RULE

Department of Health
Bureau of Health Services Financing

Early and Periodic Screening, Diagnosis and Treatment
School-Based Health Services
(LAC 50:XV.Chapter 95)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XV.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 XV. Services for Special Populations
Subpart 5. Early and Periodic Screening, Diagnosis and Treatment

Chapter 95. School-Based Health Services

Subchapter A. School-Based Health Service Program Guidelines

§9501. General Provisions

A. EPSDT school-based medical services are provided pursuant to a written plan of care and provided by licensed medical providers within a local education agency (LEA) to Medicaid beneficiaries ages 3 to 21 with or suspected of having a disability. The goal of these services is to prevent or mitigate disease, enhance care coordination, and reduce costs by preventing the need for tertiary care. Providing these services

in the school increases access to health care for children and youth resulting in a more efficient and effective delivery of care.

B. School-based medical services shall be covered for all beneficiaries in the school system who are eligible according to Subsection A above. Medical necessity criteria shall be determined according to the provisions of LAC 50:I.Chapter 11.

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

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

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

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

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

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

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

D. All service providers providing EPSDT school-based medical services are required to maintain an active license that is necessary for the applicable service within the state of Louisiana.

E. All participating LEAs are required to maintain an active status with Medicaid. Should an LEA’s Medicaid provider number become inactive or one LEA from a group that shares a tax identification becomes inactive, it may cause the entire cost report to be denied and the cost settlement forfeited.

F. Effective for the fiscal year ended June 30, 2021 cost report year, the individual cost settlement amounts for each

program (therapy services, behavioral health services, nursing services, personal care services, and other medical direct services) will be combined into one cost settlement for the LEA. Settlement letters will be sent to the LEA with the individual final cost reports for its records. Medicaid administrative claiming (MAC) cost reports are derived by using the MAC-related time study results and cost related to each of the EPSDT programs. All costs will have been certified by the LEA with the EPSDT cost report, so no additional signatures or certifications are required for MAC. Therefore, MAC cost reports shall remain separate.

1. – 2. Repealed.

G. LEAs that terminate business must notify the Louisiana Medicaid fiscal intermediary, immediately. Instructions will need to be provided to Department of Health/Rate Setting and Audit and/or Department of Education as to the final disposition of cost settlements and previous dollars owed to or from Louisiana Medicaid.

1. For LEAs that transfer to new management companies and owe the department, the new owners shall assume all obligations of repayment for the new LEA. Overpayments will be recouped from future earnings of the new management company.

2. For separating LEAs that are owed reimbursements, the department will cut a supplemental check to the LEA or the

new management company. However, failure to provide instructions to the department within 10 days of closure may result in forfeiture of payment.

3. Repealed.

H. Dollars owed will be assessed to all future cost settlements for the LEA and will be applied to the earliest cost report year with an overpayment. For example, if an LEA has an overpayment for nursing services and an amount due to them for therapy services, the payment for therapy services will be applied to the LEA’s overpayment for the nursing services. The net balance from this offset will:

1. be used to offset overpayments in other periods (from oldest period moving forward to the current period);

2. create a net overpayment that will be carried forward and offset against future billings and/or payments; and

3. be remitted to the LEA.

I. Service Exclusion. Services are not covered if they are performed for educational purposes (e.g., academic testing) or determined not medically necessary. Medicaid does not reimburse for social or educational needs.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:2760

(October 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1298 (August 2016), LR 45:561 (April 2019), LR 47:738 (June 2021), LR 49:

§9503. Covered Services

A. The following medically necessary services provided by local education agencies (LEAs) are reimbursable when included on a beneficiary's individualized service plan (IEP), a section 504 accommodation plan, an individualized health care plan, or a medical need based written plan of care:

1. medical and remedial behavioral health care including applied behavior analysis (ABA);

a. – c. Repealed.

2. personal care services;

a. – e. Repealed.

3. physical therapy;

4. occupational therapy;

a. Repealed.

5. speech therapy/pathology; and

6. audiology.

B. Medically necessary services shall be provided by local education agencies (LEAs) that correct or ameliorate a child's health condition.

C. Services must be performed by qualified providers as set forth in the State Plan following Louisiana scope of practice laws for the respective provider furnishing services.

1. Services rendered by certified school psychologists must be practicing under the supervision of a licensed psychologist consistent with R.S. 17:7.1.

2. Licensed master social workers or certified master licensed social worker must practice under the supervision of a licensed clinical social worker.

D. LEAs are responsible for proper medical documentation and record keeping. Services shall promote appropriate continuity of care.

E. The following services are covered for any EPSDT eligible beneficiary in schools.

1. EPSDT Program Periodicity Schedule for Screenings. Qualified individuals employed by a school district may perform any of these screens within their licensure. The results of these screens must be made available as part of the care coordination plan of the district. The screens shall be performed according to the periodicity schedule including any inter-periodic screens.

2. EPSDT Medical/Nursing Assessment/Evaluation Services. A licensed health care provider employed by a school district may perform services to protect the health status of

children and correct health problems. These services may include health counseling and triage of childhood illnesses and conditions.

a. Consultations are to be face-to-face contact in one-on-one sessions. These are services for which a parent would otherwise seek medical attention at a physician or health care provider’s office. Telemedicine/telehealth is not a covered service, but is an applicable service delivery method. When otherwise covered by Louisiana Medicaid, telemedicine/telehealth is allowed for all CPT codes located in Appendix P of the CPT manual. This service is available to all Medicaid individuals eligible for EPSDT.

