that will meet the needs of the individual;
7. be a resident of Louisiana;
8. be a citizen of the United States or a qualified alien; and
9. have assurance that health and welfare of the individual can be maintained in the community with the provision of the ROW services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2441 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services

Financing and the Office for Citizens with Developmental Disabilities, LR 41:2155 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2530 (December 2017), LR 45:1764 (December 2019), LR 47:1508 (October 2021), repromulgated LR 48:1559 (June 2022).

§16106. Money Follows the Person Rebalancing Demonstration

A. The Money Follows the Person (MFP) Rebalancing Demonstration is a federal demonstration grant awarded by the Centers for Medicare and Medicaid Services to the Department of Health. The MFP demonstration is a transition program that targets individuals using qualified institutional services and moves them to home and community-based long-term care services. The MFP rebalancing demonstration will stop allocation of opportunities when the demonstration expires.

1. For the purposes of these provisions, a qualified institution is a nursing facility, hospital, or Medicaid enrolled intermediate care facility for individuals with intellectual disabilities (ICF/IID).

B. Individuals must meet the following criteria for participation in the MFP Rebalancing Demonstration.

1. Individuals with a developmental disability must:

a. occupy a licensed, approved Medicaid enrolled nursing facility, hospital or ICF/IID bed for at least 60 days; and

b. be Medicaid eligible, eligible for state developmental disability services, and meet an ICF/IID level of care.

2. The beneficiary or his/her responsible representative must provide informed consent for both transition and participation in the demonstration.

C. Individuals in the demonstration are not required to have a protected date on the developmental disabilities request for services registry (RFSR).

D. All other ROW provisions apply to the Money Follows the Person Rebalancing Demonstration.

E. MFP beneficiaries cannot participate in ROW shared living services which serve more than four persons in a single residence.

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 for Citizens with Developmental Disabilities, LR 41:2155 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1508 (October 2021), LR 48:1559 (June 2022).

§16107. Programmatic Allocation of Waiver Opportunities

A. The intellectual/developmental disabilities request for services registry, hereafter referred to as “the registry,” shall

be used to identify individuals with intellectual and/or developmental disabilities who are waiting for an OCDD waiver opportunity. Individuals who are found eligible for developmental disabilities services using standardized tools, and who request waiver services will be added to the registry. The request for services registry (RFSR) is arranged by urgency of need and date of application for developmentally disabled (DD) waiver services.

B. The ROW serves eligible individuals in the following populations and is based on the following priorities:

1. Priority 1. The one-time transition of persons eligible for developmental disability (DD) services in either OAAS Community Choices Waiver (CCW) or OAAS Adult Day Health Care (ADHC) Waiver to the ROW.

2. Priority 2. Individuals living at Pinecrest Supports and Services Center or in a publicly operated ICF/IID when it was transitioned to a private ICF/IID through a cooperative endeavor agreement (CEA facility), or their alternates. Alternates are defined as individuals living in a private ICF/IID who will give up the private ICF/IID bed to an individual living at Pinecrest or to an individual who was living in a publicly operated ICF/IID when it was transitioned to a private ICF/IID through a cooperative endeavor agreement. Individuals requesting to transition from Pinecrest are awarded a slot when one is requested and their health and safety can be assured in an OCDD waiver. This also applies to individuals who were residing in a state operated facility at the time the facility was privatized and became a CEA facility.

3. Priority 3. Individuals on the registry who have the highest level of need and the earliest registry date shall be notified in writing when a funded OCDD waiver opportunity is available and that he/she is next in line to be evaluated for a possible waiver assignment, and the ROW shall have justification based on a uniform needs-based assessment and a person-centered planning that the ROW is the OCDD waiver that will best meet the needs of the individual.

4. Priority 4. Individuals transitioning from ICF/IID facilities utilizing ROW conversion.

C. OCDD has the responsibility to monitor the utilization of ROW opportunities. At the discretion of OCDD, specifically allocated waiver opportunities may be reallocated to better meet the needs of citizens with developmental disabilities in the state of Louisiana.

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 for Citizens with Developmental Disabilities, LR 33:2441 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2155 (October 2015), LR 42:62 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2530 (December 2017), LR 45:1764 (December 2019), LR 47:1508 (October 2021).

§16109. Admission Denial or Discharge Criteria

A. Admission to the ROW Program shall be denied if one of the following criteria is met.

1. The individual does not meet the requirements for an ICF/IID level of care.
2. The individual does not meet the requirements for an ICF/IID level of care.
3. The individual does not meet developmental disability system eligibility.
4. The individual is incarcerated or under the jurisdiction of penal authorities, courts or state juvenile authorities.
5. The individual resides in another state.
6. The health and welfare of the individual cannot be assured through the provision of ROW services.
7. The individual fails to cooperate in the eligibility determination process or in the development of the POC.
8. The individual does not have justification, based on a uniform needs-based assessment and a person-centered planning discussion that the ROW is the OCDD waiver that will meet the needs of the individual.

B. Beneficiaries shall be discharged from the ROW if any of the following conditions are determined:

1. loss of Medicaid financial eligibility as determined by the Medicaid Program;
2. loss of eligibility for an ICF/IID level of care;
3. loss of developmental disability system eligibility;
4. incarceration or placement under the jurisdiction of penal authorities, courts, or state juvenile authorities;
5. change of residence to another state;
6. admission to an ICF/IID or nursing facility with the intent to stay and not to return to waiver services;
7. the health and welfare of the beneficiary cannot be assured through the provision of ROW services in accordance with the beneficiary's approved POC;
8. the beneficiary fails to cooperate in the eligibility renewal process or the implementation of the approved POC, or the responsibilities of the ROW beneficiary;
9. continuity of stay for consideration of Medicaid eligibility under the special income criteria is interrupted as a result of the beneficiary not receiving ROW services during a period of 30 consecutive days;
 - a. continuity of stay is not considered to be interrupted if the beneficiary is admitted to a hospital, nursing facility, or ICF/IID;
 - b. the beneficiary shall be discharged from the ROW if the treating physician documents that the institutional stay will exceed 90 days; or

10. continuity of services is interrupted as a result of the beneficiary not receiving ROW services during a period of 30 consecutive days.

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 for Citizens with Developmental Disabilities, LR 33:2443 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2156 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1765 (December 2019), LR 47:1509 (October 2021), LR 48:1560 (June 2022).

Chapter 163. Covered Services**§16301. Assistive Technology and Specialized Medical Equipment and Supplies**

A. Assistive technology and specialized medical equipment and supplies (AT/SMES) service includes providing specialized devices, controls, or appliances which enable a beneficiary to increase his/her ability to perform activities of daily living, ensure safety, and/or to perceive, control, and communicate within his/her environment.

1. This service also includes items that meet at least one of the following criteria:

- a. items that are necessary for life support;
- b. items that are necessary to address physical conditions, along with ancillary supplies;
- c. address physical conditions;
- d. items that will increase, maintain, or improve ability of the beneficiary to function more independently in the home and/or community; and
- e. equipment necessary to the proper functioning of such items.

2. This service also includes medically necessary durable and non-durable equipment not available under the Medicaid State Plan and repairs to such items and equipment necessary to increase/maintain the independence and well-being of the beneficiary.

a. All equipment, accessories and supplies must meet all applicable manufacture, design and installation requirements.

b. The services under the Residential Options Waiver are limited to additional services not otherwise covered under the Medicaid State Plan.

3. The services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

B. AT/SMES services provided through the ROW include the following services:

1. the evaluation of assistive technology needs of a beneficiary including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the beneficiary in the customary environment of the beneficiary;

2. services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;

3. coordination of necessary therapies, interventions or services with assistive technology devices;

4. training or technical assistance on the use and maintenance of the equipment or device for the beneficiary or, where appropriate, his/her family members, legal guardian or responsible representative;

5. training or technical assistance, on the use for the beneficiary, or where appropriate, family members, guardians, advocates, authorized representatives of the beneficiary, professionals, or others;

6. all service contracts and warranties included in the purchase of the item by the manufacturer;

7. equipment or device repair and replacement of batteries and other items that contribute to ongoing maintenance of the equipment or device;

a. separate payment will be made for repairs after expiration of the warranty only when it is determined to be cost effective; and

8. services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for beneficiaries.

C. Approval of AT/SMES services through ROW is contingent upon the denial of a prior authorization request for the item as a Medicaid State Plan service and demonstration of the direct medical, habilitative, or remedial benefit of the item to the beneficiary.

1. Items reimbursed in the ROW may be in addition to any medical equipment and supplies furnished under the Medicaid State Plan.

D. All assistive technology items must meet applicable manufacture, design and installation requirements.

E. Service Exclusions

1. Assistive technology devices and specialized equipment and supplies that are of general utility or maintenance and items that are not of direct medical or remedial benefit to the beneficiary are excluded from coverage.

2. Any equipment, device, appliance or supply that is covered and has been approved under the Medicaid State Plan is excluded from coverage.

3. For adults over the age of 20 years, specialized chairs, whether mobile or travel are not covered.

F. Provider Participation Requirements. Providers of AT/SMES services must meet the following participation requirements. The provider must:

1. be enrolled in the Medicaid Program;

2. provide documentation on manufacturer's letterhead that the agency listed on the Louisiana Medicaid Enrollment Form and Addendum (PE-50) is:

a. authorized to sell and install assistive technology, specialized medical equipment and supplies, or devices for assistance with activities of daily living; and

b. has training and experience with the application, use fitting and repair of the equipment or devices they propose to sell or repair; and

3. Upon completion of the work and prior to payment, the provider shall give the beneficiary a certificate of warranty for all labor and installation and all warranty certificates.

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 for Citizens with Developmental Disabilities, LR 33:2443 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2156 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1509 (October 2021), LR 48:1560 (June 2022)..

§16303. Community Living Supports

A. Community living supports (CLS) are provided to a beneficiary in his/her own home and in the community to achieve and/or to maintain the outcomes of increased independence, productivity, and enhanced family functioning, to provide relief of the caregiver, and to provide for inclusion in the community. Community living supports may be a self-directed service.

B. Community living supports focus on the achievement of one or more goals as indicated in the beneficiary's approved plan of care by incorporating teaching and support strategies. Supports provided are related to the acquisition, improvement, and maintenance of independence, autonomy and adaptive skills. These skills include:

1. self-help skills;

2. socialization skills;

3. cognitive and communication skills; and

4. development of appropriate, positive behaviors.

C. Place of Service. CLS services are furnished to adults and children who live in a home that is leased or owned by the beneficiary or his/her family. Services may be provided in the home or community, with the place of residence as the primary setting.

D. Community living supports may be shared by up to three beneficiaries who may or may not live together, and

who have a common direct service provider agency. In order for CLS services to be shared, the following conditions must be met.

1. An agreement must be reached among all of the involved beneficiaries, or their legal guardians, regarding the provisions of shared CLS services. If the person has a legal guardian, their approval must also be obtained. In addition, CLS direct support staff may be shared across the Children's Choice or New Opportunities Waiver at the same time.

2. The health and welfare must be assured for each beneficiary.

3. Each beneficiary's plan of care must reflect shared services and include the shared rate for the service indicated.

4. A shared rate must be billed.

5. The cost of transportation is built in to the community living services rate and must be provided when integral to community living services.

E. Service Exclusions

1. Community living supports staff are not allowed to sleep during billable hours of community living supports.

2. Payment does not include room and board or the maintenance, upkeep, and improvement of the provider's or family's residence.

3. Community living supports may not be provided in a licensed respite care facility.

4. Community living supports services are not available to beneficiaries receiving any of the following services:

- a. shared living;
- b. host home; or
- c. companion care.

5. Community living supports may not be billed at the same time on the same day as:

- a. day habitation;
- b. prevocational services;
- c. supported employment;
- d. respite care services-out of home;
- e. transportation-community access;
- f. monitored in-home caregiving (MIHC); or
- g. adult day health care.

F. Provider Qualifications. CLS providers must be licensed by the Department of Health as a home and community-based services provider and meet the module requirements for personal care attendant in LAC 48:I.Chapter 50.

1. Family members who provide CLS services must meet the same standards as providers who are unrelated to the beneficiary. Service hours shall be capped at 40 hours

per week, Sunday to Saturday, for services delivered by family members living in the home.

2. Legally responsible individuals (such as a parent or spouse) and legal guardians may provide community living supports services for a beneficiary provided that the care is extraordinary in comparison to that of a beneficiary of the same age without a disability and the care is in the best interest of the beneficiary.

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§16305. Companion Care

A. Companion care services provide supports to assist the beneficiary in achieving and/or maintaining increased independence, productivity and community inclusion as identified in the beneficiary's plan of care. These services are designed for individuals who live independently and can manage their own household with limited supports. The companion provides personal care and supportive services to a beneficiary who resides as a roommate with his/her caregiver. This service includes:

- 1. providing assistance with all of the activities of daily living as indicated in the beneficiary's POC; and
- 2. community integration and coordination of transportation services, including medical appointments.

B. Companion care services can be arranged by licensed providers who hire companions. The beneficiary must be able to self-direct services to companion. The companion is a principal care provider who is at least 18 years of age, who lives with the beneficiary as a roommate, and provides services in the beneficiary's home. The companion is a contracted employee of the provider agency and is paid as such by the provider.

C. Provider Responsibilities

1. The provider organization shall develop a written agreement that defines all of the shared responsibilities between the companion and the beneficiary. This agreement becomes a part of the beneficiary's plan of care. The written agreement shall include, but is not limited to:

- a. types of support provided by the companion;
- b. activities provided by the companion; and
- c. a typical weekly schedule.

2. Revisions to this agreement must be facilitated by the provider and approved as part of the plan of care following the same process as would any revision to a plan of care. Revisions can be initiated by the beneficiary, the

companion, the provider, or a member of the beneficiary's support team.

3. The provider is responsible for performing the following functions which are included in the daily rate:

- a. arranging the delivery of services and providing emergency services as needed;
- b. conducting an initial inspection of the beneficiary's home with on-going periodic inspections of a frequency determined by the provider;
- c. making contact with the companion at a minimum of once per week, or more often as specified in the beneficiary's plan of care; and
- d. providing 24-hour oversight, back-up staff, and companion supervision.

4. The provider shall facilitate a signed written agreement between the companion and the beneficiary.

D. Responsibilities of the companion include:

1. providing assistance with activities of daily living (ADLs);
2. community integration;
3. providing transportation;
4. coordinating and assisting as needed with transportation to medical/therapy appointments;
5. participating in and following the beneficiary's plan of care and any support plans;
6. maintaining documentation/records in accordance with state and provider requirements;
7. being available in accordance with a pre-arranged time schedule as outlined in the beneficiary's plan of care;
8. purchasing own personal items and food; and
9. being available 24 hours a day (by phone contact) to the beneficiary to provide supports on short notice as a need arises.

E. Service Limits

1. The provider must provide relief staff for scheduled and unscheduled absences, available for up to 360 hours (15 days) per plan of care year. The companion care provider's rate includes funding for relief staff for scheduled and unscheduled absences.

F. Service Exclusions

1. Companion care is not available to individuals receiving the following services:

- a. respite care service—out of home;
- b. shared living;
- c. community living supports;
- d. host home; or
- e. monitored in-home caregiving (MIHC).

2. Companion care services are not available to beneficiaries under the age of 18.

3. Legally responsible individuals and legal guardians may provide companion care services for a relative who beneficiary provided that the care is extraordinary in comparison to that of a beneficiary of the same age without a disability and the care is in the best interest of the beneficiary.

4. Payment does not include room and board or maintenance, upkeep, and improvement of the beneficiaries or provider's property.

5. Transportation is billed by the vocational provider.

G. Provider Qualifications. Providers must be licensed by the Department of Health as a home and community-based services provider and meet the module requirements for personal care attendant in LAC 48:I.Chapter 50.

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§16307. Day Habilitation Services

A. Day habilitation is services that assist the beneficiary to gain desired community living experience, including the acquisition, retention, or improvement in self-help, socialization, and adaptive skills, and/or to provide the beneficiary an opportunity to contribute to his or her community. These services shall be coordinated with any physical, occupational, or speech therapies identified in the individualized plan of care. Day habilitation services may include assistance with personal care or with activities of daily living, but such assistance should not be the primary activity. Day habilitation services may serve to reinforce skills or lessons taught in other settings. Volunteer activities may be a part of this service and should follow the state guidelines for volunteering.

B. Day habilitation may be delivered in a combination of these three service types:

1. onsite day habilitation;
2. community life engagement; and
3. virtual day habilitation.

C. Day habilitation services are provided on a regularly scheduled basis for one or more days per week in a variety of community settings that are separate from the beneficiary's private residence, with the exception of virtual day habilitation. Day habilitation services should not be limited to a fixed site facility. Activities and environments are designed to foster personal choice in developing the

beneficiary's meaningful day including community activities alongside people who do not receive home and community-based services.

D. The day habilitation provider is responsible for all transportation between day habilitation sites and while providing community life engagement services in the community.

1. Transportation can only be billed on the day that an in-person day habilitation service is provided.

2. Transportation is not a part of the service for virtual day habilitation.

E. Beneficiaries receiving day habilitation services may also receive prevocational and/or individual supported employment services on the same day, but these services cannot be provided during the same time period or total more than five hours per day combined.

F. Service Exclusions

1. Time spent in transportation between the beneficiary's residence/location and the day habilitation site is not to be included in the total number of day habilitation service hours per day, except when the transportation is for the purpose of travel training.

a. Travel training for the purpose of teaching the beneficiary to use transportation services may be included in determining the total number of service hours provided per day. Travel training must be included in the beneficiary's plan of care.

2. Transportation-community access will not be used to transport ROW beneficiaries to any day habilitation services.

3. Day habilitation services cannot be billed for at the same time on the same day as:

- a. community living supports;
- b. professional services, except when there are direct contacts needed in the development of a support plan;
- c. respite—out of home;
- d. adult day health care;
- e. monitored in-home caregiving (MIHC);
- f. prevocational services; or
- g. supported employment.

4. Day habilitation services shall be furnished on a regularly scheduled basis for up to eight hours per day, one or more days per week.

a. Services are based on a 15 minute unit of service and on time spent at the service site by the beneficiary. Any time less than 15 minutes of service is not billable or payable. No rounding up of units is allowed.

b. Services are based on the person centered plan and the beneficiary's ROW budget.

5. All virtual day habilitation services must be approved by the local governing entity or the OCDD state office.

6. Day habilitation may not provide for the payment of services that are vocational in nature – for example, the primary purpose of producing goods or performing services.

G. Provider Qualifications. Providers must be licensed by the Department of Health as a home and community-based services provider and meet the module requirements for adult day care in LAC 48:I.Chapter 50.

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§16309. Dental Services

A. Dental services are available to adult beneficiaries over the age of 21 as of component of the ROW. Covered dental services include:

1. adult diagnostic services;
2. preventative services;
3. restorative services;
4. endodontics;
5. periodontics;
6. prosthodontics;
7. oral and maxillofacial surgery;
8. orthodontics;
9. emergency care; and
10. adjunctive general services.

B. Dental Service Exclusions

1. ROW dental services are not available to children (up to 21 years of age). Children access dental services through the EPSDT benefit.

2. services must first be exhausted prior to accessing ROW dental services. Non-covered services include but are not limited to the following:

- a. services that are not medically necessary to the beneficiary's dental health;
- b. dental care for cosmetic reasons;
- c. experimental procedures;
- d. plaque control;

e. any periapical radiographic images, occlusal radiographic images, complete series, or panoramic radiographic images taken annually or routinely at the time of a dental examination for screening purposes;

f. routine post-operative services – these services are covered as part of the fee for the initial treatment provided;

g. treatment of incipient or non-carious lesions (other than covered sealants and fluoride);

h. services that are eligible for reimbursement by insurance or covered under any other insurance or medical health plan;

i. dental expenses related to any dental services:

i. started after the beneficiary's coverage ended, or

ii. received before the beneficiary became eligible for these services; and

j. administration of in-office pre-medication.

C. **Provider Qualifications.** Providers are enrolled through the LA Dental Benefit Program, which is responsible for maintaining provider lists.

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§16311. Environmental Accessibility Adaptations

A. Environmental accessibility adaptations are physical adaptations to the beneficiary's home or vehicle which are necessary to ensure health, welfare, and safety of the beneficiary, or which enable the beneficiary to function with greater independence, without which the beneficiary would require additional supports or institutionalization. Environmental adaptations must be specified in the beneficiary's plan of care.

1. Reimbursement shall not be paid until receipt of written documentation that the job has been completed to the satisfaction of the beneficiary.

B. Environmental adaptation services to the home and vehicle include the following:

1. performance of necessary assessments to determine the type(s) of modifications that are needed;

2. training the beneficiary and the provider in the use and maintenance of the environmental adaptation(s);

3. repair of equipment and/or devices, including battery purchases for vehicle lifts and other reoccurring

replacement items that contribute to the ongoing maintenance of the approved adaptation(s); and

4. standard manufacturer provided service contracts and warranties.

C. Home adaptations which pertain to modifications that are made to a beneficiary's primary residence. Such adaptations to the home may include bathroom modifications, ramps, or other adaptations to make the home accessible to the beneficiary.

1. The service must be for a specific approved adaptation.

2. The service may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the beneficiary.

D. Modifications may be applied to rental or leased property only with the written approval of the landlord and approval of OCDD.

E. All environmental accessibility adaptations to home and to a vehicle must meet all applicable standards of manufacture, design, and installation.

F. Service Exclusions for Home Adaptations

1. Home modification funds are not intended to cover basic construction cost. Waiver funds may only be used to pay the cost of purchasing specific approved adaptations for the home, not for the construction costs of additions to the home.

2. Home modifications shall not be furnished to adapt living arrangements that are owned or leased by paid caregivers or providers of waiver services.

3. Home modifications may not include modifications which add to the total square footage of the home, except when the additional square footage is necessary to make the required adaptations function appropriately.

EXAMPLE: if a bathroom is very small and a modification cannot be done without increasing the total square footage, this would be considered as an approvable cost.

a. When new construction or remodeling is a component of the service, payment for the service is to only cover the difference between the cost of typical construction and the cost of specialized construction.

4. Home modifications may not include modifications to the home which are of general utility and not of direct medical or remedial benefit to the beneficiary, including, but not limited to:

a. flooring;

b. roof repair;

c. central air conditioning;

d. hot tubs;

e. swimming pools;

- f. exterior fencing; or
- g. general home repair and maintenance.

5. Home modification funds may not be used for service warranties and contracts above those provided by the manufacturer at the time of purchase (e.g., extended warranties, extended service contracts).

G. Vehicle adaptations pertain to modifications to a vehicle that is the waiver beneficiary's primary means of transportation in order to accommodate his/her special needs.

1. Such adaptations to the vehicle may include a lift, or other adaptations, to make the vehicle accessible to the participant or for the beneficiary to drive.

2. The service must be for a specific approved adaptation.

H. Service Exclusions for Vehicle Adaptations

1. Payment will not be made to:

- a. adapt vehicles that are owned or leased by paid caregivers or providers of waiver services, or
- b. purchase or lease of a vehicle.

2. Vehicle modification funds may not be used for modifications which are of general utility and are not of direct medical or remedial benefit to the beneficiary.

3. Vehicle modification funds may not be used for regularly scheduled upkeep and maintenance of a vehicle, except upkeep and maintenance of the modifications.

4. Car seats are not considered a vehicle adaptation.

5. Vehicle modification funds may not be used for service warranties and contracts above those provided by the manufacturer at the time of purchase (e.g., extended warranties, extended service contracts).

I. Provider Responsibilities

1. The environmental accessibility adaptation(s) must be delivered, installed, operational and reimbursed in the POC year in which it was approved.

2. A written itemized detailed bid, including drawings with the dimensions of the existing and proposed floor plans relating to the modifications, must be obtained and submitted for prior authorization.

3. Vehicle modifications must meet all of the applicable standards of manufacture, design and installation for all adaptations to the vehicle.

4. Upon completion of the work and prior to payment, the provider shall give the beneficiary a certificate of warranty for all labor and installation and all warranty certificates from manufacturers.

J. Provider Qualifications. In order to participate in the Medicaid Program, providers must meet the following qualifications.

1. Home Adaptations. Providers of environmental accessibility adaptations for the home must:

a. be registered through the State Licensing Board for Contractors as a home improvement contractor. The provider must have a current license from the State Licensing Board for Contractors for any of the following building trade classifications:

- i. general contractor;
- ii. home improvement; or
- iii. residential building; or

b. If a current Louisiana Medicaid provider of durable medical equipment, have documentation from the manufacturing company (on its letterhead) that confirms that the provider is an authorized distributor of a specific product that attaches to a building. The letter must specify the product and state that the provider has been trained on its installation.

2. Vehicle Adaptations. Providers of environmental accessibility adaptations to vehicles must be licensed by the Louisiana Motor Vehicle Commission as a specialty vehicle dealer and accredited by the National Mobility Equipment Dealers Association under the Structural Vehicle Modifier category.

3. All environmental adaptations providers must comply with all applicable local (city or parish) occupational license(s).

4. All environmental adaptation providers, as well as the person performing the service (i.e., building contractors, plumbers, electricians, engineers, etc.), must meet any state or local requirements for licensure or certification. When state and local building or housing code standards are applicable, modifications to the home shall meet such standards, and all services shall be provided in accordance with applicable State or local requirements.

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§16313. Host Home

A. Host home services are personal care and supportive services provided to a beneficiary who lives in a private home with a family who is not the beneficiary's parent, legal representative, or spouse. Host home families are a stand-alone family living arrangement in which the principle caregiver in the host home assumes the direct responsibility for the beneficiary's physical, social, and emotional well-being and growth in a family environment. Host home services are to take into account compatibility with the host

home family members, including age, support needs, and privacy needs.

B. Host home services include assistance with:

1. personal care, assistance with the activities of daily living and adaptive living needs;
2. leisure activities, assistance to develop leisure interests and daily activities in the home setting;
3. social development/family inclusion, assistance to develop relationships with other members of the household; and
4. community inclusion supports in accessing community services and activities and pursuing and developing recreational and social interests outside the home.

NOTE: Natural supports are also encouraged and supported when possible. Supports are to be consistent with the beneficiary's skill level, goals, and interests.

C. Host home provider agencies oversee and monitor the host home contractor to ensure the availability, quality, and continuity of host home services. Host home provider agencies are responsible for the following functions:

1. arranging, training, and overseeing host home services (host home family);
2. making an initial inspection and periodic inspections of the host home and upon any significant changes in the host family unit or significant events which may impact the beneficiary;
3. having 24-hour responsibility over host home services to the beneficiary, which includes back-up staffing for scheduled and unscheduled absences of the host home family for up to 360 hours (15 days) as authorized by the beneficiary's plan of care; and
4. providing relief staffing in the beneficiary's home or in another host home family's home.

D. Host home contractors are responsible for:

1. attending the beneficiary's plan of care meeting and participating, including providing information needed in the development of the plan;
2. following all aspects of the beneficiary's plan of care and any support plans;
3. maintaining the beneficiary's documentation;
4. assisting the beneficiary in attending appointments (i.e., medical, therapy, etc.) and undergoing any specialized training deemed necessary by the provider agency, or required by the department, to provide supports in the host home setting;
5. following all requirements for staff as in any other waiver service including immediately reporting to the department and applicable authorities any major issues or concerns related to the beneficiary's safety and well-being; and

6. providing transportation as would a natural family member.

E. Host home contractors who serve children are required to provide daily supports and supervision on a 24-hour basis.

1. If the beneficiary is a child, the host home family is to provide the supports required to meet the needs of a child as any family would for a minor child.
2. Support needs are based on the child's age, capabilities, health, and special needs.
3. A host home family can provide compensated supports for up to two beneficiaries, regardless of the funding source

F. Host home contractors serving adults are required to be available for daily supervision, support needs or emergencies as outlined in the adult beneficiary's POC based on medical, health and behavioral needs, age, capabilities and any special needs.

1. Host home contractors that serve adults who have been interdicted must ensure that services are furnished in accordance with the legal requirements of the interdiction.

G. Host home contractors who are engaged in employment outside the home must adjust these duties to allow the flexibility needed to meet their responsibilities to the beneficiary.

H. Host Home Capacity. Regardless of the funding source, a host home contractor may not provide services for more than two beneficiaries in the home.

I. Service Exclusions

1. Separate payment will not be made for community living supports since these services are integral to, and inherent in, the provision of host home services.

2. Payment will not be made for the following:

- a. respite care services-out of home;
- b. shared living/shared living conversion;
- c. community living supports;
- d. companion care;
- e. monitored in-home caregiving (MIHC);
- f. transportation-community access; or
- g. one-time transition services.

3. The host home contractor may not be the same individual as the owner or administrator of the designated provider agency.

4. Payment will not be made for services provided by a relative who is a:

- a. parent(s) of a minor child;
- b. legal guardian of an adult or child with developmental disabilities;

c. parent(s) for an adult child, regardless of whether or not the adult child has been interdicted; or

d. spouse of the beneficiary.

5. Children eligible for Title IV-E services are not eligible for host home services.

6. Payment does not include room and board or maintenance, upkeep, or improvement of the host home family's residence.

7. Environmental adaptations are not available to beneficiaries receiving host home services since the beneficiary's place of residence is owned or leased by the host home family.

J. Provider Qualifications

1. Home host service provider agencies must meet the following qualifications:

a. have experience in delivering therapeutic services to persons with developmental disabilities;

b. have staff who have experience working with persons with developmental disabilities;

c. screen, train, oversee and provide technical assistance to the host home family in accordance with OCDD requirements, including the coordination of an array of medical, behavioral and other professional services geared to persons with developmental disabilities (DD); and

d. provide on-going assistance to the host home family so that all HCBS waiver health and safety assurances, monitoring, and critical incident reporting requirements are met.

2. Agencies serving children must be licensed by the Department of Children and Family Services as a Class "A" Child Placing Agency under the Specialized Provider Licensing Act (R.S. 46:1401-46:1430), LAC 67:V.Chapter 73.

3. Agencies serving adults must be licensed by the Department of Health as a home and community-based services provider and meet the module requirements for substitute family care in LAC 48:I.Chapter 50.

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§16317. Nursing Services

A. Nursing services are medically necessary services ordered by a physician and provided by a licensed registered nurse or a licensed practical nurse under the supervision of a registered nurse, within the scope of the State's Nurse

Practice Act. Nursing services provided in the ROW are an extension of nursing services provided through the Home Health Program covered under the Medicaid State Plan.

1. Nursing services must be included in the beneficiary's plan of care and must have the following:

a. physician's order;

b. physician's letter of medical necessity;

c. Form 90-L;

d. Form 485;

e. individual nursing service plan;

f. summary of medical history; and

g. skilled nursing checklist.

2. The beneficiary's nurse must submit updates every 60 days and include any changes to the beneficiary's needs and/or physician's orders.

B. Consultations include assessments, health related training/education for the beneficiary and the beneficiary's caregivers, and healthcare needs related to prevention and primary care activities.

1. Assessment services are offered on an individualized basis only and must be performed by a registered nurse.

2. Consulting services may also address healthcare needs related to prevention and primary care activities.

3. Health related training and education service is the only nursing procedure which can be provided to more than one beneficiary simultaneously.

C. Service Limitations

1. Services are based on 15-minute units of service.

D. Service Requirements

1. Nursing services are secondary to EPSDT services for beneficiaries under the age of 21 years. Beneficiaries under the age of 21 have access to nursing services (home health and extended care) under the Medicaid State Plan.

2. Adults have access only to home health nursing services under the Medicaid State Plan. Beneficiaries must access and exhaust all available Medicaid State Plan services prior to accessing ROW nursing services.

E. Provider Qualifications

1. In order to participate in the Medicaid Program, a provider agency must possess a current, valid license as a home health agency under R.S. 40:2116.31–40:2116.40 as verified by the LDH Health Standards Section; or

2. If under the ROW shared living conversion model, a provider agency must be licensed by the Department of Health as a home and community-based services provider and meet the module requirements for supervised independent living-conversion in LAC 48:I.Chapter 50.

F. Staffing Requirements

1. Nursing services shall be provided by individuals with either a current, valid license as a registered nurse from the State Board of Nursing or a current, valid license as a practical nurse from the Board of Practical Nurse Examiners.

2. Nurses must have one-year experience serving persons with developmental disabilities. Experience may include any of the following:

a. full-time experience gained in advanced and accredited training programs, (i.e., masters or residency level training programs) which includes treatment services to persons with a developmental disability;

b. paid, full-time nursing experience in specialized service/treatment settings for persons with a developmental disability (i.e., intermediate care facilities for persons with a developmental disability);

c. paid, full-time nursing experience in multi-disciplinary programs for persons with a developmental disability (i.e., mental health treatment programs for persons with dual diagnosis - mental illness and a developmental disability); or

d. paid, full-time nursing experience in specialized educational, vocational, and therapeutic programs or settings for persons with a developmental disability (i.e., school special education program).

3. Two years of part-time experience (minimum of 20 hours per week) may be substituted for one year of full-time experience.

4. The following activities do not qualify for the required experience:

a. volunteer nursing experience; or

b. experience gained by caring for a relative or friend with developmental disabilities.

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§16319. One Time Transitional Services

A. One-time transitional services are non-reoccurring set-up expenses to assist a beneficiary who is moving from an institutional setting to his or her own home. The beneficiary's support coordinator assists in accessing funds and making arrangements in preparation for moving into the residence.

B. One-time transitional services may be accessed for the following:

1. non-refundable security deposit;
2. utility deposits (set-up/deposit fee for telephone service);
3. essential furnishings to establish basic living arrangements, including:
 - a. bedroom furniture;
 - b. living room furniture;
 - c. tables and chairs;
 - d. window blinds; and
 - e. kitchen items (i.e., food preparation items, eating utensils, etc.);
4. moving expenses; and
5. health and safety assurances (i.e., pest eradication, one-time cleaning prior to occupancy, etc.).

C. Service Limits

1. There is a one-time, lifetime maximum services cap of \$3,000 per beneficiary.

2. Service expenditures will be prior authorized and tracked by the prior authorization contractor.

D. Service Exclusions

1. One-time transitional services may not be used to pay for the following:

- a. housing, rent, or refundable security deposits; or

NOTE: Non-refundable security deposits are not to include rental payments.

- b. furnishings or setting up living arrangements that are owned or leased by a waiver provider.

