RULE

Department of Health
Bureau of Health Services Financing

Dental Benefits Prepaid Ambulatory Health Plan
(LAC 50:I.2101 and 2105)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:I.2101 and §2105 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 I. Administration
Subpart 3. Managed Care for Physical and Behavioral Health

Chapter 21. Dental Benefits Prepaid Ambulatory Health Plan

§2101. General Provisions

A. ...

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:

§2105. Prepaid Ambulatory Health Plan Responsibilities

A. – A.5. ...

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

B.3. – N. ...

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

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

2. compliance with departmental and contract requirements.

O.2. – U.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 40:784 (April 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 46:1228 (September 2020), LR 49:

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.

Stephen R. Russo

LDH Secretary

RULE

Department of Health
Bureau of Health Services Financing
and
Office of Aging and Adult Services

Home and Community-Based Services Waivers
Adult Day Health Care Waiver
Direct Support Worker Wages and Bonus Payments
(LAC 50:XXI.Chapter 29)

The Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services have adopted LAC 50:XXI.Chapter 29 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 XXI. Home and Community-Based Services Waivers
Subpart 3. Adult Day Health Care Waiver

Chapter 29. Reimbursement

§2901. Adult Day Health Care (ADHC) Direct Support Worker Wages, Other Benefits, and Workforce Retention Bonus Payments

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 49:

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.

Stephen R. Russo

LDH Secretary

RULE

Department of Health
Bureau of Health Services Financing
And
Office of Aging and Adult Services

Home and Community-Based Services Waivers
Community Choices Waiver
Direct Support/Service Worker Wages and Bonus Payments
(LAC 50:XXI.Chapter 95)

The Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services have adopted LAC 50:XXI.Chapter 95 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 XXI. Home and Community-Based Services Waivers
Subpart 7. Community Choices Waiver

Chapter 95. Reimbursement

§9503. Direct Support/Service Worker Wages, Other Benefits, and Workforce 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:

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.

Stephen R. Russo

LDH Secretary

RULE

Department of Health
Bureau of Health Services Financing
and
Office of Aging and Adult Services

Home and Community-Based Services Waivers
Support Coordination Workforce Bonus Payments
(LAC 50:XXI.553)

The Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services have adopted LAC 50:XXI.553 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 XXI. Home and Community-Based Services Waivers
Subpart 1. General Provisions

Chapter 5. Support Coordination Standards for Participation for Office of Aging and Adult Services Waiver Programs

Subchapter C. Provider Responsibilities

§553. Workforce 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.

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:

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.

Stephen R. Russo

LDH Secretary

RULE

Department of Health
Bureau of Health Services Financing

Inpatient Hospital Services

The Department of Health, Bureau of Health Services Financing has repealed the following uncodified Rules in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act:

Register Date	Title	Register Volume, Number	Page Number
July 20, 1977	Policy Change to allow hospital reimbursement when dentists admit patients	Vol 3 No 7	309
March 20, 1980	Inpatient Hospital Benefits for Diagnostic Procedures	Vol 6 No 3	113
June 20, 1983	Discontinue use of Professional Standards Review Organizations (PSROs)	Vol 9 No 6	413
August 20, 1984	Office of Family Security—Change in in-patient hospital reimbursement methodology	Vol 10 No 8	599
December 20, 1985	Medical Assistance Program (MAP) – Delete prior authorizations for surgical procedures	Vol 11 No 12	1147
February 20, 1987	Medical Assistance Program (MAP) – Elimination of categories O, F, V and I	Vol. 13 No. 2	92
October 20, 1987	Medical Assistance Program (MAP) – Psychiatric hospitals standards for payments	Vol. 13 No. 10	578
June 20, 1988	Office of Eligibility Determination—MAP—Hospital program rate freeze	Vol. 14 No. 6	351
October 20, 1992	Inpatient Hospital Services Reimbursement	Vol. 18 No. 10	1132