F. Policy transmittals, State Plan amendments, regulations, provider bulletins, provider manuals, and fee schedules, issued by the department are the final authority regarding services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:2760 (October 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 45:562 (April 2019), LR 47:738 (June 2021), LR 49:

§9505. Reimbursement Methodology

A. Cost Reporting. Settlement payments for EPSDT school-based medical direct, therapy, behavioral health, and PCS services shall be based on the most recent school year's actual costs as determined by desk review and/or audit for each LEA provider.

1. Each LEA shall determine cost annually by using LDH's cost report for medical service cost form based on the direct services cost report.

2. Direct costs shall be limited to the amount of total compensation (salaries, vendor payments and fringe benefits) of current medical service providers as allocated to medical services for Medicaid beneficiaries. There are no additional direct costs included in the rate.

3. ...

4. To determine the amount of EPSDT services costs that may be attributed to Medicaid; the ratio of total Medicaid students in the LEA is multiplied by total direct (direct plus indirect) cost. Cost data are subject to certification by each LEA. This serves as the basis for obtaining federal Medicaid funding.

B. Licensed master social workers practicing under the supervision of a licensed clinical social worker, and certified school psychologist practicing under the supervision of a licensed psychologist that has the authority to practice in the

community/outside of schools will be required to show proof of verification when the cost report is monitored.

1. – 6. Repealed.

C. For the EPSDT services the participating LEA’s actual cost of providing the services shall be claimed for Medicaid federal financial participation (FFP) based on the following methodology.

1. Develop Direct Cost—The Payroll Cost Base and Vendor Cost Base. The state shall gather actual expenditure information for each LEA through its employee payroll/benefits and vendor accounts payable system. Total annual salaries and benefits paid, as well as contracted (vendor) payments, shall be obtained initially from each LEA’s payroll/benefits and accounts payable system. This data shall be reported on LDH’s direct services cost report form for all direct service personnel (i.e., all personnel providing LEA medical services covered under the state plan).

2. Adjust the Payroll and Vendor Cost Base. The payroll and vendor cost base shall be reduced for amounts reimbursed by non-state and local funding sources (e.g., federal grants). The payroll and vendor cost base shall not include any amounts for staff whose compensation is 100 percent reimbursed by a funding source other than state/local funds. This application results in total adjusted employee salary and vendor cost.

3. Determine the Percentage of Time to Provide All EPSDT Services. A time study, which incorporates the CMS-approved Medicaid administrative claiming (MAC) methodology for direct service employees, shall be used to determine the percentage of time EPSDT service providers spend on EPSDT direct services and general and administrative (G and A) time. This time study will assure that there is no duplicate claiming. The G and A percentage shall be reallocated in a manner consistent with the CMS-approved Medicaid administrative claiming methodology. Total G and A time shall be allocated to all other activity codes based on the percentage of time spent on each respective activity. To reallocate G and A time to EPSDT services, the percentage of time spent on EPSDT services shall be divided by 100 percent minus the percentage of G and A time. This shall result in a percentage that represents the EPSDT services with appropriate allocation of G and A. This percentage shall be multiplied by total adjusted salary cost as determined by the adjusted payroll cost base to allocate cost to school-based services. The product represents total direct cost.

a. A sufficient amount of EPSDT service providers' time shall be sampled to ensure results that will have a confidence level of at least 95 percent with a precision of plus or minus 5 percent overall.

b. Time study moments are to be completed and submitted by all participating LEA participants. Participants will have 48 hours (not counting weekends or holidays) from the time of the moment to complete each moment. Reminder emails will be sent to the participant and the Medicaid coordinator each morning until the moment expires. Once a time study moment has expired, it will no longer be able to be completed and will be deemed not returned. Any LEA that fails to return at least 85 percent of its moments from the time study for two quarters in a cost report year for any program, will be suspended from that program for the entire cost report year.

c. Unsupported Time Study Moments. LEAs will be penalized the lessor of $1,000 times the number of unsupported moments or 50 percent of their cost report. This only applies to LEAs that cannot support at least 50 percent of the moments selected for testing.

d. The time study percentage used for cost reimbursement calculation is an average of the four quarterly statewide time study results for each school-based Medicaid program. LEAs must participate in all four time study quarters to be reimbursed all costs for the fiscal year. Any LEA that does not submit a cost report for any program for which any billings were submitted will be required to pay back any billing

dollars received for that cost report year. This will be handled in the school based claiming cost settlement process.

e. Vendors are not subject to the time study process. Vendors are only at a school to provide the direct service enumerated in the contract. Vendors are not expected to perform G and A tasks and will be reimbursed based on a rate per service. This rate per service should include all direct and indirect costs. The rate per service should cover the time spent providing the direct service, administrative time and any other time related to tasks related to that service.

4. Determine Indirect Costs. Indirect costs shall be determined by multiplying each LEA's indirect unrestricted rate assigned by the cognizant agency (the Department of Education) by total adjusted direct cost. No additional indirect costs shall be recognized outside of the cognizant agency's indirect rate. The sum of direct costs and indirect costs shall be the total direct service cost for all students receiving EPSDT services.

D. Allocate Direct Service Costs to Medicaid. To determine the costs that may be attributed to Medicaid, total direct service cost (employee and vendor) shall be multiplied by the ratio of Medicaid enrolled students in the LEA to all students in the LEA. This results in total cost that may be certified as Medicaid's portion of school-based EPSDT services cost. The Medicaid enrolled student ratio is calculated one time in each

cost report year. This calculation is based on the statewide student count performed in October each year.

1. – 9. Repealed.