2. One-time transitional services are not available to beneficiaries who are receiving host home services.

3. One-time transitional services are not available to beneficiaries who are moving into a family member's home.

E. The Office for Citizens with Developmental Disabilities shall be the entity responsible for coordinating the delivery of one time transitional services. Providers must have a BHSF (Medicaid) provider enrollment agreement as a transition support provider as verified by Department of Health (LDH) Health Standards Section.

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§16321. Personal Emergency Response System (PERS)

A. Personal emergency response system (PERS) service is an electronic device connected to the beneficiary's phone that enables him or her to secure help in an emergency. The service also includes an option in which the beneficiary would wear a portable help button. The device is programmed to emit a signal to the PERS response center where trained professionals respond to the beneficiary's emergency situation.

B. Beneficiary Qualifications. PERS service is most appropriate for beneficiaries who:

1. are able to identify when they are in an emergency situation and then able to activate the system requesting assistance; and
2. are unable to summon assistance by dialing 911 or other emergency services available to the general public.

C. Coverage of the PERS is limited to the rental of the electronic device. PERS services shall include the cost of maintenance and training the beneficiary to use the equipment.

D. Service Exclusions

1. Separate payment will not be made for shared living services.
2. PERS services are not available to beneficiaries who receive 24-hour direct care supports.

E. Provider Qualifications

1. The provider must be authorized by the manufacturer to install and maintain equipment for personal emergency response systems.
2. Providers must comply with all applicable federal, state, county (parish), and local laws and regulations.
3. Providers must meet manufacturer's specifications, response requirements, maintenance records, and enrollee education.
4. The provider's response center shall be staffed by trained professionals.

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§16323. Prevocational Services

A. Prevocational services are individualized, person centered services that assist beneficiaries in establishing their path to obtain individualized community employment. This service is time limited and targeted for people who have an interest in becoming employed in individual jobs in the

community but who may need additional skills, information, and experiences to determine their employment goal and to become successfully employed. Beneficiaries receiving prevocational services may choose to leave this service at any time or pursue employment opportunities at any time.

B. Prevocational services may be delivered in a combination of these three service types:

1. onsite prevocational services;
2. community career planning; and
3. virtual prevocational services.

C. Prevocational services are to be provided in a variety of locations in the community and are not to be limited to a fixed site facility. Activities associated with prevocational services should focus on preparing the beneficiary for integrated individual employment in the community. These services are operated through a provider agency that is licensed by the appropriate state licensing agency.

D. Beneficiaries receiving prevocational services must participate in activities designed to establish an employment goal. Prevocational services are designed to help create a path to integrated community-based employment for which a beneficiary is compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Prevocational services may include assistance with personal care or with activities of daily living.

E. The prevocational provider is responsible for all transportation between prevocational sites. Transportation may be provided between the beneficiary's residence, or other location as agreed upon by the beneficiary or authorized representative, and the prevocational site. The beneficiary's transportation needs shall be documented in the plan of care.

F. Service Limitations

1. Service limits shall be based on the person centered plan and the beneficiary's ROW budget. Services are delivered in a 15-minute unit of service for up to eight hours per day, one or more days per week. The 15-minute unit of service must be spent at the service site by the beneficiary.

a. Any time less than 15 minutes of service is not billable or payable.

b. No rounding up of units of service is allowed.

2. Prevocational services are not available to individuals who are eligible to participate in programs funded under section 110 of the Rehabilitation Act of 1973 or sections 602(16) and (17) of the Individuals with Disabilities Education Act [20 U.S.C. 1401(26) and (29)] as amended, and those covered under the state plan, if applicable.

3. Prevocational services cannot be billed for at the same time on the same day as other ROW services.

a. community living supports;

- b. professional services, except when there are direct contacts needed in the development of a support plan;
- c. respite—out of home;
- d. adult day healthcare;
- e. monitored-in-home caregiving (MIHC);
- f. day habilitation services; or
- g. supported employment.

4. Prevocational services may otherwise be billed at the same time on the same day as professional services when there are direct contacts needed in the development of a support plan.

5. Transportation is only provided on the day that a prevocational service is provided. Transportation is part of the service except for virtual prevocational services.

a. Time spent in transportation between the beneficiary's residence/location and the prevocational site is not to be included in the total number of prevocational service hours per day, except when the transportation is for the purpose of travel training. Travel training must be included in the beneficiary's plan of care.

b. During travel training, providers must not also bill for the transportation component as this is included in the rate for the number of service hours provided.

c. Transportation-community access services shall not be used for transportation to or from any prevocational services.

G. Restrictions

1. Beneficiaries receiving prevocational services may also receive day habilitation and/or individualized supported employment services, but these services cannot be provided during the same time period or total more than five hours per day combined.

2. All virtual prevocational services must be approved by the local governing entity or the OCDD state office.

H. Provider Qualifications. Providers must be licensed by the Department of Health as a home and community-based services provider and meet the module requirements for adult day care in. LAC 48:I.Chapter 50.

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§16325. Professional Services

A. Professional services are direct services to beneficiaries based on the beneficiary's need, which assist the beneficiary, unpaid caregivers, and/or paid caregivers in carrying out the beneficiary's approved plan and which are necessary to improve the beneficiary's independence and inclusion in his/her community. The beneficiary must be present in order for the professional to bill for services. Professional services include nutritional services, speech therapy, occupational therapy, physical therapy, social work, and psychological services. All services are to be included in the beneficiary's plan of care. The specific service provided to a beneficiary must be within the professional's area of specialty and licensing.

B. Professional services include services provided by the following licensed professionals:

1. occupational therapists;
2. physical therapists;
3. speech therapists;
4. registered dietitians;
5. social workers; and
6. psychologists.

C. Professional services can include:

1. assessments and/or re-assessments specific to the area of specialty with the goal of identifying status and developing recommendations, treatment, and follow-up;

2. providing training to the beneficiary, family, and caregivers with the goal of increased skill acquisition and proficiency;

3. intervening in a crisis situation with the goal of stabilizing and addressing issues related to the cause(s) of the crisis. Activities may include development of support plan(s), training, documentation strategies, counseling, on-call supports; back-up crisis supports, on-going monitoring, and intervention;

4. provide consultative services and recommendations as the need arises;

5. providing information to the beneficiary, family, and caregivers, along with other support team members, to assist in planning, developing, and implementing a beneficiary's plan of care;

6. providing training and counseling services for natural supports and caregivers in a home setting with the goal of developing and maintaining healthy, stable relationships;

a. emphasis is placed on the acquisition of coping skills by building upon family strengths; and

b. services are intended to maximize the emotional and social adjustment and well-being of the individual, family, and caregiver;

7. providing nutritional services, including dietary evaluation and consultation with individuals or their care provider;

a. services are intended to maximize the individual's nutritional health;

8. providing therapy to the beneficiary necessary to the development of critical skills; and

9. assistance in increasing independence, participation, and productivity in the beneficiary home, work, and/or community environments.

NOTE: Psychologists and social workers will provide supports and services consistent with person-centered practices and Guidelines for Support Planning.

D. Service Exclusions

1. Private insurance must be billed and exhausted prior to accessing waiver funds. Professional services may only be furnished and reimbursed through ROW when the services are medically necessary, or have habilitative or remedial benefit to the beneficiary.

2. Children must access and exhaust services through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program prior to accessing waiver funds.

E. Provider Qualifications. The provider of professional services must be a Medicaid-enrolled provider. Each professional must possess a current valid Louisiana license to practice in his/her field and have at least one year of experience post licensure in his/her area of expertise.

1. Enrollment of individual practitioners. Individual practitioners who enroll as providers of professional services must:

a. have a current, valid license from the appropriate governing board of Louisiana for that profession; and

b. have a minimum of one year experience delivering services to persons with developmental disabilities.

c. In addition, the specific service delivered must be consistent with the scope of the license held by the professional.

2. Provider agency enrollment of professional services.

a. The following provider agencies may enroll to provide professional services:

i. a Medicare certified free-standing rehabilitation center;

ii. a licensed home health agency;

iii. a supervised independent living agency licensed by the department to provide shared living services;

iv. a substitute family care agency licensed by the department to provide host home services; or

v. a federally qualified health center (U.S. Department of Health and Human Services, Health

Resources and Services Administration (HRSA) grant recipient or Clinical Laboratory Improvement Amendments (CLIA) certificate holder.

b. Enrolled provider agencies may provide professional services by one of the following methods:

i. employing the professionals; or

ii. contracting with the professionals.

c. Provider agencies are required to verify that all professionals employed by or contracted with their agency meet the same qualifications required for individual practitioners as stated in §16325.E.1.a-c.

3. All professionals delivering professional services must meet the required one year of service delivery experience as defined by the following:

a. full-time experience gained in advanced and accredited training programs (i.e. master's or residency level training programs), which includes treatment services for persons with a developmental disability;

b. paid, full-time professional experience in specialized service/treatment settings for persons with a developmental disability (i.e., intermediate care facilities for persons with a developmental disability);

c. paid, full-time professional experience in multi-disciplinary programs for persons with a developmental disability (i.e., mental health treatment programs for persons with dual diagnosis – mental illness and a developmental disability); or

d. paid, full-time professional experience in specialized educational, vocational, and therapeutic programs or settings for persons with a developmental disability (i.e., school special education program).

NOTE: Two years of part-time experience (minimum of 20 hours per week) may be substituted for one year of full-time experience.

4. The following activities do not qualify for the required experience:

a. volunteer professional experience; or

b. experience gained in caring for a relative or friend with a developmental disability.

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§16327. Respite Care Services—Out of Home

A. Respite care services—out of home are provided on a short-term basis to beneficiaries who are unable to care for themselves due to the absence of, or need for, relief of

caregivers who normally provide care and support. Services are provided by a center-based respite provider.

1. A licensed respite care facility shall insure that community activities are available to the beneficiary in accordance with his approved POC, including transportation to and from these activities.

2. While receiving respite care services, the beneficiary's routine is maintained in order to attend school, school activities or other community activities. Community activities and transportation to and from these activities in which the beneficiary typically engages in are to be available while receiving respite services-out of home.

a. These activities should be included in the beneficiary's approved plan of care. This will provide the beneficiary the opportunity to continue to participate in typical routine activities.

b. Transportation costs to and from these activities are included in the respite services-out of home rate.

B. Service Limits

1. Respite care services are limited to 720 hours per beneficiary, per POC year.

2. The process for approving hours in excess of 720 hours must go through the established approval process with proper justification and documentation.

3. Federal financial participation (FFP) will be claimed for the cost of room and board only if it is provided as part of respite care furnished in a respite center approved by the state that is not a private residence.

C. Service Exclusions

1. Room and board shall be covered only if it is provided as part of respite care furnished in a state-approved facility that is not a private residence.

2. Respite care services-out of home is not a billable waiver service to beneficiary receiving the following services:

- a. community living supports;
- b. companion care;
- c. host home;
- d. shared living; or
- e. monitored in-home caregiving (MIHC).

3. Respite care services-out of home cannot be provided in a personal residence.

4. Payment will not be made for transportation-community access.

D. Provider Qualifications. Providers must be licensed by the Department of Health as a home and community-based services provider and meet the module requirements for center-based respite in LAC 48:I.Chapter 50.

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§16329. Shared Living Services

A. Shared living services are provided to a beneficiary in his/her home and community to achieve, improve, and/or maintain social and adaptive skills necessary to enable the beneficiary to reside in the community and to participate as independently as possible. Services are chosen by the beneficiary and developed in accordance with his/her goals and wishes with regard to compatibility, interests, age and privacy in the shared living setting.

1. A shared living services provider delivers supports which include:

- a. 24-hour staff availability;
- b. assistance with activities of daily living included in the beneficiary's POC;
- c. a daily schedule;
- d. health and welfare needs;
- e. transportation;
- f. any non-residential ROW services delivered by the shared living services provider; and
- g. other responsibilities as required in each beneficiary's POC.

2. Shared living services focus on the beneficiary's preferences and goals.

3. Supports provided are related to the acquisition, improvement, and maintenance in level of independence, autonomy, and adaptive skills and are to be included in each beneficiary's plan of care. This includes:

- a. self-care skills;
- b. adaptive skills; and
- c. leisure skills.

4. The overall goal is to provide the beneficiary the ability to successfully reside with others in the community while sharing supports.

5. Shared living services take into account the compatibility of the beneficiaries sharing services, which includes individual interests, age of the beneficiaries, and the privacy needs of each beneficiary.

a. Each beneficiary's essential personal rights of privacy, dignity and respect, and freedom from coercion are protected.

6. The shared living setting is selected by each beneficiary among all available alternatives and is identified in each beneficiary's plan of care.

a. Each beneficiary has the ability to determine whether or with whom he or she shares a room.

b. Each beneficiary has the freedom of choice regarding daily living experiences, which include meals, visitors, and activities.

c. Each beneficiary is not limited in opportunities to pursue community activities.

7. Shared living services may be shared by up to four beneficiaries who have a common shared living provider agency.

8. Shared living services must be agreed to by each beneficiary and the health and welfare must be able to be assured for each beneficiary.

a. If the person has a legal guardian, the legal guardian's approval must also be obtained.

b. Each beneficiary's plan of care must reflect the shared living services and include the shared rate for the service indicated.

9. The shared living service setting is integrated in, and facilitates each beneficiary's full access to, the greater community, which includes providing beneficiaries with the same opportunities as individuals without disabilities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community.

B. An ICF/IID may elect to permanently relinquish its ICF/IID license and all of its Medicaid facility need review approved beds from the total number of certificate of need (CON) beds for that home and convert it into a shared living waiver home or in combination with other ROW residential options as deemed appropriate in the approved conversion agreement.

1. In order to convert, provider request must be approved by the department and by OCDD.

2. ICF/IID residents who choose transition to a shared living waiver home must also agree to conversion of their residence.

3. If choosing ROW services, persons may select any ROW services and provider(s) based upon freedom of choice.

4. All shared living service beneficiaries are required to have an individualized back-up staffing plan and an individualized emergency evacuation plan which are to be submitted with their plan of care.

5. Shared living services are not located in a building that is a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or disability-specific housing complex. Shared living

services are not provided in settings that are isolated from the larger community.

6. Family members who provide shared living services must meet the same standards as unrelated provider agency staff.

7. Shared living service providers are responsible for providing 24-hour staff availability along with other identified responsibilities as indicated in each beneficiary's individualized plan of care. This includes responsibility for each beneficiary's routine daily schedule, for ensuring the health and welfare of each beneficiary while in his or her place of residence and in the community, and for any other waiver services provided by the shared living services provider.

8. Shared living services may be provided in a residence that is owned or leased by the provider or that is owned or leased by the beneficiary. Services may not be provided in a residence that is owned or leased by any legally responsible relative of the beneficiary. If shared living services are provided in a residence that is owned or leased by the provider, any modification of the conditions must be supported by specific assessed needs and documented in the beneficiary's plan of care. The provider is responsible for the cost of, and implementation of, the modification when the residence is owned or leased by the provider.

9. In a provider-owned or controlled residential setting, the following additional conditions must be met. Any modifications of the conditions must be supported by a specific assessed need and documented in the plan of care:

a. the unit or room is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the beneficiary receiving services, and the beneficiary has, at a minimum, the same responsibilities and protections from eviction that the tenants have under the landlord/tenant laws of the state, parish, city, or other designated entity;

b. each beneficiary has privacy in their sleeping or living unit, which requires the following:

i. units have lockable entrance doors, with appropriate staff having keys to doors;

ii. beneficiaries share units only at the beneficiary's choice; and

iii. beneficiaries have the freedom to furnish and decorate their sleeping or living units;

c. beneficiaries have the freedom and support to control their own schedules and activities, and have access to food at any time;

d. beneficiaries are able to have visitors of their choosing at any time; and

e. the setting is physically accessible to the beneficiary.

C. Shared Living Options

1. Shared Living Conversion Option. The shared living conversion option is only allowed for providers of homes which were previously licensed and Medicaid certified as an ICF/IID for up to a maximum of eight licensed and Medicaid-funded beds on October 1, 2009.

a. The number of beneficiaries for the shared living conversion option shall not exceed the licensed and Medicaid-funded bed capacity of the ICF/IID on October 1, 2009, or up to six individuals, whichever is less.

b. The ICF/IID used for the shared living conversion option must meet the department's operational, programming and quality assurances of health and safety for all beneficiaries.

c. The provider of shared living services is responsible for the overall assurances of health and safety for all beneficiaries.

d. The provider of shared living conversion option may provide nursing services and professional services to beneficiaries utilizing this residential services option.

2. Shared Living Non-Conversion (New) Option. The shared living non-conversion option is allowed only for new or existing ICF/IID providers to establish a shared living waiver home for up to a maximum of three individuals.

a. The shared living waiver home must be located separate and apart from any ICF/IID.

b. The shared living waiver home must be either a home owned or leased by the waiver beneficiaries or a home owned or leased and operated by a licensed shared living provider.

c. The shared living waiver home must meet department's operational, programming and quality assurances for home and community-based services.

d. The shared living provider is responsible for the overall assurances of health and safety for all beneficiaries.

3. ICF/IID providers who convert an ICF/IID to a shared living home via the shared living conversion model must be approved by OCDD and licensed by HSS prior to providing services in this setting, and prior to accepting any ROW beneficiary or applicant for residential or any other developmental disability service(s).

4. An ICF/IID provider who elects to convert to a shared living home via the shared living conversion process shall obtain the approval of all of the residents of the home(s) (or the responsible parties for these residents) regarding the conversion of the ICF/IID prior to beginning the process of conversion.

5. ICF/IID providers who elect to convert to a shared living home via the shared living conversion process shall submit a licensing application for a HCBS provider license, shared living module.

D. Service Exclusions and Limitations

1. Payment does not include room and board or maintenance, upkeep or improvements of the beneficiary's or the provider's property.

2. Payments shall not be made for environmental accessibility adaptations when the provider owns or leases the residence.

3. Beneficiaries may receive one-time transitional services only if the beneficiary owns or leases the home and the service provider is not the owner or landlord of the home.

4. MFP beneficiaries cannot participate in ROW shared living services which serve more than four persons in a single residence.

5. Transportation-community access services cannot be billed or provided for beneficiaries receiving shared living services, as this is a component of shared living services.

6. The following services are not available to beneficiaries receiving shared living services:

- a. community living supports;
- b. respite care services-out of home;
- c. companion care;
- d. host home;
- e. monitored in-home caregiving (MIHC);
- f. transportation-community access; or
- g. environmental accessibility adaptations (if housing is leased or owned by the provider).

7. Shared living services are not available to beneficiary 17 years of age and under.

8. The shared living services rate includes the cost of transportation.

a. The provider is responsible for providing transportation for all community activities except for vocational services.

b. Transportation for vocational services is included in the rate of the vocational service.

9. All Medicaid State Plan nursing services must be utilized and exhausted.

10. Payment will not be made for services provided by a relative who is a:

- a. parent(s) of a minor child;
- b. legal guardian of an adult or child with developmental disabilities;
- c. parent(s) for an adult child regardless of whether or not the adult child has been interdicted; or
- d. spouse of the beneficiary.

11. The shared living staff may not live in the beneficiary's place of residence.

E. **Provider Qualifications.** Providers must be licensed by the Department of Health as a home and community-based services provider and meet the module requirements for supervised independent living and/or supervised independent living-conversion in LAC 48:I.Chapter 50.

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§16333. Support Coordination

A. Support coordination services are provided to all beneficiaries to provide assistance in gaining access to needed waiver services and Medicaid State Plan services, as well as needed medical, social, education, and other services, regardless of the funding source for the services. Support coordination services include assistance with the selection of service providers, development/revision of the plan of care, and monitoring of services.

1. Support coordinators shall be responsible for ongoing monitoring of the provision of services included in the beneficiary's approved POC.

2. Support coordinators shall also participate in the evaluation and re-evaluation of the beneficiary's POC.

3. Support coordination services includes on-going support and assistance to the beneficiary.

B. When beneficiaries choose to self-direct their waiver services, the support shall provide information, assistance, and management of the service being self-directed.

C. Service Limits

1. Support coordination shall not exceed 12 units. A calendar month is a unit. Virtual visits are permitted; however, the initial and annual plan of care meeting and at least one other meeting per year must be conducted face-to-face. When a relative living in the home or a legally responsible individual or legal guardian provides a paid ROW service, all support coordination visits must be conducted face-to-face, with no option for virtual visits.

2. ROW will utilize support coordination for assisting with the moving of individuals from the institutions. Up to 90 consecutive days or per LDH policy, but not to exceed 180 days will be allowed for transition purposes.

a. Payment will be made upon certification and may be retroactive no more than 90 days or per LDH policy, but not to exceed 180 days prior to the certification date.

3. OCDD supports and services centers are prohibited from providing case management/support coordination services in the ROW.

D. **Provider Qualifications.** Providers must have a current, valid license as a case management agency and meet all other requirements for targeted case management services as set forth in case management, LAC 48:I.Chapter 49.

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§16335. Supported Employment

A. Supported employment services consist of intensive, ongoing supports and services necessary for a beneficiary to achieve the desired outcome of employment in a community setting where a majority of the persons employed are without disabilities. Beneficiaries utilizing these services may need long-term supports for the life of their employment due to the nature of their disability, and natural supports may not meet this need.

B. Supported employment services provide supports in the following areas:

1. individual job placement, group employment, or self-employment;
2. job assessment, discovery, and development; and
3. initial job support and job retention.

C. When supported employment services are provided at a work site where a majority of the persons employed are without disabilities, payment is made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, but payment will not be made for the supervisory activities rendered as a normal part of the business setting.

D. The provider is responsible for all transportation to all work sites related to the provision of services in group employment. Transportation to and from the service site is offered and billable as a component of the supported employment service.

1. Transportation is payable only when a supported employment service is provided on the same day.

2. Time spent in transportation to and from the program shall not be included in the total number of supported employment services hours provided per day.

E. These services are also available to those beneficiaries who are self-employed. Funds for self-employment may not be used to defray any expenses associated with setting up or operating a business.

F. Supported employment services may be furnished by a coworker or other job-site personnel under the following circumstances:

1. the services furnished are not part of the normal duties of the coworker or other job-site personnel; and

2. these individuals meet the pertinent qualifications for the providers of service.

G. **Service Limits.** Beneficiaries may receive more than one type of vocational or habilitation service per day as long as the billing criteria is followed and as long as the requirements for the minimum time spent on site are adhered to. The required minimum number of service hours per day, per beneficiary are as follows.

1. Individual supported employment services—one hour (four units). One-on-one services shall be billed in quarterly hour units and shall be based on the person centered plan and the beneficiary's ROW budget.

2. Services that assist a beneficiary to develop and operate a micro-enterprise—one hour (four units). One-on-one services shall be billed in quarterly hour units and shall be based on the person centered plan and the beneficiary's ROW budget.

3. Group employment services shall be billed in quarterly hour units of service up to eight hours per day and shall be based on the person centered plan and the beneficiary's ROW budget.

4. Individual job follow-along services may be delivered virtually.

H. **Service Exclusions and Restrictions.** Beneficiaries receiving individual supported employment services may also receive prevocational, day habilitation, or group supported employment services. However, these services cannot be provided during the same service hours on the same day.

1. Payment will only be made for the adaptations, supervision and training required by individuals receiving waiver services, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

2. Supportive employment cannot be billed for the same time as any other ROW services.

3. Any time less than the minimum 15 minute unit of service is provided for any model is not billable or payable. No rounding up of service units is allowed.

4. Time spent in transportation to and from the program shall not be included in the total number of services hours provided per day.

a. Travel training for the purpose of teaching the beneficiary how to use transportation services may be included in determining the total service numbers hours provided per day, but only for the period of time specified in the POC.

b. Transportation is payable only when a supported employment service is provided on the same day.

5. All virtual supported employment services must be approved by the local governing entity or the OCDD state office.

6. Supported employment services are not available to individuals who are eligible to participate in services that are available from programs funded under section 110 of the Rehabilitation Act of 1973 or sections 602(16) or (17) of the Individuals with Disabilities Education Act [20 U.S.C. 1401 (26) and (29)] and those covered under the state plan, if applicable.

I. **Provider Qualifications.** The provider must possess a valid certificate of compliance as a community rehabilitation provider (CRP) from an approved program or the certification and training as required.

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 for Citizens with Developmental Disabilities, LR 33:2453 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2166 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1767 (December 2019), LR 47:1521 (October 2021), LR 48:1569 (June 2022).

§16337. Transportation-Community Access

A. Transportation-community access services are provided to assist the beneficiary in becoming involved in his or her community. The service encourages and fosters the developmental of meaningful relationships in the community which reflects the beneficiary's choice and values. This service provides the beneficiary with a means of access to community activities and resources. The goal is to increase the beneficiary's independence, productivity, and community inclusion and to support self-directed employees benefits as outlined in the beneficiary's POC.

1. Transportation-community access services are to be included in the beneficiary's plan of care.

2. The beneficiary must be present for the service to be billed.

3. Prior to accessing transportation-community access services, the beneficiary is to utilize free transportation provided by family, friends, and community agencies.

4. When appropriate, the beneficiary should access public transportation or the most cost-effective method of transportation prior to accessing transportation-community access services.

B. Service Limits

1. Community access trips are limited to no more than three round trips per day and must be arranged for geographic efficiency.

2. Greater than three trips per day require approval from the department or its designee.

C. Service Exclusions

1. Transportation-community access services shall not replace the following services:

- a. transportation services to medically necessary services under the Medicaid State Plan;
- b. transportation services provided as a means to get to and from school; or
- c. transportation services to or from day habilitation, prevocational services, or supported employment services.

2. Transportation-community access services are not available to beneficiaries receiving the following services:

- a. shared living;
- b. host home; or
- c. companion care.

3. Transportation-community access will not be used to transport beneficiaries to day habilitation, pre-vocational, or supported employment services.

4. Transportation-community access services may not be billed for the same day at the same time as community living supports.

D. Provider Qualifications. Friends and family members who furnish transportation-community access services to waiver beneficiaries must be enrolled as Medicaid non-emergency medical transportation (NEMT) family and friends providers with the Department of Health (Bureau of Health Services Financing).

1. In order to receive reimbursement for transporting Medicaid recipients to waiver services, family and friends must maintain compliance with the following:

- a. state minimum automobile liability insurance coverage;
- b. possess a current state inspection sticker; and
- c. possess a current valid driver's license.

2. No special inspection by the Medicaid agency will be conducted.

3. Documentation of compliance with the three listed requirements for this class of provider must be submitted when enrollment in the Medicaid agency is sought. Acceptable documentation shall be the signed statement of the individual enrolling for payment that all three requirements are met.

a. The statement must also have the signature of two witnesses.

4. NEMT (family and friends transportation) providers may provide for up to three identified waiver beneficiaries.

E. Vehicle Requirements. All vehicles utilized by for profit and non-profit transportation services providers for transporting waiver beneficiaries must comply with all of the

applicable state laws and regulations and are subject to inspection by the department or its designee.

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 for Citizens with Developmental Disabilities, LR 33:2454 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2166 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1768 (December 2019), LR 47:1523 (October 2021), LR 48:1570 (June 2022).

§16339. Housing Stabilization Transition Services

A. Housing stabilization transition services enable beneficiaries who are transitioning into a permanent supportive housing unit, including those transitioning from institutions, to secure their own housing. This service is provided while the beneficiary is in an institution and preparing to exit the institution using the waiver. The service includes the following components:

1. conducting a housing assessment to identify the beneficiary's preferences related to housing (i.e., type, location, living alone or with someone else, accommodations needed, and other important preferences), and his/her needs for support to maintain housing, including:

- a. access to housing;
- b. meeting the terms of a lease;
- c. eviction prevention;
- d. budgeting for housing/living expenses;
- e. obtaining/accessing sources of income necessary for rent;
- f. home management;
- g. establishing credit; and
- h. understanding and meeting the obligations of tenancy as defined in the lease terms;

2. assisting a beneficiary to view and secure housing, as needed. This may include the following:

- a. arranging or providing transportation;
- b. assisting in securing supporting documents/records;
- c. completing/submitting applications;
- d. securing deposits; and
- e. locating furnishings;

3. developing an individualized housing support plan, based upon the housing assessment, that:

- a. includes short- and long-term measurable goals for each issue;

b. establishes the beneficiary's approach to meeting the goal; and

c. identifies where other provider(s) or services may be required to meet the goal;

4. participating in the development of the plan of care and incorporating elements of the housing support plan; and

5. exploring alternatives to housing if permanent supportive housing is unavailable to support completion of transition.

B. This service is only available to beneficiaries upon referral from the support coordinator, and is not duplicative of other waiver services, including support coordination.

1. beneficiaries must be residing in a state of Louisiana permanent supportive housing unit; or

2. beneficiaries must be linked for the state of Louisiana permanent supportive housing selection process.

C. Beneficiaries are limited to receiving no more than 165 combined units of this service and the housing stabilization transition service. This limit on combined units can only be exceeded with written approval from OCDD.

D. Provider Qualifications. The permanent supportive housing (PSH) agency must be under contract and enrolled with the Department of Health statewide management organization for behavioral health services, and must also either:

1. meet the requirements for completion of the training program as verified by the PSH director; or

2. have at least one year of completion of housing support team experience in the PSH program as verified by the PSH director.

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 for Citizens with Developmental Disabilities, LR 41:2169 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1523 (October 2021), LR 48:1570 (June 2022).

§16341. Housing Stabilization Services

A. Housing stabilization services enable waiver beneficiaries to maintain their own housing as set forth in the approved plan of care. Services must be provided in the home or a community setting. Housing stabilization services include the following components:

1. conducting a housing assessment identifying the beneficiary's preferences related to housing (type, location, living alone or with someone else, accommodations needed, and other important preferences), and needs for support to maintain housing, including:

a. access to housing;

b. meeting the terms of a lease;

c. eviction prevention;

d. budgeting for housing/living expenses;

e. obtaining/accessing sources of income necessary for rent;

f. home management;

g. establishing credit; and

h. understanding and meeting the obligations of tenancy as defined in the lease terms;

2. assisting a beneficiary to view and secure housing, as needed and may include the following:

a. arranging or providing transportation;

b. assisting in securing supporting documents/records;

c. completing/submitting applications;

d. securing deposits; and

e. locating furnishings;

3. developing an individualized housing stabilization service provider plan, based upon the housing assessment, that:

a. includes short- and long-term measurable goals for each issue;

b. establishes the beneficiary's approach to meeting the goal; and

c. identifies where other provider(s) or services may be required to meet the goal;

4. participating in the development of the plan of care, incorporating elements of the housing stabilization service provider plan, and in plan of care renewal and updates, as needed;

5. providing supports and interventions according to the individualized housing stabilization service provider plan. If additional supports or services are identified as needed outside of the scope of housing stabilization services, the needs must be communicated to the support coordinator;

6. providing ongoing communication with the landlord or property manager regarding:

a. the beneficiary's disability;

b. accommodations needed; and

c. components of emergency procedures involving the landlord or property manager; and

7. if at any time the beneficiary's housing is placed at risk (i.e., eviction, loss of roommate or income), housing stabilization services will provide supports to retain housing or locate and secure housing to continue community-based supports, including locating new housing, sources of income, etc.

B. This service is only available upon referral from the support coordinator, and is not duplicative of other waiver services, including support coordination.

1. beneficiaries must be residing in a state of Louisiana permanent supportive housing unit; or

2. beneficiaries must be linked for the state of Louisiana permanent supportive housing selection process.

C. Beneficiaries are limited to receiving no more than 165 combined units of this service and the housing stabilization transition service. This limit on combined units can only be exceeded with written approval from OCDD.

D. Provider Qualifications. The permanent supportive housing (PSH) agency must be under contract and enrolled with the Department of Health and statewide management organization for behavioral health services, and must also either:

1. meet the requirements for completion of the training program as verified by the PSH director; or

2. have at least one year of completion of housing support team experience in the PSH program as verified by the PSH director.

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 for Citizens with Developmental Disabilities, LR 41:2170 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1524 (October 2021), LR 48:1570 (June 2022).

§16343. Adult Day Health Care Services

A. Adult day health care (ADHC) services shall be furnished as specified in the POC and at an ADHC facility in a non-institutional, community-based setting encompassing both health/medical, and social services needed to ensure the optimal functioning of the beneficiary.

B. ADHC services include those core service requirements identified in the ADHC licensing standards (LAC 48:I.4243), in addition to the following:

1. medical care management;
2. transportation between the beneficiary's place of residence and the ADHC (if the beneficiary is accompanied by the ADHC staff) in accordance with licensing standards;
3. assistance with activities of daily living;
4. health and nutrition counseling;
5. an individualized exercise program;
6. an individualized goal-directed recreation program;
7. health education classes;
8. individualized health/nursing services; and

9. meals. Meals shall not constitute a full nutritional regimen (three meals per day), but shall include a minimum of two snacks and a hot, nutritious lunch per day.

C. The number of people included in the service per day depends on the licensed capacity and attendance at each facility. The average capacity per facility is 49 beneficiaries.

D. Nurses shall be involved in the beneficiary's service delivery as specified in the plan of care (POC) or as needed. Each beneficiary has a plan of care from which the ADHC shall develop an individualized service plan based on the beneficiary's POC. If the individualized service plan calls for certain health and nursing services, the nurse on staff shall ensure that the services are delivered while the beneficiary is at the ADHC facility.

E. ADHC services shall be provided no more than 10 hours per day and no more than 50 hours per week.

F. The following services are not available to ADHC recipients:

1. monitored in-home caregiving (MIHC).

G. Provider Qualifications:

1. ADHC providers must be licensed according to the adult day health care provide licensing requirements contained in the Revised Statutes (R.S. 40:2120.41-40:2120.47).

2. ADHC providers must be enrolled as a Medicaid ADHC provider.

3. ADHC providers must comply with LDH rules and regulations.

4. Qualifications for ADHC center staff are set forth in the *Louisiana Administrative Code*.

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 for Citizens with Developmental Disabilities, LR 42:62 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:1768 (December 2019), LR 47:1524 (October 2021), LR 48:1571 (June 2022).

§16345. Monitored In-Home Caregiving Services

A. Monitored in-home caregiving (MIHC) services are provided to a beneficiary living in a private home with a principal caregiver. The principal caregiver shall be contracted by the licensed HCBS provider having a MIHC service module. The principal caregiver shall reside with the beneficiary. Professional staff employed by the HCBS provider shall provide oversight, support and monitoring of the principal caregiver, service delivery, and beneficiary outcomes through on-site visits, training, and daily web-based electronic information exchange.

