RULE

Department of Health
Bureau of Health Services Financing

Disproportionate Share Hospital Payments
Major Medical Centers
(LAC 50:V.2503 and 2719)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:V.2503 and adopted §2719 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 V. Hospital Services
Subpart 3. Disproportionate Share Hospital Payments

Chapter 25. Disproportionate Share Hospital Payment Methodologies

§2503. Disproportionate Share Hospital Qualifications

A. In order to qualify as a disproportionate share hospital, a hospital must:

1. – 9. ...

10. effective June 29, 2016, be a major medical center located in the central and northern areas of the state as defined in §2715.A;

11. be a major medical center with a specialized care unit located in the southwestern area of the state as defined in §2717.A;

12. be a major medical center located in the southeastern area of the state as defined in §2719.A; and

13. effective July 1, 1994, must also have a Medicaid inpatient utilization rate of at least 1 percent.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:655 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3294 (December 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 43:962 (May 2017), LR 45:

Chapter 27. Qualifying Hospitals

§2719. Major Medical Centers Located in the Southeastern Area of the State

A. Effective for dates of service on or after January 1, 2020, hospitals qualifying for payments as major medical centers located in the southeastern area of the state shall meet the following criteria:

1. be a private, non-rural hospital located in Department of Health administrative region 1;

2. have at least 175 inpatient beds as reported on the Medicare/Medicaid cost report, Worksheet S-3, column 2, lines 1-18, for the state fiscal year ending June 30, 2018. For qualification purposes, inpatient beds shall exclude nursery and Medicare-designated distinct part psychiatric unit beds;

3. is certified as an advanced comprehensive stroke center by the Joint Commission as of June 30, 2018;

4. does not qualify as a Louisiana low-income academic hospital under the provisions of §3101; and

5. does not qualify as a party to a low income and needy care collaboration agreement with the Department of Health under the provisions of §2713.

B. Payment Methodology. Effective for dates of service on or after January 1, 2020, each qualifying hospital shall be paid a DSH adjustment payment which is the pro rata amount calculated by dividing their hospital specific allowable uncompensated care costs by the total allowable uncompensated care costs for all hospitals qualifying under this category and multiplying by the funding appropriated by the Louisiana Legislature in the applicable state fiscal year for this category of hospitals.

1. Costs, patient specific data and documentation that qualifying criteria is met shall be submitted in a format specified by the department.

2. Reported uncompensated care costs shall be reviewed by the department to ensure compliance with the reasonable costs definition in the Medicare Provider Reimbursement Manual, Part l, Chapter 21, Section2102.1, Revision 454. Allowable uncompensated care costs must be calculated using the Medicare/Medicaid cost report methodology.

3. Aggregate DSH payments for hospitals that receive payment from this category, and any other DSH category, shall not exceed the hospital’s specific DSH limit. If payments calculated under this methodology would cause a hospital’s aggregate DSH payment to exceed the limit, the payment from this category shall be capped at the hospital’s specific DSH limit.

4. A pro rata decrease, necessitated by conditions specified in §2501.B.1 above for hospitals described in this Section, will be calculated based on the ratio determined by dividing the hospital's uncompensated costs by the uncompensated costs for all of the qualifying hospitals described in this Section, then multiplying by the amount of disproportionate share payments calculated in excess of the federal DSH allotment.

a. If additional payments or recoupments are required based on the results of the mandated DSH audit report, they shall may be made within one year after the final report for the state fiscal year is submitted to the Centers for Medicare and Medicaid Services (CMS).

b. Additional payments shall be limited to the aggregate amount recouped from the qualifying hospitals described in this section, based on the reported DSH audit results.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 45:

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

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing
and
Office for Citizens with Developmental Disabilities

Home and Community-Based Services Waivers
Residential Options Waiver
(LAC 50:XXI.Chapters 161, 163 and §16901)

The Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities have amended LAC 50:Chapters 161, 163 and §16901 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 13. Residential Options Waiver

Chapter 161. General Provisions

§16101. Introduction

A. ...

B. The goal of the Residential Options Waiver is to promote independence through strengthening the individual's capacity for self-care, self-sufficiency and community integration utilizing a wide array of services, supports and

residential options, which best meets the individual's needs and preferences, while supporting the dignity, quality of life, and security in the everyday life of the individual as he/she is a member of his/her community.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2441 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2154 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:

§16103. Program Description

A. The ROW is designed to utilize the principles of self-determination and to supplement the family and/or community supports that are available to maintain the individual in the community and are designed to allow an individual experience that mirrors the experiences of individuals without disabilities. These services are not to be restrictive, but liberating, by empowering individuals to experience life in the most fulfilling manner as defined by the individual while still assuring health and safety. In keeping with the principles of

self-determination, ROW includes a self-direction option, which allows for greater flexibility in hiring, training and general service delivery issues. ROW services are meant to enhance, not replace existing informal networks.