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

F. Interim Billing. The Centers for Medicare and Medicaid Services (CMS) requires each LEA to bill for all Medicaid services provided. CMS and the Office of Inspector General (OIG) rely on interim billing data for documentation of the number of services provided by each LEA and gives them a mechanism to

compare the cost reimbursed to the number of services being provided. If there are no claim submissions within an 18 month period, Medicaid management information system (MMIS) automatically terminates eligibility of a provider number making the LEA Medicaid ineligible. Any LEA that is Medicaid ineligible will have all interim claims denied and its cost report for all programs in which the LEA participated will be rejected.

G. Cost Settlement Process. As part of its financial oversight responsibilities, the department shall develop a risk assessment and an audit plan to ensure cost reasonableness and accuracy in accordance with current CMS guidelines. Based on the audit plan, the department will develop agreed upon procedures to review and process all final settlements to LEAs. The agreed upon procedures will be performed to review cost reports submitted by LEAs.

1. The financial oversight of all LEAs shall include reviewing the costs reported on the EPSDT services cost report against the allowable costs, performing desk reviews and conducting limited reviews.

2. The department will make every effort to audit each LEA at least every four years. These activities shall be performed to ensure that audit and final settlement occurs no later than two years from the LEA’s fiscal year end for the cost

reporting period audited. LEAs may appeal audit findings in accordance with LDH appeal procedures.

3. The department shall adjust the affected LEA's payments no less than annually, when any reconciliation or final settlement results in significant underpayments or overpayments to any LEA. By performing the reconciliation and final settlement process, there shall be no instances where total Medicaid payments for services exceed 100 percent of actual, certified expenditures for providing LEA services for each LEA.

4. If the interim payments exceed the actual, certified costs of an LEA's Medicaid services, the department shall recoup the overpayment from current and following years cost report settlement until the amount due is zero.

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

6. Type 1 and 3 charter schools in Orleans Parish will be required to submit acceptable documentation (board minutes, letter from the school board, etc.) that authorizes the charter to act as its own LEA, upon enrollment. Likewise, in order to receive a cost settlement, confirmation that the authorization is still in good standing with the school board will be required to accompany the submission of the cost report.

Failure to provide this documentation at the time the cost report is filed may cause the cost report to be rejected and not be considered as timely filed.

H. Delinquent Cost Report Penalty. Cost reports must be submitted annually. In order to be eligible to submit a cost report, LEAs must participate in all four time study quarters for the fiscal year.

1. The due date for filing annual cost reports is November 30. There shall be no automatic extension of the due date for filing of cost reports. If an LEA experiences unavoidable difficulties in preparing its cost report by the prescribed due date, one 30-day extension may be permitted, upon written request submitted to the department or its designee prior to the due date. The request must explain in detail why the extension is necessary. Extensions beyond 30 days may be approved for situations beyond the LEA’s control.

2. Delinquent cost reports that have not been received by November 30 and an extension was not received, will be deemed non-compliant and may be subject to a non-refundable reduction of 5 percent of the total cost settlement. This reduction may be increased an additional 5 percent each month until the completed cost report is submitted or the penalties total 100 percent. LEAs that have not filed their cost report by

six months or more beyond the due date cannot bill for services until the cost report is filed.

I. State Monitoring. If the department becomes aware of potential instances of fraud, misuse or abuse of LEA services and Medicaid funds, it will perform timely audits and investigations to identify and take necessary actions to remedy and resolve the problem.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:2761 (October 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 45:562 (April 2019), LR 47:739 (June 2021), LR 49:

§9507. Local Education Agency Responsibilities

A. The LEA shall ensure that its licensed and unlicensed EPSDT service professionals are employed or contracted according to the requirement specified under the Individuals with Disabilities Education Act (IDEA).

B. LEAs shall ensure that individual professional requirements are in compliance with Medicaid qualifications, Department of Education Bulletin 746, and Louisiana Standards for State Certification of School Personnel prior to an LEA billing for any services of a clinician under Medicaid.

C. Anyone providing EPSDT services must operate within their scope of practice license or certification under the supervision of a licensed practitioner. Licensed practitioners assume professional liability for unlicensed/certified practitioners under their supervision and within their scope of practice. The provider shall create and maintain documents to substantiate that all requirements are met.

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

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

Subchapter B. School-Based EPSDT Transportation Services

§9511. General Provisions

A. A special transportation trip is only billable to Medicaid on the same day that a Medicaid-eligible child is receiving a Medicaid Service included in the child's individualized service plan (IEP). Transportation shall be provided on a specially adapted bus. The need for transportation must be documented in the child's IEP.

B. ...

C. Local education agency responsibilities shall be followed in accordance with §9507.

D. Service Exclusion. Transportation services are not covered if performed for educational purposes (e.g., academic

testing) or, as the result of the assessment and evaluation, it is determined the service is not reflected in an IEP. Medicaid does not reimburse for social or educational needs.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 45:563 (April 2019), amended LR 47:740 (June 2021), LR 49:

§9515. Reimbursement Methodology

A. Medically necessary specialized transportation that is included on the student’s IEP, provided by LEAs to beneficiaries under age 21 is reimbursed based on the most recent school year's actual cost as determined by desk review and/or audit for each LEA provider. Each LEA shall determine cost annually by using LDH’s specialized transportation cost report form. There is no time study for the transportation program.

1. Direct cost shall be the cost of fuel, repairs and maintenance, rentals, contracted vehicle use cost and the amount of total compensation (salaries, vendor payments, and fringe benefits) of specialized transportation employees or contract cost for contract drivers, as allocated to special transportation services for Medicaid beneficiaries. There are no additional direct costs included in the rate.

2. Indirect cost is derived by multiplying the direct cost by the cognizant agency’s unrestricted indirect cost rate assigned by the Department of Education to each LEA by the allowable costs. There are no additional indirect costs included.