1. The goal of this service is to provide a community-based option that provides continuous care, supports, and professional oversight.

2. This goal is achieved by promoting a cooperative relationship between a beneficiary, a principal caregiver, the professional staff of a monitored in-home caregiver agency provider, and the beneficiary support coordinator.

B. The principal caregiver is responsible for supporting the beneficiary to maximize the highest level of independence possible by providing necessary care and supports that may include:

1. supervision or assistance in performing activities of daily living;
2. supervision or assistance in performing instrumental activities of daily living;
3. protective supervision provided solely to assure the health and welfare of a beneficiary;
4. supervision or assistance with health related tasks (any health related procedures governed under the Nurse Practice Act) in accordance with applicable laws governing the delegation of medical tasks/medication administration;
5. supervision or assistance while escorting or accompanying the individual outside of the home to perform tasks, including instrumental activities of daily living, health maintenance or other needs as identified in the plan of care and to provide the same supervision or assistance as would be rendered in the home; and
6. extension of therapy services to maximize independence when the caregiver has been instructed in the performance of the activities by a licensed therapist or registered nurse.

C. Service Exclusions and Restrictions

1. Beneficiaries electing monitored in-home caregiving are not eligible to receive the following Residential Options Waiver services during the period of time that the beneficiaries are receiving monitored in-home caregiving services:

- a. community living supports (CLS);
- b. companion care supports;
- c. host home;
- d. shared living supports; and
- e. adult day health care services.

D. Monitored in-home caregiving: providers must be agency providers who employ professional nursing staff, including a registered nurse and a care manager, and other professionals to train and support principal caregivers to perform the direct care activities performed in the home.

1. The agency provider must assess and approve the home in which services will be provided, and enter into contractual agreements with caregivers whom the agency has approved and trained.

2. The agency provider will pay per diem stipends to caregivers.

3. The agency provider must capture daily notes electronically and use the information collected to monitor beneficiary health and caregiver performance.

4. The agency provider must make such notes available to support coordinators and the state, upon request.

E. The MIHC provider must use secure, web-based information collection from principal caregivers for the purposes of monitoring beneficiary health and caregiver performance. All protected health information must be transferred, stored, and otherwise utilized in compliance with applicable federal and state privacy laws. Providers must sign, maintain on file, and comply with the LDH HIPAA business associate addendum.

F. The department shall reimburse for monitored in-home caregiving services based on a two-tiered model which is designed to address the beneficiary's acuity.

G. Provider Qualifications

1. MIHC providers must be licensed according to the home and community based service provider licensing requirements contained in the R.S. 40:2120.2-2121.9.

2. MIHC providers must enroll as a Medicaid monitored in-home caregiving provider.

3. MIHC providers must comply with LDH rules and regulations.

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 45:1768 (December 2019), amended LR 47:1525 (October 2021), LR 48:1571 (June 2022).

Chapter 165. Self-Direction Initiative

§16501. Self-Direction Service Option

A. Self-direction is a service delivery option which allows beneficiaries (or their authorized representative) to exercise employer authority in the delivery of their authorized self-directed services (community living supports).

1. Beneficiaries are informed of all available services and service delivery options, including self-direction, at the time of the initial assessment, annually, or as requested by beneficiaries or their authorized representative. Beneficiaries, who are interested in self-direction, need only notify their support coordinator, who will facilitate the enrollment process.

2. A contracted fiscal/employer agent is responsible for processing the beneficiary's employer-related payroll, withholding and depositing the required employment-related taxes, and sending payroll reports to the beneficiary or his/her authorized representative.

3. Support coordinators assist beneficiaries by providing the following activities:

- a. the development of the beneficiary's plan of care;

- b. organizing the unique resources the beneficiary needs;
- c. training beneficiaries on their employer responsibilities;
- d. completing required forms for participation in self-direction;
- e. back-up service planning;
- f. budget planning;
- g. verifying that potential employees meet program qualifications; and
- h. ensuring beneficiary's needs are being met through services.

B. **Beneficiary Eligibility.** Selection of the self-direction option is strictly voluntary. To be eligible to participate in the self-direction service option, waiver beneficiaries must:

- 1. be able to participate in the self-direction option without a lapse in or decline in quality of care or an increased risk to health and welfare;
- 2. complete the training programs (e.g., initial enrollment training) designated by OCDD; and
- 3. understand the rights, risks, and responsibilities of managing his or her own care and effectively managing his or her plan of care.

NOTE: If the waiver beneficiary is unable to make decisions independently, the beneficiary must have a willing decision maker (an authorized representative as listed on the beneficiary's plan of care) who understands the rights, risks, and responsibilities of managing the care and supports of the beneficiary within the plan of care.

C. **Beneficiary Responsibilities.** Responsibilities of the waiver beneficiary or his or her authorized representative include the following:

- 1. Beneficiaries must adhere to the health and welfare safeguards identified by the support team, including the following:
 - a. the application of a comprehensive monitoring strategy and risk assessment and management system; and
 - b. compliance with the requirement that employees under this option must have criminal background checks prior to working with waiver beneficiaries.
- 2. Waiver beneficiary's participation in the development and management of the approved personal purchasing plan.
 - a. This annual budget is determined by the recommended service hours listed in the beneficiary's POC to meet his needs.
 - b. The beneficiary's individual budget includes a potential amount of dollars within which the beneficiary, or his/her authorized representative, exercises decision-making responsibility concerning the selection of services and service providers.

3. Beneficiaries are informed of the self-direction option at the time of the initial assessment, annually, or as requested by beneficiaries or their authorized representative. If the beneficiary is interested, the support coordinator will provide more information on the principles of self-determination, the services that can be self-directed, the roles and responsibilities of each service option, the benefits and risks of each service option, and the process for enrolling in self-direction.

4. Prior to enrolling in self-direction, the beneficiary or his/her authorized representative is trained by the support coordinator on the process for completing the following duties:

- a. best practices in recruiting, hiring, training, and supervising staff;
- b. determining and verifying staff qualifications;
- c. the process for obtaining criminal background checks on staff;
- d. determining the duties of staff based on the service specifications;
- e. determining the wages for staff within the limits set by the state;
- f. scheduling staff and determining the number of staff needed;
- g. orienting and instructing staff in duties;
- h. best practices for evaluating staff performance;
- i. verifying time worked by staff and approving timesheets;
- j. terminating staff, as necessary;
- k. emergency preparedness planning; and
- l. back-up planning.

5. This training also includes a discussion on the differences between self-direction and other service delivery options (which includes the benefits, risks, and responsibilities associated with each service option) and the roles and responsibilities of the employer, support coordinator, and fiscal/employer agent.

6. Beneficiaries who choose self-direction verify that they have received the required training by signing the service agreement form.

7. Authorized representatives may be the employer in the self-directed option but may not also be the employee.

D. **Termination of Self-Direction Service Option.** Termination of participation in the self-direction service option requires a revision of the POC, the elimination of the fiscal agent and the selection of the Medicaid-enrolled waiver service provider(s) of choice.

1. **Voluntary Termination.** The waiver beneficiary may choose at any time to withdraw from the self-direction service option and return to the traditional provider agency management of services.

a. Proper arrangements will be made by the support coordinator to ensure that there is no lapse in services.

b. Should the request for voluntary withdrawal occur, the beneficiary will receive counseling and assistance from his or her support coordinator immediately upon identification of issues or concerns in any of the above situations.

2. Involuntary Termination. The department may terminate the self-direction service option for a beneficiary and require him or her to receive provider-managed services under the following circumstances:

a. the beneficiary does not receive self-directed services for 90 days or more;

b. the health, safety, or welfare of the beneficiary is compromised by continued participation in the self-direction service option;

c. the beneficiary is no longer able to direct his own care and there is no responsible representative to direct the care;

d. there is misuse of public funds by the beneficiary or the authorized representative;

e. over three payment cycles in the period of a year, the beneficiary or authorized representative:

i. permits employees to work over the hours approved in the beneficiary's plan of care or allowed by the participant's program;

ii. places barriers to the payment of the salaries and related state and federal payroll taxes of direct support staff;

iii. fails to follow the personal purchasing plan and the POC;

iv. fails to provide required documentation of expenditures and related items; or

v. fails to cooperate with the fiscal agent or support coordinator in preparing any additional documentation of expenditures; or

f. the beneficiary or the authorized representative consistently violates Medicaid program rules or guidelines of the self-direction option.

3. When action is taken to terminate a beneficiary from self-direction involuntarily, the support coordinator immediately assists the beneficiary in accessing needed and appropriate services through the ROW and other available programs, ensuring that no lapse in necessary services occurs for which the beneficiary is eligible. There is no denial of services, only the transition to a different payment option. The beneficiary and support coordinator are provided with a written notice explaining the reason for the action and citing the policy reference.

E. Employees of beneficiaries in the self-direction service option are not employees of the fiscal agent or the department.

1. Employee Qualifications. All employees under the self-direction option must meet the qualifications for furnishing personal care services as set forth in LAC 48:I.Chapter 92.

F. Relief coverage for scheduled or unscheduled absences, which are not classified as respite care services, can be covered by other participant-directed providers and the terms can be part of the agreement between the beneficiary and the primary companion care provider.

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 for Citizens with Developmental Disabilities, LR 33:2455 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2167 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1525 (October 2021), LR 48:1572 (June 2022), LR 49:1727 (October 2023).

Chapter 167. Provider Participation

§16701. General Provisions

A. In order to participate in the Medicaid Program as a provider of services in the Residential Options Waiver, a provider must:

1. meet all of the requirements for licensure and the standards for participation in the Medicaid Program as a home and community-based services provider in accordance with state laws and the rules promulgated by the department;

2. comply with the regulations and requirements specified in LAC 50:XXI, Subparts 1 and 13 and the ROW provider manual;

3. comply with all of the state laws and regulations for conducting business in Louisiana, and when applicable, with the state requirements for designation as a non-profit organization; and

4. comply with all of the training requirements for providers of waiver services.

B. Providers must maintain adequate documentation to support service delivery and compliance with the approved POC and provide said documentation upon the department's request.

C. In order for a provider to bill for services, the waiver beneficiary and the direct service worker or professional services practitioner rendering service must be present at the time the service is rendered.

1. Exception. The following services may be provided when the beneficiary is not present:

- a. environmental accessibility adaptations;
- b. personal emergency response systems; and
- c. one-time transitional services.

2. All services must be documented in service notes which describe the services rendered and progress towards the beneficiary's personal outcomes and his POC.

D. If transportation is provided as part of a waiver service, the provider must comply with all of the state laws and regulations applicable to vehicles and drivers.

E. All services rendered shall be prior approved and in accordance with the POC.

F. Some ROW services may be provided by a member of the beneficiary's family, provided that the family member meets all the requirements of a non-family direct support worker and provision of care by a family member is in the best interest of the beneficiary.

1. Payment for services rendered are approved by prior and post authorization as outlined in the POC.

2. Payments to legally responsible individuals, legal guardians, and family members living in the home shall be audited on a semi-annual basis to ensure payment for services rendered.

G. Providers of ADHC services must:

1. be licensed as ADHC providers by the state of Louisiana in accordance with R.S. 40:2120.41-2120.47;

2. comply with all of the department's rules and regulations; and

3. be enrolled as an ADHC provider with the Medicaid program.

a. ADHC facility staff shall meet the requirements of department rules and regulations, as well as state licensing provisions.

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 for Citizens with Developmental Disabilities, LR 33:2455 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2168 (October 2015), LR 42:63 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1527 (October 2021), LR 48:1573 (June 2022).

§16703. Staffing Restrictions and Requirements

A. Legally responsible individuals may only be paid for services when the care is extraordinary in comparison to that of a beneficiary of the same age without a disability and the care is in the best interest of the beneficiary.

B. In order to receive payment, relatives must meet the criteria for the provision of the service and the same provider qualifications specified for the service as other providers not related to the beneficiary.

1. Relatives must also comply with the following requirements:

a. become an employee of the beneficiary's agency of choice and meet the same standards as direct support staff who are not related to the individual;

b. become a Medicaid enrolled provider agency; or

c. if the self-direction option is selected, relatives must:

i. become an employee of the self-direction beneficiary; and

ii. have a Medicaid provider agreement executed by the fiscal agent as authorized by the Medicaid agency.

2. Family members who may provide services include:

a. parents of an adult child;

b. siblings;

c. grandparents;

d. aunts, and uncles; and

e. cousins.

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 for Citizens with Developmental Disabilities, LR 41:2168 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1527 (October 2021), LR 48:1573 (June 2022).

§16705. Electronic Visit Verification

A. Effective for dates of service on or after July 1, 2015, Residential Options Waiver providers shall use the electronic visit verification (EVV) system designated by the department for automated scheduling, time and attendance tracking, and billing for certain home and community-based services.

B. Reimbursement shall only be made to providers with documented use of the EVV system. The services that require use of the EVV system will be published in the ROW provider manual.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:1287 (July 2015).

Chapter 169. Reimbursement

§16901. Unit of Reimbursement

A. Reimbursement for the following services shall be a prospective flat rate for each approved unit of service provided to the waiver beneficiary. One quarter hour (15 minutes) is the standard unit of service and reimbursement shall not be made for less than one quarter hour of service. This covers both the service provision and administrative costs for these services:

1. respite care;
2. housing stabilization transition;
3. housing stabilization;
4. community living supports (CLS);
 - a. up to three beneficiaries may share CLS services if they share a common provider of this service;
 - b. there is a separate reimbursement rate for CLS when these services are shared;
5. professional services furnished by a/an:
 - a. psychologist;
 - b. speech therapist;
 - c. physical therapist;
 - d. occupational therapist;
 - e. social worker;
 - f. registered dietician;
6. supported employment;
 - a. individual placement;
 - b. micro-enterprise;
7. adult day health care;
8. pre-vocational service; and
9. day habilitation.

EXCEPTION: The reimbursement for support coordination shall be at a fixed monthly rate and in accordance with the terms of the established contract.

B. The following services are reimbursed at the cost of adaptation device, equipment or supply item:

1. environmental accessibility adaptations; and
 - a. Upon completion of the environmental accessibility adaptations and prior to submission of a claim for reimbursement, the provider shall give the beneficiary a certificate of warranty for all labor and installation work and supply the beneficiary with all manufacturers' warranty certificates.
2. assistive technology/specialized medical equipment and supplies.

C. The following services are reimbursed at a per diem rate:

1. host home;
2. companion care services;
3. shared living services;
 - a. per diem rates are established based on the number of individuals sharing the living service module for both shared living non-conversion and shared living conversion services; and
4. monitored in-home caregiving services.

a. The per diem rate for monitored in-home caregiving services does not include payment for room and board, and federal financial participation is not claimed for room and board.

D. The reimbursement for transportation services is a flat fee based on a capitated rate.

E. Nursing services are reimbursed at either an hourly or per visit rate for the allowable procedure codes.

F. Installation of a personal emergency response system (PERS) is reimbursed at a one-time fixed rate and maintenance of the PERS is reimbursed at a monthly rate.

G. Transition expenses from an ICF/IID or nursing facility to a community living setting are reimbursed at the cost of the service(s) up to a lifetime maximum rate of \$3,000.

H. Dental Services. Dental services are reimbursed according to the LA Dental Benefit Program.

I. The assessment performed by the monitored in-home caregiving provider shall be reimbursed at the authorized rate or approved amount of the assessment when the service has been prior authorized by the plan of care.

J. Reimbursement Exclusion. No payment will be made for room and board under this waiver program.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2456 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:1049 (April 2013), LR 41:2168, 2170 (October 2015), LR 42:63 (January 2016), LR 42:900 (June 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2530 (December 2017), LR 45:1769 (December 2019), LR 47:1527 (October 2021), LR 48:1573 (June 2022).

§16903. Direct Service Worker Wages and Bonus Payments

A. Establishment of Direct Service Worker Wage Floor for Medicaid Home and Community-Based Services for Intellectual and Developmental Disabilities

1. Effective October 1, 2021, providers of Medicaid home and community-based waiver services operated through the Office for Citizens with Developmental Disabilities employing direct service workers will receive the equivalent of a \$2.50 per hour rate increase.

2. Effective October 1, 2021, this increase or its equivalent will be applied to all service units provided by direct service workers with an effective date of service for the identified home and community based waiver services provided beginning October 1, 2021.

3. The minimum hourly wage floor paid to direct service workers shall be \$9 per hour.

4. All providers of services affected by this rate increase shall be subject to a direct service worker wage floor of \$9 per hour. This wage floor is effective for all affected direct service workers of any work status, whether full-time or part-time.

5. The Department of Health reserves the right to adjust the direct service worker wage floor as needed through appropriate rulemaking promulgation consistent with the Louisiana Administrative Procedure Act.

B. Establishment of Direct Service Worker Workforce Bonus Payments

1. Providers who provided services from April 1, 2021 to October 31, 2022 shall receive bonus payments of \$300 per month for each direct service worker that worked with participants for those months.

2. The direct service worker 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 provider. This bonus payment is effective for all eligible direct service workers of any working status, whether full-time or part-time.

3. Bonus payments will end October 31, 2022.

4. LDH reserves the right to adjust the amount of the bonus payments paid to the direct service worker as needed through appropriate rulemaking promulgation consistent with the Administrative Procedure Act.

C. Audit Procedures for Direct Service Worker Wage Floor and Workforce Bonus Payments

1. The wage enhancement and bonus payments reimbursed to providers shall be subject to audit by LDH.

2. Providers shall provide to LDH or its representative all requested documentation to verify that they are in compliance with the direct service worker wage floor and bonus payments.

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

4. Providers shall produce the requested documentation upon request and within the timeframe provided by LDH.

5. Non-compliance or failure to demonstrate that the wage enhancement and/or bonus payments were paid directly to direct service workers may result in the following:

- a. sanctions; or
- b. disenrollment from the Medicaid Program.

D. Sanctions for Direct Service Worker Wage Floor and Workforce Bonus Payments

1. The provider will be subject to sanctions or penalties for failure to comply with this Rule or with requests issued by LDH pursuant to this Rule. The severity of such action will depend upon the following factors:

- a. Direct Service Worker Wage Floor
 - i. failure to pay I/DD HCBS direct service workers the wage floor minimum of \$9 per hour;
 - ii. the number of I/DD HCBS direct service workers identified as having been paid less than the wage floor minimum of \$9 per hour; or
 - iii. the persistent failure to pay I/DD HCBS direct service workers the wage floor minimum of \$9 per hour;
- b. Direct Service Worker Workforce Bonus Payments
 - i. failure to pay eligible I/DD HCBS direct service workers the \$250 monthly workforce bonus payments;
 - ii. the number of eligible I/DD HCBS direct service workers who are identified as having not been paid the \$250 monthly workforce bonus payments; or
 - iii. the persistent failure to pay wage eligible I/DD HCBS direct service workers the \$250 monthly workforce bonus payments; or
- c. 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 and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2456 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2169 (October 2015), LR 42:900 (June 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities LR 48:42R (January 2022), LR 49:1071 (June 2023).

§16905. Support Coordination

A. Establishment of Support Coordination Workforce Bonus Payments

1. Support coordination providers who provided services from April 1, 2021 to October 31, 2022 shall receive bonus payments of \$300 per month for those months for each support coordination worker that worked with participants for those months.

2. The support coordination worker that worked with participants from April 1, 2021 to October 31, 2022 must receive at least \$250 of this \$300 bonus payment paid to the provider. This bonus payment is effective for all eligible support coordination workers of any working status, whether full-time or part-time.

B. Audit Procedures for Support Coordination Workforce Bonus Payments

1. The bonus payments reimbursed to support coordination providers shall be subject to audit by LDH.

2. Support coordination providers shall provide to LDH or its representative all requested documentation to

verify that they are in compliance with the support coordination bonus payments.

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

4. Support coordination providers shall produce the requested documentation upon request and within the timeframe provided by the LDH.

5. Noncompliance or failure to demonstrate that the bonus payments were paid directly to support coordination workers may result in the following:

- a. sanctions; or
- b. disenrollment from the Medicaid Program.

C. Sanctions for Support Coordination Workforce Bonus Payments

1. The support coordination provider will be subject to sanctions or penalties for failure to comply with this Rule or with requests issued by LDH pursuant to this Rule. The

severity of such action will depend upon the following factors:

a. failure to pay support coordination workers the \$250 monthly workforce bonus payments;

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

c. the persistent failure to pay the \$250 monthly workforce 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 and the Office for Citizens with Developmental Disabilities, LR 49:1072 (June 2023).

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXII. 1115 Demonstration Waivers
Subparts 1. - 3. Reserved

Subpart 5. Louisiana Hurricane Relief Waiver

Chapter 41. General Provisions

§4101. Purpose

A. As a result of the devastation caused by Hurricanes Katrina and Rita, many Louisiana health care providers have incurred costs in furnishing medical services and supplies to hurricane evacuees and other affected individuals who do not have health care coverage through insurance or any other financial mechanism. The purpose of the uncompensated care costs (UCC) pool is to provide reimbursement to health care providers through federal financial participation for services rendered for which there is no other source of payment.

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 32:1903 (October 2006).

Chapter 43. Eligible Populations

§4301. Definitions

Affected Individual—an individual who resided in a designated individual assistance county or parish pursuant to section 408 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, as declared by the President as a result of Hurricanes Katrina and Rita, and continues to reside in the same state where such county or parish is located.

Evacuee—an affected individual who has been displaced to another state.

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 32:1903 (October 2006).

§4303. Eligibility Requirements

A. In order to qualify as a member of the eligible population, an individual must be either a United States citizen or a legal alien who resided in a designated individual assistance county or parish for Hurricane Katrina or Hurricane Rita as declared by the President.

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 32:1903 (October 2006).

Chapter 45. Covered Services

§4501. Medicaid State Plan Services

A. Reimbursement is available through the UCC pool for the following services covered under the Louisiana Medicaid State Plan:

1. inpatient and outpatient hospital services, including ancillary services;
2. physician services (inpatient and outpatient);
3. mental health clinic services;
4. inpatient psychiatric services (free-standing psychiatric hospitals and distinct part psychiatric units);
5. emergency ambulance services;
6. home health services;
 - a. coverage of durable medical equipment and supplies is limited to emergency items;
7. nursing facility services;
8. pharmacy services;
9. laboratory services;
10. x-ray services;
11. hemodialysis services;
12. hospice services;
13. rural health clinic services; and
14. federally qualified health center services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:1903 (October 2006).

§4503. Non-Medicaid State Plan Services

A. Reimbursement is available through the UCC pool for methadone and suboxone substance abuse treatments only to the extent that these services are not otherwise reimbursable under other funding sources including, but not limited to, grant or reimbursement programs offered through:

1. the Federal Emergency Management Agency;

2. the Substance Abuse and Mental Health Services Administration;
3. the National Institutes of Health; or
4. any other federal or state program (Medicaid, SCHIP, Medicare), private insurance or any private source.

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 32:1903 (October 2006).

Chapter 47. Provider Participation

§4701. Participation Requirements

A. In order to qualify for reimbursement through the UCC pool for Medicaid State Plan covered services, the provider must have been enrolled to participate in the Louisiana Medicaid Program on or before August 24, 2005.

B. In order to qualify for reimbursement through the UCC pool for methadone and suboxone substance abuse treatments, the provider must be approved by the Office of Addictive Disorders.

C. Qualifying providers may be either a public or a private provider.

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 32:1903 (October 2006).

Chapter 49. Requests for Payment

§4901. Submission Requirements

A. Requests for payment must be “person specific” for each Hurricane Katrina or Rita evacuee or other affected individual. The request must contain the following data, if known, for the evacuee or other affected individual:

1. last name;
2. first name;
3. middle initial;
4. Social Security number;
5. date of birth;
6. residential address the week prior to Hurricane Katrina or Hurricane Rita;
7. parish of residence the week prior to Hurricane Katrina or Hurricane Rita;
8. date(s) of service; and
9. any other identifying data that would assist in establishing the recipient’s identity in the absence of any of the items cited in paragraphs 1-8 above.

B. Providers may submit requests for payment of costs incurred during the following time periods:

1. dates of service from August 24, 2005 through January 31, 2006 for Hurricane Katrina; and
2. dates of service from September 23, 2005 through January 31, 2006 for Hurricane Rita.

C. Providers shall be required to sign an attestation that confirms that:

1. the services provided were medically necessary;
2. they have not received payment from any other source;
3. they will not subsequently bill another source for payment;
4. they are not aware of any other payment source for the services rendered; and
5. payment will be accepted as payment in full for the services rendered.

D. The deadline for submission of all payment requests is June 30, 2006.

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 32:1903 (October 2006).

Chapter 51. Uncompensated Care Pool Reimbursement

§5101. Allowable Payment

A. Reimbursement through the UCC pool is only available for covered services provided within the State of Louisiana to individuals who meet the requirements to be a member of the eligible population.

B. Payment through the UCC pool for Medicaid State Plan services shall be an interim payment up to 70 percent of the Medicaid fee-for-service rate currently on file for the respective service. Additional payments shall be contingent on the availability of funds in the UCC Pool.

1. UCC pool payments to hospitals that qualify for Medicaid disproportionate share hospital (DSH) payments will be offset from the cost of treating uninsured patients for the state fiscal year to which the DSH payment is applicable to determine the hospital specific DSH limits.

C. Payment through the UCC pool for methadone and suboxone substance abuse treatment services shall be an interim payment up to 70 percent of the fee schedule established by the Office of Addictive Disorders. Additional payments shall be contingent on the availability of funds in the UCC Pool.

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 32:1904 (October 2006).

Chapter 53. Administrative Appeals

§5301. Fair Hearings and Appeals

A. There are no provisions under this demonstration waiver for fair hearings for those individuals who have received medical services or supplies and do not have insurance coverage or any other source of payment.

B. There are no provisions under this demonstration waiver for appeals for health care providers who have incurred costs associated with the provision of the uncompensated care.

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 32:1904 (October 2006).

Subpart 7. Healthy Louisiana Opioid Use Disorder/Substance Use Disorder Waiver

Chapter 61. General Provisions

§6101. Purpose

A. The Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health hereby implement a section 1115(a) demonstration waiver called the Healthy Louisiana Opioid Use Disorder/Substance Use Disorder (OUD/SUD) Waiver which is designed to maintain critical access to OUD/SUD services and continue delivery system improvements for these services to provide more coordinated and comprehensive OUD/SUD treatment for Medicaid recipients. This demonstration waiver provides the state with the authority to provide high-quality, clinically appropriate OUD/SUD treatment services for residents in residential and inpatient treatment settings that qualify as an institution for mental disease (IMD).

B. The Healthy Louisiana OUD/SUD Waiver is a 59-month demonstration project which was approved by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) effective February 1, 2018 and will span five years, through December 31, 2022. Louisiana may request an extension of this demonstration project through CMS prior to the expiration date.

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

HISTORICAL NOTE: Promulgated by the Louisiana Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 45:271 (February 2019).

Chapter 63. Eligibility

§6301. General Provisions

A. The Healthy Louisiana OUD/SUD Waiver services shall be available to individuals who:

1. meet the eligibility criteria for Medicaid set forth in the State Plan;

2. meet clinical criteria, including having a SUD diagnosis; and

3. receive OUD/SUD treatment services in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise matchable expenditures under §1903 of the Social Security Act.

B. Retroactive coverage is not available in the Healthy Louisiana OUD/SUD Waiver program.

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

HISTORICAL NOTE: Promulgated by the Louisiana Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 45:271 (February 2019).

Chapter 65. Services

§6501. Covered Services

A. The coverage of OUD/SUD residential treatment and withdrawal management services during residential stays under the scope of this demonstration project are:

1. inpatient services provided to recipients in IMDs;
2. residential treatment provided to recipients in IMDs;
3. clinically managed withdrawal management provided to recipients in IMDs;
4. medically monitored/managed withdrawal management provided to recipients in IMDs; and
5. medication-assisted treatment (MAT) provided to recipients in IMDs.

B. A licensed mental health practitioner (LMHP) or physician who is acting within the scope of his/her professional license and applicable state law shall determine the medical necessity of all OUD/SUD services furnished under this waiver.

1. For the purposes of this Chapter, the term medically necessary means that the services provided under this waiver are reasonably calculated by an LMHP or a physician:

- a. to reduce the disability resulting from the illness; and
- b. to restore the recipient to his/her best possible functioning level in the community.

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

HISTORICAL NOTE: Promulgated by the Louisiana Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 45:272 (February 2019).

§6503. Service Delivery

A. All Healthy Louisiana OUD/SUD Waiver services are to be provided to recipient groups through a managed care delivery system, except for the following:

1. spend-down medically needy population.

B. All of the covered services under this waiver shall be delivered by an IMD provider contracted with one or more

of the managed care organizations (MCOs) operating within the state's Medicaid system.

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

HISTORICAL NOTE: Promulgated by the Louisiana Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 45:272 (February 2019).

Chapter 67. Provider Participation

§6701. General Provisions

A. All providers participating in the delivery of services covered under the Healthy Louisiana OUD/SUD Waiver shall adhere to all of the applicable federal and state regulations, policies, rules, manuals and laws.

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

HISTORICAL NOTE: Promulgated by the Louisiana Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 45:272 (February 2019).

§6703. Reporting Requirements

A. MCOs and their contracted providers of OUD/SUD services under this demonstration project shall be required to provide data as outlined or requested by the Department of Health.

B. Data shall be provided in the format and frequency specified by the department including any additional data requests as identified by the department.

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

HISTORICAL NOTE: Promulgated by the Louisiana Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 45:272 (February 2019).

Chapter 69. Reimbursement

§6901. General Provisions

A. MCOs and their contracted IMD providers shall ensure that reimbursement for services covered under the

Healthy Louisiana OUD/SUD Waiver is requested and paid only for those recipients who meet the eligibility criteria and for whom services were rendered:

1. providers/IMDs shall retain any and all supporting financial information and documents that are adequate to ensure that payment is made in accordance with applicable federal and state laws;

2. any such documents shall be retained for a period of at least six years from the date of service, or until the final resolution of all litigation, claims, financial management reviews or audits pertaining, whichever is the longest time period; and

3. there shall not be any restrictions on the right of the state and federal government to conduct inspections and/or audits as deemed necessary to assure quality, appropriateness or timeliness of services and reasonableness of costs.

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

HISTORICAL NOTE: Promulgated by the Louisiana Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 45:272 (February 2019).

§6903. Reimbursement Methodology

A. For recipients enrolled in one of the MCOs, the department or its fiscal intermediary shall make monthly capitation payments to the MCOs inclusive of coverage for the provision of residential and inpatient substance use services for recipients. The capitation rates paid to the MCOs shall be actuarially sound rates and the MCOs will determine the rates paid to its contracted providers. No payment shall be less than the minimum Medicaid rate.

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

HISTORICAL NOTE: Promulgated by the Louisiana Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 45:272 (February 2019).

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXIII. All Inclusive Care for the Elderly

Chapter 1. General Provisions

§101. Purpose and Scope

A. The Department of Health, Bureau of Health Services Financing implemented the Program of All Inclusive Care for the Elderly (PACE) in accordance with federal regulations at 42 CFR 460 et seq. These regulations set forth:

1. the requirements that an entity must meet to be approved as a PACE organization that operates a PACE program under Medicare and Medicaid;
2. how individuals may qualify to enroll in a PACE program;
3. how Medicare and Medicaid payments will be made for PACE services;
4. provisions for federal and state monitoring of PACE programs; and
5. procedures for sanctions and terminations.

B. The purpose of the Program of All Inclusive Care for the Elderly is to provide prepaid, capitated, comprehensive health care services designed to meet the following objectives:

1. enhance the quality of life and autonomy for enrolled participants;
2. maximize the dignity of, and respect for, enrolled participants;
3. enable enrolled participants to live in the community as long as medically and socially feasible; and
4. preserve and support the enrolled participant's family unit.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:244 (February 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:387 (March 2024).

§103. Organization Application and Evaluation

A. A PACE organization shall be licensed as an adult day health care (ADHC) provider.

B. If a PACE organization uses their own staff to provide personal care attendant (PCA) services to PACE participants, the PACE organization shall acquire a home and community-based services (HCBS) license under the PCA module.

C. The Department of Health (LDH) shall grant appropriate waivers of ADHC and HCBS PCA licensing requirements in instances where licensing regulations conflict with federal PACE requirements and when such waivers are determined to have no adverse effect on participants' health, safety, and quality of life.

D. A PACE organization shall not be required to be licensed as a health maintenance organization under the Louisiana regulations for risk-based entities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:245 (February 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:387 (March 2024).

§105. Administrative Requirements

A. A PACE organization must have a fiscally sound operation, as demonstrated by:

1. total assets greater than total unsubordinated liabilities;
2. sufficient cash flow and adequate liquidity to meet obligations as they become due; and
3. a net operating surplus or a financial plan for solvency that is satisfactory to the Centers for Medicaid and Medicare Services (CMS) and the Department of Health.

B. A PACE organization shall operate under the control of an identifiable governing body such as a board of directors, which must include at least one community representative. The following advisory committees shall also be established to advise the board of directors:

1. Consumer Advisory Committee;
2. Ethics Committee;
3. Restraint Committee; and
4. any other committees as required by CMS and/or LDH.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:245 (February 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:387 (March 2024).

Chapter 3. Services

§301. Medicare and Medicaid Coordination

A. If a Medicare beneficiary or Medicaid participant chooses to enroll in a PACE program:

1. the participant, while enrolled in a PACE program, must receive Medicare and Medicaid benefits solely through the PACE organization; and
2. Medicare and Medicaid benefit limitations and conditions relating to amount, duration, scope of services, deductibles, co-payments, coinsurance, or other cost-sharing do not apply.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:245 (February 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:387 (March 2024).

