RULE

Department of Health
Bureau of Health Services Financing

Crisis Receiving Centers
Licensing Standards
(LAC 48:I.Chapter 96)

The Department of Health, Bureau of Health Services Financing has amended LAC 48:I.Chapter 96 as authorized by R.S. 36:254 and R.S. 40:2100-2115. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 48
PUBLIC HEALTH–GENERAL
Part I. General Administration
Subpart 3. Licensing and Certification

Chapter 96. Hospitals—Crisis Receiving Centers

Subchapter A. General Provisions

§9601. Introduction

A. A hospital crisis receiving center is a specialty unit of a hospital that provides health care services to individuals who are experiencing a behavioral health crisis.

B. ...

§9603. Licensure Requirements

A. All crisis receiving center specialty units shall be licensed by the department and shall comply with the provisions of §9333 of these hospital licensing standards.

B. A crisis receiving center specialty unit (CRC-SU) shall have approval from the Office of Behavioral Health (OBH) and/or the appropriate human service district or authority before applying to become licensed as part of the hospital.

C. Prior to securing licensure and operating the CRC-SU, the hospital shall submit architectural plans of the CRC-SU to the Office of the State Fire Marshal (OSFM) for licensing approval.

D. – F. ...

G. If the CRC-SU is located at an offsite campus or is at a free-standing psychiatric hospital which does not have a dedicated emergency department, the CRC-SU shall be considered a dedicated emergency department. The CRC-SU shall comply with all EMTALA regulations if the unit meets one of the following criteria:

1. the entity is licensed by the state as an emergency department of the hospital;

2. - 3. ...

H. The following levels of a CRC-SU may be licensed as an optional service of the hospital:

1. Level I CRC-SU only; or

2. Level I CRC-SU and Level II CRC-SU.

I. A CRC-SU shall maintain compliance with the:

1. Office of Public Health (OPH) regulations; and

2. Office of State Fire Marshal regulations.

3. Repealed.

J. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:513 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:

§9605. Licensing Process

A. The hospital shall submit the following items to the department in order to add a CRC-SU to its existing license:

1. ...

2. the required licensing fee, if applicable;

3. a copy of the prerequisite approval from OBH and/or the appropriate human service district or authority; and

4. other documentation as required by the department, including a current Office of Public Health (OPH)/Sanitation approval and Office of State Fire Marshal approval for occupancy and licensing plan review.

B. – C. ...

1. The sub-license/certificate shall designate the level of the CRC-SU and the licensed capacity of the CRC-SU.

C.2. – E. ...

F. The sub-license/certificate shall be valid only for the designated geographic location and shall be issued only for the person/premises named in the application. The geographic location of the CRC-SU shall not be moved, changed, or relocated without notification to HSS, approval by HSS, and the re-issuance of the sub-license/certificate.

G. The department may conduct on-site surveys and inspections at the CRC-SU as necessary to ensure compliance with these licensing standards.

H. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:513 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:

§9607. Discharges, Referrals or Transfers

A. Patients who are discharged home from the CRC-SU shall be given verbal and written discharge instructions and any referral information, including information for appointments regarding follow-up care and treatment.

B. – C. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:514 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:

§9609. Training Requirements

A. A CRC-SU shall ensure that all staff providing direct patient care has documentation of successful completion of crisis services and intervention training in accordance with this Chapter.

B. Crisis services and intervention training shall include, but is not limited to the following:

1. an organized training program that includes an initial 40 hours of training to be completed upon hire and a minimum of 12 hours of training to be completed annually thereafter. Required training includes, but is not limited to the following areas:

a. – j. ...

k. an overview of mental illness and substance abuse diagnoses and treatment;

l. – n. ...

o. confidentiality and Health Insurance Portability and Accountability Act (HIPAA) regulations; and

p. ...

C. All formal training shall be provided by a licensed mental health professional (LMHP) or other qualified licensed behavioral health personnel with extensive experience in the field in which they provide training. Nonviolent physical interventions shall be taught by a trainer with documented current certification by a nationally established crisis intervention program (e.g. Crisis Prevention and Intervention, Tactical Crisis Intervention, Crisis Intervention Training, etc.).