B. The transportation cost report initially provides the total cost of all special transportation services provided, regardless of payer. To determine the amount of special transportation costs that may be attributed to Medicaid, total cost is multiplied by the ratio of one-way Medicaid eligible trips to one-way trips for all students transported via specialized transportation. This results in total cost that may be certified as Medicaid’s portion of school-based specialized transportation services cost. Trip data is derived from transportation logs maintained by drivers for each one-way trip. This ratio functions in lieu of the time study methodology and student ratio used for the direct services cost report. Cost data on the transportation cost report is subject to certification by each parish and serves as the basis for obtaining federal Medicaid funding.

C. The participating LEA's actual cost of providing specialized transportation services will be claimed for Medicaid federal financial participation (FFP) based on the methodology described in the steps below. The state will gather actual expenditure information for each LEA through the LEA's

payroll/benefits and accounts payable system. These costs are also reflected in the annual financial report (AFR) that all LEAs are required to certify and submit to the Department of Education. All costs included in the amount of cost to be certified and used subsequently to determine the reconciliation and final settlement amounts as well as interim rates are identified on the CMS-approved transportation cost report and are allowed in OMB Circular A-87.

1. – 3. ...

4. Step 4—Total Cost. The sum of direct costs and indirect cost is the total specialized transportation direct cost for all students with an IEP indicating medical need.

5. Step 5—Allocate Specialized Transportation Cost to Medicaid. Special transportation drivers shall maintain logs of all students transported on each one-way trip. These logs shall be utilized to aggregate total annual one-way trips which will be reported by each LEA on the special transportation cost report. To determine the amount of special transportation cost that may be attributed to Medicaid, total cost is multiplied by the ratio of one-way trips by Medicaid students to one-way trips for all students transported via special transportation. This results in total cost that may be certified as Medicaid’s portion of school based special transportation services cost.

D. Medicaid One-Way Trip Ratios for Specialized Transportation

Calculation–Medicaid trip ratio times specialized transportation costs [(direct services) plus (direct services times indirect rate)].

Denominator–the total number of one-way trips for all children that ride a specialized transportation bus.

Numerator–the number of one-way trips for Medicaid enrolled children who received specialized transportation to and from the IEP service destination will be claimed as a Medicaid eligible trip when the child receives a Medicaid service included in an IEP on a particular day and specialized transportation is specifically listed in the IEP.

D.3.a. – 5. Repealed.

E. Reimbursement of LEA Certified Costs. Each LEA shall complete and submit the specialized transportation cost report no later than five months after the fiscal year end (June 30), and reconciliation should be completed within 12 months from the fiscal year end. All filed cost reports shall be subject to desk review or audit by the department's audit contractor. The financial oversight of all LEAs will include reviewing the costs reported on the specialized transportation cost reports against the allowable costs in accordance with 2 CFR 200, performing desk reviews and conducting limited reviews. The department shall

issue a notice of final reimbursement, after all reviews, which denotes the amount due to the LEA.

F. As part of financial oversight responsibilities, the department shall develop a risk assessment and audit plan to ensure cost reasonableness and accuracy in accordance with current CMS guidelines. Based on the audit plan, the department will develop agreed upon procedures to review and process all reimbursements to LEAs. The agreed upon procedures will be performed to review cost reports submitted by LEAs.

1. The financial oversight of all LEAs shall include reviewing the costs reported on the specialized transportation cost report against the allowable costs, performing desk reviews and conducting limited reviews.

2. The department shall make every effort to audit each LEA at least every four years. These activities shall be performed to ensure that audit and final reimbursement occurs no later than two years from the LEA’s fiscal year end for the cost reporting period audited. LEAs may appeal audit findings in accordance with LDH appeal procedures.

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 45:563 (April 2019), amended LR 49:

Subchapter C. School-Based Medicaid Personal Care Services

§9521. General Provisions

A. General provisions shall be followed in accordance with §9501.

B. Early and periodic screening, diagnosis and treatment personal care services must be prescribed by a licensed practitioner within the scope of their practice initially and every 180 days thereafter (or rolling six months) and when changes in the plan of care occur.

C. Local education agency responsibilities shall be followed in accordance with §9507.

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, Bureau of Health Services Financing, LR 45:564 (April 2019), amended LR 47:740 (June 2021), LR 49:

§9523. Covered Services

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

1. – 3. ...

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

5. provides assistance with transfers, positioning and repositioning; and

6. provide positive behavior support strategies to assist students with prompting to perform services related to physical and/or behavioral health needs.

B. – C.4. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 45:565 (April 2019), amended LR 47:740 (June 2021), LR 49:

§9525. Reimbursement Methodology

A. Cost reporting will be handled in accordance with §9505.A.

1. – 4. Repealed.

B. For the personal care services, the participating LEAs' actual cost of providing the services shall be claimed for

Medicaid federal financial participation (FFP) based on the following methodology for employees/vendors:

1. Develop Direct Cost-The Payroll Cost Base. Total annual salaries and benefits paid, as well as contracted (vendor) payments, shall be obtained initially from each LEA's payroll/benefits and accounts payable system. This data shall be reported on LDH's direct services cost report form for all personal care service employees or vendors (i.e., all personnel providing LEA personal care treatment services covered under the state plan).

2. Adjust the Payroll/Vendor Cost Base. The payroll cost base shall be reduced for amounts reimbursed by non-state and local funding sources (e.g., federal grants). The payroll/vendor cost base shall not include any amounts for staff whose compensation is 100 percent reimbursed by a funding source other than state/local funds. This application results in total adjusted salary cost.

3. Personal care providers will not be subject to a time study.

4. Determine Indirect Cost. Indirect cost shall be determined by multiplying each LEA's indirect unrestricted rate assigned by the cognizant agency (the Department of Education) by total adjusted direct cost. No additional indirect cost shall be recognized outside of the cognizant agency indirect rate. The

sum of direct cost and indirect cost shall be the total direct service cost for all students receiving personal care services.