§303. Services Provided

A. The PACE benefit package for all participants, regardless of the source of payment, must include:

1. all Medicaid-covered services, as specified in the state's approved Medicaid plan;
2. interdisciplinary assessment and treatment planning;
3. primary care, including physician and nursing services;
4. social services;
5. behavioral health services;
6. restorative therapies, including:
 - a. physical therapy;
 - b. occupational therapy; and
 - c. speech-language pathology services;
7. personal care and supportive services;
8. nutrition counseling;
9. recreational therapy;
10. transportation;
11. meals;
12. medical specialty services including, but not limited to:
 - a. anesthesiology;
 - b. audiology;
 - c. cardiology;
 - d. dentistry;
 - e. dermatology;

- f. gastroenterology;
- g. gynecology;
- h. internal medicine;
- i. nephrology;
- j. neurosurgery;
- k. oncology;
- l. ophthalmology;
- m. oral surgery;
- n. orthopedic surgery;
- o. otorhinolaryngology;
- p. plastic surgery;
- q. pharmacy consulting services;
- r. podiatry;
- s. psychiatry;
- t. pulmonary disease;
- u. radiology;
- v. rheumatology;
- w. general surgery;
- x. thoracic and vascular surgery; and
- y. urology;

13. laboratory tests, x-rays, and other diagnostic procedures;

14. drugs and biologicals;

15. prosthetics, orthotics, durable medical equipment, corrective vision devices, such as:

- a. eyeglasses and lenses;
- b. hearing aids;
- c. dentures;
- d. repair and maintenance of these items; and
- e. wheelchairs, including custom wheelchairs that are medically necessary;

16. acute inpatient care, including:

- a. ambulance;
- b. emergency room care and treatment room services;
- c. semi-private room and board;
- d. general medical and nursing services;
- e. medical surgical/intensive care/coronary care unit;
- f. laboratory tests, x-rays, and other diagnostic procedures;
- g. drugs and biological;

- h. blood and blood derivatives;
 - i. surgical care, including the use of anesthesia;
 - j. use of oxygen;
 - k. physical, occupational, recreational therapies, and speech-language pathology services;
 - l. social services; and
 - m. psychiatric treatment;
17. nursing facility care, including:
- a. semi-private room and board;
 - b. physician and skilled nursing services;
 - c. custodial care;
 - d. personal care and assistance;
 - e. drugs and biologicals;
 - f. physical, occupational, recreational therapies, and speech-language pathology, if necessary;
 - g. social services; and
 - h. medical supplies and appliances;

18. other services determined necessary by the interdisciplinary team to improve and maintain the participant's overall health status.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:245 (February 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:388 (March 2024).

§305. Excluded Services

A. Services excluded from coverage are:

- 1. any service that is not authorized by the interdisciplinary team, even if it is a required service, unless it is an emergency service;
- 2. private room and private duty nursing services in an inpatient facility (unless medically necessary), and nonmedical items for personal convenience such as telephone charges and radio or television rental (unless specifically authorized by the interdisciplinary team as part of the participant's plan of care);
- 3. cosmetic surgery, which does not include surgery that is required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction following mastectomy;
- 4. experimental medical, surgical or other health procedures;
- 5. services furnished outside of the United States except as follows:
 - a. in accordance with 42 CFR 424.122-424.124; or

b. as permitted under the state's approved Medicaid plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:246 (February 2004) amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:388 (March 2024).

§307. Conditions of Service

A. A PACE organization must establish and implement a written plan to furnish care that meets the needs of each participant in all care settings 24 hours a day, every day of the year.

B. The PACE organization must furnish comprehensive medical, health, and social services that integrate acute and long-term care.

C. These services must be furnished in, at least, the PACE center, the home, and inpatient facilities.

D. The PACE organization may not discriminate against any participant in the delivery of required PACE services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or source of payment.

E. The frequency of a participant's attendance at a center is determined by the interdisciplinary team, based on the needs and preferences of each participant.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:246 (February 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:388 (March 2024).

§309. Emergency Services

A. A PACE organization must establish and maintain a written plan to handle emergency care. The written plan must ensure that CMS, the state, and PACE participants are held harmless if the PACE organization does not pay for emergency services.

B. Emergency care is appropriate when services are needed immediately because of an injury or sudden illness and the time required to reach the PACE organization or one of its contract providers would cause risk of permanent damage to the participant's health. Emergency services include inpatient and outpatient services that:

- 1. are furnished by a qualified emergency services provider, other than the PACE organization or one of its contract providers, either in or out of the PACE organization's service area;
- 2. are needed to evaluate or stabilize an emergency medical condition.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:246 (February 2004).

Chapter 5. Recipient Enrollment

§501. Eligibility

A. In order to be eligible for services from a PACE site an applicant must:

1. be 55 years of age or older;
2. be determined by the state administering agency to meet nursing facility level of care, as established by the Department of Health;
3. reside in the service area of the PACE organization; and
4. at the time of enrollment, an individual must be able to live in a community setting without jeopardizing his or her health or safety.

B. Eligibility to enroll in a PACE program is not restricted to an individual who is either a Medicare beneficiary or Medicaid participant. A potential participant may be, but is not required to be, any or all of the following:

1. entitled to Medicare Part A;
2. enrolled under Medicare Part B; or
3. eligible for Medicaid.

C. The determination whether a potential participant can be cared for in the community at the time of enrollment without jeopardizing his or her safety is based on the PACE organization's evaluation of the potential participant. The following are issues to consider when making this determination.

1. The potential participant does not have the capability to call for emergency assistance or does not have the capability to determine when emergency assistance is needed.

2. A physician, familiar with the potential participant's health and social history, has documented a condition for the potential participant that requires 24-hour/7-days per week of skilled care.

3. The potential participant's residence:

- a. has been condemned; or
- b. has been determined unsafe by habitation by PACE provider (detailed documentation of specifics required); or
- c. poses a threat to PACE program staff due to:
 - i. physical condition and integrity of dwelling; or
 - ii. evidence of abuse and/or neglect from other household members; or

- iii. criminal activities or behavior; or
- iv. illegal drug use; or
- v. brandishing of weapons; or
- vi. dangerous pets/animals.

4. The potential participant exhibits health concerns that involve dangerous behavior(s) which would pose a threat to him/her, other PACE participants, or PACE program staff.

5. The potential participant whose current medical treatment or regimen requires 24-hour supervision and whose care is more appropriately provided in an institutional setting (hospital or skilled nursing facility).

D. If the PACE organization determines that an applicant's health and safety cannot be ensured with the services that PACE can provide, the PACE organization shall submit the following within five working days to the Office of Aging and Adult Services (OAAS):

1. justification for the determination that health and safety cannot be ensured; and
2. any and all assessments and medical records use to make the determination;

E. If OAAS agrees with the PACE organization, OAAS will provide documentation to the PACE organization in writing acknowledging the health and safety concern.

F. If the potential participant is denied enrollment because the potential participant's health or safety would be jeopardized by living in a community setting, the PACE organization must meet the following requirements:

1. notify the potential participant in writing of the reason for denial with notification of appeal rights through the state fair hearing process;
2. refer the potential participant to alternative services, as appropriate;
3. maintain supporting documentation of the reason for denial; and
4. notify CMS and OAAS in the form and manner specified by CMS and make the documentation available for review.

G. If OAAS disagrees with the PACE organization, OAAS will provide the PACE organization with specific information as to why OAAS believes that with PACE services in place, a plan of care can be developed that is adequate to ensure the participant's health, social, and welfare needs. In addition, OAAS will provide suggestions for services that would be beneficial to the participant.

H. A PACE organization shall assess the potential participant to ensure that he or she can be cared for appropriately in a community setting and that he or she meets all requirements for PACE eligibility.

I. Reevaluation of Eligibility

1. LDH shall annually reevaluate whether the participant continues to meet level of care for nursing facility services. LDH may permanently waive the annual recertification of level of care requirements for a participant if it determines that there is no reasonable expectation of improvement or significant change in the participant's condition because of the severity of a chronic condition or the degree of impairment of functional capacity.

2. LDH may determine that a PACE participant who no longer meets the state Medicaid nursing facility level of care requirements be deemed to continue to be eligible for the PACE program until the next annual reevaluation, if, in the absence of continued coverage under this program, the participant reasonably would be expected to meet the nursing facility level of care requirement within the next six months.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:247 (February 2004), LR 33:850 (May 2007), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:389 (March 2024).

§503. Enrollment

A. Enrollment Period

1. A participant's enrollment in the program is effective on the first day of the calendar month following the date the PACE organization receives the signed enrollment agreement.

2. Enrollment continues until the participant's death, regardless of changes in health status, unless either of the following actions occurs:

- a. the participant voluntarily disenrolls; or
- b. the participant is involuntarily disenrolled (see §505.B below).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:247 (February 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:389 (March 2024).

§505. Disenrollment

A. A PACE organization shall submit proposed denial of enrollment determinations of applicants for health and safety reasons and all involuntary disenrollments of participants to LDH for review prior to notifying applicants/participants of such adverse decisions. The Department shall review denials of PACE enrollment eligibility and disenrollments in a timely manner.

B. Involuntary Disenrollment

1. A participant may be involuntarily disenrolled for any of the following reasons:

- a. a participant fails to pay, or to make satisfactory arrangements to pay, any premium due to the PACE organization after a 30 calendar day grace period;
- b. the participant engages in disruptive or threatening behavior, as described in Paragraph 2 below;
- c. the participant moves out of the PACE program service area or is out of the service area for more than 30 consecutive days, unless the PACE organization and/or LDH agrees to a longer absence due to extenuating circumstances;
- d. the participant is determined to no longer meet the state Medicaid nursing facility level of care requirements and is not deemed eligible;
- e. the PACE program agreement with CMS and LDH is not renewed or is terminated;
- f. the PACE organization is unable to offer health care services due to the loss of state licenses or contracts with outside providers; or
- g. the participant who is permanently placed in a nursing facility fails to pay, or to make satisfactory arrangements to pay, the amount of patient liability that would be required to be paid by a Medicaid eligible resident of a nursing facility if he/she was not a participant in a PACE organization.

2. The following are considered disruptive or threatening behavior for purposes of involuntary disenrollment:

- a. behavior that jeopardizes his or her health or safety, or the health or safety of others;
- b. consistent refusal to comply with his or her individual plan of care or the terms of the PACE enrollment agreement by a participant with decision-making capacity, but not if the behavior is related to a mental or physical condition of the participant. Noncompliant behavior includes repeated noncompliance with medical advice and/or repeated failure to keep appointments; or

3. if a PACE organization proposes to disenroll a participant based on the disruptive or threatening behavior of the participant or the participant's caregiver, the organization shall document the following information in the participant's medical record:

- a. the reasons for the proposal to disenroll the participant; and
- b. all efforts made to remedy the situation and the outcome of the use of those efforts.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:247 (February 2004), LR 33:850 (May 2007), amended by the Department of Health, Bureau of Health

Services Financing and the Office of Aging and Adult Services, LR 50:390 (March 2024).

Chapter 7. Quality Assessment and Performance Improvement

§701. Organization Responsibilities

A. A PACE organization must develop, implement, maintain, and evaluate an effective, data-driven quality assessment and performance improvement program.

B. The program must reflect the full range of services furnished by the PACE organization.

C. A PACE organization must take actions that result in improvements to its performance in all types of care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:248 (February 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:390 (March 2024).

§703. Quality Assessment and Performance Improvement Plan

A. A PACE organization must have a written quality assessment and performance improvement plan.

B. The PACE governing body must review the plan annually and revise it, if necessary.

C. At a minimum, the plan must specify how the PACE organization proposes to meet the following requirements:

1. identify areas to improve or maintain the delivery of services and care of the participants;
2. develop and implement plans of action to improve or maintain quality of care;
3. document and disseminate to PACE staff and contractors the results from the quality assessment and performance improvement activities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:248 (February 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:390 (March 2024).

§705. Minimum Requirements

A. A PACE organization's quality assessment and performance improvement program shall include, but is not limited to, the use of objective measures to demonstrate improved performance with regard to:

1. utilization of PACE services, such as decreased inpatient hospitalizations and emergency room visits;
2. caregiver and participant satisfaction;

3. outcome measures that are derived from data collected during assessments, including data on the following:

- a. physiological wellbeing;
- b. functional status;
- c. cognitive ability;
- d. social/behavioral functioning; and
- e. quality of life of participants;

4. effectiveness and safety of staff-provided and contracted services, including:

- a. competency of clinical staff;
- b. promptness of service delivery; and
- c. achievement of treatment goals and measurable outcomes;

5. nonclinical areas, such as grievances and appeals, transportation services, meals, life safety, and environmental issues.

B. Outcome measures must be based on current clinical practice guidelines and professional practice standards applicable to the care of PACE participants.

C. The PACE organization must meet or exceed minimum levels of performance, established by CMS and the state administering agency, on standardized quality measures, such as influenza immunization rates, which are specified in the PACE program agreement.

D. The PACE organization must ensure that all data used for outcome monitoring are accurate and complete.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:248 (February 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:390 (March 2024).

§707. Internal Activities

A. A PACE organization must do the following:

1. use a set of outcome measures to identify areas of good or problematic performance;
2. take actions targeted at maintaining or improving care based on outcome measures;
3. incorporate actions resulting in performance improvement into standards of practice for the delivery of care and periodically track performance to ensure that any performance improvements are sustained over time;
4. set priorities for performance improvement, considering prevalence and severity of identified problems, and give priority to improvement activities that affect clinical outcomes; and

Chapter 9. Sanctions

5. immediately correct any identified problem that directly or potentially threatens the health and safety of a PACE participant.

B. A PACE organization must designate an individual to coordinate and oversee performance improvement activities.

C. Involvement in Quality Assessment and Performance Improvement Activities

1. A PACE organization must ensure that all interdisciplinary team members, PACE staff, and contract providers are involved in the development and implementation of quality assessment and performance improvement activities and are aware of the results of these activities.

2. The quality improvement coordinator must encourage a PACE participant and his or her caregivers to be involved in quality assessment and performance improvement activities, including providing information about their satisfaction with services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:248 (February 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:390 (March 2024).

§709. Additional Activities

A. A PACE organization must meet external quality assessment and reporting requirements as specified by CMS or the state administering agency, in accordance with Section 460.202 of the Social Security Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:249 (February 2004).

§711. Committees with Community Input

A. A PACE organization must establish one or more committees with community input to:

1. evaluate data collected pertaining to quality outcome measures;

2. address the implementation of, and results from, the quality assessment and performance improvement plan; and

3. provide input related to ethical decision-making, including end-of-life issues and implementation of the Patient Self-Determination Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:249 (February 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:391 (March 2024).

§901. Violations

A. Sanctions may be imposed against a PACE organization if it commits one or more of the following violations:

1. fails to provide medically necessary items and services to a participant that are covered PACE services, and that failure has adversely affected (or has substantial likelihood of adversely affecting) the participant;

2. involuntarily disenrolls a participant in violation of 42 CFR 460.164;

3. discriminates in the enrollment or disenrollment of Medicare beneficiaries or Medicaid participants, or both, who are eligible to enroll in a PACE program on the basis of a participant's health status or need for health care services;

4. engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment, except as permitted by Section 460.150, by Medicare beneficiaries or Medicaid participants whose medical condition or history indicates a need for substantial future medical services;

5. imposes charges on participants enrolled under Medicare or Medicaid for premiums in excess of the premiums permitted;

6. misrepresents, falsifies, or fails to disclose information that is furnished to:

a. CMS or the state under this Part XXIII; or

b. an individual or any other entity under this Part XXIII;

7. prohibits or otherwise restricts a covered health care professional from advising a participant who is a patient of the professional about the participant's health status, medical care, or treatment for the participant's condition or disease, regardless of whether the PACE program provides benefits for that care or treatment, if the professional is acting within his or her lawful scope of practice;

8. operates a physician incentive plan that does not meet the requirements of Section 1876(i)(8) of the Social Security Act; or

9. employs or contracts with any individual who is excluded from participation in Medicare or Medicaid under Section 1128 or Section 1128A of the Social Security Act (or with any entity that employs or contracts with that individual) for the provision of health care, utilization review, medical social work, or administrative services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:249 (February 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:391 (March 2024).

§903. Imposition of Sanctions by CMS

A. The CMS may impose the following sanctions for violations specified in §901:

1. suspend enrollment of Medicare beneficiaries;
2. suspend Medicare payment to the PACE organization;
3. deny payment to the state for medical assistance for services furnished under the PACE program agreement. The state will suspend payments to the PACE organization when payment of the federal portion of PACE reimbursement is denied;
4. impose civil money penalties as specified in federal regulations.

B. CMS or the state may determine that the PACE organization is not in substantial compliance with PACE requirements, and may take one or more of the following actions:

1. condition the continuation of the PACE program agreement upon timely execution of a corrective action plan;
2. withhold some or all payments under the PACE program agreement until the organization corrects the deficiency;
3. terminate the PACE program agreement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:249 (February 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:391 (March 2024).

Chapter 11. Appeals**§1101. Participant Rights, Grievances, and Appeals**

A. The PACE organization must have a formal written appeals process in accordance with 42 CFR 460.122, with specified timeframes for response, to address noncoverage or nonpayment of a service, and involuntary disenrollment.

B. Additional appeal rights under Medicare or Medicaid are available to the participant if an adverse decision is made in the PACE organization appeal process, or if the participant is involuntarily disenrolled from the PACE program. A PACE organization must inform a participant in writing of additional appeal rights available under Medicare or Medicaid.

C. Medicaid-eligible participants who appeal through Medicaid shall be heard by the Division of Administrative Law (DAL) within the timeframes applicable to processing Medicaid appeals except in cases where federal PACE requirements require a more expeditious decision. The PACE organization shall prepare the Summary of Evidence in preparation for the appeal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:249 (February 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:391 (March 2024).

Chapter 13. Reimbursement**§1301. Payment**

A. Participants shall be eligible for Medicaid payment of the PACE premium on their behalf if they meet the categorically needy income and resource criteria for Medicaid eligibility for nursing facility and Home and Community Based Services waiver services.

B. Participants are eligible for Medicare payment of the PACE premium on their behalf if they are covered by Medicare. The amount of Medicare premiums is calculated by the Centers for Medicare and Medicaid Services, the federal oversight agency.

C. Medicaid payment to a PACE organization on behalf of a Medicaid-eligible participant shall be a prospective monthly capitated amount that is equal to or less than the amount that would otherwise have been paid under the State Plan if the participant was not enrolled under the PACE program.

1. Initially, each site specific upper payment limit shall be calculated for each state fiscal year using service area data, by zip code, from actual paid fee-for-service claims for populations who are age 55 or older in nursing facilities and in home and community based waiver and state plan services that utilize nursing facility level of care and serve people age 55 or older.

2. Site specific upper payment limits and Medicaid premiums for PACE shall be periodically calculated in accordance with the approved State Plan methodology for such calculation, including trending of historical data. Premiums for every PACE organization in the state will be based on upper payment limits.

3. Premium amount shall be a negotiated rate, not to exceed 95 percent of the upper payment limit.

4. No retroactive capitated payments shall be made.

D. There shall be a minimum of two Medicaid upper payment limits calculated annually:

1. one for participants who are eligible for both Medicare and Medicaid; and

2. one for participants who are eligible only for Medicaid.

E. Medicaid payment to a PACE organization shall be made for each Medicaid-eligible participant who is identified on Medicaid files as linked to the PACE provider and is enrolled for the subsequent month.

1. Enrolled participants are those who have signed an enrollment agreement and who have been linked by Medicaid to the PACE provider.

2. Medicaid-eligible participants are those who have been determined to be eligible for Medicaid payment effective as of or before the first day of the month, including those who are retroactively eligible, when such date is on or before the first day of the month.

F. The amount of the Medicaid premium is a fixed amount regardless of changes in the participant's health status.

G. A PACE organization may not charge a premium to a participant who is eligible for both Medicare and Medicaid, or who is only eligible for Medicaid.

H. Participants who are not eligible for Medicaid must pay a premium to the PACE organization equal to the amount of the Medicaid premium, except that a different negotiated amount may be paid as a governmental premium on behalf of participants whose care is financed by governmental agencies such as Veterans Administration.

I. Participants who are not eligible for Medicaid and are also not eligible for either Medicare Part A or Medicare Part B must pay a premium to the PACE organization equal to the amount of the Medicaid premium and also amount(s) equal to the Medicare premium for Part A or Part B, or both.

J. A Medicaid PACE participant, who is in a nursing facility reimbursed by PACE on his/her behalf, shall be responsible for payment of patient liability.

1. The amount of patient liability is the same amount that would be required to be paid by a Medicaid eligible

resident of a nursing facility if he/she was not a participant in a PACE organization.

2. The patient liability obligation for Medicaid participants begins the day it is determined by the PACE provider that the nursing facility stay is permanent.

3. The PACE organization shall determine whether the patient liability is to be paid to the PACE organization or the nursing facility.

K. Effective for dates of service on or after August 1, 2010, the monthly capitated amount paid to a PACE organization shall be reduced by 2 percent of the capitated amount on file as of July 31, 2010.

L. Effective for dates of service on or after January 1, 2011, the monthly capitated amount paid to a PACE organization shall be reduced by 3.09 percent of the capitated amount on file as of December 31, 2010.

M. Effective for dates of service on or after July 1, 2012, the monthly capitated amount paid to a PACE organization shall be reduced by 2 percent of the capitated amount on file as of June 30, 2012.

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 30:250 (February 2004), amended LR 33:850 (May 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:1572 (June 2011), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:1572 (June 2011), LR 39:316 (February 2013).

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXV. Adult Dentures

Chapter 1. General Provisions

§101. Prior Authorization

A. Only those services specified as covered under the Adult Denture Program are reimbursable and then only as allowed by this Part XXV.

B. Prior authorization is required for all adult denture services except for denture repairs. Items requiring prior authorization are noted with an asterisk in §501.

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 31:80 (January 2005), repromulgated LR 31:1589 (July 2005).

Chapter 3. Provider Participation and Recipient Criteria

§301. Participation Requirement

A. Provider participation is limited to those dentists who are duly licensed and authorized to practice dentistry in the state of Louisiana and who are enrolled in the Medicaid Program as a dental provider.

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 31:80 (January 2005), repromulgated LR 31:1589 (July 2005).

§303. Recipient Qualifications

A. Medicaid recipients who are 21 years of age and older and whose Medicaid coverage includes the full range of Medicaid services are eligible for denture services. Recipients who are not eligible for adult denture services include, but are not limited to, recipients who are certified as Qualified Medicare Beneficiary only (QMB only), adult recipients who are certified for Medicaid in the Medically Needy Program and pregnant women who are certified with presumptive eligibility.

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 31:80 (January 2005), repromulgated LR 31:1589 (July 2005).

Chapter 5. Covered Services

§501. Adult Denture Services

A. Only the following services are reimbursable under the Adult Denture Program and only in accordance with program policy and guidelines:

1. comprehensive oral examination*;
2. intraoral radiographs, complete series*;
3. complete denture, maxillary*;
4. complete denture, mandibular*;
5. immediate denture, maxillary*;
6. immediate denture, mandibular*;
7. maxillary partial denture, resin base (including clasps)*;
8. mandibular partial denture, resin base (including clasps)*;
9. repair broken complete denture base;
10. replace missing or broken tooth, complete denture, per tooth;
11. repair resin denture base, partial denture;
12. repair or replace broken clasp, partial denture;
13. replace broken teeth, partial denture, per tooth;
14. add tooth to existing partial denture;
15. add clasp to existing partial denture;
16. reline complete maxillary denture (laboratory)*;
17. reline complete mandibular denture (laboratory)*;
18. reline maxillary partial denture (laboratory)*;
19. reline mandibular partial denture (laboratory)*;
20. unspecified removable prosthodontic procedure, by report*.

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 31:81 (January 2005), repromulgated LR 31:1589 (July 2005).

§503. Denture Replacement and Denture Reline

A. Effective for dates of service on or after January 22, 2010, only one complete or partial denture per arch is allowed in an eight-year period. The eight-year time period begins from the date that the previous complete or partial

denture for the same arch was delivered. A combination of two complete or partial denture relines per arch or one complete or partial denture and one reline per arch is allowed in an eight-year period, as prior authorized by the bureau or its designee.

B. For relines, at least one year shall have elapsed since the complete or partial denture was delivered or last relined.

C. Cast partial dentures continue to be a noncovered service in the Adult Denture Program.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:81 (January 2005), repromulgated LR 31:1589 (July 2005), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2039 (September 2010).

Chapter 7. Reimbursement

§701. Fees

A. Fees for these services shall be reimbursed as established in the Adult Denture Program fee schedule.

B. Effective for dates of service on or after July 1, 2012, the reimbursement fees on file for the following adult denture services shall be reduced to the following percentages of the 2009 National Dental Advisory Service comprehensive fee report 70th percentile, unless otherwise stated in this Chapter:

1. 65 percent for the comprehensive evaluation exam; and
2. 56 percent for full mouth x-ray.

C. Removable prosthodontics shall be excluded from the July 1, 2012 reimbursement rate reduction.

D. Effective for dates of service on or after August 1, 2013, the reimbursement for adult denture services shall be reduced by 1.5 percent of the fee amounts on file as of July 31, 2013.

1. Removable prosthodontics shall be excluded from the August 1, 2013 reimbursement rate reduction.

E. Effective for dates of service on or after July 1, 2023, the reimbursement rates for adult denture services shall be reimbursed based on the Louisiana Medicaid fee schedule. All rates in the fee schedule are published on the Medicaid provider website at www.lamedicaid.com.

1. Implementation of these rates is subject to approval by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:81 (January 2005), repromulgated LR 31:1589 (July 2005), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:316 (February 2013), LR 40:1006 (May 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 49:1214 (July 2023).

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXVII. Medical Transportation Program

**Chapter 3. Emergency Medical
Transportation**

Subchapter A. Reserved.

**Subchapter B. Ground
Transportation**

§325. Reimbursement

A. The Medicaid reimbursement for ground ambulance services is the rate established in the state fee schedule for emergency ambulance transport, basic life support, advanced life support and mileage, oxygen, intravenous fluids, and disposable supplies administered during the emergency ambulance transport minus the amount paid by any liable third party coverage.

B. For dates of service on or after September 1, 2006, the base rate for emergency ambulance transportation services is increased by 5 percent of the rates in effect on August 31, 2006.

C. For dates of service on or after September 1, 2006, the ground mileage reimbursement rate for emergency ambulance transportation services is increased by 17 percent of the rates in effect on August 31, 2006.

D. For dates of service on or after September 1, 2007, the ground mileage reimbursement rate for emergency ambulance transportation services in effect on August 31, 2007 is increased by \$2.50.

E. For dates of service on or after September 1, 2007, the ancillary services rate for emergency ambulance transportation services is increased by 70 percent of the rate in effect on August 31, 2007.

F. Effective for dates of service on or after August 4, 2009, the reimbursement rates for the following supplies shall be reduced by 36 percent of the rate on file as of August 3, 2009:

1. advanced life support special service disposable intravenous supplies; and
2. advanced life support routine disposable supplies.

G. Effective for dates of service on or after January 22, 2010, the reimbursement rates for emergency ambulance transportation services shall be reduced by 5 percent of the rate on file as of January 21, 2010.

H. Effective for dates of service on or after January 1, 2011, the reimbursement rates for emergency ambulance transportation services shall be reduced by 2 percent of the rate on file as of December 31, 2010.

I. Effective for dates of service on or after July 1, 2012, the reimbursement rates for emergency ambulance transportation services shall be reduced by 5.25 percent of the rates on file as of June 30, 2012.

J. Effective for dates of service on or after August 1, 2012, the reimbursement rates for emergency ambulance transportation services shall be reduced by five percent of the rates on file as of July 31, 2012.

K. Effective for dates of service on or after July 1, 2023, the reimbursement rates for emergency ground ambulance transportation services shall be reimbursed based on the Louisiana Medicaid fee schedule.

EXCEPTION: Except as otherwise noted in the plan, state-developed fee schedule rates are established separately for governmental, New Orleans-based governmental, and private providers of ambulance transportation services to account for cost variability across these provider types and to maintain access to care through alignment with historic payment levels.

1. The agency's fee schedule rate, set as of July 1, 2023, is effective for services provided on or after that date. All rates are published on the agency's website at: <https://www.lamedicaid.com>.

2. The fee schedule was established as a function of historical rates in effect as of January 1, 2023 plus an enhancement which was calculated to achieve total fee schedule reimbursement as a percentage of average commercial rates (ACR), with the clarifications listed within Subparagraph a through c below:

a. governmental ambulance providers include those ambulance providers who are owned or operated by a public organization such as state, federal, parish, or city entities;

b. New Orleans-based governmental ambulance providers include ambulance providers located within the city of New Orleans; and

c. private ambulance transportation providers include corporations, limited liability companies, partnerships, or sole proprietors. Private providers must comply with all state laws and the regulations of any governing state agency, commission, or local entity to which they are subject as a condition of enrollment and continued participation in the Medicaid program.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:878 (May 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:1248 (June 2010), LR 36:2564 (November 2010), LR 37:3029 (October 2011), LR 39:1285 (May 2013), LR 40:1379 (July 2014, amended by the Department of Health, Bureau of Health Services Financing, LR 50:216 (February 2024).

§327. Supplemental Payments for Ambulance Providers

A. Effective for dates of service on or after September 20, 2011, quarterly supplemental payments shall be issued to qualifying ambulance providers for emergency medical transportation services rendered during the quarter if the department has received an appropriation from the legislature for these payments.

B. Qualifying Criteria. Ambulance service providers must meet the following requirements in order to qualify to receive supplemental payments. The ambulance service provider must be:

1. licensed by the state of Louisiana;
2. enrolled as a Louisiana Medicaid provider; and
3. a provider of emergency medical transportation or air ambulance services pursuant to 42 CFR 440.170 and a provider of the corresponding medical and remedial care and services in the approved Medicaid state plan.

C. Payment Methodology. The supplemental payment to each qualifying ambulance service provider will not exceed the sum of the difference between the Medicaid payments otherwise made to these qualifying providers for emergency medical transportation and air ambulance services and the average amount that would have been paid at the equivalent community rate.

D. The supplemental payment will be determined in a manner to bring payments for these services up to the community rate level. The *community rate* is defined as the average amount payable by commercial insurers for the same services.

E. Supplemental Payment Calculation. The following methodology shall be used to establish the quarterly supplemental payment for ambulance providers.

1. The department shall identify Medicaid ambulance service providers that were qualified to receive supplemental Medicaid reimbursement for emergency medical transportation services and air ambulance services during the quarter.

2. For each Medicaid ambulance service provider identified to receive supplemental payments, the department shall identify the emergency medical transportation and air ambulance services for which the Medicaid ambulance service providers were eligible to be reimbursed.

3. For each Medicaid ambulance service provider described in Paragraph E.1, the department shall calculate the reimbursement paid to the Medicaid ambulance service providers for the emergency medical transportation and air ambulance services identified under Paragraph E.2.

4. For each Medicaid ambulance service provider described in Paragraph E.1, the department shall calculate the Medicaid ambulance service provider's equivalent community rate for each of the Medicaid ambulance service provider's services identified under Paragraph E.2.

5. For each Medicaid ambulance service provider described in Paragraph E.1, the department shall subtract an amount equal to the reimbursement calculation for each of the emergency medical transportation and air ambulance services under Paragraph E.3 from an amount equal to the amount calculated for each of the emergency medical transportation and air ambulance services under Paragraph E.4.

6. For each Medicaid ambulance service provider described in Paragraph E.1, the department shall calculate the sum of each of the amounts calculated for emergency medical transportation and air ambulance services under Paragraph E.5.

7. For each Medicaid ambulance service provider described in Paragraph E.1, the department shall calculate each emergency ambulance service provider's upper payment limit by totaling the provider's total Medicaid payment differential from Paragraph E.6.

8. The department will reimburse providers based on the following criteria.

- a. For ambulance service providers identified in E.1 located in large urban areas and owned by governmental entities, reimbursement will be up to 100 percent of the provider's average commercial rate calculated in Paragraph E.7.

- b. For all other ambulance service providers identified in Paragraph E.1, reimbursement will be up to 80 percent of the provider's average commercial rate calculated in Paragraph E.7.

F. Calculation of Average Commercial Rate. The supplemental payment will be determined in a manner to bring payments for these services up to the average commercial rate level.

1. For purposes of these provisions, the *average community rate level* is defined as the average amount payable by the commercial payers for the same services.

2. The state will align the paid Medicaid claims with the Medicare fees for each HCPCS or CPT code for the ambulance provider and calculate the Medicare payment for those claims. The state will then calculate an overall Medicare to commercial conversion factor for each ambulance provider by dividing the total amount of the average commercial payments for the claims by the total Medicare payments for the claims. The commercial to Medicare ratio for each provider will be re-determined at least every three years.

G. The supplemental payment will be made effective for emergency medical transportation provided on or after September 20, 2011. This payment is based on the average amount that would have been paid at the equivalent community rate. After the initial calculation for fiscal year 2011-2012, the department will rebase the equivalent community rate using adjudicated claims data for services from the most recently completed fiscal year. This

calculation may be made annually, but shall be made no less than every three years.

H. The total amount to be paid by the state to qualified Medicaid ambulance service providers for supplemental Medicaid payments shall not exceed the total of the Medicaid payment differentials calculated under §327.E.6 for all qualified Medicaid ambulance service providers.

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 40:1530 (August 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 50:217 (February 2024).

§331. Enhanced Reimbursements for Qualifying Emergency Ground Ambulance Service Providers

A. Emergency Medical Transportation

1. Qualifying emergency ambulance service providers assessed a fee as outlined in LAC 48:I.4001.E.1.a-b shall receive enhanced reimbursement for emergency ground ambulance transportation services rendered during the quarter through the Supplemental Payment Program described in the Medicaid State Plan if the department has received an appropriation from the legislature for these payments.

2. Effective for dates of service on or after July 1, 2019, qualifying emergency ambulance service providers assessed a fee as outlined in LAC 48:I.4001.E.1.a-d shall receive enhanced reimbursement for non-emergency ground ambulance transportation services rendered during the quarter through the Supplemental Payment Program described in the Medicaid State Plan if the department has received an appropriation from the legislature for these payments.

B. Calculation of Average Commercial Rate

1. The enhanced reimbursement shall be determined in a manner to bring the payments for these services up to the average commercial rate level as described in Subparagraph C.3.h. The average commercial rate level is defined as the average amount payable by the commercial payers for the same service.

2. The department shall align the paid Medicaid claims with the Medicare fees for each healthcare common procedure coding system (HCPCS) or current procedure terminology (CPT) code for the ambulance provider and calculate the Medicare payment for those claims.

3. The department shall calculate an overall Medicare to commercial conversion factor for each ambulance provider by dividing the total amount of the average commercial payments for the claims by the total Medicare payments for the claims.

4. The commercial to Medicare ratio for each provider will be re-determined at least every three years.

C. Payment Methodology

1. Payment will include non-emergency ground ambulance services after July 1, 2019. The enhanced reimbursement to each qualifying emergency ground ambulance provider shall not exceed the sum of the difference between the Medicaid payments otherwise made to these providers for the provision of emergency and non-emergency ground ambulance transportation services and the average amount that would have been paid at the equivalent community rate.