1. An LMHP is an individual who is currently licensed to practice independently and in good standing in the state of Louisiana to practice within the scope of all applicable state laws, practice acts, and the individual's professional license, as one of the following:

a. medical psychologist;

b. licensed psychologist;

c. licensed clinical social worker (LCSW);

d. licensed professional counselor (LPC);

e. licensed marriage and family therapist (LMFT);

f. licensed addiction counselor (LAC);

g. advance practice registered nurse (APRN); or

h. licensed rehabilitation counselor (LRC).

D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:514 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:

Subchapter B. Level I Crisis Receiving Centers

§9615. General Provisions

A. ...

B. The length of a patient stay for a Level I CRC-SU shall not exceed 24 hours, unless there is documented evidence of the CRC-SU's measures taken to transfer the patient to the appropriate level of needed care and the reasons the transfer of the patient exceeds 24 hours.

C. Services required of a Level I CRC-SU include, but are not limited to:

1. – 2. ...

3. assessment services, including medication management;

4. brief intervention and stabilization; and

5. ...

D. The Level I CRC-SU shall develop and implement policies and procedures for instituting an increased level of

supervision for patients at risk for suicide and other self-injurious behaviors.

E. – F. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:514 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:

§9617. Level I Services

A. – B.3. ...

4. The triage/screening shall include:

a. – e. ...

f. a medical screening including at a minimum, vital signs and a medical history, as soon as the patient's condition permits.

5. The triage/screening shall be conducted by licensed professionals in the medical or behavioral health fields that have the training and experience to triage/screen individuals for both behavioral and medical emergent needs in accordance with the scope of practice of their licensed discipline.

B.6. – C.2. ...

3. The assessment shall be initiated within two hours of the triage/screening evaluation and shall include:

a. a full psychiatric assessment;

b. – c. ...

4. A full psychiatric assessment shall include:

a. patient interviews by board certified/eligible licensed psychiatrist(s) or psychiatric nurse practitioner(s) trained in emergency psychiatric assessment and treatment;

b. a review of the medical and psychiatric records of current and past diagnoses, treatments, medications and dose response, side-effects and compliance, if available;

c. contact with current behavioral health providers whenever possible;

d. – g. ...

h. a detailed assessment of substance use, abuse, and misuse; and

i. an assessment for possible abuse and neglect; such assessment shall be conducted by an LMHP trained in how to conduct an assessment to determine abuse and neglect. The CRC-SU shall ensure that every patient is assessed for sexual, physical, emotional, and verbal abuse and/or neglect.

5. All individuals shall be seen by a licensed psychiatrist or a licensed APRN within eight hours of the

triage/screening. The board certified/eligible psychiatrist or APRN shall formulate a preliminary psychiatric diagnosis based on review of the assessment data collected.

a. The APRN must be a nurse practitioner specialist in adult psychiatric and mental health, family psychiatric and mental health, or a certified nurse specialist in psychosocial, gerontological psychiatric mental health, adult psychiatric and mental health, or child-adolescent mental health and may practice to the extent that services are within the APRN's scope of practice.

6. A physical health assessment shall be conducted by a licensed physician, licensed advanced nurse practitioner, or a licensed physician's assistant and shall include the following:

a. – d. ...

e. pregnancy test in all women of child-bearing age, as applicable;

f. – h. ...

7. Repealed.

D. Brief Intervention and Stabilization

1. If an assessment reveals that immediate stabilization services are required, the Level I CRC-SU shall provide behavioral health interventions and stabilization which may include the use of psychotropic medications.

2. Following behavioral health interventions and stabilization measures, the Level I CRC-SU shall assess the patient to determine if referral to community based behavioral health services is appropriate or a higher level of care is required.

E. Linking/Referral Services

1. If an assessment reveals a need for emergency or continuing care for a patient, the Level I CRC-SU shall make arrangements to place the patient into the appropriate higher level of care. Patients in a Level I CRC-SU shall be transitioned out of the Level I CRC-SU within 24 hours unless there is documented evidence of the CRC-SU's measures taken to transfer the patient to the higher level of needed care and the reasons the transfer of the patient exceeds 24 hours.