B. ROW offers an alternative to institutional care that:

1. utilizes a wide array of services, supports and residential options, which best meet the individual's needs and preferences;

B.2. – D. ...

E. The total expenditures available for each waiver participant is established through an assessment of individual support needs and may not exceed the approved ICF/ID ICAP rate/ROW budget level established for that individual except as approved by Office for Citizens with Developmental Disabilities' (OCDD's) assistant secretary, deputy assistant secretary or his/her designee to prevent institutionalization.

1. When the department determines that it is necessary to adjust the ICF/ID ICAP rate, each waiver participant's annual service budget may be adjusted to ensure that the participant's total available expenditures do not exceed the approved ICAP rate.

F. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2441 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2154 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:

§16104. Settings for Home and Community Based Services

A. ROW participants are expected to be integrated in and have full access to the greater community while receiving services, to the same extent as individuals without disabilities. Providers shall meet the requirements of the Centers for Medicare and Medicaid Services (CMS) home and community-based setting requirements for home and community-based services (HCBS) waivers as delineated in LAC 50:XXI, Subpart 1 or any subsequent rule.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:

§16105. Participant Qualifications

A. In order to qualify for Residential Options Waiver (ROW), individuals of all ages must meet all of the following criteria:

1. – 8. ...

B. Individuals age 18 through 20 may be offered a funded ROW opportunity if the results of the uniform needs-based assessment and person-centered planning discussion determine that the ROW is the most appropriate waiver. These offers are subject to the approval of the OCDD assistant secretary/designee.

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 for Citizens with Developmental Disabilities, LR 33:2441 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2155 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2530 (December 2017), LR 45:

§16107. Programmatic Allocation of Waiver Opportunities

A. – B.2. ...

3. Individuals on the registry who have the highest level of need and the earliest registry date shall be notified in writing when a funded OCDD waiver opportunity is available and that he/she is next in line to be evaluated for a possible waiver assignment. Participants shall have justification, based on a uniform needs-based assessment and a person-centered planning discussion that the ROW is the OCDD waiver that will meet the needs of the individual.

B.4. – 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 for Citizens with Developmental Disabilities, LR 33:2441 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2155 (October 2015), LR 42:62 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2530 (December 2017), LR 45:

§16109. Admission, Denial or Discharge Criteria

A. Admission to the ROW Program shall be denied if one of the following criteria is met.

1. – 7. ...

8. The individual does not have justification, based on a uniform needs-based assessment and a person-centered planning discussion that the ROW is the OCDD waiver that will meet the needs of the individual.

B. – B.10. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2443 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2156 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:

Chapter 163. Covered Services

§16303. Community Living Supports

A. – E.6. ...

7. Community living supports services are not available to individuals receiving the following services:

a. ...

b. host home;

c. companion care; or

d. monitored in-home caregiving.

8. Community living supports cannot be billed or provided for during the same hours on the same day that the participant is receiving the following services:

a. – c. ...

d. respite out-of-home services;

e. transportation-community access;

f. monitored in-home caregiving; or

g. adult day health care.

F. – F.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 for Citizens with Developmental Disabilities, LR 33:2443 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2157 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:

§16305. Companion Care

A. – F. ...

1. Companion care is not available to individuals receiving the following services:

a. – b. ...

c. community living supports;

d. host home; or

e. monitored in-home caregiving.

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, Office for Citizens with Developmental Disabilities, LR 33:2444 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2158 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:

§16307. Day Habilitation Services

A. – A.3. ...

B. Day habilitation services shall:

1. – 3. ...

4. be furnished on a regularly scheduled basis for one or more days per week;

a. services are based on a 15 minute unit of service and on time spent at the service site by the participant;

b. services shall not exceed 32 units of service on any given day or 160 units in any given week in a plan of care;

c. any time less than the 15 minute unit of service is not billable or payable; and

d. no rounding up of hours is allowed.

e. Repealed.

C. – E.2. ...

3. Day habilitation services cannot be billed or provided during the same hours on the same day as any of the following services:

a. ...

b. professional services, except those direct contacts needed to develop a behavioral management plan or any other type of specialized assessment/plan;

c. respite care services—out of home;

d. adult day health care; or

e. monitored in-home caregiving.

F. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2445 (November 2007), amended by the

Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2158 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:

§16313. Host Home

A. – I.1. ...

2. Separate payment will not be made for the following residential service models if the participant is receiving host home services:

a. – b. ...

c. shared living-conversion;

d. companion care; or

e. monitored in-home caregiving.

I.3. – J.2. ...