2. The enhanced reimbursement shall be determined in a manner to bring payments for these services up to the community rate level.

a. *Community Rate*—the average amount payable by commercial insurers for the same services.

3. The specific methodology to be used in establishing the enhanced reimbursement payment for ambulance providers is as follows.

a. The department shall identify Medicaid ambulance service providers that qualify to receive enhanced reimbursement Medicaid payments for the provision of emergency and non-emergency ground ambulance transportation services.

b. For each Medicaid ambulance service provider identified to receive enhanced reimbursement Medicaid payments, the department shall identify the emergency and non-emergency ground ambulance transportation services for which the provider is eligible to be reimbursed.

c. For each Medicaid ambulance service provider described in Subparagraph C.3.a of this Section, the department shall calculate the reimbursement paid to the provider for the provision of emergency and non-emergency ground ambulance transportation services identified under Subparagraph C.3.b of this Section.

d. For each Medicaid ambulance service provider described in Subparagraph C.3.a of this Section, the department shall calculate the provider's equivalent community rate for each of the provider's services identified under Subparagraph C.3.b of this Section.

e. For each Medicaid ambulance service provider described in Subparagraph C.3.a of this Section, the department shall subtract an amount equal to the reimbursement calculation for each of the emergency and non-emergency ground ambulance transportation services under Subparagraph C.3.c of this Section from an amount equal to the amount calculated for each of the emergency and non-emergency ground ambulance transportation services under Subparagraph C.3.d of this Section.

f. For each Medicaid ambulance service provider described in Subparagraph C.3.a of this Section, the department shall calculate the sum of each of the amounts calculated for emergency and non-emergency ground ambulance transportation services under Subparagraph C.3.e. of this Section.

g. For each Medicaid ambulance service provider described in Subparagraph C.3.a of this Section, the

department shall calculate each provider's upper payment limit by totaling the provider's total Medicaid payment differential from Subparagraph C.3.f of this Section.

h. The department shall reimburse providers identified in Subparagraph C.3.a of this Section up to 100 percent of the provider's average commercial rate.

D. Effective Date of Payment

1. The enhanced reimbursement payment shall be made effective for emergency ground ambulance transportation services provided on or after August 1, 2016, and for non-emergency ground transportation services provided after July 1, 2019. This payment is based on the average amount that would have been paid at the equivalent community rate.

2. After the initial calculation for fiscal year 2015-2016 for emergency ground ambulance transportation services and after the initial calculation for fiscal year 2019-2020 for non-emergency ground ambulance transportation services, the department will rebase the equivalent community rate using adjudicated claims data for services from the most recently completed fiscal year. This calculation may be made annually but shall be made no less than every three years.

E. Maximum Payment

1. The total maximum amount to be paid by the department to any individually qualified Medicaid ambulance service provider for enhanced reimbursement Medicaid payments shall not exceed the total of the Medicaid payment differentials calculated under Subparagraph C.3.f of this Section

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 42:1890 (November 2016), amended LR 45:1598 (November 2019), LR 50:217 (February 2024).

Subchapter C. Aircraft Transportation

§351. Standards for Participation

A. Rotor winged (helicopters) and fixed winged emergency aircraft must be certified by the Department of Health, Bureau of Health Services Financing in order to receive Medicaid reimbursement. All air ambulance services must be provided in accordance with state laws and regulations governing the administration of these services.

B. All air ambulance services must comply with state laws and regulations governing the personnel certifications of the emergency medical technicians, registered nurses, respiratory care technicians, physicians and pilots as administered by the appropriate agency of competent jurisdiction.

C. Prior Approval. Prior approval shall not be required for emergency air ambulance transportation services, including mileage. Approval shall be done during post

payment review and shall not be completed prior to service delivery. Claims for payment of emergency air ambulance transportation services are received and reviewed retrospectively. The clinical documentation for each emergency air ambulance transportation service shall not be required for submission concurrent with the claim. If required, clinical documentation shall be required post claim submission.

1. Air ambulance claims will be reviewed and a determination will be made based on the following requirements. Air ambulance services are covered only if:

a. speedy admission of the beneficiary is essential and the point of pick-up of the beneficiary is inaccessible by a land vehicle; or

b. great distance or other obstacles are involved in getting the beneficiary to the nearest hospital with appropriate services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 35:70 (January 2009), amended by the Department of Health, Bureau of Health Services Financing, LR 50:217 (February 2024).

§353. Reimbursement

A. Fixed Winged Air Ambulance. The reimbursement for fixed winged air ambulance services is the Medicare base rate plus mileage in effect as of January 1, 1995.

1. Payment for air mileage is limited to actual air mileage from the point of pick-up to the point of delivery of the patient.

2. Payment for a round trip transport on the same day between two hospitals is the base rate plus the round trip mileage.

B. Rotor Winged (Helicopters) Air Ambulance. Effective for dates of service on or after September 17, 2008, the reimbursement rate paid for rotor winged air ambulance services shall be increased to 100 percent of the 2008 Louisiana Medicare allowable rate.

C. If a ground ambulance must be used for part of the transport, the ground ambulance provider will be reimbursed separately according to the provisions governing emergency ground transportation.

D. Reimbursement for oxygen and disposable supplies is made separately when the provider incurs these costs. Reimbursement for these services is based on Medicare rates as established in the state's fee schedule effective April 1, 1995.

E. Effective for dates of service on or after January 22, 2010, the reimbursement rates for fixed winged and rotor winged emergency air ambulance services shall be reduced by 5 percent of the rate on file as of January 21, 2010.

F. Effective for dates of service on or after January 1, 2011, the reimbursement rates for fixed winged and rotor

winged emergency air ambulance services shall be reduced by 2 percent of the rate on file as of December 31, 2010.

G. Effective for dates of service on or after July 1, 2012, the reimbursement rates for fixed winged and rotor winged emergency air ambulance services shall be reduced by 5.25 percent of the rates on file as of June 30, 2012.

H. Effective for dates of service on or after August 1, 2012, the reimbursement rates for fixed winged and rotor winged emergency air ambulance services shall be reduced by five percent of the rates on file as of July 31, 2012.

I. Effective for dates of service on or after September 1, 2014, the reimbursement rates for rotor winged emergency air ambulance services, which originate in areas designated as rural and/or super rural by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, shall be increased to the following rates:

1. base rate, \$4,862.72 per unit; and
2. mileage rate, \$33.65 per unit.

J. The reimbursement rates for emergency and non-emergency, rotor winged and fixed winged air ambulance transportation services shall be reimbursed based on the Louisiana Medicaid fee schedule. These rates include both in state and out-of-state air ambulance transportation. The agency's fee schedule rate was set as of January 1, 2022 and is effective for services provided on or after that date. All rates are published on the agency's website at: <https://www.lamedicaid.com>.

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 35:70 (January 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2564 (November 2010), amended LR 37:3029 (October 2011), LR 39:1285 (May 2013), LR 40:1379 (July 2014), LR 42:277 (February 2016), amended by the Department of Health, Bureau of Health Service Financing, LR 50:217 (February 2024).

§355. Supplemental Payments for Ambulance Providers

A. Effective for dates of service on or after September 20, 2011, quarterly supplemental payments shall be issued to qualifying ambulance providers for emergency medical air transportation services rendered during the quarter if the department has received an appropriation from the legislature for these payments.

B. Qualifying Criteria. Ambulance service providers must meet the following requirements in order to qualify to receive supplemental payments. The ambulance service provider must be:

1. licensed by the state of Louisiana;
2. enrolled as a Louisiana Medicaid provider; and
3. a provider of emergency medical transportation or air ambulance services pursuant to 42 CFR 440.170 and a

provider of the corresponding medical and remedial care and services in the approved Medicaid state plan.

C. Payment Methodology. The supplemental payment to each qualifying ambulance service provider will not exceed the sum of the difference between the Medicaid payments otherwise made to these qualifying providers for emergency medical transportation and air ambulance services and the average amount that would have been paid at the equivalent community rate.

D. The supplemental payment will be determined in a manner to bring payments for these services up to the community rate level. The *community rate* is defined as the average amount payable by commercial insurers for the same services.

E. Supplemental Payment Calculation. The following methodology shall be used to establish the quarterly supplemental payment for ambulance providers.

1. The department shall identify Medicaid ambulance service providers that were qualified to receive supplemental Medicaid reimbursement for emergency medical transportation services and air ambulance services during the quarter.

2. For each Medicaid ambulance service provider identified to receive supplemental payments, the department shall identify the emergency medical transportation and air ambulance services for which the Medicaid ambulance service providers were eligible to be reimbursed.

3. For each Medicaid ambulance service provider described in Paragraph E.1, the department shall calculate the reimbursement paid to the Medicaid ambulance service providers for the emergency medical transportation and air ambulance services identified under E.2.

4. For each Medicaid ambulance service provider described in Paragraph E.1, the department shall calculate the Medicaid ambulance service provider's equivalent community rate for each of the Medicaid ambulance service provider's services identified under Paragraph E.2.

5. For each Medicaid ambulance service provider described in Paragraph E.1, the department shall subtract an amount equal to the reimbursement calculation for each of the emergency medical transportation and air ambulance services under Paragraph E.3 from an amount equal to the amount calculated for each of the emergency medical transportation and air ambulance services under Paragraph E.4.

6. For each Medicaid ambulance service provider described in Paragraph E.1, the department shall calculate the sum of each of the amounts calculated for emergency medical transportation and air ambulance services under Paragraph E.5.

7. For each Medicaid ambulance service provider described in Paragraph E.1, the department shall calculate each emergency ambulance service provider's upper payment limit by totaling the provider's total Medicaid payment differential from Paragraph B.6.

8. The department will reimburse providers based on the following criteria.

a. For ambulance service providers identified in Paragraph E.1 located in large urban areas and owned by governmental entities, reimbursement will be up to 100 percent of the provider's average commercial rate calculated in Paragraph E.7.

b. For all other ambulance service providers identified in E.1, reimbursement will be up to 80 percent of the provider's average commercial rate calculated in Paragraph E.7.

F. Calculation of Average Commercial Rate. The supplemental payment will be determined in a manner to bring payments for these services up to the average commercial rate level.

1. For purposes of these provisions, the *average commercial rate level* is defined as the average amount payable by the commercial payers for the same services.

2. The state will align the paid Medicaid claims with the Medicare fees for each HCPCS or CPT code for the ambulance provider and calculate the Medicare payment for those claims. The state will then calculate an overall Medicare to commercial conversion factor for each ambulance provider by dividing the total amount of the average commercial payments for the claims by the total Medicare payments for the claims. The commercial to Medicare ratio for each provider will be re-determined at least every three years.

G. The supplemental payment will be made effective for air ambulance services provided on or after September 20, 2011. This payment is based on the average amount that would have been paid at the equivalent community rate. After the initial calculation for fiscal year 2011-2012, the department will rebase the equivalent community rate using adjudicated claims data for services from the most recently completed fiscal year. This calculation may be made annually, but shall not be made less often than every three years.

H. The total amount to be paid by the state to qualified Medicaid ambulance service providers for supplemental Medicaid payments shall not exceed the total of the Medicaid payment differentials calculated under §327.E.6 for all qualified Medicaid ambulance service providers.

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 40:1531 (August 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 50:218 (February 2024).

Chapter 5. Non-Emergency Medical Transportation

Subchapter A. General Provisions

§501. Introduction

A. Non-emergency medical transportation (NEMT) is provided to Medicaid beneficiaries to and/or from a medically necessary Medicaid covered service. NEMT is intended to provide transportation only after all reasonable means of free transportation have been explored and found to be unavailable.

NOTE: Non-emergency ambulance transportation (NEAT) is a form of NEMT; NEAT provisions are located in LAC 50:XXVII Chapter 7.

B. Medicaid covered transportation is available to Medicaid beneficiaries when:

1. the beneficiary is enrolled in a Medicaid benefit program that explicitly includes transportation services; and
2. the beneficiary or their representative has stated that they have no other means of transportation.

C. This Chapter applies to the fee-for-service and managed care programs for the provision of NEMT to and/or from medically necessary Medicaid covered services.

1. Managed care entities may utilize fully credentialed NEMT providers within their networks to transport managed care enrollees to non-Medicaid covered services when approved by the department as a value-added benefit at the managed care entity's expense.

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 47:1638 (November 2021).

§503. Prior Approval and Scheduling

A. The department or its designee will review and approve or deny the transportation requests, prior to scheduling, for beneficiary eligibility and verification of the following:

1. that the originating or destination address belongs to a healthcare provider or facility; or
2. that the service is a prior authorized Medicaid covered service performed in the community.

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 47:1639 (November 2021).

§505. Requirements for Coverage

A. Payment shall only be authorized for the least costly means of transportation available. The least costly means of transportation shall be determined by the department or its designee and considered the beneficiary's choice of transportation, the level of service required to safely

transport the beneficiary (e.g., ambulatory, wheelchair, transfer), and the following hierarchy:

1. public providers;
2. gas reimbursement providers who are enrolled in the Medicaid Program;
3. non-profit providers who are enrolled in the Medicaid Program; and
4. for-profit providers enrolled in the Medicaid Program.

B. Beneficiaries shall be allowed a choice of transportation profit providers as long as it remains the least costly means of transportation.

C. Beneficiaries are encouraged to utilize healthcare providers of their choice in the community in which they reside when the beneficiary requires Medicaid reimbursed transportation services.

1. Beneficiaries may seek medically necessary services in another state when it is the nearest option available.

2. In the managed care program, transportation will only be approved to and/or from a healthcare provider within the department's geographic access standards, unless granted an extension by the department or its designee.

D. Beneficiaries and healthcare providers should give advance notice when requesting transportation.

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 47:1639 (November 2021), amended LR 49:877 (May 2023).

Subchapter B. Beneficiary Participation

§511. General Provisions

A. Beneficiaries shall participate in securing transportation at a low cost and shall agree to use public transportation or solicit transportation from family and friends as an alternative to costlier means of transport.

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 47:1639 (November 2021).

Subchapter C. Provider Responsibilities

§517. Provider Enrollment

A. All NEMT providers must comply with all applicable federal, state, and local laws and regulations, including, but not limited to, those pertaining to enrollment and participation in the Medicaid Program.

B. Non-emergency medical transportation profit providers shall have a minimum liability insurance coverage of \$25,000 per person, \$50,000 per accident and \$25,000 property damage policy.

1. The liability policy shall cover:

- a. any autos, hired autos, and non-owned autos; or
- b. scheduled autos, hired autos, and non-owned autos.

2. Statements of insurance coverage from the agent writing the policy are not acceptable. Proof must include the dates of coverage and a 30-day cancellation notification clause. Proof of renewal must be received by the department or its designee no later than 48 hours prior to the end date of coverage. The policy must provide that the 30-day cancellation notification be issued to the department or its designee.

3. Upon notice of cancellation or expiration of the coverage, the department or its designee will suspend the provider's Medicaid enrollment, effective on the date of cancellation or expiration.

C. As a condition of reimbursement for transporting Medicaid beneficiaries to and/or from healthcare services, gas reimbursement providers must maintain a current valid vehicle registration, the state minimum automobile liability insurance coverage, and a current valid driver's license. Proof of compliance with these requirements must be submitted to the department or its designee during the enrollment process. Gas reimbursement providers are allowed to transport up to five specified Medicaid beneficiaries or all members of one household. Individuals transporting more than five Medicaid beneficiaries or all members of one household shall be considered profit providers and shall be enrolled as such and comply with all profit provider requirements.

D. All NEMT providers must agree to cover the entire parish or parishes for which he or she provides non-emergency medical transportation 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, Bureau of Health Services Financing, LR 47:1639 (November 2021), amended LR 49:877 (May 2023).

Subchapter D. Reimbursement

§523. General Provisions

A. Reimbursement for NEMT services shall be based upon the current fee schedule.

B. Reimbursement will not be made for any additional person(s) who must accompany the beneficiary to the medical provider.

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 47:1639 (November 2021).

Subchapter E. Non-Emergency Medical Transportation American Rescue Plan Act

§531. Non-Emergency Medical Transportation Bonus Payments

A. General Provisions

1. Non-emergency medical transportation (NEMT) providers that are fully credentialed in the Medicaid Program may be eligible to receive a bonus payment under the Department of Health's (LDH) American Rescue Plan Act (ARPA) NEMT Program until the program's federal funds are exhausted or through the conclusion of the program.

2. Fully credentialed NEMT providers who meet all eligibility requirements are entitled to a monthly disbursement of \$500 per vehicle, for up to three vehicles per month, totaling a maximum payment of \$1,500 per month per transportation provider. The managed care organization (MCO) will determine eligibility for monthly payments based on the NEMT provider's ongoing compliance for all provider, driver, and vehicle requirements set forth by the Medicaid Program and the LDH ARPA NEMT Program.

3. A NEMT provider is a provider of NEMT services and for the purpose of this bonus payment, includes non-profit and for-profit providers.

4. The MCO will provide a weekly report to LDH containing all newly acquired NEMT providers. LDH will assign each active NEMT provider to an affiliated MCO.

5. The MCO will administer all payments for the LDH ARPA NEMT Program.

6. In order to receive payments under the LDH ARPA NEMT Program, the NEMT provider shall do the following:

a. accede to all provisions of the LDH ARPA NEMT Program and execute a contractual agreement with the MCO, solely for the distribution of ARPA funds;

b. maintain ongoing compliance for all provider, driver, and vehicle requirements set forth by the Medicaid Program;

c. submit reporting and credentialing documentation for all drivers and vehicles within their individual company used for NEMT services on a monthly basis. Failure to meet both LDH and the MCO's time requirements shall result in loss of the monthly bonus payment; and

d. submit a monthly attestation to the MCO which certifies the accuracy of the submitted supporting and credentialing documentation.

7. NEMT services are ineligible and shall not be submitted as a completed service if the status of the NEMT service rendered results in one of the following:

- a. the provider is a no-show;
- b. no NEMT vehicle is available;
- c. no NEMT driver is available; or

d. the NEMT provider is late which causes the beneficiary to miss his or her scheduled Medicaid covered service.

B. Payments

1. Transportation providers that meet the requirements for both the LDH ARPA NEMT Program and Medicaid Program will receive a single lump sum payment of \$500 per vehicle, for a maximum of three vehicles, totaling a maximum payment of \$1,500 per month. Transportation providers must meet all requirements on a monthly basis for payment eligibility.

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 49:877 (May 2023), amended by the Department of Health, Bureau of Health Services Financing, LR 50:218 (February 2024).

Chapter 7. Non-Emergency Ambulance Transportation

§701. Introduction

A. Non-emergency ambulance transportation (NEAT) is ground or air ambulance transportation provided to Medicaid beneficiaries to and/or from a medically necessary Medicaid covered service when the beneficiary's condition is such that use of any other method of transportation is contraindicated or would make the beneficiary susceptible to injury.

B. Medicaid covered transportation is available to Medicaid beneficiaries when:

1. the beneficiary is enrolled in a Medicaid benefit program that explicitly includes transportation services; and

2. the beneficiary or their representative has stated that they have no other means of transportation.

C. This Chapter applies to the fee for service and managed care programs for the provision of NEAT to and/or from medically necessary Medicaid covered 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, Bureau of Health Services Financing, LR 47:1639 (November 2021).

§703. Provider Responsibilities

A. All ambulance providers must be licensed by the Department of Health, Bureau of Emergency Medical Services.

B. All NEAT providers must comply with all applicable federal, state, local laws, and regulations, including, but not limited to, those pertaining to enrollment and participation in the Medicaid 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, Bureau of Health Services Financing, LR 47:1640 (November 2021).

§705. Prior Approval and Scheduling

A. The department or its designee must review and approve or deny the transportation requests, prior to scheduling, for beneficiary eligibility and verification of the following:

1. that the originating or destination address belongs to a healthcare provider or facility; and

2. that a completed certification of ambulance transportation form is received for the date of service.

B. Out-of-state NEAT and non-emergency air ambulance services may require additional approval.

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 47:1640 (November 2021).

§707. Reimbursement

A. Reimbursement for NEAT services shall be based upon the current Medicaid fee schedule.

B. Reimbursement for NEAT claims shall be allowed only when accompanied by the certification of ambulance transportation form justifying the need for ambulance services.

C. Reimbursement will not be made for any additional person(s) who must accompany the beneficiary to the medical provider.

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 47:1640 (November 2021).

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXIX. Pharmacy

Chapter 1. General Provisions

§105. Medicaid Pharmacy Benefits Management System Point of Sale—Prospective Drug Utilization Program

A. The Louisiana Medicaid Pharmacy Benefits Management System (LMPBM) includes a Point-of-Sale/Prospective Drug Utilization Review component.

B. The Louisiana Department of Health reserves the right for ultimate decision making relative to certain drug class information and drug contraindications or interactions.

C. Covered Drug List. The list of covered drugs is managed through multiple mechanisms. Drugs in which the manufacturer entered into the Medicaid Drug Rebate Program with CMS are included in the list of covered drugs. National average drug acquisition cost (NADAC) and usual and customary charges assist in managing costs on the covered drug list. Federal upper limits provide for dispensing of multiple source drugs at established limitations unless the prescribing practitioner specifies that the brand product is medically necessary for a patient. Establishment of co-payments also provides for management.

D. Reimbursement Management. The cost of pharmaceutical care is managed through NADAC of the ingredient or through wholesale acquisition cost (WAC) when no NADAC is assigned, and compliance with FULL regulations, the establishment of the professional dispensing fee, drug rebates and copayments. Usual and customary charges are compared to other reimbursement methodologies and the "lesser of" is reimbursed.

E. Claims Management. The claims management component is performed through the processing of pharmacy claims against established edits. Claim edit patterns and operational reports are analyzed to review the effectiveness of established edits and to identify those areas where the development of additional edits are needed.

F. Pharmacy Program Integrity. Program integrity is maintained through the following mechanisms:

1. retrospective drug utilization review;
2. Lock-In Program for patient education;
3. Surveillance and Utilization Review Systems (SURS) Program processes which provide for on-going review for mis-utilization, abuse and fraud and audits of the pharmacy providers.

G. Pharmacy Provider Network. Enrolled Medicaid pharmacy providers are required to comply with all applicable federal and state laws and regulations.

H. Point-of-Sale Prospective Drug Utilization Review System. This on-line point-of-sale system provides electronic claims management to evaluate and improve drug utilization quality. Information about the patient and the drug will be analyzed through the use of therapeutic modules in accordance with the standards of the National Council of Prescription Drug Programs. The purpose of prospective drug utilization review is to reduce duplication of drug therapy, prevent drug-to-drug interactions, and assure appropriate drug use, dosage and duration. The prospective modules may screen for drug interactions, therapeutic duplication, improper duration of therapy, incorrect dosages, clinical abuse/misuse and age restrictions. Electronic claims submission inform pharmacists of potential drug-related problems and pharmacists document their responses by using interventions codes. By using these codes, pharmacists will document prescription reporting and outcomes of therapy for Medicaid recipients.

I. POS/PRO-DUR Requirements Provider Participation

1. Point-of-sale (POS) enrollment amendment and certification is required prior to billing POS/PRO-DUR system. Annual recertification is required.

2. All Medicaid enrolled pharmacy providers will be required to participate in the Pharmacy Benefits Management System.

3. Eligibility verification is determined at the point of sale.

4. Pharmacy providers and prescribing providers may obtain assistance with clinical questions from the University of Louisiana at Monroe.

5. Prescribers and pharmacy providers are required to participate in the educational and intervention features of the pharmacy benefits management system.

J. Recipient Participation. Pharmacy patients are encouraged to take an active role in the treatment or management of their health conditions through participation in patient counseling efforts with their prescribing providers and pharmacists.

K. Disease and Outcomes Management. Disease management will be focused on improving the drug therapy for certain disease states by developing procedures to assure direct interventions and increasing compliance of patients. Patient populations will be targeted for disease therapy monitoring and educational efforts

L. Peer Counseling and Conference Management. The department will analyze data for individual prescribers and pharmacists. Quality management strategies will be used for peer counseling and conferences with prescribers and/or

pharmacists to assure appropriate prescribing and dispensing.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:1053 (June 2006), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1180 (June 2017), LR 43:1553 (August 2017), LR 45:570 (April 2019), amended LR 45:665 (May 2019).

§107. Prior Authorization

A. The medication must be prescribed by a practitioner who is authorized to prescribe under state law. The national drug code (NDC) must be identified on each pharmacy claim for reimbursement. Prescription drugs considered for payment are subject to rebates from manufacturers as mandated by federal law and regulations.

B. Covered Drugs. Coverage of drugs shall be limited to specific drug products authorized for reimbursement by therapeutic category and listed by generic name, strength/unit, NDC, and brand name. Those drug products subject to mandatory coverage as a result of a rebate agreement with the federal government will be covered until written notice is received from the Centers for Medicare and Medicaid Services that coverage will be terminated. Providers will be given notice of termination of coverage.

C. Prior Authorization with a Preferred Drug List

1. A prior authorization process is established which utilizes a preferred drug list (PDL) for selected therapeutic classes. Drugs in selected therapeutic classes that are not included on the PDL shall require prescribers to obtain prior authorization. Lists of covered drug products, including those that require prior authorization, will be maintained on the Louisiana Medicaid web site.

2. The prior authorization process provides for a turn-around response by either telephone or other telecommunications device within 24 hours of receipt of a prior authorization request. In emergency situations, providers may dispense at least a 72-hour supply of medication.

3. The Pharmaceutical and Therapeutics Committee will make recommendations to the Department regarding drugs to be considered for prior authorization. The composition of and appointment to the Pharmaceutical and Therapeutics Committee complies with R.S. 46:153.3(D) and 42 U.S.C.s1396r-8.

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

1. select covered outpatient drugs when used for anorexia, weight loss, or weight gain as determined by the department;
2. select covered outpatient drugs when used to promote fertility as determined by the department;

3. select covered outpatient drugs when used for symptomatic relief of cough and cold as determined by the department;

4. select prescription vitamin and mineral covered outpatient drugs as determined by the department; and

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

E. Otherwise Restricted Drugs

1. The state will cover agents when used for cosmetic purposes or hair growth only when the state has determined that use to be medically necessary.

2. Select drugs for erectile dysfunction, except when used for the treatment of conditions, or indications approved by the FDA, other than erectile dysfunction.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:1053 (June 2006), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1180 (June 2017), LR 43:1553 (August 2017), amended LR 45:665 (May 2019), LR 46:33 (January 2020), LR 48:1582 (June 2022), LR 49:2106 (December 2023), LR 50:978 (July 2024).

§109. Medicare Part B

A. The Department of Health, Bureau of Health Services Financing pays the full co-insurance and the Medicare deductible on outpatient pharmacy claims for services reimbursed by the Medicaid Program for Medicaid recipients covered by Medicare Part B.

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 32:1055 (June 2006), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1181 (June 2017), LR 43:1553 (August 2017)

§111. Copayment

A. Payment Schedule

1. A copayment requirement in the Pharmacy Program is based on the following payment schedule.

Calculated State Payment	Copayment
\$10.00 or less	\$0.50
\$10.01 to \$25.00	\$1.00
\$25.01 to \$50.00	\$2.00
\$50.01 or more	\$3.00

2. The pharmacy provider shall collect a copayment from the Medicaid beneficiary for each drug dispensed and covered by Medicaid. The following pharmacy services are exempt from the copayment requirements:

- a. services furnished to pregnant women;
- b. emergency services;
- c. family planning services;

d. preventive medications as designated by the U.S. Preventive Services Task Force's A and B recommendations; and

e. services provided during a federal public health emergency (PHE).

3. The following population groups are exempt from copayment requirements:

a. individuals under the age of 21;

b. individuals residing in a long-term care facility;

c. individuals receiving hospice care;

d. Native Americans and Alaskan Eskimos;

e. women whose basis for Medicaid eligibility is breast or cervical cancer; and

f. home and community-based services waiver recipients.

B. In accordance with federal regulations, the following provisions apply.

1. The provider may not deny services to any eligible individual on account of the individual's inability to pay the copayment amount. However, this service statement does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the copayment.

2. Providers shall not waive the recipient copayment liability.

3. Departmental monitoring and auditing will be conducted to determine provider compliance.

4. Violators of this Section maybe subject to a penalty, including but not limited to, termination from the Medicaid Program.

5. The state will ensure Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household do not exceed an aggregate limit of 5 percent of the family's income applied on a monthly basis.

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, LR 32:1055 (June 2006), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1181 (June 2017), LR 43:1553 (August 2017), LR 46:34 (January 2020), LR 48:2975 (December 2022).

§113. Prescription Limit

A. Effective February 1, 2011, the Department of Health and Hospitals will pay for a maximum of four prescriptions per calendar month for Medicaid recipients.

B. The following federally mandated recipient groups are exempt from the four prescriptions per calendar month limitation:

1. persons under 21 years of age;

2. persons who are residents of long-term care institutions, such as nursing homes and ICF-DD facilities; and

3. pregnant women.

C. The four prescriptions per month limit can be exceeded when the prescriber determines an additional prescription is medically necessary and communicates the following information to the pharmacist in his own handwriting or by telephone or other telecommunications device:

1. "medically necessary override;" and

2. a valid diagnosis code that is directly related to each drug prescribed that is over the four prescription limit (literal descriptions are not acceptable).

D. The prescriber should use the Clinical Drug Inquiry (CDI) internet web application developed by the fiscal intermediary in his/her clinical assessment of the patient's disease state or medical condition and the current drug regime before making a determination that more than four prescriptions per calendar month is required by the recipient.

E. Printed statements without the prescribing practitioner's signature, check-off boxes or stamped signatures are not acceptable documentation.

F. An acceptable statement and ICD-10-CM, or its successor, diagnosis code are required for each prescription in excess of four per calendar month.

G. Pharmacists and prescribers are required to maintain documentation to support the override of a prescription limitation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 14:88 (February 1988), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 16: 313 (April 1990), LR 29:2115 (October 2003). Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:1055 (June 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1901 (September 2009), LR 37:3270 (November 2011), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1181 (June 2017).

§115. Drug Coverage Limits

A. Reimbursement for multi-source prescription drugs shall be limited in accordance with state and federal law and rules pertaining thereto, with the following exception: reimbursement shall be provided for any drug prescribed by a prescribing provider that, in his professional judgment and within the lawful scope of his practice, he considers appropriate for the diagnosis and treatment of the patient with the following limitations.

1. The prescribed drug has been approved and designated as safe and effective by the Food and Drug Administration.

2. The prescribed drug is not classified as a DESI drug (drugs which have been identified by the FDA as lacking evidence of safety/effectiveness).

3. The prescribed drug is not a compounded prescription (mixtures of two or more ingredients).

4. The prescribed drug is not methadone prescribed only for narcotic addiction.

5. The prescription is not for medications which are included in the reimbursement to Title XIX facilities, including, but not limited to:

- a. hospitalized recipients;
- b. recipients receiving benefits under Part A of Title XVIII in a skilled nursing facility; or
- c. resident/patients at Villa Feliciana or any state mental hospital.

6. The prescribed drug is an excluded or otherwise restricted drug.

7. The prescribed drug is not an experimental or investigational drug which are generally labeled:

Caution—limited by federal law to investigational use, unless a specific exception has been granted by the federal government.

8. The prescribed drug is not an immunosuppressant drug prescribed and billed to Medicare for a Title XIX transplant recipient who has Medicare Part B coverage.

9. The prescribed drug is not an immunosuppressant drug covered by Medicare Part B which is prescribed for a nontransplant patient with Medicare Part B coverage and identified in the Title XIX provider manual as subject to special billing procedures.

B. Drug Listing

1. The bureau's fiscal intermediary or agent will provide coverage information on any specific drug. Providers should contact the fiscal intermediary's or agent's provider/pharmacy relations unit when a specific coverage question arises.

2. The Title XIX provider manual shall include a listing of examples of prescribed medications and/or supplies which are not payable under pharmaceutical services of the Medicaid Program.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:1055 (June 2006), LR 32:2083 (November 2006), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1182 (June 2017), LR 46:34 (January 2020).

§117. Time Limits

A. Filling Prescriptions. Prescriptions for drugs covered by Medicaid other than a controlled substance shall expire one year after the date prescribed by a licensed prescriber.

These prescriptions shall not be refilled more than 11 times in one year. A prescription for a controlled dangerous substance listed in schedule II shall expire 90 days after the date written, and no refills are allowed. A prescription for a controlled dangerous substance listed in schedule III, IV or V shall expire six months after the date written. Expired prescriptions shall not be refillable or renewable. Payment shall be made for prescriptions refilled for controlled substances in schedule III, IV and V not more than five times or more than six months after issue date and only to the extent indicated by the prescriber on the original prescription, and is restricted by state and federal statutes.

B. Transferring Prescriptions. Transfer of a prescription from one pharmacy to another is allowed if less than one year has passed since the date prescribed and in accordance with the Louisiana Board of Pharmacy requirements. Transfer of a prescription for a controlled substance in schedule III, IV and V from one pharmacy to another is allowed if less than six months has passed since the date prescribed, and transfer of a prescription for a controlled substance in Schedule II is not allowed. Transfers of prescriptions shall be allowed in accordance with the Louisiana Board of Pharmacy regulations.

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 32:1056 (June 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:368 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1182 (June 2017).

§119. Maximum Quantity

A. For all prescriptions, the maximum quantity payable shall be a month's supply or 100 unit doses, whichever is greater. The quantity billed shall be that prescribed, unless it exceeds the maximum quantity payable in which case the maximum quantity payable shall be filled.

B. When maintenance drugs are prescribed and dispensed for chronic illnesses they shall be in quantities sufficient to effect economy in dispensing and yet be medically sound. Maintenance type drugs should be prescribed and dispensed in at least a month's supply after the initial fill. A 90-day supply is allowed on maintenance drugs after a beneficiary has been on the same drug and strength for 60 days. Contraceptives should be dispensed in a six-month supply, after a beneficiary has been on the same drug and strength for six months, unless the beneficiary or prescriber requests a smaller supply.

C. For patients in nursing homes, the pharmacist shall bill for a minimum of a month's supply of medication unless the treating physician specifies a smaller quantity for a special medical reason. A 90-day supply is allowed on maintenance drugs after a beneficiary has been on the same drug and strength for 60 days.

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 32:1056 (June 2006), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1182 (June 2017), LR 46:34 (January 2020), LR 48:2975 (December 2022).