	(Infants Under One Year)		
June 20, 1993	Inpatient Psychiatric Services—Reimbursement	Vol. 19 No. 6	751
July 20, 1993	Hospital Neurological Rehabilitation Program	Vol. 19 No. 7	893
June 20,1994	Pre-admission Certification and Length of Stay Criteria for Inpatient Hospital Services	Vol. 20 No. 6	668
June 20, 1995	Inpatient Psychiatric Services	Vol.21 No. 6	575
January 20, 1996	Hospital Program-Reimbursement Inflation	Vol.22 No. 1	33
February 20, 1996	Hospital Program—Acute Inpatient Hospital Services, Outlier	Vol. 22 No. 2	106
February 20, 1997	Hospital Prospective Reimbursement Methodology for Rehabilitation Hospitals	Vol. 23 No. 2	202
May 20, 1999	Hospital Neurological Rehabilitation Program—Reimbursement Methodology	Vol. 25 No. 5	875
May 20, 1999	Inpatient Psychiatric Services Reimbursement Methodology	Vol. 25 No. 5	875
June 20, 1999	Office of Secretary, BHSF—Private Hospital—Reimbursement Methodology	Vol. 25 No. 6	1099
March 20, 2000	Hospital Prospective Reimbursement Methodology—Teaching Hospitals	Vol 26 No. 03	498
June 20, 2000	Inpatient Hospital Reimbursement Medicare Part A Claims	Vol 26 No. 06	1299
June 20, 2001	Inpatient Hospital Services Extensions and Retrospective Reviews of Length of Stay	Vol. 27 No. 6	856
December 20, 2001	Inpatient Psychiatric Services Reimbursement Increase	Vol. 27 No. 12	2238
June 20, 2003	Private Hospitals Outlier Payments	Vol. 29 No. 06	914
December 20, 2003	Public Hospitals Inpatient Reimbursement	Vol. 29 No. 12	2803

	Methodology Target Rate per Discharge		
February 20, 2004	Public Hospitals Reimbursement Methodology Upper Payment Limit	Vol. 30 No. 2	254
June 20, 2004	State Owned or Operated Hospitals Inpatient Psychiatric Services Reimbursement Increase	Vol. 30 No. 6	1211
November 20, 2004	Private and Public Non-State Owned and Operated Hospitals Inpatient Psychiatric Services Reimbursement Increase	Vol. 30 No. 11	2489
February 20, 2006	Inpatient Hospital Services—State Hospitals—Reimbursement Methodology	Vol. 32 No. 2	247
February 20, 2007	Inpatient Psychiatric Services—Private Hospitals—Reimbursement Rate Increase	Vol. 33 No. 2	289

This Rule is promulgated in accordance with the provisions of the Administrative Procedures Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

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.

Stephen R. Russo

LDH Secretary

RULE

Department of Health
Bureau of Health Services Financing

Intermediate Care Facilities for Persons with Intellectual Disabilities
Reimbursement Methodology
Dental Services
(LAC 50:VII.Chapter 329)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:Chapter 329 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 VII. Long-Term Care
Subpart 3. Intermediate Care Facilities for Persons with Intellectual Disabilities

Chapter 329. Reimbursement Methodology

Subchapter A. Non-State Facilities

§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. ...

C. A resident’s per diem rate will be the sum of:

1. – 3. ...

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. – D.1. ...

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.

b. – d. ...

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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/IID 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.

1.e.i.- 2. ...

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.

2.b. – 3. ...

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.

3.b. – 4. ...

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. – d.i.

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.

E.1. – G. ...

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. ...

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.

I.1.a. – J. ...

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:

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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 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:

§32904. Temporary Reimbursement for Private Facilities

A. – B. ...

C. The temporary Medicaid reimbursement rate is all-inclusive and incorporates the following cost components:

1. – 4. ...

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. – E.2.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, Bureau of Health Services Financing, LR 47:593 (May 2021), amended LR 48:2129 (August 2022), LR 49:

§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. 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, Office of the Secretary, Bureau of Health Services Financing, LR 31:1593 (July 2005), repromulgated LR 31:2254 (September 2005), LR 49:

§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. – 4. ...

B. ICAP Review Committee

1. Requests for Pervasive Plus must be reviewed and approved by the LDH ICAP Review Committee.

B.2. – 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, 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:

§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 unauditable, 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. ...

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. – 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, 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:

§32913. Leave of Absence Days

A. The reimbursement to non-state ICFs/IID for hospital leave of absence days is 85 percent of the applicable per diem rate.

B. ...

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. Effective for dates of service on or after February 20, 2009, the reimbursement to non-state ICFs/IID for leave of absence days is 85 percent of the applicable per diem rate on file as of February 19, 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 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:

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;

A.2. – B. ...

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:

§32967. Quasi-Public Facilities

A. ...

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;

B.2. – 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 39:326 (February 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 49:

§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. – 2.a. ...

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. – G. ...

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

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

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have a positive impact on family functioning, stability and autonomy as described in R.S. 49:972, since it assures access to Medicaid covered dental services for adult beneficiaries residing in intermediate care facilities for individuals with intellectual disabilities.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have a positive impact on child, individual, or family poverty in relation to individual or community asset development

as described in R.S. 49:973, as it assures access to Medicaid covered dental services for adult beneficiaries residing in intermediate care facilities for individuals with intellectual disabilities.