5. – 6. Repealed.

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

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

a notice of final settlement, after all reviews, that denotes the amount due to or from the LEA. This reconciliation is inclusive of all services provided by the LEA.

1. – 5. Repealed.

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

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 45:565 (April 2019), amended LR 47:741 (June 2021), LR 49:

Subchapter D. School-Based Therapy Services

§9531. General Provisions

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, Bureau of Health Services Financing, LR 45:566 (April 2019), amended LR 46:343 (March 2020), LR 47:741 (June 2021), repealed LR 49:

§9533. Covered Services

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, Bureau of Health Services Financing, LR 45:566 (April 2019), amended by the Department of Health, Bureau of Health Services Financing, LR 46:343 (March 2020), LR 47:741 (June 2021), repealed LR 49:

§9535. Reimbursement Methodology

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, Bureau of Health Services Financing, LR 45:567 (April 2019), amended by the Department of Health, Bureau of Health Services Financing, LR 46:343 (March 2020), LR 47:741 (June 2021), repealed LR 49:

Subchapter E. School-Based Applied Behavior Analysis-Based Services

§9541. General Provisions

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, Bureau of Health Services Financing, LR 46:185 (February 2020), amended LR 47:741 (June 2021), repealed 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, JD

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Home Health Program
Reimbursement Rate Increase
(LAC 50:XIII.701)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XIII.701 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 XIII. Home Health Program
Subpart 1. Home Health Services

Chapter 7. Reimbursement Methodology

§701. Nursing and Home Health Aide Services

A. – D. ...

E. Effective for dates of service on or after April 3, 2023, the reimbursement rates for all home health services shall be reimbursed based on the Louisiana Medicaid fee schedule. All rates in the fee schedule are published on the Medicaid provider website at www.lamedicaid.com.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:654 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2281 (October 2010), LR 37:2159 (July 2011), LR 39:1051 (April 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 49:

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, JD

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Inpatient Hospital Services
Well Baby and Transplant Payments
(LAC 50:V.Chapter 9)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:V.Chapter 9 and 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 Numbers
July 20, 1996	Transplant Services - Reimbursement	Volume 22, No. 07	584
September 20, 2001	Inpatient Hospital Services – Reimbursement Methodology – Well Baby Care	Volume 27, No. 09	1522
March 20, 2005	Hospital Program – Transplant Services	Volume 31, No. 03	667

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 V. Hospital Services
Subpart 1. Inpatient Hospitals Services

Chapter 9. Non-Rural, Non-State Hospitals

Subchapter A. General Provisions

§907. Well Baby Care

A. A separate prospective per diem rate shall be paid to qualifying hospitals for well baby care rendered to infants who are discharged at the same time that the mother is discharged.

B. Qualifying Criteria. Non-state, non-rural hospitals that perform more than 1,500 Medicaid deliveries per year shall be eligible for this payment. The department will verify that qualifying hospitals meet the 1,500 Medicaid delivery threshold each state fiscal year. Well baby payments shall be discontinued should a hospital no longer qualify.

C. Reimbursement Methodology. The per diem rate for well baby care shall be the same prospective rate that is paid for nursery boarder baby service.

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

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

Subchapter B. Reimbursement Methodology

§953. Acute Care Hospitals

A. – I.5. ...

J. Effective for dates of service on or after August 4, 2009, the prospective per diem rate paid to acute care hospitals shall be reduced by 6.3 percent of the per diem rate on file as of August 3, 2009.

1. Payments to small rural hospitals as defined in R.S. 40:1189.3 shall be exempt from this reduction.

2. Repealed.

K. Low Income and Needy Care Collaboration. Effective for dates of service on or after January 1, 2010, quarterly supplemental payments will be issued to qualifying non-rural, non-state acute care hospitals for inpatient services rendered during the quarter. Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal year.

1. Qualifying Criteria. In order to qualify for the supplemental payment, the non-rural, non-state hospital must be affiliated with a state or local governmental entity through a low income and needy care collaboration agreement.

a. A non-state hospital is defined as a hospital which is owned or operated by a private entity.

b. A low-income and needy care collaboration agreement is defined as an agreement between a hospital and a state or local governmental entity to collaborate for purposes of providing healthcare services to low income and needy patients.

2. Each qualifying hospital shall receive quarterly supplemental payments for the inpatient services rendered during

the quarter. Quarterly payment distribution shall be limited to one-fourth of the lesser of:

a. the difference between each qualifying hospital's inpatient Medicaid billed charges and Medicaid payments the hospital receives for covered inpatient services provided to Medicaid recipients. Medicaid billed charges and payments will be based on a 12 consecutive month period for claims data selected by the department; or

i. – ii. Repealed.

b. for hospitals participating in the Medicaid Disproportionate Share Hospital (DSH) Program, the difference between the hospital's specific DSH limit and the hospital's DSH payments for the applicable payment period.

3. Effective for dates of service on or after January 1, 2011, all parties that participate in supplemental payments under this Section, either as a qualifying hospital by receipt of supplemental payments or as a state or local governmental entity funding supplemental payments, must meet the following conditions during the period of their participation.

a. Each participant must comply with the prospective conditions of participation in the Louisiana Private Hospital Upper Payment Limit Supplemental Reimbursement Program.

b. A participating hospital may not make a cash or in-kind transfer to their affiliated governmental entity that

has a direct or indirect relationship to Medicaid payments and would violate federal law.

c. A participating governmental entity may not condition the amount it funds the Medicaid Program on a specified or required minimum amount of low income and needy care.

d. A participating governmental entity may not assign any of its contractual or statutory obligations to an affiliated hospital.

e. A participating governmental entity may not recoup funds from an affiliated hospital that has not adequately performed under the low income and needy care collaboration agreement.

f. A participating hospital may not return any of the supplemental payments it receives under this Section to the governmental entity that provides the non-federal share of the supplemental payments.

g. A participating governmental entity may not receive any portion of the supplemental payments made to a participating hospital under this Section.