§123. Medication Administration

A. Vaccine Administration. The department shall provide coverage for administration of vaccines by a qualified pharmacist when:

1. the pharmacist has been credentialed by the Louisiana Board of Pharmacy to administer medications; and
2. the pharmacist is Medicaid-enrolled.

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 36:1783 (August 2010), amended LR 40:82 (January 2014), LR 46:34 (January 2020), amended LR 46:345 (March 2020).

Chapter 3. Lock-In Program

§301. Introduction

A. Recipients shall have free choice of pharmacy unless subject to the agency's Lock-In program.

B. Lock-in is a mechanism for restricting Medicaid recipients to a specific physician and/or a specific pharmacy provider. The lock-in mechanism does not prohibit the recipient from receiving services from providers who offer services other than physician and pharmacy benefits. The lock-in mechanism:

1. ensures appropriate use of Medicaid benefits by recipients and/or providers; and
2. serves as an educational and monitoring parameter in instructing recipients in the most efficient method of using Medicaid services to ensure maximum health benefits.

C. A Medicaid recipient who has shown a consistent pattern of misuse or overuse of program benefits may be placed into the lock-in mechanism. Misuse and overuse is a determination made by the Department of Health and Hospitals, Bureau of Health Services Financing. Misuse and overuse can occur in a variety of ways.

1. Misuse may take the form of obtaining prescriptions under the pharmacy program from various prescribers and/or pharmacies in an uncontrolled and unsound way.

2. Misuse may take the form of obtaining prescriptions or the dispersal of prescriptions by fraudulent actions.

D. The Bureau of Health Services Financing or its medical designee shall be responsible to determine when a recipient should be enrolled in lock-in.

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 32:1056 (June 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:3268 (November 2011).

§303. Recipient Placement in the Lock-In Mechanism

A. Potential lock-in recipients will be identified through review of various reports or by referral from other interested parties. Department of Health designee(s) who are medical professionals examine data for a consistent pattern of misuse/overuse of program benefits by a recipient. Contact with involved providers may be initiated for additional information. The medical professionals render a recommendation to place a recipient in the Physician/Pharmacy Lock-In Program or Pharmacy-Only Lock-In Program. The decision making authority rests solely with the Department of Health, Bureau of Health Services Financing.

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 32:1057 (June 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:3268 (November 2011), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1182 (June 2017).

§307. Notification Directives

A. The department's contract designee shall notify the recipient of the decision to lock-in providers and shall include the following additional information:

1. the department's intention to allow the recipient to choose one primary care provider, one pharmacy provider, and up to three specialist providers, if warranted;
2. that Medicaid will make payments only to the physician and pharmacy providers chosen by the recipient and subsequently approved by the department;
3. that the recipient is advised to contact the department's contract designee to discuss the Pharmacy Lock-In Program; and
4. that the recipient has the right to appeal the initial lock-in decision.

B. The department's contract designee shall be responsible for the following:

1. initiate contact with the recipient in instances when the recipient fails to contact the department, or its contractor;
2. conduct a telephone interview when warranted with the recipient regarding the Lock-In Program and the recipient's rights and responsibilities;
3. assist the recipient, if necessary, in exercising due process rights and complete the appropriate forms at the initial contact; and
4. notify Lock-In providers of their selection.

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 32:1057 (June 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:3268 (November 2011), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1182 (June 2017).

§309. Restrictions

A. Recipients shall be prohibited from choosing physicians and pharmacists who overprescribe or oversupply drugs. When the agency cannot approve a recipient's choice of provider(s), the Lock-In recipient shall be required to make another selection.

1. In order to be approved as a Lock-In provider, the physician or pharmacy shall accept Medicaid as reimbursement for services rendered. Recipients are prohibited from paying cash for services rendered.

B. A recipient loses freedom of choice of providers once the lock-in decision has been made. Only the initial lock-in decision can be appealed. Provider selection is not appealable.

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 32:1057 (June 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:3269 (November 2011), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1183 (June 2017).

§311. Appeals

A. Administration Reconsideration. A recipient may request an administrative reconsideration of the department's determination to place the recipient in the Lock-In Program. An administrative reconsideration is an informal telephone discussion among the Bureau of Health Services Financing staff, the LDH contract designee, and the recipient. An explanation of the reason for recommending the recipient to be placed in the Lock-In Program will be provided to the recipient. An administrative reconsideration is not in lieu of the administrative appeals process and does not extend the time limits for filing an administrative appeal under the provisions of the Administrative Procedure Act. The designated official shall have the authority to affirm the decision, to revoke the decision, to affirm part or revoke in part, or to request additional information from either the department or the recipient.

B. Administrative Appeal Process. Upon notification of LDH's determination to place the Medicaid recipient into the Lock-In Program, the recipient shall have the right to appeal such action by submitting a written request to the Division of Administrative Law within 30 days of said notification. If an appeal is timely made, the decision to Lock-In is stayed pending the hearing of the appeal.

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 32:1057 (June 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:3269 (November 2011), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1183 (June 2017).

§313. Changing Lock-In Providers

A. Recipients may change lock-in providers every year without cause. With good cause, they may change lock-in providers only with the bureau's approval. Recipients may change providers for the following "good cause" reasons:

1. a recipient relocates;
2. a recipient's primary diagnosis changes;
3. the Lock-In provider(s) request(s) that the recipient be transferred; or
4. the Lock-In provider(s) stop(s) participating in the Medicaid Program and does not accept Medicaid as reimbursement for services.

a. The recipient may still receive other program services available through Medicaid such as hospital, transportation, etc., which are not controlled or restricted by placing a recipient in Lock-In for pharmacy and physician services. No recipient on Lock-In status shall be denied the service of a physician or pharmacist on an emergency basis within program regulations. In instances in which a recipient is referred by his Lock-In physician to another enrolled Medicaid physician who is accepting Medicaid recipients, reimbursement shall be made to the physician to whom the recipient was referred.

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 32:1058 (June 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:3269 (November 2011), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1183 (June 2017).

§315. Recipient Profile Review

A. Recipients profiles are to be reviewed periodically as described in the Lock-In Procedure Manual (for determination of continuance or discontinuance of lock-in). The department's medical designee(s) examine(s) a recipient's profile for a continued pattern of misuse or overuse of program benefits. Periods of ineligibility for Medicaid will not affect the lock-in status of the individual. A review at the end of the first four months of ineligibility of lock-in closure will be made to determine if lock-in should be continued. Based upon a recommendation of the department's medical designee, a decision may be made to restore unrestricted benefits and appropriate notification will be provided to the recipient.

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 32:1058 (June 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:3269 (November 2011).

Chapter 5. Narcotics and Controlled Substances

§501. Schedule II Narcotic Analgesic Prescriptions

A. Schedule II narcotic analgesic prescriptions covered under the Louisiana Medicaid Program shall be filled within 90 days of the date prescribed by a physician or other prescribing practitioner. Also, in accordance with guidance from the drug enforcement agency, the prescriber has the ability to issue multiple prescriptions for the same schedule II medication to the same patient on the same day. All prescriptions must be dated and signed on the date issued. The prescriber may issue dispensing instruction, e.g., “do not dispense until a specified date.”

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 32:1058 (June 2006), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1183 (June 2017), LR 46:34 (January 2020).

Chapter 9. Methods of Payment

Subchapter A. General Provisions

§901. Definitions

Brand Name—any registered trade name commonly used to identify a drug.

Legend Drugs—drugs which bear the federal legend: “Caution: federal law prohibits dispensing without a prescription.”

Multiple Source Drug—a drug marketed or sold by two or more manufacturers or labelers or a drug marketed or sold by the same manufacturer or labeler under two or more different proprietary names or both under a proprietary name and without such a name.

National Average Drug Acquisition Cost (NADAC)—a national pricing benchmark that is reflective of actual invoice costs that pharmacies pay to acquire prescription and over-the-counter drugs. It is based upon invoice cost data collected from retail community pharmacies and reflects actual drug purchases.

Professional Dispensing Fee—the fee paid by the Medicaid Program to reimburse for the professional services provided by a pharmacist when dispensing a prescription. Per legislative mandate, the provider fee assessed for each prescription filled in the state of Louisiana, or shipped into the state of Louisiana, will be reimbursed separately.

Single Source Drug—a drug mandated or sold by one manufacturer or labeler.

Usual and Customary Charge—the lowest price the pharmacy would charge to a particular customer if such

customer were paying cash for the identical prescription drug or prescription drug services on the date dispensed.

Wholesale Acquisition Cost (WAC)—the manufacturer’s published catalog price for a drug product to wholesalers as reported to Medicaid by one or more national compendia on a weekly basis.

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 32:1061 (June 2006), amended LR 34:87 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:1558 (July 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1184 (June 2017), LR 43:1554 (August 2017), LR 45:571 (April 2019).

§903. Claims Documentation

A. The manufacturer number, product number, and package number for the drug dispensed shall be listed on all claims. This information shall be taken from the actual package from which the drug is usually purchased by a provider, from a supplier whose products are generally available to all pharmacies and reported in one or more national compendia. Repackaged drug products supplied through co-ops, franchises, or other sources not readily available to other providers shall not be used. In such instances, the manufacturer number, product number, and package number for the largest package size, as reported in one or more national compendia for the drug shall be listed.

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 Finances, LR 32:1062 (June 2006).

Subchapter B. Professional Dispensing Fee

§915. General Provisions

A. The professional dispensing fee shall be set by the department and reviewed periodically for reasonableness, and when deemed appropriate by the Medicaid Program, may be adjusted considering such factors as fee studies or surveys.

B. Provider participation in the Louisiana cost of dispensing survey shall be mandatory. A provider’s failure to cooperate in the survey shall result in his/her removal from participation as a provider of pharmacy services in the Medicaid Program. Any provider removed from participation shall not be allowed to re-enroll until a professional dispensing fee survey document is properly completed and submitted to the department.

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 36:1558 (July 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1554 (August 2017).

Subchapter C. Estimated Acquisition Cost

§935. Estimated Acquisition Cost Formula

A. Estimated acquisition cost (EAC) is the national average drug acquisition cost (NADAC) of the drug dispensed. If there is not a NADAC available, the EAC is equal to the wholesale acquisition cost, as reported in the drug pricing compendia utilized by the department's fiscal intermediary/pharmacy benefits manager (PBM).

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

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Subchapter D. Maximum Allowable Costs

§945. Reimbursement Methodology

A. Maximum Pharmaceutical Price Schedule

1. The maximum payment by the agency for a prescription shall be no more than the cost of the drug established by the state plus the established professional dispensing fee.

B. Payment will be made for medications in accordance with the payment procedures for any fee-for-service (FFS) Medicaid eligible person.

C. The pharmacy must be licensed to operate in Louisiana except:

1. as provided for a person residing near the state line; or
2. as provided for a recipient visiting out-of-state.

D. Payment will be made only to providers whose records are subject to audit.

E. Payment will be made to providers only for medications furnished to persons eligible for medical vendor payments on a prescription written by a practitioner who is authorized to prescribe in Louisiana and is enrolled in FFS Medicaid.

F. Payments will be made only for the drugs covered under Louisiana Medicaid's Pharmacy Program.

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

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Services Financing, LR 43:1184 (June 2017), LR 45:571 (April 2019).

§947. Payments to Dispensing Physician

A. Payment will be made for medications dispensed by a physician on a continuing basis only when his main office is more than five miles from a facility which dispenses drugs.

1. Under the above circumstances, vendor payments (when the treating prescriber dispenses his own medications and bills Medical Assistance Program under his own name) will be made on the same basis as a pharmacist as specified in §945.A.1-2.

B. A prescriber who has a sub-office in an area more than five miles from a pharmacy or other facility dispensing medications will not be paid for medications he dispenses if his main office is within five miles of a pharmacy or other facility dispensing medications.

C. When a prescriber bills Medicaid for medications he dispenses, he shall certify that he himself, or a pharmacist, dispensed the medications and he shall maintain the same records as required of the pharmacist.

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 32:1065 (June 2006), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1185 (June 2017).

§949. Fee for Service Cost Limits

A. Brand Drugs. The department shall make payments for single source drugs (brand drugs) based on the lower of:

1. national average drug acquisition cost (NADAC) plus the professional dispensing fee:

a. if no NADAC is available, use the wholesale acquisition cost (WAC) plus the professional dispensing fee; or

2. the provider's usual and customary charges to the general public not to exceed the department's "maximum payment allowed."

a. For purposes of these provisions, the term *general public* does not include any person whose prescriptions are paid by third-party payors, including health insurers, governmental entities, and Louisiana Medicaid.

B. Generic Drugs. The department shall make payments for multiple source drugs (generic drugs), other than drugs subject to "physician certifications", based on the lower of:

1. NADAC plus the professional dispensing fee:

a. if no NADAC is available, use the WAC plus the professional dispensing fee; or

2. federal upper payment limits plus the professional dispensing fee; or

3. the provider's usual and customary charges to the general public not to exceed the department's "maximum payment allowed."

a. For purposes of these provisions, the term general public does not include any person whose prescriptions are paid by third-party payors, including health insurers, governmental entities, and Louisiana Medicaid.

C. Federal Upper Payment Limits for Multiple Source Drugs

1. Except for drugs subject to "physician certification," the Medicaid Program shall utilize listings established by the Centers for Medicare and Medicaid Services (CMS) that identify and set upper limits for multiple source drugs that meet all of the following requirements:

a. All of the formulations of the drug approved by the Food and Drug Administration (FDA) have been evaluated as therapeutically equivalent in the most current edition of their publication, Approved Drug Products with Therapeutic Equivalence Evaluations (including supplements or in successor publications).

b. At least three suppliers list the drug, which has been classified by the FDA as category "A" in the aforementioned publication based on listings contained in current editions (or updates) of published compendia of cost information for drugs available for sale nationally.

2. Medicaid shall utilize the maximum acquisition cost established by CMS in determining multiple source drug cost.

3. The Medicaid Program shall provide pharmacists who participate in Medicaid reimbursement with updated lists reflecting:

a. the multiple source drugs subject to federal multiple source drug cost requirements;

b. the maximum reimbursement amount per unit; and

c. the date such costs shall become effective.

D. Physician Certifications

1. Limits on payments for multiple source drugs shall not be applicable when the prescriber certifies that the brand name drug is medically necessary for the care and treatment of a recipient in his own handwriting or via an electronic prescription. Such certification shall be written directly on the prescription, on a separate sheet which is dated and attached to the prescription, or submitted electronically. A standard phrase such as "brand necessary" indicating the medical necessity of the brand will be acceptable.

E. Fee for Service 340B Purchased Drugs. The department shall make payments for self-administered drugs that are purchased by a covered entity through the 340B program at the actual acquisition cost which can be no more than the 340B ceiling price plus the professional dispensing fee, unless the covered entity has implemented the Medicaid

carve-out option, in which case 340B drugs should not be billed to or reimbursed by Medicaid. 340B contract pharmacies shall not bill 340B stock to Medicaid. Fee-for-service outpatient hospital claims for 340B drugs shall use a cost to charge methodology on the interim cost report and settled during final cost settlement. Federally qualified health center (FQHC) and rural health clinic (RHC) claims for physician administered drugs shall be included in the all-inclusive T1015 encounter rate.

F. Federal Supply Schedule Drugs. Drugs acquired at federal supply schedule (FSS) and at a nominal price shall be reimbursed at actual acquisition cost plus a professional dispensing fee.

G. Indian Health Service All-Inclusive Encounter Rate. Pharmacy services provided by the Indian Health Service (IHS) shall be included in the encounter rate. No individual pharmacy claims shall be reimbursed to IHS providers.

H. Mail Order, Long-Term Care and Specialty Pharmacy. Drugs dispensed by mail order, long-term care and/or specialty pharmacies (drugs not distributed by a retail community pharmacy) will be reimbursed using the brand/generic drug reimbursement methodology.

I. Physician-Administered Drugs. Medicaid-covered physician-administered drugs shall be reimbursed according to the Louisiana professional services fee schedule. Reimbursement shall be determined utilizing the following methodology, and periodic updates to the rates shall be made in accordance with the approved Louisiana Medicaid State Plan provisions governing physician-administered drugs in a physician office setting.

1. Average sales price (ASP) plus 6 percent, for drugs appearing on the Medicare file.

2. Reimbursement rates for drugs that do not appear on the Medicare file shall be determined utilizing the following alternative methods:

a. the wholesale acquisition cost (WAC) of the drug, if available;

b. if there is no WAC available, the reimbursement rate will be 100 percent of the provider's current invoice for the dosage administered.

J. Clotting Factor. Pharmacy claims for clotting factor will be reimbursed using a state generated actual acquisition cost (AAC) ingredient cost and a unit based professional dispensing fee reimbursement methodology.

K. Investigational or Experimental Drugs. Investigational or experimental drugs shall not be reimbursed by Medicaid.

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 32:1065 (June 2006), amended LR 34:88 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:1561 (July 2010), amended by the Department of Health, Bureau of Health

Services Financing, LR 43:1185 (June 2017), LR 43:1554 (August 2017), LR 44:1020 (June 2018), LR 45:571 (April 2019), LR 45:665 (May 2019), amended LR 46:35 (January 2020), LR 49:1395 (August 2023).

Subchapter E. 340B Program

§961. Definitions

Actual Acquisition Cost—the covered entity’s net payment made to purchase a drug product.

Contract Pharmacy—a pharmacy under contract with a covered entity that provides services to the covered entity’s patients, including the service of dispensing the covered entity’s 340B drugs, in accordance with Health Resources and Services Administration (HRSA) guidelines (75 FR 10272, March 5, 2010). Contract pharmacies are not allowed to bill Medicaid for pharmacy claims.

Covered Entity—a provider or program that meets the eligibility criteria for participating in the 340B Program as set forth in section 340B(a)(4) of the Public Health Service Act. Covered entities include eligible disproportionate share hospitals that are owned by, or under contract with, state or local government, community health centers, migrant health centers, health centers for public housing, health centers for the homeless, AIDS drug assistance programs and other AIDS clinics and programs, black lung clinics, hemophilia treatment centers, native Hawaiian health centers, urban Indian clinics/638 tribal centers, 340s school-based programs, Title X family planning clinics, sexually-transmitted disease clinics and tuberculosis clinics.

Estimated Acquisition Cost (EAC)—the national average drug acquisition cost (NADAC) of the drug dispensed. If there is not a NADAC available, the EAC is equal to the wholesale acquisition cost, as reported in the drug pricing compendia utilized by the department’s fiscal intermediary.

Medicaid Carve-Out—a billing mechanism available to covered entities that implements the 340B requirement protecting manufacturers from giving a 340B discount and paying a Medicaid rebate on the same drug. If a covered entity elects to implement the Medicaid carve-out option, the covered entity only purchases through the 340B Program covered drugs dispensed to non-Medicaid patients; drugs dispensed to Medicaid patients are purchased outside the 340B Program.

Patient—an individual eligible to receive 340B-discounted drugs from a covered entity by virtue of being the covered entity’s patient as defined in HRSA’s 1996 patient definition guideline (61 FR 55156, October 24, 1996).

Professional Dispensing Fee—the fee paid by Medicaid for the professional services provided by a pharmacist when dispensing a prescription. Per legislative mandate, the \$0.10 provider fee assessed for each prescription filled in the state of Louisiana will be paid separately.

Wholesale Acquisition Cost (WAC)—the manufacturer’s published catalog price for a drug product to wholesalers as reported to Medicaid by one or more national compendia on a weekly basis.

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 32:1066 (June 2006), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1186 (June 2017), LR 43:1555 (August 2017), LR 45:572 (April 2019).

§963. Reimbursement

A. Self-administered drugs that are purchased by a covered entity through the 340B program and dispensed to patients who are covered by Medicaid shall be billed to Medicaid at actual acquisition cost (can be no more than the 340B ceiling price) unless the covered entity has implemented the Medicaid carve-out option, in which case 340B drugs should not be billed to Medicaid. All other drugs shall be billed in accordance with existing Louisiana Medicaid reimbursement methodologies. Indian Health Service, tribal and urban Indian pharmacy claims will be reimbursed in the encounter rate.

B. Contract Pharmacies. Contract pharmacies are not allowed to bill 340B drugs to Medicaid; therefore, they should carve out.

C. Professional Dispensing Fees. The covered entity will be reimbursed at the appropriate ingredient cost plus the maximum allowable professional dispensing fee or the usual and customary charge, whichever is less.

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 32:1066 (June 2006), amended LR 34:88 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:1561 (July 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1186 (June 2017).

Subchapter F. Antihemophilia Drugs

§971. Reimbursement

A. Anti-hemophilia drugs purchased by a covered entity through the 340B program and dispensed to Medicaid recipients shall be billed to Medicaid at actual acquisition cost and the professional dispensing fee..

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 32:1066 (June 2006), repealed LR 33:101 (January 2007), amended LR 34:881 (May 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1186 (June 2017).

Subchapter G. Reserved.

Subchapter H. Vaccines

§991. Vaccine Administration Fees

A. Reimbursement to pharmacies for immunization administration (intramuscular, subcutaneous or intranasal)

performed by qualified pharmacists, is a maximum of \$15.22. This fee includes counseling, when performed.

B. Administration of vaccines related to a declared public health emergency shall be reimbursed at up to 100 percent of the Louisiana Region 99 Medicare rate for the duration deemed necessary by the Medicaid Program to ensure access. If providers are required to purchase vaccines, then the vaccines will be reimbursed.

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 36:1783 (August 2010), amended LR 40:82 (January 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1555 (August 2017), amended LR 46:345 (March 2020), LR 47:887 (July 2021).

§993. Vaccine Reimbursement

A. Vaccines for beneficiaries aged 19 and over shall be reimbursed at wholesale acquisition cost (WAC) or billed charges, whichever is the lesser amount.

B. Vaccines related to a declared public health emergency shall not be reimbursed if furnished at no cost to providers. When providers are responsible for purchasing the vaccine, the Medicaid Program shall reimburse.

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 40:82 (January 2014), amended by the Department of Health, Bureau of Health Services Financing LR 46:345 (March 2020), amended LR 47:887 (July 2021).

Chapter 11. Value-based Agreement Programs

§1101. General Provisions

A. The Centers for Medicare and Medicaid Services approved LDH to enter into state supplemental rebate agreements with pharmaceutical manufacturer(s). LDH may enter into an agreement with a pharmaceutical manufacturer to obtain a rebate(s) in addition to federal rebates pursuant to 42 U.S.C. 1396r. Participation by a pharmaceutical manufacturer in a state supplemental rebate agreement with the department is voluntary.

B. LDH may enter into an agreement with a pharmaceutical manufacturer for outcomes-based contracts. Participation by a pharmaceutical manufacturer in an outcomes-based agreement with the department is voluntary.

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 43:966 (May 2017), amended LR 45:909 (July 2019), LR 46:35 (January 2020).

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXXI. Refugee Medical Assistance

Chapter 1. Refugee Medical Assistance Program

§101. General Provisions

A. The Immigration and Nationality Act of 1952, Public Law 82-414, allows states to provide medical assistance, during the one-year period after entry, to any refugee who does not qualify for assistance under a State Plan approved under Title XIX of the Social Security Act. The Refugee Medical Assistance (RMA) Program provides medical assistance to refugees and asylees in Louisiana who are not otherwise eligible for Medicaid/SCHIP coverage. Under the authority of the U.S. Department of Health and Human Services, Administration for Children and Families, the Department of Health and Hospitals hereby assumes responsibility for the administration of the RMA Program.

B. The Refugee Medical Assistance Program is a short-term, federally funded program designed to ensure that refugees receive the medical care they need while transitioning to life in the United States.

C. Refugee medical assistance is available to all individuals with the immigration status of refugee or asylee.

D. All recipients who receive refugee cash assistance through the Office of Refugee Resettlement, and who are not eligible for a regular Medicaid/SCHIP program, shall be certified for RMA.

1. Receipt or application for refugee cash assistance is not a requirement of the RMA program.

E. A refugee who has been certified in a regular Medicaid program and loses that coverage because of increased earnings from employment, and is within the eligibility time period, shall be transferred to RMA.

F. Retroactive coverage does not apply to RMA.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Public Law 82-414, 8 U.S. Code 1522 (e)(5).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1112 (June 2009).

§103. Eligibility Requirements

A. Individuals who meet the following requirements may receive health care coverage through the Refugee Medical Assistance Program.

1. The individual must be a refugee or asylee who is not eligible to receive benefits through a regular Medicaid or SCHIP program.

2. Application for RMA benefits must fall within the established time limit of eight months from the date of arrival in the United States for refugees or from the date asylees are granted asylum.

3. The individual must not be enrolled as a full-time student in an institution of higher education unless it is a one-year recertification program which is part of the refugee's comprehensive resettlement plan.

4. The individual must provide the name of the sponsoring Refugee Resettlement Agency.

a. Asylees are exempt from this requirement.

5. Applicants for refugee medical assistance must meet income and resource guidelines.

B. A newborn may receive RMA coverage if both parents meet the RMA requirements or the mother is receiving RMA when the child is born.

1. These children can receive RMA until the end of the mother's period of eligibility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Public Law 82-414, 8 U.S. Code 1522 (e)(5).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1112 (June 2009).

§105. Covered Services

A. Recipients of RMA are eligible to receive the full range of Medicaid covered services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Public Law 82-414, 8 U.S. Code 1522 (e)(5).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1113 (June 2009).

§107. Certification Period

A. Refugee medical assistance coverage begins the month of application.

B. The certification period shall not exceed eight months from the date of entry. For Afghan Special Immigrants, the certification period shall not exceed six months from the date of entry.

1. The date of entry for asylees is the date the individual is granted asylum.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Public Law 82-414, 8 U.S. Code 1522 (e)(5).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1113 (June 2009).

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXXIII. Behavioral Health Services

**Subpart 1. Healthy Louisiana and
Coordinated System of Care Waiver**

**Chapter 1. Managed Care
Organizations and the Coordinated
System of Care Contractor**

§101. General Provisions

A. The Medicaid Program hereby adopts provisions to establish a comprehensive system of delivery for specialized behavioral health and physical health services. These services shall be administered through the Healthy Louisiana and Coordinated System of Care (CSoC) Waiver under the authority of the Department of Health (LDH), in collaboration with managed care organizations (MCOs) and the coordinated system of care (CSoC) contractor, which shall be responsible for the necessary operational and administrative functions to ensure adequate service coordination and delivery.

B. The provisions of this Rule shall apply only to the services provided to Medicaid recipients/enrollees by or through an MCO or the CSoC contractor.

C. Managed care organizations shall operate as such, and the CSoC contractor shall operate as a prepaid inpatient health plan (PIHP). The MCOs and the CSoC contractor were procured through a competitive request for proposal (RFP) process. The MCOs and CSoC contractor shall assist with the state's system reform goals to support individuals with behavioral health and physical health needs in families' homes, communities, schools and jobs.

D. Through the utilization of MCOs and the CSoC contractor, it is the department's goal to:

1. increase access to a broad array of evidence-based home and community-based services that promote hope, recovery and resilience;
2. improve quality by establishing and measuring outcomes;
3. manage costs through effective utilization of State, federal, and local resources; and
4. foster reliance on natural supports that sustain individuals and families in homes and communities.

E. The CSoC contractor shall be paid on a risk basis for specialized behavioral health services rendered to children/youth enrolled in the Coordinated System of Care Waiver. The MCOs shall be paid on a risk basis for specialized behavioral health and physical health services rendered to adults and children/youth.

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 38:360 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2353 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 43:321 (February 2017), LR 44:1889 (October 2018).

§103. Recipient Participation

A. The following Medicaid recipients shall be mandatory participants for integrated specialized behavioral health and physical health services:

1. children who are blind or have a disability and related populations, under age 18;
2. aged and related populations, age 65 and older who are not blind, do not have a disability, and are not members of the §1931 adult population;
3. children who receive foster care or adoption assistance (title IV-E), or who are in foster care or who are otherwise in an out-of-home placement;
4. children with special health care needs as defined in §1932(a);
5. Native Americans;
6. full dual eligibles (for behavioral health services only and non-emergency medical transportation (NEMT));
7. children residing in an intermediate care facility for persons with intellectual disabilities (for behavioral health services only and NEMT);
8. all enrollees of waiver programs administered by the LDH Office for Citizens with Developmental Disabilities (OCDD) or the LDH Office of Aging and Adult Services (OAAS) (mandatory for behavioral health services only and NEMT);
9. all Medicaid children functionally eligible for the CSoC;
10. adults residing in a nursing facility (for behavioral health services only and NEMT);
11. supplemental security income/transfer of resources/long-term care related adults and children (for behavioral health services only and NEMT); and
12. transfer of resources/long-term care adults and children (for behavioral health services only and NEMT).

NOTE: Recipients qualifying for retroactive eligibility are enrolled in the waiver.

B. Mandatory participants shall be automatically enrolled and disenrolled from the MCOs.

C. Notwithstanding the provisions of Subsection A of this Section, the following Medicaid recipients are excluded from enrollment in the MCOs and the CSoC contractor:

1. for adults and children:
 - a. refugee cash assistance;
 - b. refugee medical assistance;
 - c. spend-down medically needy;
 - d. specified low-income beneficiaries (SLMB)-only;
 - e. aliens emergency services;
 - f. qualified individuals (QI) 1;
 - g. long-term care (LTC) co-insurance;
 - h. qualified disabled and working individuals (QDWI); and
 - i. qualified medicare beneficiaries (QMB)-only; and
2. adult-only populations excluded from the 1915(b) waiver:
 - a. residents of an ICF/ID;
 - b. Program of All Inclusive Care for the Elderly (PACE); and
 - c. Take Charge Plus.

D. Any Medicaid eligible person is suspended from participation during a period of incarceration.

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 38:361 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:1286 (July 2015), LR 41:2354 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 43:321 (February 2017), LR 44:1889 (October 2018).

§105. Enrollment Process

A. The MCOs and the CSoC contractor shall abide by all enrollment and disenrollment policies and procedures as outlined in the contract entered into by department.

B. The MCOs and the CSoC contractor shall ensure that mechanisms are implemented to assess each Medicaid enrollee identified as having special health care needs in order to identify any ongoing conditions that require a course of treatment or regular care monitoring. The assessment mechanism shall incorporate appropriate health care professionals.

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

38:361 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2354 (November 2015).

§107. Enrollee Rights and Responsibilities

A. The enrollee's rights shall include, but are not limited to the right to:

1. participate in treatment decisions, including the right to:
 - a. refuse treatment;
 - b. seek second opinions; and
 - c. receive assistance with care coordination from the primary care providers (PCP's) office or the enrollee's behavioral health provider;
2. express a concern about their provider or the care rendered via a grievance process;
3. appeal an MCO and CSoC contractor decision through the MCO's and CSoC contractor's internal process and/or the state fair hearing process;
4. receive a response about a grievance or appeal decision within a reasonable period of time determined by the department;
5. receive a copy of his/her medical records;
6. be furnished health care services in accordance with federal regulations, including those governing access standards;
7. choose a participating network health care professional in accordance with federal and state regulations; and
8. be allowed to receive a specialized service outside of the network if a qualified provider is not available through the network.

B. The Medicaid recipient/enrollee's responsibilities shall include, but are not limited to:

1. informing their MCO or CSoC contractor of the loss or theft of their Medicaid identification card;
2. presenting their identification card when accessing behavioral health services;
3. being familiar with their MCO's or CSoC contractor's procedures to the best of his/her abilities;
4. contacting their MCO or CSoC contractor, by telephone or in writing (formal letter or electronically, including email), to obtain information and have questions clarified;
5. providing participating network providers, or any other authorized provider, with accurate and complete medical information;
6. following the prescribed treatment of care recommended by the provider or letting the provider know the reasons the treatment cannot be followed, as soon as possible;

7. making every effort to keep any agreed upon appointments and follow-up appointments and contacting the provider in advance if unable to do so; and

8. accessing services only from specified providers contracted with their MCO or CSOC contractor.

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 38:361 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2354 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 43:322 (February 2017).

Chapter 3. Managed Care Organizations and the Coordinated System of Care Contractor Participation

§301. Participation Requirements and Responsibilities

A. In order to participate in the Medicaid Program, an MCO and the CSOC contractor shall execute a contract with the department, and shall comply with all of the terms and conditions set forth in the contract.

B. MCOs and the CSOC contractor shall:

1. manage contracted services;
2. establish credentialing and re-credentialing policies consistent with federal and state regulations;
3. ensure that provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment;
4. maintain a written contract with subcontractors that specifies the activities and reporting responsibilities delegated to the subcontractor, and such contract shall also provide for the MCOs' or CSOC contractor's right to revoke said delegation, terminate the contract, or impose other sanctions if the subcontractor's performance is inadequate;
5. contract only with providers of services who are licensed and/or certified according to state laws, regulations, rules, the provider manual and other notices or directives issued by the department, meet the state of Louisiana credentialing criteria and enrolled with the Bureau of Health Services Financing, or its designated contractor, after this requirement is implemented;
6. ensure that contracted rehabilitation providers are employed by a rehabilitation agency or clinic licensed and authorized under state law to provide these services;
7. sub-contract with a sufficient number of providers to render necessary services to Medicaid recipients/enrollees;
8. require each provider to implement mechanisms to assess each Medicaid enrollee identified as having special

health care needs in order to identify special conditions of the enrollee that require a course of treatment or regular care monitoring;

9. ensure that treatment plans or plans of care meet the following requirements:

a. are developed by the enrollee's primary care provider (PCP) or behavioral health provider with the enrollee's participation and in consultation with any specialists' providing care to the enrollee, with the exception of treatment plans or plans of care developed for recipients in the Home and Community Based Services (HCBS) Waiver. The wraparound agency shall develop plans of care according to wraparound best practice standards for recipients who receive behavioral health services through the HCBS Waiver;

b. are approved by the MCO or CSOC contractor in a timely manner, if required;

c. are in accordance with any applicable state and federal quality assurance and utilization review standards; and

d. allow for direct access to any specialist for the enrollee's condition and identified needs, in accordance with the contract; and

10. ensure that Medicaid recipients/enrollees receive information:

a. in accordance with federal regulations and as described in the contract and departmental guidelines;

b. on available treatment options and alternatives in a manner appropriate to the enrollee's condition and ability to understand; and

c. about available experimental treatments and clinical trials along with information on how such research can be accessed even though the Medicaid Program will not pay for the experimental treatment.

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 38:362 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2355 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 43:322 (February 2017), LR 44:1889 (October 2018).

§303. Benefits and Services

A. Benefits and services shall be rendered to Medicaid recipients/enrollees as provided under the terms of the contract and department-issued guidelines.