Small Business Analysis

In compliance with the Small Business Protection Act, the economic impact of this proposed Rule on small businesses has been considered. It is anticipated that this proposed Rule may have a positive impact on small businesses since it provides increased reimbursement for services.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, but may reduce the total direct and indirect cost to the provider to provide the same level of service, and may enhance the provider's ability to provide the same level of service as described in HCR 170 since this proposed Rule provides increased reimbursement for services.

Public Comments

Interested persons may submit written comments to Tara A. LeBlanc, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821–9030. Ms. LeBlanc is responsible for responding to inquiries regarding this proposed Rule. The deadline for submitting written comments is at 4:30 p.m. on March 1, 2023.

Public Hearing

Interested persons may submit a written request to conduct a public hearing by U.S. mail to the Office of the Secretary ATTN: LDH Rulemaking Coordinator, Post Office Box 629, Baton Rouge, LA 70821-0629; however, such request must be received no later than 4:30 p.m. on February 9, 2023. If the criteria set forth in R.S. 49:953(A)(2)(a) are satisfied, LDH will conduct a public hearing at 9:30 a.m. on February 28, 2023 in Room 118 of the Bienville Building, which is located at 628 North Fourth Street, Baton Rouge, LA. To confirm whether or not a public hearing will be held, interested persons should first call Allen Enger at (225) 342-1342 after February 9, 2023. If a public hearing is to be held, all interested persons are invited to attend and present data, views, comments, or arguments, orally or in writing. In the event of a hearing, parking is available

to the public in the Galvez Parking Garage, which is located between North Sixth and North Fifth/North and Main Streets (cater-corner from the Bienville Building). Validated parking for the Galvez Garage may be available to public hearing attendees when the parking ticket is presented to LDH staff at the hearing.

Stephen R. Russo

LDH Secretary

RULE

Department of Health
Bureau of Health Services Financing

Nurse Aide Training and Competency Evaluation Program
Medication Attendant Certified
Licensing Standards
(LAC 48:I.Chapter 100)

The Department of Health, Bureau of Health Services Financing has amended LAC 48:I.Chapter 100 as authorized by R.S. 36:254 and R.S. 40:2131-2141. 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 48

PUBLIC HEALTH-GENERAL
Part I. General Administration
Subpart 3. Licensing and Certification

Chapter 100. Nurse Aide Training and Competency Evaluation Program

Subchapter G. Medication Attendant Certified

§10080. Definitions

Abuse—1. – 4. Repealed.

Adult Residential Care Provider—a facility, agency, institution, society, corporation, partnership, company, entity, residence, person or persons, or any other group which provides adult residential care for compensation to two or more adults who are unrelated to the licensee or operator.

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Licensed Nurse—a licensed registered nurse (RN) or a licensed practical nurse (LPN) who is acting within the scope of practice of his/her respective licensing board(s) and/or certifications.

Licensed Practical Nurse (LPN)—a person who practices practical nursing and who is licensed to practice practical nursing in accordance with R.S. 38:961, or current law.

Licensed Long-Term Care Facility (LLCF)–nursing home as defined in R.S. 40:2009.2 and an adult residential care provider as defined in R.S. 40:2166.3.

Medication Attendant Certified (MAC)—a person certified by LDH to administer medications to licensed long-term care facility residents, hereafter referred to as a MAC.

Medication Error–the observed or identified preparation or administration of medications or biologicals that is not in accordance with:

1. the prescriber’s order(s);

2. manufacturer’s specifications regarding the preparation and administration of the medication or biological; or

3. accepted professional standards and principles that apply to professionals providing services. Accepted professional standards and principles include any state practice

regulations and current commonly accepted health standards established by national organizations, boards, and councils.

Medication Error Rate–is determined by calculating the percentage of medication errors observed during a medication administration observation. The numerator in the ratio is the total number of errors that the HSS survey team observes, both significant and non-significant. The denominator consists of the total number of observations, or opportunities for errors, and includes all the doses the HSS survey team observed being administered plus the doses ordered but not administered. The equation for calculating a medication error rate is as follows: medication error rate equals number of errors observed divided by the opportunities for errors times 100.

Nurse Aide—Repealed.

Nursing Facility or Nursing Home—an institution licensed pursuant to R.S. 40:2009.1-2009.10.

Nursing Home—Repealed.

Registered Nurse (RN)—any individual licensed and/or certified in accordance with R.S. 37:911 et seq. or current law to engage in the practice of nursing as defined in R.S. 37:913, or current law.