2. If the assessment reveals no need for a higher level of care, the Level I CRC-SU shall provide:

a. referrals, and make appointments where possible, to appropriate community-based behavioral health services for individuals with developmental disabilities, addiction disorders, and mental health issues; and

b. brief behavioral health interventions to stabilize the crises until referrals to appropriate community-based behavioral health services are established or contact is made with the individual's existing provider and a referral is

made back to the existing provider in the form of a follow-up appointment or other contact.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:515 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:

§9619. Staffing Requirements

A. – B.2. ...

C. A Level I CRC-SU shall have the following staff on call at all times and available to be onsite at the CRC-SU within one hour and who meets the following criteria:

1. is a licensed mental health professional (LMHP) who has one year of documented crisis services and intervention experience; or

a. – c. Repealed.

C.2. – E. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:516 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:

§9621. Physical Environment

A. – C. ...

D. Interior finishes, lighting, and furnishings shall conform to applicable fire safety codes. Security and safety devices shall not be presented in a manner to attract or challenge tampering by patients.

E. Grab bars, if provided, shall meet the following specifications:

1. – 2. ...

3. shall be securely fastened with tamper-proof screw heads;

4. ...

5. if mounted adjacent to a wall, the space between the wall and the grab bar shall be filled completely to prevent a cord or string being tied around the grab bar and used for hanging.

F. Towel racks, closet and shower curtain rods are not permitted.

G. – M.2. ...

3. The doors on the bathroom/toilet rooms shall swing out or be double hinged.

M.4. - O. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:516 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:

Subchapter C. Level II Crisis Receiving Centers

§9631. General Provisions

A. A Level II CRC-SU is an intermediate level of care unit that provides for:

1. – 5. ...

6. an appropriate referral and coordination of care for extended services as necessary.

B. – E. ...

F. The licensed capacity in a Level II CRC-SU shall not be licensed as hospital beds and shall not be counted in the aggregate number of licensed hospital beds.

G. – K.1. ...

L. The Level II CRC-SU shall develop and implement policies and procedures for instituting an increased level of supervision for patients at risk for suicide and other self-injurious behaviors.

M. – M.1. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:517 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:

§9633. Level II Services

A. In addition to the services required in §9617 of this Chapter, the Level II CRC-SU shall provide the following services.

1. – 3.c. ...

4. The Level II CRC-SU shall conduct a psychosocial assessment on each patient within 24 hours of admission. This assessment shall be conducted by a licensed LMHP who has one year of documented crisis services and intervention experience.

a. – a.iii. Repealed.

5. – 5.g. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:518 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:

§9635. Staffing Requirements

A. – A.1. ...

2. The Level II CRC-SU shall have sufficient numbers and types of qualified staff on duty and available at all times to provide necessary care, services, treatment and safety, based on the acuity of the patients, the mix of the patients present in the CRC-SU, the need for extraordinary levels of care and to meet the needs of the patient throughout the length of any patient stay in the CRC-SU.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:518 (March 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:

§9637. Physical Environment

A. – F. ...

G. Bathrooms

1. The Level II CRC-SU shall have a minimum of two bathrooms that contain all of the following:

a. – c.i. ...

2. If the Level II CRC-SU has more than a capacity for 12 patients, there shall be one additional bathroom for each additional capacity for four patients.

3. – 4. ...

H. The Level II CRC-SU shall have a separate bathroom and a break room designated for staff use.

I. Separate and apart from the seclusion room required in a Level I CRC-SU, the Level II CRC-SU shall have a minimum of one seclusion room for each capacity for 12 patients.

1. – 2. ...

J. The Level II CRC-SU shall have separate consultation room(s) with a minimum floor space of 100 square feet each, provided at a room-to-bed ratio of one consultation room for each capacity for 12 patients. Consultation rooms within the unit shall be available for use for interviews with the patient and/or their families. The consultation room(s) shall be designed for acoustical and visual privacy.

K. – M. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:518 (March 2010) amended by the Department of Health, Bureau of Health Services Financing, LR 45:

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Pharmacy Benefits Management Program
Pharmacy Ingredient Cost Reimbursement
(LAC 50:XXIX.105 and Chapter 9)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XXIX.105 and Chapter 9 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 50
PUBLIC HEALTH-MEDICAL ASSISTANCE
Part XXIX. Pharmacy

Chapter 1. General Provisions

§105. Medicaid Pharmacy Benefits Management System Point of Sale—Prospective Drug Utilization Program

A. – B. ...

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. 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 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. – L. ...

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:

Chapter 9. Methods of Payment

Subchapter A. General Provisions

§901. Definitions

Average Acquisition Cost (AAC)—Repealed.

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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.