B. The MCO and CSOC contractor:

1. shall ensure that medically necessary services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are being furnished and shall not be more restrictive than services provided under the Medicaid State Plan;

2. may not arbitrarily deny or reduce the amount, duration, or scope of a required service because of diagnosis, type of illness, or condition of the member;

3. may place appropriate limits on a service:

a. on the basis of medical necessity; and

b. for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose;

4. shall provide benefits and services as outlined and defined in the contract and shall provide medically necessary and appropriate care to enrollees; and

C. The benefits and services provided to enrollees shall include, but are not limited to, those services specified in the contract between the MCOs and the CSoC contractor and the department.

1. Policy transmittals, State Plan amendments, Rules and regulations, provider bulletins, provider manuals and fee schedules issued by the department are the final authority regarding services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:362 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2355 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 43:322 (February 2017).

§305. Service Delivery

A. The MCOs and CSoC contractor shall ensure that services rendered to enrollees are medically necessary, are authorized or coordinated, and are provided by professionals according to their scope of practice and licensing in the state of Louisiana.

B. Access to emergency services and family-oriented services shall be assured within the network.

C. MCOs shall offer a contract to all federally qualified health centers (FQHCs), rural health clinics (RHCs), and tribal clinics. Enrollees shall have a choice of available providers in the plan's network to select from. The CSoC contractor shall be required to contract with at least one FQHC in each medical practice region of the state (according to the practice patterns within the state) if there is an FQHC which can provide substance use disorder services or specialty mental health services under state law and to the extent that the FQHC meets the required provider qualifications.

D. MCOs and the CSoC contractor shall ensure that the recipient is involved throughout the planning and delivery of services.

1. Services shall be:

a. delivered in a culturally and linguistically competent manner; and

b. respectful of the individual receiving services.

2. Services shall be appropriate to individuals of diverse racial, ethnic, religious, sexual, and gender identities and other cultural and linguistic groups.

3. Services shall be appropriate for:

a. age;

b. development; and

c. education.

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 38:363 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2356 (November 2015).

Chapter 5. Reimbursement

§501. General Provisions

A. For recipients enrolled in one of the MCOs or with the CSoC contractor, the department or its fiscal intermediary shall make monthly capitation payments to the MCOs or CSoC contractor.

1. The capitation rates paid to the MCOs or CSoC contractor shall be actuarially sound rates.

2. The MCOs or CSoC contractor will determine the rates paid to its contracted providers.

a. No payment shall be less than the minimum Medicaid rate.

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 38:363 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 39:317 (February 2013), LR 41:2356 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1890 (October 2018).

§503. Directed Payments

A. Provider Directed Payments

1. Subject to written approval by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), the Department of Health (hereafter referred to as "the department" and/or "LDH") shall provide directed payments to qualifying providers that participate in the Healthy Louisiana Medicaid managed care program or Coordinated System of Care (CSoC) waiver, in accordance with the applicable section 438.6(c) preprint(s) approved by CMS, federal regulations, and departmental requirements. Each CMS approved directed payment arrangement is effective for one Healthy Louisiana Medicaid managed care or CSoC contract rating period, unless otherwise approved by CMS.

2. Qualifying Provider

a. High fidelity wraparound agencies (WAA) and wraparound facilitators (WF), WF supervisors, WAA coaches, and WAA administrators that meet the criteria specified in the applicable section 438.6(c) preprint approved by CMS and departmental requirements; or

b. Peer support specialists, supervisors, trainers, and administrators employed by the family support organization (FSO) that meet the criteria specified in the applicable section 438.6(c) preprint approved by CMS and departmental requirements; or

c. Licensed mental health practitioners (LMHPs) and psychiatrists that provide behavioral health outpatient services and that meet the criteria specified in the applicable section 438.6(c) preprint approved by CMS and departmental requirements.

3. The Healthy Louisiana Medicaid managed care organization (MCO) and CSoc contractor shall assign qualifying providers to provider classes based upon criteria specified in the applicable section 438.6(c) preprint(s) approved by CMS, in accordance with departmental requirements.

a. Qualifying providers shall have no right to an administrative appeal regarding the qualifying provider criteria or determination of which providers meet the qualifying provider criteria.

4. The MCO and CSoc contractor shall utilize a payment process, whereby directed payments will be calculated and paid out based on the data and methodology specified in the applicable section 438.6(c) preprint(s) approved by CMS, in accordance with departmental requirements.

a. Qualifying providers shall have no right to an administrative appeal regarding calculation of directed payments or measurement rates.

5. Based upon the methodology specified in the applicable section 438.6(c) preprint(s) approved by CMS, in accordance with departmental requirements, the department shall cause directed payments to be paid in a single upfront lump sum payment to the MCOs; and payments shall be paid to the CSoc contractor within 30 days of receipt of invoice(s), on a retrospective basis.

a. Funding for the directed payments is only available during the time period in the applicable section 438.6(c) preprint(s) approved by CMS or until payments are exhausted, whichever comes first.

6. In accordance with the applicable section 438.6(c) preprint(s) approved by CMS and departmental requirements, directed payments must be based on actual utilization and delivery of services during the applicable contract period.

a. Within six months of the end of the rating period, the MCOs and CSoc contractor shall perform a reconciliation as specified in the applicable section 438.6(c) preprint approved by CMS or as otherwise dictated in accordance with departmental requirements.

i. Qualifying providers shall have no right to an administrative appeal regarding any issue related to reconciliation, including, but not limited to, the timing, amount of the reconciliation, and process.

7. If a qualifying provider is subject to a reconciliation, the qualified provider shall pay all amounts owed to the MCO or CSoc contractor, in accordance with departmental requirements.

a. In addition to all other available remedies, the MCO and the CSoc contractor has the authority to offset all amounts owed by a qualifying provider due to a reconciliation against any payment owed to the qualifying provider, including, but not limited to, any payment owed by the MCOs or CSoc contractor.

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 of Behavioral Health, LR 49:1218 (July 2023).

Chapter 7. Grievance and Appeals Process

§701. General Provisions

A. The MCOs and the CSoc contractor shall be required to have an internal grievance system and internal appeal process. The appeal process allows a Medicaid recipient/enrollee to challenge a decision made, a denial of coverage, or a denial of payment for services.

B. An enrollee, an enrollee's authorized representative or a provider on behalf of an enrollee, with the enrollee's prior written consent, has 60 calendar days from the date on the notice of action in which to file an appeal.

C. An enrollee, an enrollee's authorized representative or a provider on behalf of an enrollee, with the enrollee's prior written consent, may file a grievance at any time after an occurrence or incident which is the basis for the grievance.

D. An enrollee must exhaust the MCO or the CSoc contractor grievance and appeal process before requesting a state fair hearing.

E. The MCO and CSoc contractor shall provide Medicaid enrollees with information about the state fair hearing process within the timeframes established by the department and in accordance with the state fair hearing policies.

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 38:363 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2356 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 43:322 (February 2017), LR 44:1890 (October 2018).

§703. Provider Grievance and Appeal Process

A. If the provider is filing a grievance or appeal on behalf of the member, the provider shall adhere to the provisions outlined in §701 of this Chapter.

B. The MCO and CSoc contractor must have a grievance and appeals process for claims, medical necessity, and contract disputes for providers in accordance with the contract and department issued guidance.

1. The MCO and CSoc contractor shall establish and maintain a procedure for the receipt and prompt internal resolution of all provider initiated grievances and appeals as specified in the contract and department issued guidance.

2. The grievance and appeals procedures, and any changes thereto, must be approved in writing by the department prior to their implementation.

3. Notwithstanding any MCO, CSoc contractor, or department grievance and appeal process, nothing contained in any document, including, but not limited to Rule or contract, shall preclude a provider's right to pursue relief through a court of appropriate jurisdiction.

4. The MCO and CSoc contractor shall report on a monthly basis all grievance and appeals filed and resolutions in accordance with the terms of the contract and department issued guidance.

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 of Behavioral Health, LR 49:1219 (July 2023).

Chapter 9. Monitoring Activities**§901. General Provisions**

A. The contracted MCOs and the CSoc contractor shall be accredited by an accrediting body that is designated in the contract, or agrees to submit an application for accreditation at the earliest possible date as allowed by the accrediting body. Once accreditation is achieved, it shall be maintained through the life of this agreement.

B. The MCOs and CSoc contractor shall be required to track grievances and appeals, network adequacy, access to services, service utilization, quality measure and other monitoring and reporting requirements in accordance with the contract with the department.

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 38:363 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2356 (November 2015).

Subpart 2. General Provisions**Chapter 17. Behavioral Health Services Reimbursements****§1701. Physician Payment Methodology**

A. The reimbursement rates for physician services rendered under the Louisiana Behavioral Health Partnership (LBHP) shall be a flat fee for each covered service as specified on the established Medicaid fee schedule. The reimbursement rates shall be based on a percentage of the Louisiana Medicare Region 99 allowable for a specified year.

B. Effective for dates of service on or after April 20, 2013, the reimbursement for behavioral health services rendered by a physician under the LBHP shall be 75 percent of the 2009 Louisiana Medicare Region 99 allowable for services rendered to Medicaid recipients.

C. Effective for dates of service on or after September 1, 2013, the reimbursement for procedure codes 90791, 90792, 90832, 90834 and 90837 shall be excluded from the January 2013 Medicare rate changes and shall remain at the Medicaid fee schedule on file as of December 31, 2012.

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 Behavioral Health, LR 40:1697 (September 2014), amended LR 40:1935 (October 2014).

Subpart 3. Children's Mental Health Services**Chapter 21. General Provisions****§2101. Introduction**

A. The Medicaid Program hereby adopts provisions to provide coverage under the Medicaid State Plan for mental health services rendered to children and youth with behavioral health disorders. These services shall be administered under the authority of the Department of Health (LDH), in collaboration with managed care organizations (MCOs) and the coordinated system of care (CSoc) contractor, which shall be responsible for the necessary operational and administrative functions to ensure adequate service coordination and delivery. The CSoc contractor shall only manage specialized behavioral health services for children and youth enrolled in the coordinated system of care.

B. The specialized behavioral health services rendered to children with emotional or behavioral disorders are those services necessary to reduce the disability resulting from the illness and to restore the individual to his/her best possible functioning level in the community.

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 38:364 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2358 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1892 (October 2018).

§2103. Recipient Qualifications

A. Individuals under the age of 21 with an identified mental health diagnosis, who meet Medicaid eligibility and clinical criteria, shall qualify to receive home and community-based behavioral health services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:364 (February 2012).

Chapter 23. Services

§2301. General Provisions

A. All specialized behavioral health services must be medically necessary. The medical necessity for services shall be determined by a licensed mental health professional (LMHP) or physician who is acting within the scope of his/her professional license and applicable state law.

B. Services provided to children and youth must include communication and coordination with the family and/or legal guardian and, for children in state custody, the custodial agency. Coordination with other child-serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the child's medical record.

1. The agency or individual who has the decision-making authority for a child or youth in state custody must request and approve the provision of services to the recipient.

C. Children who are in need of specialized behavioral health services shall be served within the context of the family and not as an isolated unit.

1. Services shall be:

a. delivered in a culturally and linguistically competent manner; and

b. respectful of the individual receiving services.

2. Services shall be appropriate to children and youth of diverse racial, ethnic, religious, sexual, and gender identities, as well as other cultural and linguistic groups.

3. Services shall also be appropriate for:

a. age;

b. development; and

c. education.

D. Evidence-based practices require prior approval and fidelity reviews on an ongoing basis as determined necessary by the department.

E. Services may be provided at a site-based facility, in the community, or in the individual's place of residence as outlined in the treatment plan.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:364 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2358 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1892 (October 2018), LR 50:983 (July 2024).

§2303. Covered Services

A. The following behavioral health services shall be reimbursed under the Medicaid Program:

1. therapeutic services delivered by licensed mental health professionals (LMHP), provisionally licensed professional counselors (PLPC), provisionally licensed marriage and family therapists (PLMFT), or licensed master social workers (LMSW);

2. rehabilitation services, including community psychiatric support and treatment (CPST) and psychosocial rehabilitation (PSR);

3. crisis intervention services; and

4. crisis stabilization services.

B. Service Exclusions. The following services shall be excluded from Medicaid reimbursement:

1. components that are not provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual;

2. services provided at a work site which are job tasks oriented and not directly related to the treatment of the recipient's needs;

3. any services or components in which the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of an individual receiving services;

4. services rendered in an institute for mental disease other than a psychiatric residential treatment facility (PRTF) or an inpatient psychiatric hospital; and

5. the cost of room and board associated with crisis stabilization.

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 38:364 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2359 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1892 (October 2018), LR 50:983 (July 2024).

Chapter 25. Provider Participation

§2501. Provider Responsibilities

A. Each provider of specialized behavioral health services shall enter into a contract with one or more of the managed care organizations (MCOs) and with the coordinated system of care (CSoC) contractor for youth enrolled in the Coordinated System of Care program in order to receive reimbursement for Medicaid covered services.

B. Providers shall deliver all services in accordance with their license and scope of practice, federal and state laws and regulations, the provisions of this Rule, the provider manual, and other notices or directives issued by the department. The provider shall create and maintain documents to substantiate that all requirements are met.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:364 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2359 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1893 (October 2018), LR 46:794 (June 2020), repromulgated LR 46:951 (July 2020).

Chapter 27. Reimbursement

§2701. General Provisions

A. For recipients enrolled with one of the managed care organizations (MCOs) or coordinated system of care (CSoC) contractor, the department or its fiscal intermediary shall make monthly capitation payments to the MCOs or the CSoC contractor.

1. The capitation rates paid to MCOs or the CSoC contractor shall be actuarially sound rates.

2. The MCOs or the CSoC contractor will determine the rates paid to its contracted providers.

a. No payment shall be less than the minimum Medicaid rate.

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 38:365 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 39:317 (February 2013), LR 41:2359 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1893 (October 2018), LR 46:794 (June 2020), repromulgated LR 46:951 (July 2020).

§2703. Reimbursement Methodology

A. Effective for dates of service on or after July 1, 2012, the reimbursement rates for the following behavioral health services provided to children/adolescents shall be reduced by 1.44 percent of the rates in effect on June 30, 2012:

1. therapeutic services;

2. rehabilitation services; and
3. crisis intervention services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2359 (November 2015).

Subpart 5. School-Based Behavioral Health Services

Chapter 41. General Provisions

§4101. Introduction

A. The Medicaid Program hereby adopts provisions to provide coverage under the Medicaid state plan for school-based behavioral health services rendered to children and youth with behavioral health disorders. These services shall be administered under the authority of the Department of Health.

B. The school-based behavioral health services rendered to children with emotional or behavioral disorders are medically necessary behavioral health services provided to Medicaid recipients in accordance with an individualized education plan (IEP), a section 504 accommodation plan pursuant to 34 C.F.R. §104.36, an individualized health care plan or are otherwise medically necessary.

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 38:400 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2171 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 45:568 (April 2019), LR 46:185 (February 2020).

§4103. Recipient Qualifications

A. Individuals at least 3 years of age and under the age of 21, who meet Medicaid eligibility and clinical criteria, shall qualify to receive behavioral health services in a setting determined by the IEP.

B. Qualifying children and adolescents must have been determined eligible for Medicaid and behavioral health services covered under Part B of the Individuals with Disabilities Education Act (IDEA), with a written service plan [an IEP, section 504 plan or individualized health care plan (IHP)] which contains medically necessary services recommended by a physician or other licensed practitioner, within the scope of his or practice under state law.

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 38:400 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2172 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the

Office of Behavioral Health, LR 45:568 (April 2019), LR 46:185 (February 2020).

Chapter 43. Services

§4301. General Provisions

A. The Medicaid Program shall provide coverage for behavioral health services pursuant to §1905(a) of the Social Security Act which are addressed in the IEP, section 504 plan, IHP or otherwise medically necessary, and that correct or ameliorate a child's health condition.

B. Services must be performed by qualified providers who provide school-based behavioral health services as part of their respective area of practice (e.g. psychologist providing a behavioral health evaluation and/or services). Services rendered by certified school psychologists must be supervised consistent with R.S. 17:7.1.

C. Services shall be provided in accordance with the established service limitations.

D. Children who are in need of behavioral health services shall be served within the context of the family and not as an isolated unit.

1. Services shall be:

a. delivered in a culturally and linguistically competent manner; and

b. respectful of the individual receiving services.

2. Services shall be appropriate to children and youth of diverse racial, ethnic, religious, sexual, and gender identities and other cultural and linguistic groups.

3. Services shall also be appropriate for:

a. age;

b. development; and

c. education.

E. Evidence-based practices require prior approval and fidelity reviews on an ongoing basis as determined necessary by the department.

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 38:400 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2172 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 45:568 (April 2019), LR 46:186 (February 2020).

§4303. Covered Services

A. School-based behavioral health services shall include Medicaid-covered services, including treatment and other services to correct or ameliorate an identified mental health or substance use diagnosis. Services are provided by or through a local education agency (LEA) to children with, or suspected of having, a disability and who attend public school in Louisiana.

B. The following school based behavioral health services shall be reimbursed under the Medicaid Program:

1. therapeutic services, including diagnosis and treatment; and

2. substance use.

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 38:400 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:384 (February 2015), LR 41:2172 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 45:569 (April 2019), LR 46:186 (February 2020).

§4305. Service Limitations and Exclusions

A. The Medicaid Program shall not cover school based behavioral health services performed solely for educational purposes (e.g. academic testing). Only services that are reflected in the IEP, section 504 plan, IHP (as determined by the assessment and evaluation) or otherwise medically necessary shall be covered.

B. Social needs, educational needs, or habilitative services are not covered school based behavioral health services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:401 (February 2012), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 45:569 (April 2019), LR 46:186 (February 2020).

Chapter 45. Provider Participation

§4501. Local Education Agency Responsibilities

A. The LEA shall ensure that its licensed and unlicensed behavioral health practitioners are employed according to the requirements specified under IDEA.

B. An LEA shall ensure that individual practitioners are in compliance with Medicaid qualifications, Department of Education Bulletin 746, and Louisiana Standards for State Certification of School Personnel prior to billing the Medicaid Program for any school based behavioral health services rendered by clinicians.

C. All services shall be delivered in accordance with federal and state laws and regulations, the provisions of this Rule, the provider manual, and other notices or directives issued by the department.

D. Providers of behavioral health services shall ensure that all services are authorized and any services that exceed established limitations beyond the initial authorization are approved for re-authorization prior to service delivery.

E. Anyone providing behavioral health services must be operating within the scope of practice of their applicable

license. The provider shall create and maintain documents to substantiate that all requirements are met.

F. Providers shall maintain case records that include, at a minimum:

1. a copy of the treatment plan;
 2. a copy of the IEP, IHP, etc.;
 3. the name of the child or youth receiving services;
 4. the dates of service;
 5. the nature, content and units of services provided;
 6. the progress made toward functional improvement;
- and
7. the goals of the treatment plan.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:401 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:385 (February 2015), LR 41:2172 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 45:569 (April 2019), LR 46:186 (February 2020).

Chapter 47. Payments

§4701. Reimbursement Methodology

A. Payments for school based behavioral health services shall be based on the most recent school year's actual cost as determined by desk review and/or audit for each LEA provider.

1. Each LEA shall determine cost annually by using LDH's cost report for behavioral health service cost form based on the direct services cost report.

2. Direct cost shall be limited to the amount of total compensation (salaries, vendor payments and fringe benefits) of current behavioral health service providers as allocated to medical services for Medicaid recipients. The direct cost related to the electronic health record shall be added to the compensation costs to arrive at the total direct costs for behavioral health services. There are no additional direct costs included in the rate.

3. Indirect cost shall be derived by multiplying the cognizant agency indirect cost unrestricted rate assigned by the Department of Education to each LEA. There are no additional indirect costs included.

4. To determine the amount of behavioral health services cost that may be attributed to Medicaid; the ratio of total Medicaid students in the LEA to all students in the LEA is multiplied by total direct cost. Cost data is subject to certification by each LEA. This serves as the basis for obtaining federal Medicaid funding.

B. For the medical services, the participating LEAs' actual cost of providing the services shall be claimed for

federal financial participation (FFP) based on the following methodology.

1. The state shall gather actual expenditure information for each LEA through its payroll/benefits and accounts payable system.

2. Develop Direct Cost-The Payroll Cost Base. Total annual salaries and benefits paid, as well as contracted (vendor) payments, shall be obtained initially from each LEA's payroll/benefits and accounts payable system. This data shall be reported on LDH's behavioral health services cost report form for all behavioral health service personnel (i.e. all personnel providing LEA behavioral health treatment services covered under the state plan).

3. Adjust the Payroll Cost Base. The payroll cost base shall be reduced for amounts reimbursed by other funding sources (e.g., federal grants). The payroll cost base shall not include any amounts for staff whose compensation is 100 percent reimbursed by a funding source other than state/local funds. This application results in total adjusted salary cost.

4. Determine the Percentage of Time to Provide All behavioral health Services. A time study which incorporates the CMS-approved Medicaid administrative claiming (MAC) methodology for nursing service personnel shall be used to determine the percentage of time nursing service personnel spend on behavioral health services and general and administrative (G and A) time. This time study will assure that there is no duplicate claiming. The G and A percentage shall be reallocated in a manner consistent with the CMS-approved Medicaid administrative claiming methodology. Total G and A time shall be allocated to all other activity codes based on the percentage of time spent on each respective activity. To reallocate G and A time to behavioral health services, the percentage of time spent on behavioral health services shall be divided by 100 percent minus the percentage of G and A time. This shall result in a percentage that represents the behavioral health services with appropriate allocation of G and A. This percentage shall be multiplied by total adjusted salary cost as determined under Paragraph B.4 above to allocate cost to school based services. The product represents total direct cost.

- a. A sufficient number of behavioral health service personnel's time shall be sampled to ensure results that will have a confidence level of at least 95 percent with a precision of plus or minus 5 percent overall.

5. Determine Indirect Cost. Indirect cost shall be determined by multiplying each LEA's indirect unrestricted rate assigned by the cognizant agency (the Department of Education) by total adjusted direct cost as determined under Paragraph B.3 above. No additional indirect cost shall be recognized outside of the cognizant agency indirect rate. The sum of direct cost and indirect cost shall be the total direct service cost for all students receiving behavioral health services.

6. Allocate Direct Service Cost to Medicaid. To determine the amount of cost that may be attributed to Medicaid, total cost as determined under Paragraph B.5

above 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 behavioral health services cost.

C. Reconciliation of LEA Certified Costs and Medicaid Management Information System (MMIS) Paid Claims. Each LEA shall complete the behavioral health 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 behavioral health 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 nursing services. The Medicaid certified cost expenditures from the behavioral health services cost report(s) will be reconciled against the MMIS paid claims data and the department shall issue a notice of final settlement pending audit that denotes the amount due to or from the LEA. This reconciliation is inclusive of all behavioral health services provided by the LEA.

D. Cost Settlement Process. As part of its financial oversight responsibilities, the department shall develop audit and review procedures to audit and process final settlements for certain LEAs. The audit plan shall include a risk assessment of the LEAs using available paid claims data to determine the appropriate level of oversight.

1. The financial oversight of all LEAs shall include reviewing the costs reported on the behavioral health services cost reports against the allowable costs, performing desk reviews and conducting limited reviews.

2. The department will make every effort to audit each LEA at least every four years. These activities shall be performed to ensure that audit and final settlement occurs no later than two years from the LEA's fiscal year end for the cost reporting period audited. LEAs may appeal audit findings in accordance with LDH appeal procedures.

3. The department shall adjust the affected LEA's payments no less than annually, when any reconciliation or final settlement results in significant underpayments or overpayments to any LEA. By performing the reconciliation and final settlement process, there shall be no instances where total Medicaid payments for services exceed 100 percent of actual, certified expenditures for providing LEA services for each LEA.

4. If the interim payments exceed the actual, certified costs of an LEA's Medicaid services, the department shall recoup the overpayment in one of the following methods:

a. offset all future claim payments from the affected LEA until the amount of the overpayment is recovered;

b. recoup an agreed upon percentage from future claims payments to the LEA to ensure recovery of the overpayment within one year; or

c. recoup an agreed upon dollar amount from future claims payments to the LEA to ensure recovery of the overpayment within one year.

5. If the actual certified costs of an LEA's Medicaid services exceed interim Medicaid payments, the department will pay this difference to the LEA in accordance with the final actual certification agreement.

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 38:401 (February 2012), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 45:569 (April 2019).

Subpart 7. Adult Mental Health Services

Chapter 61. General Provisions

§6101. Introduction

A. The Medicaid Program provides coverage under the Medicaid State Plan for mental health services rendered to adults with mental health disorders. These services shall be administered under the authority of the Department of Health and Hospitals, in collaboration with the managed care organizations (MCOs), which shall be responsible for the necessary operational and administrative functions to ensure adequate service coordination and delivery.

B. The mental health services rendered to adults shall be necessary to reduce the disability resulting from mental illness and to restore the individual to his/her best possible functioning level in the community.

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 38:358 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 42:59 (January 2016).

§6103. Recipient Qualifications

A. Individuals 21 years of age and older who meet Medicaid eligibility shall qualify to receive adult mental health services referenced in LAC 50:XXXIII.6307 if medically necessary in accordance with LAC 50:I.1101, if the recipient presents with mental health symptoms that are consistent with a diagnosable mental disorder, and the services are therapeutically appropriate and most beneficial to the recipient.

B. Additional Recipient Eligibility Criteria for Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR)

1. Members must meet the Substance Abuse and Mental Health Services Administration (SAMHSA) definition of, serious mental illness (SMI). In addition to having a diagnosable mental disorder, the condition must

substantially interfere with, or limit, one or more major life activities, such as:

- a. basic daily living (for example, eating or dressing);
- b. instrumental living (for example, taking prescribed medications or getting around the community); or
- c. participating in a family, school, or workplace.

2. A member must have a rating of three or greater on the functional status domain on the level of care utilization system (LOCUS).

3. Recipients receiving CPST and/or PSR shall have at least a level of care score of three on the LOCUS.

4. An adult with longstanding deficits who does not experience any acute changes in their status and has previously met the criteria stated in LAC 50:XXXIII.6103.B.2.-3, but who now meets a level of care score of two or lower, and needs subsequent medically necessary services for stabilization and maintenance at a lower intensity, may continue to receive CPST services and/or PSR, if deemed medically necessary.

C. An adult with a diagnosis of a substance use disorder or intellectual and developmental disability without an additional co-occurring qualifying mental health diagnosis shall not meet the criteria for adult mental health rehabilitation services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:358 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:378 (February 2015), LR 42:60 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1014 (June 2018), LR 46:794 (June 2020), repromulgated LR 46:951 (July 2020), amended LR 50:983 (July 2024).

Chapter 63. Services

§6301. General Provisions

A. All mental health services must be medically necessary, in accordance with the provisions of LAC 50:I.1101. The medical necessity for services shall be determined by a licensed mental health professional or physician who is acting within the scope of his/her professional license and applicable state law.

B. All services must be authorized.

C. There shall be recipient involvement throughout the planning and delivery of services.

1. Services shall be:

- a. delivered in a culturally and linguistically competent manner; and
- b. respectful of the individual receiving services.

2. Services shall be appropriate to individuals of diverse racial, ethnic, religious, sexual, and gender identities and other cultural and linguistic groups.

3. Services shall be appropriate for:

- a. age;
- b. development; and
- c. education.

D. Anyone providing mental health services must operate within their license and scope of practice.

E. Evidence-based practices require prior approval and fidelity reviews on an ongoing basis as determined necessary by department.

F. Services may be provided at a facility, in the community, or in the individual's place of residence as outlined in the treatment plan. Services may be furnished in a nursing facility only in accordance with policies and procedures issued by the department.

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 38:359 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:378 (February 2015), LR 42:60 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1014 (June 2018), repromulgated LR 46:952 (July 2020), amended LR 50:983 (July 2024).

§6303. Assessments

A. Assessments shall be performed by a licensed mental health professional (LMHP), provisionally licensed professional counselor (PLPC), provisionally licensed marriage and family therapist (PLMFT), or licensed master social worker (LMSW).

B. Assessments for community psychiatric support and treatment (CPST) and psychosocial rehabilitation (PSR) must be performed by a fully licensed mental health professional at least once every 365 days or any time there is significant change to the enrollee's circumstances.

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 38:359 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:378 (February 2015), LR 42:60 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1014 (June 2018), amended LR 46:795 (June 2020), repromulgated LR 46:952 (July 2020), amended LR 50:983 (July 2024).

§6305. Treatment Plan

A. Each enrollee who receives community psychiatric support and treatment (CPST) and psychosocial

rehabilitation (PSR) services shall have a treatment plan developed based upon the assessment.

B. The individualized treatment plan shall be developed according to the criteria established by the department and in accordance with the provisions of this Rule, the provider manual and other notices or directives issued by the department.

1. The treatment plan shall be reviewed at least once every 180 days or when there is a significant change in the individual's circumstances.

C. The treatment plan shall be developed by the licensed mental health professional (LMHP) in collaboration with direct care staff, the recipient, family and natural supports.

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 38:359 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 42:60 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1014 (June 2018), LR 46:795 (June 2020), repromulgated LR 46:951 (July 2020), amended LR 50:984 (July 2024).

§6307. Covered Services

A. The following mental health services shall be reimbursed under the Medicaid Program:

1. therapeutic services delivered by licensed mental health professionals (LMHPs), provisionally licensed professional counselors (PLPC), provisionally licensed marriage and family therapists (PLMFT), or licensed master social workers (LMSW), and physicians;

2. rehabilitation services, including community psychiatric support and treatment (CPST), psychosocial rehabilitation (PSR), and peer support services;

3. crisis intervention; and

4. crisis stabilization.

B. Service Exclusions. The following shall be excluded from Medicaid reimbursement:

1. components that are not provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual;

2. services provided at a work site which are job tasks oriented and not directly related to the treatment of the recipient's needs; and

3. any services or components in which the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of an individual receiving services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:359 (February 2012), amended by the Department of Health and

Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 42:61 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1015 (June 2018), LR 46:795 (June 2020), repromulgated LR 46:952 (July 2020), amended LR 46:1680 (December 2020), LR 48:1098 (April 2022), LR 50:984 (July 2024).

Chapter 65. Provider Participation

§6501. Provider Responsibilities

A. Each provider of adult mental health services shall enter into a contract with one or more of the managed care organizations (MCOs) in order to receive reimbursement for Medicaid covered services.

B. Providers shall deliver all services in accordance with their license and scope of practice, with federal and state laws and regulations, the provisions of this Rule, the provider manual and other notices or directives issued by the department. The provider shall create and maintain documents to substantiate that all requirements are met.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:360 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:378 (February 2015), LR 42:61 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1015 (June 2018), LR 46:795 (June 2020), repromulgated LR 46:952 (July 2020), amended LR 50:984 (July 2024).

Chapter 67. Reimbursement

§6701. Reimbursement Methodology

A. Effective for dates of service on or after December 1, 2015, the department, or its fiscal intermediary, shall make monthly capitation payments to the managed care organizations (MCOs).

B. The capitation rates paid to the MCOs shall be actuarially sound rates and the MCOs will determine the rates paid to its contracted providers. No payment shall be less than the minimum Medicaid rate.

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 38:360 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 42:61 (January 2016), LR 46:795 (June 2020), repromulgated LR 46:952 (July 2020).

Subpart 8. Services for Targeted Populations

Chapter 71. General Provisions

§7101. Introduction

A. The Medicaid program hereby adopts provisions to provide coverage under the 1915(b)(3) waiver for services

rendered to the targeted population of adults with mental health disorders who have transitioned from a nursing facility or been diverted from nursing facility level of care. These services shall be administered under the authority of the Department of Health, in collaboration with the managed care organizations (MCOs), which shall be responsible for the necessary operational and administrative functions to ensure adequate service coordination and delivery.

B. Personal care services (PCS) rendered to adults shall be necessary to assist and provide supervision with activities of daily living or to restore the individual to his/her best possible functioning level in the community.

C. Individual placement and support (IPS) services rendered to adults shall be necessary to reduce the disability resulting from mental illness and to restore the individual to his/her best possible functioning level in the community.

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 of Behavioral Health, LR 47:1874 (December 2021).

§7103. Recipient Qualifications

A. The targeted population for the 1915(b)(3) services shall be Medicaid recipients who:

1. are at least 21 years of age;
2. have a qualifying mental health diagnosis;
3. meet medical necessity in accordance with LAC 50:I.1101; and
4. have transitioned from a nursing facility or been diverted from nursing facility level of care.

B. Recipients of personal care services (PCS) must meet the following additional recipient eligibility criteria:

1. recipients must be medically stable;
2. recipients shall not be enrolled in a Medicaid-funded program which offers a personal care service or related benefit; and
3. recipients' care needs do not exceed that which can be provided under the scope and/or service limitations of PCS.

C. An adult with a diagnosis of a substance use disorder or intellectual and developmental disability without an additional co-occurring qualifying mental health diagnosis shall not meet the criteria for mental health 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, Bureau of Health Services Financing and the Office of Behavioral Health, LR 47:1874 (December 2021).

Chapter 73. Services

§7301. General Provisions

A. All services must be medically necessary, in accordance with the provisions of LAC 50:I.1101. The

medical necessity for services shall be determined by a licensed mental health practitioner or physician who is acting within the scope of his/her professional license and applicable state law.

B. All services must be prior authorized. Services which exceed the initial authorization must be approved for re-authorization prior to service delivery.

C. There shall be recipient involvement throughout the planning and delivery of services.

1. Services shall be:
 - a. delivered in a culturally and linguistically competent manner; and
 - b. respectful of the individual receiving services.
2. Services shall be appropriate to individuals of diverse racial, ethnic, religious, sexual, and gender identities and other cultural and linguistic groups.
3. Services shall be appropriate for:
 - a. age;
 - b. development; and
 - c. education.

D. Anyone providing services must operate within their scope of practice license.

E. Evidence-based practices require prior approval and fidelity reviews on an ongoing basis as determined necessary by department.

F. Services must be delivered in home and community-based settings.

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 of Behavioral Health, LR 47:1874 (December 2021).

§7303. Covered Services

A. The following services for the targeted populations shall be reimbursed under the Medicaid Program:

1. personal care services (PCS); and
2. individual placement and support (IPS) services.