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Significant Medication Error—one which causes the resident discomfort or jeopardizes health or safety. The significance of

medication errors is a matter of professional judgement. A significant medication error shall be determined based on the resident's condition, drug category, and frequency of error.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 37:1026.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1413 (July 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 46:29 (January 2020), LR 49:

§10081. General Provisions

A. The LDH establishes provisions for the use of MACs in LLCFs. The department shall maintain a registry of individuals who have, at a minimum:

1. passed a qualifying CNA examination and are in good standing;

2. successfully completed a state-approved MAC training course and competency evaluation) administered by a state-approved testing source; and

3. ...

B. The MAC registry shall contain the following items:

1. a list of individuals who have successfully completed the approved MAC training curriculum and competency

evaluation. Each individual listed shall have the following information maintained on the registry:

a. – iii. ...

iv. exploitation and misappropriation of property;

v. significant medication errors; and

vi. an accurate summary of findings after action on findings are final and after any appeal is ruled upon or the deadline for filing an appeal has expired;

B.1.j. – C. ...

D. Change of Information. A MAC certificate holder shall notify the department as soon as possible but no later than 30 days after changing his or her address, telephone number, e-mail address, or name.

E. ...

F. Letter of Certification. An initial letter of certification shall be valid for 12 months from the date of issuance.

1. – 3. Repealed.

G. A MAC may perform certain duties and functions delegated by a licensed RN and under direct supervision of a licensed nurse who is on-site and on duty at the LLCF. Although the performance of selected medication administration tasks are delegated to the MAC by the RN, the RN retains the

accountability for the total nursing care of the resident, regardless of whether the care is provided solely by the RN or by the RN in conjunction with other licensed or unlicensed assistive personnel. The MAC shall:

1. function in accordance with applicable laws and rules relating to administration of medication and operation of a LLCF; and

2. comply with the department’s rules applicable to such personnel used in a LLCF.

H. Persons employed as MACs in a LLCF shall comply with the requirements relating to CNAs as set forth in the Omnibus Budget Reconciliation Act of 1987, Public Law 100-203 and minimum licensure standards for nursing facilities, and CNA training and competency evaluation, or subsequent amendments.

I. Restriction. While on duty, a MAC’s sole function shall be to administer medications to residents. Persons employed as medication attendants in a LLCF may not be assigned additional responsibilities. If medication administration has been completed, they may assist in other areas.

J. LLCFs may count the MAC in required nursing hours.

J.1. – M. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 37:1026.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1413 (July 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1248 (May 2012), repromulgated LR 38:1412 (June 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 46:30 (January 2020), LR 49:

§10082. General Requirements

A. Prior to application for a certificate under this Chapter, all persons shall:

1. – 5. ...

6. be currently employed in a LLCF as a CNA on the first official day of an applicant's MAC training program;

7. have a minimum of one year experience in a LLCF; and

8. successfully pass a statewide criminal background/security check conducted by the State Police, or its designee, within 90 days of an applicant starting the MAC program and be free of abused substances as evidenced by periodic drug testing in accordance with the LLCF’s policies and procedures. Verification of these results must be received by the training entity, documented, and maintained in the personnel file.

B. A MAC may not administer medication to a resident in a LLCF unless he/she:

1. ...

2. is currently enrolled in the state approved training course and is acting under the direct supervision of faculty.

C. All MAC training and competency evaluation programs must be approved by the department. Each state-approved MAC training and competency evaluation program shall:

1. maintain qualified, approved RNs and LPNs for classroom and clinical instruction;

2. protect the integrity of the competency evaluations by keeping them secure;

3. utilize a pass rate of at least 80 percent for each individual student; and

4. assure the curriculum meets state requirements.

D. Clinical instruction shall be conducted in an approved LLCF with a ratio of no more than 5:1 under the direct supervision of the instructor.

1. – 4. Repealed.

E. Training programs that do not meet minimum standards and cannot provide an acceptable plan for correcting deficiencies shall be eliminated from participation.

F. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 37:1026.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1414 (July 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1249 (May 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 46:30 (January 2020), LR 49:

§10083. Certification Requirements

A. Initial Certification

1. be a CNA in good standing;

a. – b. Repealed.

2. be employed in a MAC approved LLCF;

3. meet requirements set forth in §10082; and

4. complete the required MAC training program.

B. Renewal Certification

1. A MAC certificate holder shall:

a. be a CNA in good standing;

b. have no findings on the MAC registry;

c. submit the following documentation to the registry prior to the expiration date of the certificate:

i. a signed attestation acknowledging review of the current MAC requirements;

ii. documentation of having completed four hours of state-approved continuing education administered by an approved institution focusing on medication administration, prior to expiration of the certificate; and

iii. documentation of having worked at least 400 hours within the previous 12 months as a MAC in an LLCF.