4. Each participant must certify that it complies with the requirements of §953.K.3 by executing the appropriate certification form designated by the department for this

purpose. The completed form must be submitted to the Department of Health, Bureau of Health Services Financing.

5. Each qualifying hospital must submit a copy of its low income and needy care collaboration agreement to the department.

6. The supplemental payments authorized in this Section shall not be considered as interim Medicaid inpatient payments in the determination of cost settlement amounts for inpatient hospital services rendered by children's specialty hospitals.

L. Effective for dates of service on or after February 3, 2010, the inpatient per diem rate paid to acute care hospitals shall be reduced by 5 percent of the per diem rate on file as of February 2, 2010.

1. Payments to small rural hospitals as defined in R.S. 40:1189.3 shall be exempt from this reduction.

2. – 2.b. Repealed.

M. Effective for dates of service on or after August 1, 2010, the inpatient per diem rate paid to acute care hospitals shall be reduced by 4.6 percent of the per diem rate on file as of July 31, 2010.

1. Payments to small rural hospitals as defined in R.S. 40:1189.3 shall be exempt from this reduction.

N. Effective for dates of service on or after January 1, 2011,the inpatient per diem rate paid to acute care hospitals shall be reduced by 2 percent of the per diem rate on file as of December 31, 2010.

1. Payments to small rural hospitals as defined in R.S. 40:1189.3 shall be exempt from this reduction.

1.a. – 6. Repealed.

O. Effective for dates of service on or after August 1, 2012, the inpatient per diem rate paid to acute care hospitals shall be reduced by 3.7 percent of the per diem rate on file as of July 31, 2012.

1. Repealed.

P. Effective for dates of service on or after February 1, 2013, the inpatient per diem rate paid to acute care hospitals shall be reduced by 1 percent of the per diem rate on file as of July 31, 2013.

1. Repealed.

Q. Effective for dates of service on or after March 1, 2017, supplemental payments to non-rural, non-state acute care hospitals that qualify as a high Medicaid hospital shall be annual. The amount appropriated for annual supplemental payments shall be reduced to $1,000. Each qualifying hospital’s annual supplemental payment shall be calculated based on the pro rata share of the reduced appropriation.

1. Repealed.

R. Effective for dates of service on or after January 1, 2017, the inpatient per diem rate paid to acute care hospitals shall be increased by 7.03 percent of the per diem rate on file as of December 31,2016.

1. Small rural hospitals as defined in R.S. 40:1189.3 and public-private partnership hospitals as defined in LAC 50:V.1701-1703 shall be exempt from this rate increase.

S. Effective for dates of service on or after January 1, 2018, the inpatient per diem rate paid to acute care hospitals shall be increased by indexing to 56 percent of the small rural hospital prospective per diem rate in effect on January 1, 2017.

1. Acute care hospitals whose per diem rates as of January 1, 2017, excluding the graduate medical education portion of the per diem, are greater than 56 percent of the January 1, 2017 small rural hospital rate shall not be increased.

2. Carve-out specialty units, nursery boarder, and well baby services are excluded from these rate increases.

T. Effective for dates of service on or after January 1, 2020, the inpatient per diem rate paid to acute care hospitals shall be increased by 3.2 percent of the per diem rate on file as of December 31, 2019.

1. Small rural hospitals as defined in R.S. 40:1189.3 and public-private partnership hospitals as defined in LAC 50:V.1701-1703 shall be exempt from this rate increase.

2. Carve-out specialty units, nursery boarder, and well baby services are included in these rate increases.

U. Effective for dates of service on or after January 1, 2021, the inpatient per diem rate paid to acute care hospitals shall be increased by 3.2 percent of the per diem rate on file as of December 31, 2020.

1. Small rural hospitals as defined in R.S. 40:1189.3 and public-private partnership hospitals as defined in LAC 50:V.1701-1703 shall be exempt from this rate increase.

2. Carve-out specialty units, nursery boarder, and well baby services are included in these rate increases.

V. – X.2. 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 34:876 (May 2008), amended LR 34:877 (May 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1895, 1896 (September 2009), repromulgated LR 35:2182 (October 2009), amended LR 36:1552 (July 2010), LR 36:2561 (November 2010), LR 37:2161 (July 2011),

LR 39:3095 (November 2013), LR 39:3297 (December 2013), LR 40:312 (February 2014), repromulgated LR 40:1939, 1940 (October 2014), LR 41:133 (January 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:963 (May 2017), LR 43:1389 (July 2017), repromulgated LR 43:1757 (September 2017), amended LR 43:2533 (December 2017), repromulgated LR 44:1445 (August 2018), amended LR 45:1770 (December 2019), LR 46:1683 (December 2020), LR 49:

§955. Long Term Hospitals

A. – C. ...

D. Effective for dates of service on or after August 4, 2009, the prospective per diem rate paid to long term hospitals for inpatient services shall be reduced by 6.3 percent of the per diem rate on file as of August 3, 2009.

1. – 2. Repealed.

E. Effective for dates of service on or after February 3, 2010, the inpatient per diem rate paid to long term hospitals shall be reduced by 5 percent of the per diem rate on file as of February 2, 2010.