3. Agencies serving adults must be licensed by the Department of Health as a provider of substitute family care services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2447 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services

Financing and the Office for Citizens with Developmental Disabilities, LR 41:2160 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:

§16319. One Time Transitional Services

A. One-time transitional services are one-time, set-up services to assist individuals in making the transition from an institution to their own home or apartment in the community of their choice.

B. – E. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2449 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2162 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:

§16323. Prevocational Services

A. Prevocational services are time limited with employment at the individual’s highest level of work in the most integrated community setting, with the job matched to the

individual’s interests, strengths, priorities, abilities and capabilities, with integrated competitive employment as the optimal outcome. Individuals receiving prevocational services may choose to pursue employment opportunities at any time. Career planning must be a major component of prevocational services.

1. – 2.b. Repealed.

B. Prevocational services are to be provided in a variety of locations in the community and are not to be limited to a fixed site facility. Activities associated with prevocational services should be focused on preparing the participant for paid employment or a volunteer opportunity in the community. These services are operated through a provider agency that is licensed by the appropriate state licensing agency. Services are furnished one or more hours per day on a regularly scheduled basis for one or more days per week.

1. – 1.c. Repealed.

C. Participants receiving services must have an employment related goal in their plan of care, and the general habilitation activities must be designed to support such employment goals. Prevocational services are designed to create a path to integrated community-based employment for which a participant is compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by the

employer for the same or similar work performed by individuals without disabilities.

1. Repealed.

D. Prevocational services can include assistance in personal care and with activities of daily living. Choice of this service and staff ratio needed to support the participant must be documented on the plan of care.

1. – 3. Repealed.

E. All transportation costs are included in the reimbursement for prevocational services. The participant must be present to receive this service. If a participant needs transportation, the provider must physically provide, arrange, or pay for appropriate transport to and from a central location that is convenient for the participant and agreed upon by the team. The participant’s transportation needs and this central location shall be documented in the plan of care.

1. – 5. Repealed.

F. Service Limitations

1. Services shall not exceed 8,320 units of service in a plan of care.

2. Prevocational services are not available to participants who are eligible to participate in programs funded under the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act.

3. Multiple vocational/habilitative services cannot be provided or billed for during the same hours on the same day as the following services:

a. community living supports;

b. professional services, except those direct contacts needed to develop a behavioral management plan or other type of specialized assessment/plan;

c. respite care services–out of home;

d. adult day healthcare; or

e. monitored-in–home caregiving.

4. Transportation to and from the service site is only payable when a vocational/habilitative service is provided on the same day.

a. Time spent in traveling to and from the prevocational program site shall not be included in the calculation of the total number of service hours provided per day.

b. During travel training, providers must not also bill for the transportation component as this is included in the rate for the number of service hours provided.

c. Transportation-community access shall not be used to transport ROW participants to any prevocational services

G. Restrictions.

1. Participants receiving prevocational services may also receive day habilitation or individualized supported employment services, but these services cannot be provided during the same time period of the day and cannot total more than five hours combined in the same service day. Group supported employment services cannot be provided on the same day, but can be utilized on a different service day.

H. There must be documentation in the participant's file that this service is not available from programs funded under section 110 of the Rehabilitation Act of 1973 or sections 602 (16) or (17) of the Individuals with Disabilities Education Act [230 U.S.C. 1401 (16 and 71)] and those covered under the state plan.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2450 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2162 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:

§16327. Respite Care Services–Out of Home

A. – C.1. ...

2. Respite care services-out of home may not be billed for participants receiving the following services:

a. ...

b. companion care;

c. host home; or

d. monitored in-home caregiving.

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 for Citizens with Developmental Disabilities, LR 33:2451 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2164 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:

§16329. Shared Living Services

A. – D.5. ...

6. The following services are not available to participants receiving shared living services:

a. – c. ...

d. host home;

e. personal emergency response system; or

f. monitored in-home caregiving.

E. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2452 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2164 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:

§16335. Supported Employment

A. Supported employment services consists of intensive, ongoing supports and services necessary for a participant to achieve the desired outcome of employment in a community setting in the state of Louisiana where a majority of the persons employed are without disabilities. Participants utilizing these services may need long-term supports for the life of their employment due the nature of their disability, and natural supports would not meet this need.

B. Supported employment services provide supports in the following areas:

1. individual job, group employment or self-employment;

2. job assessment, discovery and development; and

a. – a.iv. Repealed.

3. initial job support and job retention, including assistance in personal care with activities of daily living in the supported employment setting and follow-along.

4. – 5. Repealed.

C. When supported employment services are provided at a work site where a majority of the persons employed are without disabilities, payment is only made for the adaptations, supervision and training required by participants receiving the service as a result of their disabilities. It does not include payment for the supervisory activities rendered as a normal part of the business setting.

1. – 4. Repealed.