B. Service Exclusions. The following shall be excluded from Medicaid reimbursement:

1. components that are not provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual; and
2. services provided at a work site which are not directly related to the treatment of the recipient's needs.

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 of Behavioral Health, LR 47:1874 (December 2021).

Chapter 75. Provider Participation

§7501. Provider Responsibilities

A. Each provider of services for the target populations shall enter into a contract with one or more of the managed care organizations (MCOs) in order to receive reimbursement for Medicaid covered services.

B. Providers shall deliver all services in accordance with their license and scope of practice, federal and state laws and regulations, the provisions of this Rule, and other directives issued by the department. The provider shall create and maintain documents to substantiate that all requirements 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, Bureau of Health Services Financing and the Office of Behavioral Health, LR 47:1875 (December 2021).

Chapter 77. Reimbursement

§7701. Reimbursement Methodology

A. The department, or its fiscal intermediary, shall make monthly capitation payments to the MCOs. The capitation rates paid to the MCOs shall be actuarially sound rates and the MCOs will determine the rates paid to its contracted providers. No payment shall be less than the minimum Medicaid rate.

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 of Behavioral Health, LR 47:1875 (December 2021).

Subpart 9. Home and Community-Based Services Waiver

Chapter 81. General Provisions

§8101. Introduction

A. The Medicaid Program hereby adopts provisions to provide coverage for behavioral health services rendered to children with mental illness and severe emotional disturbances (SED) by establishing a 1915(b)(c) home and community-based services (HCBS) waiver, known as the Coordinated System of Care (CSoC) waiver. This HCBS waiver shall be administered under the authority of the Department of Health, in collaboration with the coordinated system of care (CSoC) contractor, which shall be responsible for the necessary operational and administrative functions to ensure adequate service coordination and delivery.

B. The behavioral health services provided to children in the HCBS waiver are those services necessary to reduce the disability resulting from the illness and to restore the individual to his/her best possible functioning level in the community.

C. The HCBS waiver is designed as a nursing facility and hospitalization diversion program. The goal of this

waiver is to divert nursing facility and psychiatric hospitalization placement through the provision of intensive home and community-based supportive services.

D. Local wraparound agencies will be the locus of treatment planning for the provision of all services. Wraparound agencies are the care management agencies for the day-to-day operations of the waiver in the parishes they serve. The wraparound agencies shall enter into a contract with the CSoC contractor and are responsible for the treatment planning for the HCBS waiver in their areas, in accordance with 42 CFR 438.208(c).

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 38:366 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2361 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 43:323 (February 2017), LR 46:183 (February 2020).

§8103. Recipient Qualifications

A. The target population for the Home and Community-Based Behavioral Health Services Waiver program shall be Medicaid recipients who:

1. are from the age of 5 years old through the age of 20 years old effective March 1, 2017:

a. recipients enrolled in the program prior to this date, who are between the ages of 0 through 4 or 20 through 21, may continue to be served through this waiver as long as they continue to meet the level of care criteria; and

b. prospectively enrolled recipients must be at least age 5 through age 20 to receive waiver services;

2. have a qualifying mental health diagnosis;

3. are identified as seriously emotionally disturbed (SED), which applies to youth under the age of 18 or seriously mentally ill (SMI) which applies to youth ages 18-21;

4. require hospital or nursing facility level of care or are functionally eligible for CSoC, as determined by the department's designated assessment tools and criteria;

5. meet financial eligibility criteria; and

6. reside in a home and community-based setting as defined in 42 CFR 441.301(c)(4) and in accordance with the department's policy and procedures.

B. The need for waiver services is re-evaluated at a minimum of every 180 days, and at any time the family feels that it is appropriate, as needs change, and/or as goals are completed. The re-evaluation determines if the recipient continues to be in need of psychiatric hospitalization or nursing facility level of care.

C. Recipients shall be discharged from the waiver program if one or more of the following criteria is met:

1. the recipient met his/her identified goals on the individualized plan of care created by the child and family team process;
2. the recipient relocated out of state;
3. the recipient no longer meets psychiatric hospital or nursing facility level of care or are functionally ineligible for CSoC, as determined by the department's designated assessment tools and criteria;
4. the recipient no longer meets financial eligibility criteria;
5. the recipient or his/her parent or guardian disengaged from services, evidenced by lack of face-to-face contact for a minimum of 60 consecutive calendar days or by failure to cooperate in the re-evaluation assessment at least every 180 days;
6. the recipient is incarcerated for 30 consecutive calendar days or more; or
7. the recipient is residing in a non-home and community based setting for more than 90 consecutive calendar days.

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 38:366 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2361 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 43:324 (February 2017), LR 44:1895 (October 2018), LR 46:183 (February 2020), LR 50:211 (February 2024).

Chapter 83. Services

§8301. General Provisions

A. All behavioral health services must be medically necessary. The medical necessity for services shall be determined by a licensed mental health practitioner (LMHP) or physician who is acting within the scope of his/her professional license and applicable state law.

B. All services shall be prior authorized. Services which exceed the initial authorization must be approved for re-authorization prior to service delivery.

C. Services provided to children and youth must include communication and coordination with the family and/or legal guardian and custodial agency for children in state custody. Coordination with other child-serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the child's medical record.

1. The agency or individual who has the decision making authority for a child or adolescent in state custody must approve the provision of services to the recipient.

D. Children who are in need of behavioral health services shall be served within the context of the family and not as an isolated unit.

1. Services shall be:
 - a. delivered in a culturally and linguistically competent manner; and
 - b. respectful of the individual receiving services.
2. Services shall be appropriate to children and youth of diverse racial, ethnic, religious, sexual, and gender identities and other cultural and linguistic groups.
3. Services shall also be appropriate for:
 - a. age;
 - b. development; and
 - c. education.

E. Evidence-based practices require prior approval and fidelity reviews on an ongoing basis as determined necessary by the department.

F. Services may be provided at a site-based facility, in the community or in the individual's place of residence as outlined in the plan of care. All service locations must meet the home and community-based service setting criteria in 42 CFR 441.301(c)(4) and in accordance with the department's policy and procedures.

G. Services may be provided by a member of the participant's family, provided that the participant does not live in the family member's residence and the family member is not the legally responsible relative.

1. The following family members may provide the services:
 - a. the parents of an adult recipient;
 - b. siblings;
 - c. grandparents;
 - d. aunts;
 - e. uncles; and
 - f. cousins.

2. The family member must become an employee of the provider agency or contract with the CSoC contractor and must meet the same standards as direct support staff that are not related to the individual.

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 38:367 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2361 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 43:324 (February 2017).

§8303. Service Plan Development

A. The wraparound facilitator is responsible for convening the child and family team to develop the initial waiver specific plan of care within 30 days of receipt of referral from the managed care organization.

B. If new to the system, the recipient will be receiving services based upon the preliminary plan of care (POC) while the wraparound process is being completed.

C. The POC is reviewed every 90 days with the recipient and parents or caregivers of the recipient. The wraparound facilitator works directly with the recipient, the family (or the recipient's authorized health care decision maker) and others to develop the POC. A crisis plan must be included in each recipient's POC.

D. The wraparound agency will facilitate development and implementation of a transition plan for each recipient beginning at the age of 15 years old, as he/she approaches adulthood.

E. Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.

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 38:367 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2362 (November 2015).

§8305. Covered Services

A. The following behavioral health services shall be provided in the HCBS waiver program:

1. short-term respite care;
2. independent living/skills building;
3. youth support and training; and
4. parent support and training.

B. Service Limitations

1. Short term respite care shall be pre-approved for the duration of 72 hours per episode with a maximum of 300 hours allowed per calendar year. Hours in excess of 300 may be authorized when deemed medically necessary.

2. Youth support and training services may not be provided by local education agencies and are limited to 750 hours per calendar year. Hours in excess of 750 may be authorized when deemed medically necessary.

C. Service Exclusions. The following services shall be excluded from Medicaid reimbursement:

1. components that are not provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual;

2. services provided at a work site which are job tasks oriented and not directly related to the treatment of the recipient's needs;

3. any services or components in which the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of an individual receiving services; and

4. services rendered in an institution for mental disease or any other institutional setting as defined in 42 CFR 441.301(c)(4).

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 38:367 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2362 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 43:324 (February 2017).

Chapter 85. Provider Participation

§8501. Provider Responsibilities

A. Each provider of home and community-based behavioral health waiver services shall enter into a contract with the CSoc contractor in order to receive reimbursement for Medicaid covered services.

B. All services shall be delivered in accordance with federal and state laws and regulations, the provisions of this Rule, the provider manual, and other notices or directives issued by the department.

C. Providers of waiver services shall ensure that all services are authorized and any services that exceed established limitations beyond the initial authorization are approved for re-authorization prior to service delivery.

D. Anyone providing behavioral health services must be licensed in accordance with state laws and regulations, in addition to operating within their scope of practice license. Providers requiring certification in accordance with federal or state laws, regulations, rules, the provider manual, or other notices or directives issued by the department must be appropriately certified. To be certified or recertified, providers shall meet the provisions of this Rule, the provider manual and the appropriate statutes. The provider shall create and maintain documents to substantiate that all requirements are met.

E. Providers shall maintain case records that include, at a minimum:

1. a copy of the plan of care;
2. the name of the individual;
3. the dates of service;
4. the nature, content and units of services provided;
5. the progress made toward functional improvement; and
6. the goals of the plan of care.

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 38:368 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2362 (November 2015), amended by the

Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1895 (October 2018).

Chapter 87. Reimbursement

§8701. Reimbursement Methodology

A. The department or its fiscal intermediary shall make monthly capitation payments to the CSoC contractor.

1. The capitation rates paid to the CSoC contractor shall be actuarially sound rates.

2. The CSoC contractor will make payments to its contracted providers.

a. No payment shall be less than the minimum Medicaid rate.

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 38:368 (February 2012), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1895 (October 2018).

Subpart 11. Psychiatric Residential Treatment Facility Services

Chapter 101. General Provisions

§10101. Introduction

A. The Medicaid Program hereby adopts provisions to provide coverage under the Medicaid State Plan for behavioral health services rendered to children and youth in an inpatient psychiatric residential treatment facility (PRTF). These services shall be administered under the authority of the Department of Health and Hospitals, in collaboration with managed care organizations and the coordinated system of care (CSoC) contractor, which shall be responsible for the necessary operational and administrative functions to ensure adequate service coordination and delivery.

B. The behavioral health services rendered to children with emotional or behavioral disorders are those services necessary to reduce the disability resulting from the illness and to restore the individual to his/her best possible functioning level in the community.

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 38:369 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2369 (November 2015).

§10103. Recipient Qualifications

A. Individuals under the age of 21 with an identified mental health or substance use diagnosis, who meet Medicaid eligibility and clinical criteria, shall qualify to receive inpatient psychiatric residential treatment facility services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:369 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2369 (November 2015).

Chapter 103. Services

§10301. General Provisions

A. All behavioral health services must be medically necessary. The medical necessity for services shall be determined by a licensed mental health practitioner (LMHP) or physician who is acting within the scope of his/her professional license and applicable state law.

B. All services shall be prior authorized. Services which exceed the initial authorization must be approved for re-authorization prior to service delivery.

C. Services provided to children and youth must include communication and coordination with the family and/or legal guardian and custodial agency for children in state custody. Coordination with other child-serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the child's medical record.

1. The agency or individual who has the decision making authority for a child or adolescent in state custody must request and approve the provision of services to the recipient.

D. Children who are in need of behavioral health services shall be served within the context of the family and not as an isolated unit.

1. Services shall be:

a. delivered in a culturally and linguistically competent manner; and

b. respectful of the individual receiving services.

2. Services shall be appropriate to children and youth of diverse racial, ethnic, religious, sexual, and gender identities and other cultural and linguistic groups.

3. Services shall also be appropriate for:

a. age;

b. development; and

c. education.

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 38:369 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2369 (November 2015).

§10303. Covered Services

A. The Medicaid Program may reimburse a psychiatric residential treatment facility for the following services:

1. physician (psychiatric) services;
2. pharmacy services;
3. diagnostic and radiology services;
4. laboratory services;
5. dental services;
6. vision services;
7. occupational therapy;
8. physical therapy;
9. speech-language therapy; and
10. transportation services.

B. Service Exclusions. The following services shall be excluded from Medicaid reimbursement:

1. services on the inpatient psychiatric active treatment plan that are not related to the provision of inpatient psychiatric care;
2. group education, including elementary and secondary education; and
3. activities not on the inpatient psychiatric active treatment plan.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:369 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2369 (November 2015).

Chapter 105. Provider Participation

§10501. Provider Responsibilities

A. Each provider of PRTF services shall enter into a contract with one or more of the MCOs and the CSoC contractor in order to receive reimbursement for Medicaid covered services.

B. All services shall be delivered in accordance with federal and state laws and regulations, licensing regulations, the provisions of this Rule, the provider manual, and other notices or directives issued by the department.

C. Providers of PRTF services shall ensure that all services are authorized and any services that exceed established limitations beyond the initial authorization are approved for re-authorization prior to service delivery.

D. Anyone providing PRTF services must be certified by the department, or its designee, in addition to operating within their scope of practice license. To be certified or recertified, providers shall meet the provisions of this Rule, the provider manual and the appropriate statutes. The provider shall create and maintain documents to substantiate that all requirements are met.

E. PRTF facilities shall be accredited by an approved accrediting body and maintain such accreditation. Denial,

loss of or any negative change in accreditation status must be reported to its contracted MCOs and the CSoC contractor in writing within the time limit established by the department.

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 38:369 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2369 (November 2015).

Chapter 107. Reimbursement

§10701. General Provisions

A. For recipients enrolled with the CSoC contractor, reimbursement for services shall be based upon the established Medicaid fee schedule for behavioral health services. For recipients enrolled in one of the MCOs, the department or its fiscal intermediary shall make monthly capitation payments to the MCOs. The capitation rates paid to the MCOs shall be actuarially sound rates and the MCOs will determine the rates paid to its contracted providers. No payment shall be less than the minimum Medicaid rate. Covered inpatient, physician-directed PRTF services rendered to children and youth shall be reimbursed according to the following criteria:

1. Free-Standing PRTF Facilities. The per diem rate shall include reimbursement for the following services when included on the active treatment plan:

- a. occupational therapy;
- b. physical therapy;
- c. speech therapy;
- d. laboratory services; and
- e. transportation services.

2. A free-standing PRTF shall arrange through contract(s) with outside providers to furnish dental, vision, and diagnostic/radiology treatment activities as listed on the treatment plan. The treating provider will be directly reimbursed by the MCO or the CSoC contractor.

3. Hospital-Based PRTF Facilities. A hospital-based PRTF facility shall be reimbursed a per diem rate for covered services. The per diem rate shall also include reimbursement for the following services when included on the active treatment plan:

- a. dental services;
- b. vision services;
- c. diagnostic testing; and
- d. radiology services.

4. Pharmacy and physician services shall be reimbursed when included on the recipient's active plan of care and are components of the Medicaid covered PRTF services. The MCO or the CSoC contractor shall make payments directly to the treating physician. The MCO shall

also make payments directly to the pharmacy. These payments shall be excluded from the PRTF's contracted per diem rate for the facility.

B. All in-state Medicaid participating PRTF providers are required to file an annual Medicaid cost report in accordance with Medicare/Medicaid allowable and non-allowable costs.

C. Cost reports must be submitted annually. The due date for filing annual cost reports is the last day of the fifth month following the facility's fiscal year end. Separate cost reports must be filed for the facility's central/home office when costs of that entity are reported on the facility's cost report. If the facility experiences unavoidable difficulties in preparing the cost report by the prescribed due date, a filing extension may be requested. A filing extension must be submitted to Medicaid prior to the cost report due date.

1. Facilities filing a reasonable extension request will be granted an additional 30 days to file their cost report.

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 38:370 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2370 (November 2015).

§10703. Reimbursement Methodology (Reserved)

§10705. In-State Psychiatric Residential Treatment Facilities

A. In-state publicly and privately owned and operated PRTFs shall be reimbursed for covered PRTF services according to the following provisions. The rate paid by the MCO or the CSoc contractor shall take into consideration the following ownership and service criteria:

1. free-standing PRTFs specializing in sexually-based treatment programs;
2. free-standing PRTFs specializing in substance use treatment programs;
3. free-standing PRTFs specializing in behavioral health treatment programs;
4. hospital-based PRTFs specializing in sexually-based treatment programs;
5. hospital-based PRTFs specializing in substance use treatment programs; and
6. hospital-based PRTFs specializing in behavioral health treatment programs.

B. Except as otherwise noted in these provisions, the Medicaid fee schedule is the same for governmental and private individual practitioners.

C. Risk Sharing. In-state privately owned and operated PRTF covered services provided during the time period from January 1, 2012 through June 30, 2013 shall also receive risk-sharing payments. These payments shall be made as

part of a transitional plan to include these services within the Medicaid Program.

D. Beginning July 1, 2013, no risk-sharing payments will be paid and all covered PRTF services rendered by private facilities will be reimbursed using the established Medicaid fee schedule rates.

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 38:370 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2370 (November 2015).

§10707. Out-of-State Psychiatric Residential Treatment Facilities

A. Out-of-state PRTFs shall be reimbursed in accordance with the MCO or CSoc contractor's established rate.

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 38:370 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health LR 41:2370 (November 2015).

Subpart 13. Therapeutic Group Homes

Chapter 121. General Provisions

§12101. Introduction

A. The Medicaid Program hereby adopts provisions to provide coverage under the Medicaid state plan for behavioral health services rendered to children and youth in a therapeutic group home (TGH). These services shall be administered under the authority of the Department of Health (LDH), in collaboration with managed care organizations (MCOs) and the coordinated system of care (CSoc) contractor for children and youth enrolled in the CSoc program, which shall be responsible for the necessary operational and administrative functions to ensure adequate service coordination and delivery.

B. The specialized behavioral health services rendered shall be those services medically necessary to reduce the disability resulting from the illness and to restore the individual to his/her best possible functioning level in the community.

C. A therapeutic group home provides a community-based residential service in a home-like setting of no greater than 10 beds under the supervision and program oversight of a psychiatrist or psychologist.

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 38:427 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2371 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1904 (October 2018).

§12103. Recipient Qualifications

A. Individuals under the age of 21, who meet Medicaid eligibility and clinical criteria, shall qualify to receive therapeutic group home services.

B. Qualifying children and adolescents with an identified mental health or substance use diagnosis shall be eligible to receive behavioral health services rendered by a TGH.

C. In order for a child to receive TGH services:

1. the department, or its designee, must have determined that less intensive levels of treatment are unsafe, unsuccessful, or unavailable;

2. the child must require active treatment that would not be able to be provided at a less restrictive level of care on a 24-hour basis with direct supervision/oversight by professional behavioral health staff; and

3. the child must attend a school in the community.

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 38:427 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2371 (November 2015).

Chapter 123. Services**§12301. General Provisions**

A. All behavioral health services must be medically necessary. The medical necessity for services shall be determined by a licensed mental health practitioner or physician who is acting within the scope of his/her professional license and applicable state law.

B. All services shall be prior authorized. Services which exceed the initial authorization must be approved for re-authorization prior to service delivery.

C. Services provided to children and youth must include communication and coordination with the family and/or legal guardian and custodial agency for children in state custody. Coordination with other child-serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the child's medical record.

1. The agency or individual who has the decision making authority for a child or adolescent in state custody must request and approve the provision of services to the recipient.

D. Children who are in need of behavioral health services shall be served within the context of the family and not as an isolated unit.

1. Services shall be:

a. delivered in a culturally and linguistically competent manner; and

b. respectful of the individual receiving services.

2. Services shall be appropriate to children and youth of diverse racial, ethnic, religious, sexual, and gender identities and other cultural and linguistic groups.

3. Services shall also be appropriate for:

a. age;

b. development; and

c. education.

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 38:428 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2371 (November 2015).

§12303. Covered Services

A. The Medicaid Program may reimburse a therapeutic group home for the following services:

1. screening and assessment services;

2. therapy services (individual, group, and family whenever possible);

3. on-going psychiatric assessment and intervention as needed; and

4. skill-building services.

B. Service Exclusions. The following services/components shall be excluded from Medicaid reimbursement:

1. components that are not provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual;

2. services provided at a work site which are job tasks oriented and not directly related to the treatment of the recipient's needs;

3. any services or components in which the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of an individual receiving services;

4. services rendered in an institution for mental disease;

5. room and board; and

6. supervision associated with the child's stay in the TGH.

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 38:428 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2371 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1904 (October 2018).

Chapter 125. Provider Participation

§12501. Provider Responsibilities

A. Each provider of TGH services shall enter into a contract with one or more of the MCOs in order to receive reimbursement for Medicaid covered services. Providers shall meet the provisions of this Rule, the provider manual, and the appropriate statutes.

B. All services shall be delivered in accordance with federal and state laws and regulations, the provisions of this Rule, the provider manual, and other notices or directives issued by the department. The provider shall create and maintain documents to substantiate that all requirements are met.

C. Any services that exceed established limitations beyond the initial authorization must be approved for re-authorization prior to service delivery.

D. Anyone providing TGH services shall be licensed in accordance with state laws and regulations, in addition to operating within their scope of practice license.

E. TGH facilities shall be accredited by an approved accrediting body and maintain such accreditation. Denial, loss of or any negative change in accreditation status must be reported to their contracted MCOs in writing within the time limit established by the department.

F. Providers of TGH services shall be required to perform screening and assessment services upon admission and within the timeframe established by the department thereafter to track progress and revise the treatment plan to address any lack of progress and to monitor for current medical problems and concomitant substance use issues.

G. A TGH must ensure that youth are receiving appropriate therapeutic care to address assessed needs on the child's treatment plan.

1. Therapeutic care may include treatment by TGH staff, as well as community providers.

2. Treatment provided in the TGH or in the community should incorporate research-based approaches appropriate to the child's needs, whenever possible.

H. For TGH facilities that provide care for sexually deviant behaviors, substance use, or dually diagnosed individuals, the facility shall submit documentation to their contracted MCOs regarding the appropriateness of the research-based, trauma-informed programming and training, as well as compliance with ASAM level of care being provided.

I. A TGH must incorporate at least one research-based approach pertinent to the sub-populations of TGH clients to be served by the specific program. The specific research-based model to be used should be incorporated into the program description. The research-based models must be approved by OBH.

J. A TGH must provide the minimum amount of active treatment hours established by the department, and

performed by qualified staff per week for each child, consistent with each child's plan of care and meeting assessed needs.

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 38:428 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2371 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1904 (October 2018).

Chapter 127. Reimbursement

§12701. General Provisions

A. The department or its fiscal intermediary shall make monthly capitation payments to the MCOs. The capitation rates paid to the MCOs shall be actuarially sound rates and the MCOs will determine the rates paid to its contracted providers. No payment shall be less than the minimum Medicaid rate.

1. Reimbursement for covered TGH services shall be inclusive of, but not limited to:

a. allowable cost of clinical and related services;

b. psychiatric support services;

c. allowable cost of integration with community resources; and

d. skill-building services provided by unlicensed practitioners.

2. Allowable and non-allowable costs components, as defined by the department.

B. All in-state Medicaid participating TGH providers are required to file an annual Medicaid cost report according to the department's specifications and departmental guides and manuals.

C. Costs reports must be submitted annually. The due date for filing annual cost reports is the last day of the fifth month following the facility's fiscal year end. Separate cost reports must be filed for the facilities central/home office when costs of that entity are reported on the facilities cost report. If the facility experiences unavoidable difficulties in preparing the cost report by the prescribed due date, a filing extension may be requested. A filing extension must be submitted to Medicaid prior to the cost report due date.

1. Facilities filing a reasonable extension request will be granted an additional 30 days to file their cost report.

D. Services provided by psychologists and licensed mental health practitioners shall be billed to the MCO or CSoc contractor separately.

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 38:429 (February 2012), amended by the Department of Health and

Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2372 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1904 (October 2018).

§12703. Reimbursement Methodology (Reserved)

§12705. In-State Therapeutic Group Homes

A. In-state publicly and privately owned and operated therapeutic group homes shall be reimbursed according to the MCO established rate within their contract.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:429 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR:41:2372 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1904 (October 2018).

§12707. Out-of-State Therapeutic Group Homes

A. Out-of-state therapeutic group homes shall be reimbursed for their services according to the rate established by the MCO.

B. Payments to out-of-state TGH facilities that provide covered services shall not be subject to TGH cost reporting requirements.

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 38:429 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2372 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1905 (October 2018).

Subpart 15. Substance Use Disorders Services

Chapter 141. General Provisions

§14101. Introduction

A. The Medicaid Program hereby adopts provisions to provide coverage under the Medicaid State Plan for substance use disorders (SUD) services rendered to children and adults. These services shall be administered under the authority of the Department of Health (LDH), in collaboration with managed care organizations (MCOs) and the coordinated system of care (CSoC) contractor, which shall be responsible for the necessary operational and administrative functions to ensure adequate service coordination and delivery. The CSoC contractor shall only manage specialized behavioral health services for children and youth enrolled in the CSoC program.

B. The SUD services rendered shall be those services which are medically necessary to reduce the disability resulting from the illness and to restore the individual to his/her best possible level of functioning in the community.

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 38:426 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2357 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1890 (October 2018), LR 45:270 (February 2019).

§14103. Recipient Qualifications

A. Children and adults who meet Medicaid eligibility and clinical criteria shall qualify to receive medically necessary SUD services.

B. Qualifying children and adults with an identified SUD diagnosis shall be eligible to receive SUD services covered under the Medicaid state plan.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:426 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2357 (November 2015).

Chapter 143. Services

§14301. General Provisions

A. All SUD services must be medically necessary. The medical necessity for services shall be determined by a licensed mental health practitioner (LMHP) or physician who is acting within the scope of his/her professional license and applicable state law.

B. American Society of Addiction Medicine (ASAM) levels of care require reviews on an ongoing basis, as deemed necessary by the department to document compliance with national standards.

C. Children who are in need of SUD services should be served within the context of the family and not as an isolated unit. Services provided to children and youth shall include communication and coordination with the family and/or legal guardian and custodial agency for children in state custody provided that written consent is obtained from minor. Coordination with other child-serving systems should occur as needed to achieve the treatment goals subject to the minor's consent and applicable privacy laws. All coordination and consent must be documented in the child's medical record.

1. Services shall be:

a. delivered in a culturally and linguistically competent manner; and

b. respectful of the individual receiving services.

2. Services shall be appropriate to individuals of diverse racial, ethnic, religious, sexual, and gender identities, and other cultural and linguistic groups.

3. Services shall also be appropriate for:

- a. age;
- b. development; and
- c. education.

D. Evidence-based practices require prior approval and fidelity reviews on an ongoing basis as determined necessary by the department.

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 38:426 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2357 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1890 (October 2018), LR 45:270 (February 2019).

§14303. Covered Services

A. The following SUD services shall be reimbursed under the Medicaid Program:

1. assessment;
2. outpatient treatment;
3. residential treatment; and
4. inpatient treatment.

B. Service Exclusions. The following services/components shall be excluded from Medicaid reimbursement:

1. components that are not provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual;
2. services provided at a work site which are job tasks oriented and not directly related to the treatment of the recipient's needs;
3. any services or components in which the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of an individual receiving services; and
4. room and board for any rates provided in a residential setting.

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 38:426 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2357 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1891 (October 2018), LR 45:270 (February 2019).

Chapter 145. Provider Participation

§14501. Provider Responsibilities

A. Each provider of SUD services shall enter into a contract with one or more of the managed care organizations

(MCOs) and with the Coordinated System of Care (CSoC) contractor for youth enrolled in the Coordinated System of Care program in order to receive reimbursement for Medicaid covered services.

B. Providers shall deliver all services in accordance with their license, scope of practice, federal and state laws and regulations, the provisions of this Rule, the provider manual, and other notices or directives issued by the department. The provider shall create and maintain documentation to substantiate that all requirements are met.

F. Residential treatment facilities shall meet the following additional requirements:

1. Be a licensed organization, pursuant to the residential service provider qualifications described in the Louisiana Administrative Code and the Louisiana Medicaid provider manual.

2. Residential addiction treatment facilities shall be accredited by an approved accrediting body and maintain such accreditation. Denial, loss of or any negative change in accreditation status must be reported to the MCO in writing within the time limit established by the department.

3. Provide full disclosure of ownership and control, including but not limited to any relative contractual agreements, partnerships, etc.

4. Follow all residential treatment provider qualifications and program standards in licensure, Medicaid provider manual, managed care contracts or credentialing.

5. Must deliver care consistent with the specifications in the ASAM Criteria or other OBH approved, nationally recognized SUD program standards, hours of clinical care, and credentials of staff for residential treatment settings.

6. Effective April 1, 2019, must offer medication-assisted treatment (MAT) on-site or facilitate access to MAT off-site, and appropriately document MAT options, education and facilitation efforts in accordance with requirements outlined in the Medicaid provider manual.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:427 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2357 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1891 (October 2018), LR 45:270 (February 2019), LR 46:1563 (November 2020).

Chapter 147. Reimbursement

§14701. General Provisions

A. For recipients enrolled with the CSoC contractor, the department or its fiscal intermediary shall make monthly capitation payments to the CSoC contractor, exclusive of coverage for residential substance use treatment services.

1. The capitation rates paid to the CSoC contractor shall be actuarially sound rates.

2. The CSoc contractor will determine the rates paid to its contracted providers.

a. No payments shall be less than the minimum Medicaid rate.

B. For recipients enrolled in one of the MCOs, the department or its fiscal intermediary shall make monthly capitation payments to the MCOs inclusive of coverage for the provision of residential substance use services for recipients enrolled in CSoc.

1. The capitation rates paid to the MCOs shall be actuarially sound rates.

2. The MCOs will determine the rates paid to its contracted providers.

a. No payment shall be less than the minimum Medicaid rate.

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 38:427 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 39:3301 (December 2013), LR 41:2358 (November 2015).

§14703. Reimbursement Methodology

A. Effective for dates of service on or after July 1, 2012, the reimbursement rates for outpatient SUD services provided to children/adolescents shall be reduced by 1.44 percent of the rates in effect on June 30, 2012.

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 Behavioral Health, LR 41:2358 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1891 (October 2018).

Subpart 16. Coverage for Treatment for Opioid Use Disorder in Opioid Treatment Programs

Chapter 151. General Provisions

§15101. Introduction

A. The Medicaid Program hereby adopts provisions to provide coverage for medication-assisted treatment provided in Opioid Treatment Programs, including but not limited to, methadone treatment, to all Medicaid-eligible adults and children with opioid use disorder (OUD).

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 of Behavioral Health, LR 46:27 (January 2020).

§15103. Recipient Qualifications

A. Adults and children who meet Medicaid eligibility and clinical criteria shall qualify to receive medically necessary OUD services in Opioid Treatment Programs.

B. Qualifying recipients must meet the following criteria:

1. are at least 18 years old, unless the recipient has consent from a parent or legal guardian, if applicable; and

2. meet the federal requirements regarding admission to the Opioid Treatment 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, Bureau of Health Services Financing and the Office of Behavioral Health, LR 46:27 (January 2020).

Chapter 153. Services

§15301. General Provisions

A. All treatment services must be medically necessary.

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 of Behavioral Health, LR 46:27 (January 2020).

§15303. Covered Services

A. The following services provided by Opioid Treatment Programs shall be reimbursed under the Medicaid Program:

1. the administration and dispensing of medications; and

2. treatment phases outlined in LAC 48:I.5725.

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 of Behavioral Health, LR 46:27 (January 2020).

Chapter 155. Provider Participation

§15501. Provider Responsibilities

A. Each Opioid Treatment Program shall enter into a contract with the managed care organizations (MCOs) and the coordinated system of care (CSoc) contractor in order to receive reimbursement for Medicaid covered services.

B. Opioid treatment programs shall deliver all services in accordance with federal and state laws and regulations, and the provisions of this Rule.

C. Opioid Treatment Programs must be licensed in accordance with state laws and regulations, in addition to operating within their scope of practice license.

D. Opioid Treatment Programs shall retain all records necessary to fully disclose the extent of services provided to recipients for five years from the date of service and furnish such records, and any payments claimed for services, to the Medicaid program upon request.

E. Opioid Treatment Programs shall maintain compliance with state and federal regulatory authorities for operation, including but not limited to the Substance Abuse and Mental Health Services Administration (SAMHSA), the Drug Enforcement Administration (DEA), and the State Opioid Treatment Authority.

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 of Behavioral Health, LR 46:27 (January 2020).

Chapter 157. Reimbursement

§15701. Reimbursement Methodology

A. Reimbursement rates for Opioid Treatment Programs shall be a bundled rate included in the Specialized Behavioral Health Fee Schedule as determined by the department.

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 of Behavioral Health, LR 46:27 (January 2020).

Subpart 17. Supplemental Payments

Chapter 161. General Provisions

§16101. Qualifying Criteria

A. Effective for dates of service on or after January 20, 2013, providers of behavioral health services may qualify for supplemental payments for services rendered to Medicaid recipients. To qualify for the supplemental payment, the behavioral health provider must be:

1. licensed as necessary by the state of Louisiana;
2. enrolled as a Medicaid provider; and
3. a government-owned and operated entity or a quasi-governmental entity.

B. Providers of the following services shall be eligible to receive supplemental payments:

1. providers furnishing services thru a statewide management organization;
2. children's mental health services;

3. behavioral health services;
4. home and community-based waiver services;
5. psychiatric residential treatment facility services;
6. therapeutic group home services;
7. substance abuse services; and
8. local government juvenile justice programs.

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 Behavioral Health, LR 40:1529 (August 2014).

§16103. Payment Methodology

A. The supplemental payment shall be calculated in a manner that will bring payments for these services up to the community rate level.

1. For purposes of these provisions, the community rate shall be defined as the rates paid by commercial payers for the same service.

B. The behavioral health provider shall periodically furnish satisfactory data for calculating the community rate as requested by the department.

C. The supplemental payment amount shall be determined by establishing a Medicare to community rate conversion factor for the behavioral health provider. At the end of each quarter, for each Medicaid claim paid during the quarter, a Medicare payment amount will be calculated and the Medicare to community rate conversion factor will be applied to the result. Medicaid payments made for the claims paid during the quarter will then be subtracted from this amount to establish the supplemental payment amount for that quarter.

1. The Medicare to community rate conversion factor shall be recalculated at least every three years.

D. The supplemental payments shall be made on a quarterly basis.

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 Behavioral Health, LR 40:1530 (August 2014).