F. Effective for dates of service on or after August 1, 2010, the inpatient per diem rate paid to long term hospitals shall be reduced by 4.6 percent of the per diem rate on file as of July 31, 2010.

G. Effective for dates of service on or after January 1, 2011, the inpatient per diem rate paid to long term hospitals shall be reduced by 2 percent of the per diem rate on file as of December 31, 2010.

H. Effective for dates of service on or after August 1, 2012, the inpatient per diem rate paid to long term hospitals shall be reduced by 3.7 percent of the per diem rate on file as of July 31, 2012.

I. Effective for dates of service on or after February 1, 2013, the inpatient per diem rate paid to long term hospitals shall be reduced by 1 percent of the per diem rate on file as of January 31, 2013.

J. Effective for dates of service on or after January 1, 2017, the inpatient per diem rate paid to long term hospitals shall be increased by 7.03 percent of the per diem rate on file as of December 31, 2016.

K. Effective for dates of service on or after January 1, 2018, the inpatient per diem rate paid to long term hospitals shall be increased by indexing to 42 percent of the small rural hospital prospective per diem rate in effect on January 1, 2017. Long term hospitals whose per diem rates as of January 1, 2017, excluding the graduate medical education portion of the per diem, are greater than 42 percent of the January 1, 2017 small rural hospital rate shall not be increased.

L. Effective for dates of service on or after January 1, 2020, the inpatient per diem rate paid to long term acute hospitals shall be increased by indexing to 45 percent of the small rural hospital prospective per diem rate in effect on January 1, 2019. Long term hospitals whose per diem rates as of January 1, 2019, excluding the graduate medical education portion of the per diem, are greater than 45 percent of the January 1, 2019 small rural hospital rate shall not be increased.

M. Effective for dates of service on or after January 1, 2021, the inpatient per diem rate paid to long term acute hospitals shall be increased by 3.2 percent of the per diem rate on file as of December 31, 2020.

N. 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: 34:876 (May 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1895 (September 2009), amended LR 36:1554 (July 2010), LR 36:2562 (November 2010), LR 37:2162 (July 2011), LR 40:312 (February 2014), repromulgated LR 40:1940 (October 2014), amended by the Department of Health, Bureau of Health Services

Financing, LR 43:964 (May 2017), LR 43:2533 (December 2017), repromulgated LR 44:1445 (August 2018), amended LR 45:1770 (December 2019), LR 46:1683 (December 2020), LR 49:

§957. Hospital Intensive Neurological Rehabilitation Units

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 34:876 (May 2008), repealed by the Department of Health, Bureau of Health Services Financing, LR 49:

§959. Inpatient Psychiatric Hospital Services

A. – C. ...

D. Effective for dates of service on or after August 4, 2009, the prospective per diem rate paid to non-rural, non-state free-standing psychiatric hospitals shall be reduced by 5.8 percent of the rate on file as of August 3, 2009.

1. – 2.b. Repealed.

E. Effective for dates of service on or after August 4, 2009, the prospective per diem rate paid to non-rural, non-state distinct part psychiatric units shall be reduced by 6.3 percent of the rate on file as of August 3, 2009.

1. – 2.b. Repealed.

F. Effective for dates of service on or after February 3, 2010, the prospective per diem rate paid to non-rural, non-state free-standing psychiatric hospitals and distinct part psychiatric units within non-rural, non-state acute care hospitals shall be reduced by 5 percent of the per diem rate on file as of February 2, 2010.

G. Effective for dates of service on or after August 1, 2010, the prospective per diem rate paid to non-rural, non-state free-standing psychiatric hospitals and distinct part psychiatric units within non-rural, non-state acute care hospitals shall be reduced by 4.6 percent of the per diem rate on file as of July 31, 2010.

H. Effective for dates of service on or after January 1, 2011, the prospective per diem rate paid to non-rural, non-state free-standing psychiatric hospitals and distinct part psychiatric units within non-rural, non-state acute care hospitals shall be reduced by 2 percent of the per diem rate on file as of December 31, 2010.

I. Low Income and Needy Care Collaboration. Effective for dates of service on or after January 1, 2012, quarterly supplemental payments shall be issued to qualifying non-rural, non-state free-standing psychiatric hospitals for inpatient services rendered during the quarter. Maximum aggregate payments

to all qualifying hospitals in this group shall not exceed the available upper payment limit per state fiscal year.

1. Qualifying Criteria. In order to qualify for the supplemental payment, the non-state free-standing psychiatric hospital must be affiliated with a state or local governmental entity through a low income and needy care collaboration agreement.

a. A non-state free-standing psychiatric hospital is defined as a free-standing psychiatric hospital which is owned or operated by a private entity.

b. A low income and needy care collaboration agreement is defined as an agreement between a hospital and a state or local governmental entity to collaborate for the purposes of providing healthcare services to low income and needy patients.

2. Each qualifying hospital shall receive quarterly supplemental payments for the inpatient services rendered during the quarter. Quarterly payment distribution shall be limited to one-fourth of the lesser of:

a. the difference between each qualifying hospital’s inpatient Medicaid billed charges and Medicaid payments the hospital receives for covered inpatient psychiatric services provided to Medicaid recipients. Medicaid billed

charges and payments will be based on a 12 consecutive month period for claims data selected by the department; or

b. for hospitals participating in the Medicaid Disproportionate Share Hospital (DSH) program, the difference between the hospital's specific DSH limit and the hospital's DSH payment for the applicable payment period.

J. Effective for dates of service on or after February 10, 2012, a Medicaid-enrolled non-state acute care hospital that enters into a cooperative endeavor agreement (CEA) with the Department of Health, Office of Behavioral Health to provide inpatient psychiatric services to Medicaid and uninsured patients, and which also assumes the operation and management of formerly state-owned and operated psychiatric hospitals/visits, shall be paid a per diem rate of $581.11 per day.