1.d. – 3. Repealed.

C. Denial of Renewal. The department shall deny renewal of the certificate of a MAC who is in violation of this Chapter at the time of the application renewal.

1. – 3. Repealed.

D. Reciprocity. A person who holds a valid license, registration or certificate as a MAC issued by another state shall also be certified in Louisiana if the transferring state's training program is at least 120 hours or more and the applicant passed that state's-approved MAC competency examination.

1. The applicant shall initially submit an application for reciprocity to the CNA registry as set forth in the CNA training competency evaluation program, §10035 of this Chapter.

2. Once placed on the CNA registry in the state of Louisiana, the applicant may submit an application for reciprocity to the MAC Registry.

3. The application shall include a certified copy of the license or certificate for which the reciprocal certificate is requested.

4. The department shall contact the issuing agency to verify the applicant’s status with the agency.

5. The applicant shall submit documentation of 400 hours employed as a MAC within the previous 12 months.

E. Expired Certification. A MAC whose certificate has expired shall not perform medication administration until the certificate has been reissued. The following criteria shall be met and documentation submitted to the registry for consideration of certificate re-issuance:

1. Documentation of 400 employment hours worked within the last 12 months in a LLCF as a MAC; and

2. A signed attestation acknowledging review of the current MAC requirements within 30 calendar days of expiration of the certification; or

3. Documentation supporting completion of a minimum of 40 hours of re-orientation of medication administration and the job duties of the MAC within 12 months of expiration of certification to be provided by a MAC approved LLCF. At a minimum the re-orientation shall:

a. include authorized duties and prohibited duties described in this Subchapter, and the facility's medication administration policies;

b. be provided by a licensed RN who is employed by the LLCF in which the MAC is currently employed; and

c. include documentation of a competency evaluation through skills demonstration and written examination.

4. Failure to meet the certificate renewal or re-issuance requirements within 12 months from the expiration of the certification, will be considered a voluntary surrender of the MAC certification.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 37:1026.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1415 (July 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1249 (May 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 46:31 (January 2020), LR 49:

§10084. Coordinators, Instructors, and Trainers

A. Program Coordinator. The state-approved MAC training program shall have a program coordinator who provides general supervision of the training received by the MAC trainees.

1. The program coordinator shall be an RN and shall have the following experience and qualifications:

a. a minimum of two years of nursing experience, of which at least one year must be in caring for the elderly or chronically ill, obtained through employment in any of the following:

i. a LLCF unit;

ii. a geriatrics department;

iii. a chronic care hospital;

iv. other long-term care setting; or

v. experience in varied responsibilities including, but not limited to, direct resident care or supervision and staff education; and

b. completion of Vocational Trade and Industrial Education (VTIE) or Career and Technical Trade and Industrial Education (CTTIE) licensure, “train the trainer” type program, or a master’s degree or higher.

2. The program coordinator shall supervise no more than two MAC training programs simultaneously and shall be on the premises where the program is being conducted for at least 50 percent of the duration of the program.

3. – 4. Repealed.

B. Instructors. Instructors shall be RNs or LPNs in a ratio such that not less than 50 percent of the instructors are

RNs and shall hold a current, unencumbered Louisiana nursing license or PTP. Licensed practical (vocational) nurses, under the direct supervision of the coordinator, may provide classroom and clinical skills instruction and supervision of trainees if they have two years of experience in caring for the elderly and/or chronically ill of any age or have equivalent experience.

1. Such experience may be obtained through employment in:

a. a LLCF;

b. a geriatrics department;

c. a chronic care hospital; or

d. another long-term care setting.

2. Experience in resident care, supervision and staff education is preferred.

3. The ratio of instructors to trainees in clinical training shall not exceed 1:5 and the ratio of instructors to trainees in the classroom shall not exceed 1:15.

4. – 5. Repealed.

C. Program Trainers. Qualified resource personnel from the health field may participate as program trainers as needed for discussion or demonstration of specialized medication procedures.

1. Qualified resource personnel shall have a minimum of one year of experience in their health care field and shall

be licensed, registered and/or certified, if applicable, and may include:

a. registered nurses;

b. licensed practical/vocational nurses;

c. pharmacists;

d. dietitians;

e. LLCF administrators;

f. gerontologists;

g. physical therapists and occupational therapists;

h. activities specialists; and

i. speech/language/hearing therapists.

2. All program trainers shall have a minimum of one year of current experience in caring for the elderly and/or chronically ill of any age or have equivalent experience.

3. The training program may utilize other persons such as residents, experienced aides, and ombudsmen as resource personnel if these persons are needed to meet the planned program objectives or a specific unit of training.