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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.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 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:

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.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:1064 (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 43:1184 (June 2017), LR 45:

Subchapter D. Maximum Allowable Costs

§945. Reimbursement Methodology

A. – A.1. ...

B. Payment will be made for medications in accordance with the payment procedures for any fee-for-service (FFS) Medicaid eligible person.

C. – F. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:1064 (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 43:1184 (June 2017), LR 45:

§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. – 2.a. ...

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. 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.

3. – 3.a. Repealed.

C. Physician Certifications

1. Limits on payments for multiple source drugs shall not be applicable when the prescriber certifies in his own handwriting that a specified brand name drug is medically necessary for the care and treatment of a recipient. Such certification may be written directly on the prescription or on a separate sheet which is dated and attached to the prescription. A standard phrase in the prescriber's handwriting, such as “brand necessary” will be acceptable.

a. – b. Repealed.

2. Any practice which precludes the prescriber’s handwritten statement shall not be accepted as a valid certification. Such practices include, but are not limited to:

a. a printed box on the prescription blank that could be checked by the prescriber to indicate brand necessity;

b. a handwritten statement transferred to a rubber stamp and then stamped on the prescription blank; and

c. preprinted prescription forms using a facsimile of the prescriber’s handwritten statement.

3. – 3.c. Repealed.

D. 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 are not permitted to bill 340B stock to Medicaid. Fee-for-service outpatient hospital claims for 340B drugs shall use a cost to charge methodology on the interim and settled at cost during final 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.

1. – 2.c. Repealed.

E. Federal Supply Schedule Drugs. Drugs acquired at federal supply schedule (FSS) and at nominal price shall be reimbursed at actual acquisition cost plus a professional dispensing fee.

F. 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.

G. 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.

H. 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. Reimbursement for Medicaid-covered physician-administered drugs in a physician office setting shall be established at the current Louisiana Medicare rate, which is average sales price (ASP) plus 6 percent, for drugs appearing on the Medicare file.

2. Reimbursement rates for physician-administered drugs in a physician office setting 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 the drug has no WAC available, one of the following methods shall be used:

i. the provider’s actual cost of the drug as documented by invoice or other acceptable documentation as deemed appropriate by the department;

ii. Medicaid rate of other states;

iii. commercial payer rate; or

iv. medical consultant recommendation.

I. Clotting Factor. Pharmacy claims for clotting factor will be reimbursed using the brand/generic drug reimbursement methodology.

1. – 2.b.iv. Repealed.

J. Investigational or Experimental Drugs. Investigational or experimental drugs shall not be reimbursed by Medicaid.

K. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 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:

Subchapter E. 340B Program

§961. Definitions

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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.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 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:

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

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing
and
Office of Behavioral Health

School-Based Health Services
(LAC 50:XV.Chapter 95 and XXXIII.Chapter 41)

The Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health have amended LAC 50:XV.Chapter 95 and XXXIII.Chapter 41 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 50
PUBLIC HEALTH-MEDICAL ASSISTANCE
Part XV. Services for Special Populations
Subpart 5. Early and Periodic Screening, Diagnosis, and Treatment

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 an individualized service plan (IEP), a section 504 accommodation plan, an individualized health care plan, an individualized family service plan, or are otherwise medically necessary services provided by a licensed medical provider

(physician, optometrist, respiratory therapist, registered nurse, licensed practical nurse, dentist, dental hygienist and chiropractor)within a local education agency (LEA). 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. All medical service providers providing school-based medical services are required to maintain an active license that is necessary for the applicable service with the state of Louisiana.

C. School-based medical services shall be covered for all recipients in the school system who are eligible.

D. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:2760 (October 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1298 (August 2016), LR 45:

§9503. Covered Services

A. The following school-based medical services shall be covered.

1. Chronic Medical Condition Management and Care Coordination. This is care based on one of the following criteria.

a. The child has a chronic medical condition or disability requiring implementation of a health plan/protocol (examples would be children with asthma, diabetes, or cerebral palsy). There must be a written health care plan based on a health assessment performed by the medical services provider. The date of the completion of the plan and the name of the person completing the plan must be included in the written plan. Each health care service required and the schedule for its provision must be described in the plan.

b. Medication Administration. This service is scheduled as part of a health care plan developed by either the treating physician or the school district LEA. Administration of medication will be at the direction of the physician and within the license of the individual provider and must be approved within the district LEA policies.

c. Implementation of Physician’s Orders. These services shall only be provided as a result of receipt of a written plan of care from the child’s physician or included in the student’s IEP, IHP, 504 plan, IFSP or are otherwise medically necessary for students with disabilities.

d. Repealed.