K. Effective for dates of service on or after January 1, 2017, the prospective per diem rate paid to non-rural, non-state free-standing psychiatric hospitals, and distinct part psychiatric units within non-rural, non-state acute care hospitals, shall be increased by 2 percent of the per diem rate on file as of December 31, 2016.

1. Inpatient hospital psychiatric services provided under a public-private partnership as defined in §959.J of this Chapter, LAC 50:V.1701 and LAC 50:V.2901 shall be exempt from this rate increase.

1.a. – 2.b. Repealed.

L. Effective for dates of service on or after January 1, 2018, the prospective per diem rate paid to non-rural, non-state free-standing psychiatric hospitals, and distinct part psychiatric units within non-rural, non-state acute care hospitals, shall be increased by indexing to 31 percent of the small rural hospital prospective per diem rate in effect on January 1, 2017.

1. Psychiatric hospitals and units whose per diem rates as of January 1, 2017, excluding the graduate medical education portion of the per diem, are greater than 31 percent of the January 1, 2017 small rural hospital rate shall not be increased.

2. Inpatient hospital psychiatric services provided under a public-private partnership as defined in §959.J of this Chapter, LAC 50:V.1701 and LAC 50:V.2901 shall be exempt from this rate increase.

M. Effective for dates of service on or after January 1, 2020, the prospective per diem rate paid to non-rural, non-state free-standing psychiatric hospitals, and distinct part psychiatric units within non-rural, non-state acute care hospitals, shall be increased by 32 percent of the small rural hospital prospective per diem rate in effect on January 1, 2019.

1. Psychiatric hospitals and units whose per diem rates as of January 1, 2019, excluding the graduate medical portion of the per diem, are greater than 32 percent of the January 1, 2019 small rural hospital rate shall not be increased.

2. Inpatient hospital psychiatric services provided under a public-private partnership as defined in §959.J of this Chapter, LAC 50:V.1701 and LAC 50:V.2901 shall be exempt from this rate increase.

N. Effective for dates of service on or after January 1, 2021, the inpatient per diem rate paid to non-rural, non-state free-standing psychiatric hospitals, and distinct part psychiatric units within non-rural, non-state acute care hospitals, shall be increased by 3.2 percent of the per diem rate in on file as of December 31, 2020.

1. Inpatient hospital psychiatric services provided under a public-private partnership as defined in §959.J of this Chapter, LAC 50:V.1701 and LAC 50:V.2901 shall be exempt from this rate increase.

N.2. – P.1. 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 34:876 (May 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1895 (September 2009), amended LR 36:1554 (July 2010), LR 36:2562 (November 2010), LR 37:2162 (July 2011), LR 39:94 (January 2013), LR 39:323 (February 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 43:964 (May 2017), LR 43:2533 (December 2017), LR 44:1446 (August 2018), LR 45:1771 (December 2019), LR 46:1683 (December 2020), LR 49:

§969. Transplant Services

A. Qualifying Criteria. The hospital must be a Medicare approved transplant center for each type of organ transplant to qualify for reimbursement of Medicaid transplant services. Bone marrow transplant, stem cell transplant, and certain autologous immunotherapies (such as CAR T-cell therapy) services shall only be allowable for payment to hospitals that are accredited by the Foundation for the Accreditation of Cellular Therapy (FACT).

B. Reimbursement Methodology. Reimbursement shall be limited to the lesser of allowable cost, net of capital and medical education cost, or the hospital-specific per diem limitation calculated for each type of transplant.

1. Allowable cost is defined as the ratio of cost to charges from the annual filed cost report multiplied by the

covered charges, net of capital and medical education cost, for the specific transplant type.

2. The per diem limitation is calculated by deriving the hospital's per diem for the transplant type from the hospital's base period trended forward using the annual Medicare target rate inflation percentage for prospective payment system (PPS)-exempt hospitals.

3. The base period is the cost report period for the hospital's fiscal year ending September 30, 1983 through August 31, 1984. The base period for types of transplants that were not performed in the base period shall be the first cost report filed subsequently that includes costs for that type of transplant.

4. Reasonable capital and medical education costs as calculated per the annual filed cost report shall be paid as a pass through cost and included in cost report settlement amounts.

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

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

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, JD

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Medicaid Eligibility
Twelve-Month Continuous Eligibility
(LAC 50:III.2525)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:III.2525 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-GENERAL
Part III. Eligibility
Subpart 3. Eligibility Groups and Factors

Chapter 25. Eligibility Factors

§2525. Twelve-Month Continuous Eligibility

A. – B. ...

C. A child’s eligibility may not be terminated during a continuous eligibility period, regardless of any changes in circumstances, unless the child meets an exception set forth in 42 CFR 435.926(d) or 42 CFR 457.342.

1 – 6. 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 34:253 (February 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 47:737 (June 2021), 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, JD

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Pharmacy Benefits Management Program
Reimbursement for Clotting Factor
(LAC 50:XXIX.949)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XXIX.949 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 9. Methods of Payment

Subchapter D. Maximum Allowable Costs

§949. Fee for Service Cost Limits

A. – I.2.b. ...

J. Clotting Factor. Pharmacy claims for clotting factor will be reimbursed using a state generated actual acquisition cost (AAC) ingredient cost and a unit based professional dispensing fee reimbursement methodology.

K. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:1065 (June 2006), amended LR 34:88 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:1561 (July 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1185 (June 2017), LR 43:1554 (August 2017), LR 44:1020 (June 2018), LR 45:571 (April 2019), LR 45:665 (May 2019), LR 46:35 (January 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, JD

Secretary