D. Trainees

1. Each MAC trainee shall be clearly identified as a trainee during all clinical portions of the training. Identification should be recognizable to residents, family members, visitors and staff.

a. – c. Repealed.

2. Trainees shall take the competency evaluation (through skills demonstration and written examination) within 30 days after completion of the training program. Trainees will be given a maximum of two opportunities within 90 days following completion of the training program to successfully complete the competency evaluation program.

3. If a trainee fails to successfully complete the competency evaluation program, he or she shall re-enroll in the approved training program.

4. – 30. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 37:1026.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1415 (July 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1250 (May 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 46:31 (January 2020), LR 49:

§10085. Training Curriculum

A. The goal of the MAC training and competency evaluation program is the provision of safe, effective and timely

administration of medication to residents by MACs who are able to:

1. communicate and interact completely on a one-to-one basis with residents as part of the team implementing resident care;

2. demonstrate sensitivity to the resident’s emotional, social and mental health needs through skillful, directed interactions;

3. exhibit behavior to support and promote the rights of residents; and

4. demonstrate proficiency in the skills related to medication administration.

B. Each MAC training program shall provide all trainees with a LLCF orientation that is not included in the required minimum 120 hours of core curriculum. The orientation program shall include, but not be limited to:

1. an explanation of the facility’s organizational structure;

2. the facility’s policies and procedures;

3. discussion of the facility’s philosophy of care;

4. a description of the resident population; and

5. employee policies and procedures.

C. Core Curriculum. The curriculum content for the training program must include material which provides a basic

level of knowledge and demonstrable skills for each individual completing the program. The content should include the needs of populations which may be served by an individual LLCF.

1. The core curriculum shall be a minimum of 120 hours in length which shall include a minimum of 45 clinical hours.

2. Each unit objective shall be behaviorally-stated for each topic of instruction. Each objective must state performance criteria which are measurable and will serve as the basis for the competency evaluation.

D. Minimum Curriculum. The training program shall be developed and conducted to ensure that each MAC, at a minimum, is able to demonstrate competency in the following areas including, but not limited to:

1. the basic principles of medication administration and the responsibilities of the MAC including:

a. the role and functions of a MAC;

b. the professional relationship between the MAC and the residents and their families; and

c. prohibited functions or duties;

2. definition of nurse delegation;

3. definition of the basic terms used in medication administration, including identification of the abbreviations

used in medication orders and on the medication administration records;

4. review of the various forms of medications;

5. methods of medication administration including:

a. proper positioning of resident for various medication administrations; and

b. the value of good body alignment prior to and after medication administration;

6. requirements for proper storage and security of medications;

7. proper methods for disposal of drugs;

8. infection control;

9. basic anatomy and physiology;

10. the functions of the gastrointestinal, musculoskeletal, integumentary, nervous, sensory, renal and urinary, reproductive, cardiovascular, respiratory, and endocrine systems;

a. description of the common disorders associated with these systems; and

b. the effect of aging on these systems;

11. definition of pharmacology including:

a. medication classifications;

b. a description of a controlled drug and how administration of these drugs differ;

c. the cycle of a drug in the body; and

d. side effects of medications;

12. the safe administration of all forms of oral medication including;

a. a description of the difference among all forms of oral medication; and

b. special precautions observed when administering time-released capsules, enteric-coated tablets and oral suspensions;

13. appropriate procedures to follow when the resident is nothing by mouth (NPO), dysphagic, refuses the medication, vomits the medication, or has allergies;

14. application of topical medications and the standard precautions utilized in administering a topical medication;

15. the safe instillation of ophthalmic drops and ointments;

16. the safe administration of nose drops;

17. proper technique for administration of inhalant medications including:

a. a description of when the MAC may administer an inhalant;

18. the safe administration of a rectal suppository;

19. the safe administration of a vaginal medication;

20. developing proficiency in measuring liquid medications in a medicine cup or syringe;

21. measuring apical pulse and/or blood pressure (B/P) prior to medication administration;

22. the importance of the "chain of command;"

23. developing effective communication and interpersonal skills;

24. maintaining communication with the licensed nurse including:

a. a description of the situations that must be reported to the nurse;

25. the purpose of the clinical record and the importance of timely, clear and complete documentation in the medication administration record;

26. methods for avoiding medication errors:

a. reporting and documentation requirements when medication errors occur;

27. a resident's rights related to medication administration;

28. a discussion of the "rights" of medication administration;

29. the application and certification; and

30. violations of the laws and rules that may result in disciplinary action and/or loss of certification.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 37:1026.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1416 (July 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1250 (May 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 46:32 (January 2020), LR 49:

§10086. Competency Evaluation

A. A competency evaluation shall be developed by the training entity and conducted to ensure that each trainee, at a minimum, is able to demonstrate competencies taught in each part of the training curriculum.