2. Immunization Assessments. These services are nursing assessments of health status (immunizations) required by the Office of Public Health. This service requires a medical provider to assess the vaccination status of children in these cohorts once each year. This assessment is limited to the following children:

a. children enrolling in school for the first time;

b. pre-kindergarten children;

c. kindergarten children;

d. children entering sixth grade; or

e. any student 11 years of age regardless of grade.

3. 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.

a. – e. Repealed.

4. 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 physician or health care provider’s office. This service is available to all Medicaid individuals eligible for EPSDT.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 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:

§9505. Reimbursement Methodology

A. Payment for EPSDT school-based medical 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 medical 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 medical 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 medical 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 by the allowable costs. There are no additional indirect costs included.

4. To determine the amount of medical 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 Medicaid federal financial participation (FFP) based on the following methodology.

1. ...

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 medical services cost report form for all medical service personnel (i.e. all personnel providing LEA medical treatment services covered under the state plan).

3. ...

4. Determine the Percentage of Time to Provide All Medical 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 medical 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 medical services, the percentage of time spent on medical services shall be divided by 100 percent minus the percentage of G and A time. This shall result in a percentage that represents the medical 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 medical 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 five 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 medical 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 medical services cost.

C. Reconciliation of LEA Certified Costs and Medicaid Management Information System (MMIS) Paid Claims. Each LEA shall complete the medical 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 medical 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 medical 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 medical services provided by the LEA.

D. ...

1. The financial oversight of all LEAs shall include reviewing the costs reported on the medical 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. – 5. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 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:

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 IDEA services included in the child's individualized service plan (IEP), a section 504 accommodation plan, an individualized health care plan (IHP), an individualized family service plan (IFSP), or are otherwise medically necessary and the transportation is provided in a vehicle that is part of special transportation in the LEA's annual financial report certified and submitted to the Department of Education. The need for transportation must be documented in the child's IEP, IHP, 504 plan, IFSP or are otherwise medically necessary.

B. School-based EPSDT transportation services shall be covered for all recipients in the school system who are eligible 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 45:

§9515. Reimbursement Methodology

A. Payment is based on the most recent school year's actual cost as determined by desk review and/or audit for each LEA provider, which is the parish or city. Each local education agency (LEA) shall determine cost annually by using LDH's cost report for special transportation (transportation cost report) form as approved by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) November 2005.

1. Direct cost is limited to the cost of fuel, repairs and maintenance, rentals, contracted vehicle use cost and the amount of total compensation (salaries and fringe benefits) of special transportation employees or contract cost for contract drivers, as allocated to special transportation services for Medicaid recipients based on a ratio explained in Step 4 below.

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. 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, the

ratio of Medicaid covered trips to all student trips determined in step 4 below is multiplied by total direct 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 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—Allocate Direct Service 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. Total annual one-way trips by Medicaid students will be determined by LDH from the MMIS claims system. To determine the

amount of special transportation cost that may be attributed to Medicaid, total cost as determined under step 3 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. Cost Settlement Process. As part of its financial oversight responsibilities, the department will develop audit and review procedures to audit and process final settlements for certain LEAs. The audit plan will include a risk assessment of the LEAs using paid claim data available from the department to determine the appropriate level of oversight. The financial oversight of all LEAs will include reviewing the costs reported on the direct services and transportation cost reports against the allowable costs in accordance with OMB Circular A-87, performing desk reviews and conducting limited reviews. For example, field audits will be performed when the department finds a substantial difference between information on the filed direct services and/or transportation cost reports and Medicaid claims payment data for particular LEAs. These activities will 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.

1. LEAs may appeal audit findings in accordance with LDH appeal procedures.

2. Medicaid will 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 will be no instances where total Medicaid payments for services exceed 100 percent of actual, certified expenditures for providing LEA services for each LEA.

3. If the interim payments exceed the actual, certified costs of an LEA's Medicaid services, the department will 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.

4. If the actual certified costs of an LEA’s Medicaid services exceed interim Medicaid payments, the Bureau will pay this difference to the LEA in accordance with the final actual certification agreement.