B. Written examinations shall be provided by the training entity or organizations approved by the department. The examination shall reflect the content and emphasis of the training curriculum and will be developed in accordance with accepted educational principles.

1. – 12. Repealed.

C. The entity responsible for the training and competency evaluation shall report to the registry the names of all individuals who have satisfactorily completed the curriculum after the training is completed. Within 15 days after a MAC has

successfully completed the training and competency evaluation, the training entity shall notify the registry.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 37:1026.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1416 (July 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1250 (May 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 46:32 (January 2020), LR 49:

§10087. Authorized Duties

A. The MAC may perform certain duties and functions delegated by a licensed RN and under the direct supervision of a licensed nurse who is on-site and on duty. These authorized duties shall apply to MAC trainees under the supervision of the clinical instructor. The ratio of MACs to licensed nurses shall not exceed two medication attendants to one licensed nurse at any given time.

1. – 16. Repealed.

B. MACs may:

1. observe and report to the licensed nurse a resident’s adverse reaction to a medication;

2. administer medications which require vital signs only with direct authorization from the licensed nurse prior to administration;

3. take and record vital signs prior to the administration of medication that could affect or change the vital signs;

4. in an emergency only, administer oxygen at 2 liters per minute per nasal cannula and immediately after the emergency, verbally notify the licensed nurse on duty and appropriately document the action and notification;

5. administer regularly prescribed medication only after personally preparing (setting up) the medications to be administered;

6. deliver and administer certain prescribed medications ordered by an authorized prescriber by the following methods:

a. orally;

b. topically (to intact skin only);

c. drops and sprays for the eye, ear or nose;

d. vaginally;

e. rectally;

f. transdermally;

g. by metered dose oral inhalation; or

h. sublingually;

7. record medications administered in the resident's chart and/or medication administration record;

8. chart medication effects and side effects;

9. administer medications which require vital signs, only with direct authorization from the licensed nurse prior to administration:

a. the results of the vital signs must be documented in the clinical record;

10. administer pro re nata (prn), as needed medications only with direct authorization of the licensed nurse;

11. measure prescribed liquid medication only if verified by the licensed nurse prior to administration; and

12. crush prescribed medications only if ordered by the physician and verified by the licensed nurse.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 37:1026.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1416 (July 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 46:32 (January 2020), LR 49:

§10088. Prohibited Duties

A. Medication attendants certified shall not:

1. administer any controlled dangerous substances (schedules II through V) as set forth by the Drug Enforcement Agency or the Louisiana Board of Pharmacy;

2. administer any medications by the following parenteral routes:

a. intramuscular;

b. intravenous;

c. subcutaneous;

d. intradermal; or

e. other routes restricted in department rules;

3. administer any medication used for intermittent positive pressure breathing (IPPB) treatments;

4. administer an initial dose of a medication that has not been previously administered to a resident as determined by the clinical record;

5. calculate medication doses for administration;

6. administer medications or feedings by way of a tube inserted in a cavity of the body;

7. receive or assume responsibility for writing any verbal or telephone order from an authorized prescriber;

8. order new medications or medications whose directions have changed from the pharmacy;

9. apply topical medications that involve the treatment of skin that is broken;

10. steal, divert or otherwise misuse medication;

11. violate any provision of this Chapter;

12. procure or attempt to procure a certificate by fraudulent means;

13. neglect to administer prescribed medications in a responsible and timely manner;

14. perform a task involving the administration of a medication which requires:

a. an assessment of the patient's physical status;

b. an assessment of the need for the medication;

c. a calculation of the dose of the medication; or

d. the conversion of the dose;

15. perform a task involving the administration of a medication if the patient is unstable or has changing nursing needs, unless the supervising nurse is able to monitor the patient and the effect of the medication on the patient; or

16. administer medications if he/she is unable to do so with reasonable skill and safety to the resident if the resident is impaired by reason of excessive use of mood altering drugs, narcotics, chemicals or any other type of material.

B. – F. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 37:1026.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1417 (July 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1250 (May 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 46:32 (January 2020), LR 49:

§10089. Allegations of Medication Attendant Certified Wrong-Doing

A. – B.3.a. ...

C. Through the formal hearing process, determinations will be made on both the certificate for MAC pursuant to this Section and the certificate for CNA practice in accordance with LAC 48:I.§10061-§10079.