5. 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 the 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, Bureau of Health Services Financing, LR 45:

Subchapter C. School-Based Medicaid Personal Care Services

§9521. General Provisions

A. EPSDT school-based personal care services (PCS) are provided by a personal care assistant pursuant to an individualized service plan (IEP), a section 504 accommodation plan, an individualized health care plan, an individualized family service plan, or are otherwise medically necessary within a local education agency (LEA). The goal of these services is to enable the recipient to be treated on an outpatient basis rather than an inpatient basis to the extent that services on an outpatient basis are projected to be more cost effective than services provided on an inpatient basis.

B. All personal care assistants providing school-based personal care services shall not be a member of the recipient’s immediate family (immediate family includes father, mother,

sister, brother, spouse, child, grandparent, in-law, or any individual acting as parent or guardian of the recipient). Personal care services may be provided by a person of a degree of relationship to the recipient other than immediate family, if the relative is not living in the recipient's home, or if she/he is living in the recipient's home solely because her/his presence in the home is necessitated by the amount of care required by the recipient. Personal care assistants must meet all training requirements applicable under state law and regulations and successfully complete the applicable examination for certification for PCS.

C. School-based personal care services shall be covered for all recipients in the school system.

D. Personal care services must meet medical necessity criteria as established by the Bureau of Health Services Financing (BHSF) which shall be based on criteria equivalent to at least an intermediate care facility I (ICF-1) level of care; and the recipient must be impaired in at least two of daily living tasks, as determined by BHSF.

E. Early and periodic screening, diagnosis, and treatment personal care services must be prescribed by the recipient's attending physician 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 for submission to BHSF only after the physician signs and dates the completed form.

AUTHORITY NOTE: 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:

§9523. Covered Services

A. The following school-based personal care services shall be covered:

1. basic personal care, toileting and grooming activities, including bathing, care of the hair and assistance with clothing;

2. assistance with bladder and/or bowel requirements or problems, including helping the client to and from the bathroom or assisting the client with bedpan routines, but excluding catheterization;

3. assistance with eating and food, nutrition, and diet activities, including preparation of meals for the recipient only;

4. performance of incidental household services essential to the client’s health and comfort in her/his home; and

EXAMPLES: Changing and washing bed linens and rearranging furniture to enable the recipient to move about more easily in his/her own home.

5. accompanying, but not transporting, the recipient to and from his/her physician and/or medical facility for necessary medical services.

B. EPSDT personal care services are not:

1. to be provided to meet childcare needs nor as a substitute for the parent in the absence of the parent;

2. allowable for the purpose of providing respite care to the primary caregiver; and

3. reimbursable when provided in an educational setting if the services duplicate services that are or must be provided by the Department of Education.

C. Documentation for EPSDT PCS provided shall include at a minimum, the following:

1. documentation of approval of services by BHSF or its designee;

2. daily notes by PCS provider denoting date of service, services provided (checklist is adequate);

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.

D. 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:

§9525. Reimbursement Methodology

A. Payment for EPSDT school-based personal care 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 personal care 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 personal care service providers as allocated to personal care 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 personal care 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 by the allowable costs. There are no additional indirect costs included.

4. To determine the amount of personal care 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 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.

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 personal care services cost report form for

all personal care service personnel (i.e., all personnel providing LEA personal care 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. Due to the nature of personal care services, 100 percent of the personal care provider’s time will be counted as reimbursable. Personal care providers will not be subject to a time study.

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 personal care 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 personal care services cost.

C. Reconciliation of LEA Certified Costs 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 nursing 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 pending audit that denotes the amount due to or from the LEA. This reconciliation is inclusive of all personal care 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 personal care 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, Bureau of Health Services Financing, LR 45:

Subchapter D. School-Based Therapy Services

§9531. General Provisions

A. EPSDT school-based therapy services are provided pursuant to an individualized service plan (IEP), a section 504 accommodation plan, an individualized health care plan, an individualized family service plan, or are otherwise medically necessary within a local education agency (LEA). School-based therapy services include physical therapy, occupational therapy and other services, including services provided by audiologists and services for individuals with speech, hearing and language

disorders, performed by, or under the direction of, providers who meet the qualifications set forth in the therapist licensing requirement.

B. Therapists providing school-based therapy services are required to maintain an active therapist license with the state of Louisiana.

C. School-based therapy services shall be covered for all recipients in the school system who are eligible 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 45:

§9533. Covered Services

A. The following school-based therapy services shall be covered.

1. Audiology Services. The identification and treatment of children with auditory impairment, using at risk criteria and appropriate audiology screening techniques. Therapists and/or audiologists must meet qualifications established in 42 CFR 440.110(c).

2. Speech Pathology Services. The identification and treatment of children with communicative or oropharyngeal disorders and delays in development of communication skills

including diagnosis. Therapists and/or audiologists must meet qualifications established in 42 CFR 440.110(c).

3. Occupational Therapy Services. Addresses the functional needs of a child related to the performance of self-help skills, adaptive behavior, play and sensory, motor and postural development. Therapists must meet qualifications established in 42 CFR 440.110(b).

4. Physical Therapy Services. Designed to improve the child’s movement dysfunction. Therapists must meet qualifications established in 42 CFR 440.110(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, Bureau of Health Services Financing, LR 45:

§9535. Reimbursement Methodology

A. Local education agencies (LEAs) will only be reimbursed for the following Individuals with Disabilities Education Act (IDEA) services:

1. audiology;

2. speech pathology;

3. physical therapy;

4. occupational therapy; and

5. psychological services.

B. Services provided by local education agencies to recipients ages 3 to 21 that are medically necessary and included on the recipient's individualized service plan (IEP), a section 504 accommodation plan, an individualized health care plan, an individualized family service plan, or are otherwise medically necessary are reimbursed according to the following methodology.

1. Speech/language therapy services shall continue to be reimbursed in accordance with the Medicaid published fee schedule.

C. Cost Reporting. Settlement payments for EPSDT school-based therapy 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 therapy 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 therapy service providers as allocated to therapy 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

therapy 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 by the allowable costs. There are no additional indirect costs included.

4. To determine the amount of therapy 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.

D. For the therapy services, the participating LEAs' actual cost of providing the services shall be claimed for Medicaid 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 therapy services cost report form for all

therapy service personnel (i.e. all personnel providing LEA therapy 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 Therapy Services. A time study which incorporates the CMS-approved Medicaid administrative claiming (MAC) methodology for therapy service personnel shall be used to determine the percentage of time therapy service personnel spend on therapy 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 therapy services, the percentage of time spent on therapy services shall be divided by 100 percent minus the percentage of G and A time. This shall result in a percentage that represents the therapy 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 therapy service personnel shall be sampled to ensure results that will have a confidence level of at least 95 percent with a precision of plus or minus five 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 D.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 therapy 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 D.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 therapy services cost.

E. Reconciliation of LEA Certified Costs and Medicaid Management Information System (MMIS) Paid Claims. Each LEA

shall complete the therapy 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 therapy 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 therapy services. The Medicaid certified cost expenditures from the therapy 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 therapy services provided by the LEA.

F. 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 therapy 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, Bureau of Health Services Financing, LR 45:

Part XXXIII. Behavioral Health Services
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 service plan, a section 504 accommodation plan pursuant to 34 C.F.R. §104.36, an individualized health care plan, an individualized family service 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:

§4103. Recipient Qualifications

A. ...

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, individualized health care plan (IHP), or an individualized family service plan (IFSP)) 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:

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, IFSP 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). Services rendered by certified school psychologists must be supervised consistent with R.S. 17:7.1.

1 Applied behavior analysis-based (ABA) services rendered in school-based settings 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 licensed medical psychologist, hereafter

referred to as the licensed professional. Payment for services must be billed by the licensed professional

C. – E. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, 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:

§4303. Covered Services

A. ...

B. The following school based behavioral health services shall be reimbursed under the Medicaid Program:

1. ...

2. rehabilitation services, including community psychiatric support and treatment (CPST);

3. addiction services; and

4. 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.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 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:

§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). Services that are not reflected in the IEP, section 504 plan, IHP or IFSP (as determined by the assessment and evaluation) shall not be covered.

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, 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:

Chapter 45. Provider Participation

§4501. Local Education Agency Responsibilities

A. – D. ...

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. – F.6. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 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:

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.

1. – 2. Repealed.

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:

§4703. Cost Calculations

Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:401 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2172 (October 2015), repealed by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 45:

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

Rebekah E. Gee MD, MPH

Secretary