1. If the allegation of wrongdoing results in determinations being made against both the MAC and CNA certification simultaneously, both certifications must be brought to informal dispute resolution or appeal together.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 37:1026.1 et seq.

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

Services Financing, LR 34:1417 (July 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1250 (May 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 46:33 (January 2020), LR 49:

§10090. Suspension, Revocation or Denial of Renewal

A. ...

B. The following are grounds for disciplinary actions:

1. ...

2. procuring or attempting to procure a certificate by fraudulent means;

3. violating any provision of this Chapter; or

4. knowingly making false claims or providing false, forged, or altered information in the resident’s medical record or providing false, forged, or altered documentation to the department.

C. – E.3. ...

F. The department shall investigate prior to making a final determination on a suspended certificate. During the time of suspension, the suspended certificate holder shall not perform as a MAC in any capacity.

1. – G.1. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 37:1026.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1417 (July 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1250 (May 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 46:33 (January 2020), LR 49:

§10091. Provider Participation and Responsibilities

A. An LLCF with a license that is in good standing with the department may apply to the department to utilize MACs. Upon receipt of a facility's application, the department shall review the facility's compliance history.

B. If a facility is non-compliant with program regulations, the department shall take into consideration the findings that resulted in the facility's noncompliance before making a determination whether or not to allow the facility to utilize MACs. Emphasis shall be placed on deficiencies cited in the area of medication administration such as significant medication errors, medication error rates and repeat deficiencies of such.

C. The department may deny a facility's request to use MACs if it is determined that, based upon the compliance history, the safety and well-being of residents would be jeopardized. If the facility is denied participation, the

facility may ask for a reconsideration and review of the circumstances which contributed to the denial of the application.

1. knowingly making false claims, or providing false, forged, or altered information or documentation to the department, law enforcement, or authorized agencies shall permanently render revocation of the LLCF’s participation in the MAC program.

D. The following application information shall be submitted to the HSS for consideration of approval of MAC utilization:

1. the number of beds for the entire LLCF and beds per unit;

2. the total resident capacity for the LLCF;

3. the type of LLCF;

4. policy and procedure describing the plan for orientation, utilization of MACs, tracking and trending of medication errors for MACs, including orientation of all staff to the role of MACs;

5. documentation of the number and type of medication errors in the year prior to the utilization of MACs; and

6. a statement that the LLCF will utilize the MACs in accordance with the department’s rules and regulations and will provide evaluation information as indicated.

E. A facility’s application that is not complete within 90 calendar days of receipt by the department shall be considered null and void.

F. Approved LLCFs shall have written policies and procedures that a minimum, address the MAC’s role, responsibilities, authorized duties, prohibited duties, and medication errors.

G. Disqualification of MAC program. The department may sanction a facility and/or revoke a facility’s participation in the MAC program for a period of two years, if it is determined by the department that, based upon the facility’s compliance history, the safety and well-being of residents is jeopardized by the facility’s non-compliance with licensing standards. The department may also sanction and/or revoke a facility’s participation in the MAC program, if the facility provides false statements and/or documentation concerning their MAC program. If the facility’s participation is revoked, the facility may ask for a reconsideration and review of the circumstances which contributed to the revocation of participation in the MAC program.

H. Reinstatement of MAC Provider Participation. A LLCF who has lost their MAC program and/or nurse aide training and competency evaluation programming (NATCEP) program due to non-compliance resulting in substandard quality of care, harm or immediate jeopardy, including but not limited to medication errors, may re-apply to participate in the MAC program upon the end of the two-year period of the prohibition timeframe. If the facility's participation in the MAC program is revoked for providing false statements or documentation, the facility may not reapply for reinstatement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 37:1026.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 49:

Stephen R. Russo

LDH Secretary

RULE

Department of Health
Bureau of Health Services Financing
and
Office of Aging and Adult Services

Personal Care Services–Long Term
Direct Service Worker Wages and Bonus Payments
(LAC 50:XV.12917 and 12921)

The Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services have amended LAC 50:XXI.12917 and adopted §12921 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 9. Personal Care Services

Chapter 129 Long Term Care

§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.

C. 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 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:

§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:

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.

Stephen R. Russo

LDH Secretary

RULE

Department of Health
Bureau of Health Services Financing

Targeted Case Management
Reimbursement Methodology
Workforce Retention Bonus Payments
(LAC 50:XV.10704)

The Department of Health, Bureau of Health Services Financing has adopted LAC 50:XV.10704 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 7. Targeted Case Management

Chapter 101. General Provisions

§10704. Targeted Case Management Workforce Bonus Payments

A. Establishment of Targeted Case Management Workforce 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:

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.

Stephen R. Russo

LDH Secretary