D. Transportation is included in supported employment services, but whenever possible, family, neighbors, friends, coworkers or community resources that can provide needed transportation without charge should be utilized.

1. – 8. Repealed.

E. These services are also available to those participants who are self-employed. Funds for self-employment

may not be used to defray any expenses associated with setting up or operating a business.

F. Supported employment services may be furnished by a coworker or other job-site personnel under the following circumstances:

1. the services furnished are not part of the normal duties of the coworker or other job-site personnel; and

2. these individuals meet the pertinent qualifications for the providers of service.

G. Service Limits. Participants may receive more than one vocational or habilitative service per day as long as the service and billing requirements for each service are met.

1. Services for individual/micro-enterprise job assessment, discovery and development in individual jobs and self-employment shall not exceed 2,880 units of service in a plan of care year.

2. Services for group job assessment, discovery and development in group employment shall not exceed 480 units of service in a plan of care year.

3. Services for initial job support, job retention and follow-along for individual/micro-enterprise shall not exceed 1280 quarter hour units of service in a plan of care year.

4. Services for initial job support, job retention and follow-along in group employment shall not exceed 8,320 quarter hour units of service in a plan of care year.

H. Service Exclusions/Restrictions. Participants receiving individual supported employment services may also receive prevocational or day habilitation services. However, these services cannot be provided during the same service hours and cannot total more than five hours of services in the same day. Participants receiving group supported employment services may also receive prevocational or day habilitation services; however, these services cannot be provided in the same service day.

1. Payment will only be made for the adaptations, supervision and training required by individuals receiving waiver services, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

2. Any time less than one hour for individual placement and micro-enterprise is not billable or payable.

3. Supported employment services cannot be billed for the same time as any of the following services:

a. community living supports;

b. professional services except direct contacts needed to develop a behavioral management plan; or

c. respite care services–out of home;

d. adult day health care; or

e. monitored in-home caregiving.

4. Any time less than fifteen minutes for enclaves and mobile crews is not billable or payable.

5. Time spent in traveling to and from the prevocational program site shall not be included in the calculation of the total number of service hours provided per day.

a. Travel training for the purpose of teaching the participant how to use transportation services may be included in determining the total service numbers hours provided per day, but only for the period of time specified in the POC.

6. The following incentive payments, subsidies or unrelated vocational training expenses are excluded from coverage in supported employment services:

a. incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

b. payments that are passed through to users of supported employment programs; or

c. payments for vocational training that is not directly related to an individual's supported employment program.

7. There must be documentation in the participant's file that these services are not available from programs funded under the Rehabilitation Act of 1973 or sections 602 (16) or (17) of the Individuals with Disabilities Education Act [230 U.S.C. 1401 (16 and 17)] and those covered under the State Plan.

8. No rounding up of service units is allowed.

I. Provider Qualifications. In order to enroll in the Medicaid Program, providers must have a compliance certificate from the Louisiana Rehabilitation Services as a community rehabilitation program or a current, valid license as an adult day care center.

F. Choice of this service and staff ratio needed to support the participant must be documented on the plan of care.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2453 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2166 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:

§16337. Transportation-Community Access

A. – C.1. ...

2. Separate payment will not be made for transportation-community access and the following services:

a. shared living services;

b. community living services;

c. companion care;

d. adult day health care; or

e. monitored in-home caregiving.

C.3. – E. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2454 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:2166 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:

§16343. Adult Day Health Care Services

A. ...

B. ADHC services include those core service requirements identified in the ADHC licensing standards (LAC 48.I.4243), in addition to:

1. medical care management;

2. transportation between the participant's place of residence and the ADHC (if the participant is accompanied by the ADHC staff);

3. assistance with activities of daily living;

4. health and nutrition counseling;

5. an individualized exercise program;

6. an individualized goal-directed recreation program;

7. health education;

8. individualized health/nursing services; and

9. meals.

B.9.a. - E. ...

F. The following services are not available to AFDC recipients:

1. respite care services-out of home;

2. shared living;

3. companion care, or

4. monitored in-home caregiving.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 42:62

(January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:

§16345. Monitored In-Home Caregiving Services

A. Monitored in-home caregiving (MIHC) services are provided by a principal caregiver to a participant who lives in a private unlicensed residence. The principal caregiver shall be contracted by the licensed HCBS provider having a MIHC service module. The principal caregiver shall reside with the participant. Professional staff employed by the HCBS provider shall provide oversight, support and monitoring of the principal caregiver, service delivery, and participant outcomes through on-site visits, training, and daily, web-based electronic information exchange.

B. The principal caregiver is responsible for supporting the participant to maximize the highest level of independence possible by providing necessary care and supports that may include:

1. supervision or assistance in performing activities of daily living;

2. supervision or assistance in performing instrumental activities of daily living;

3. protective supervision provided solely to assure the health and welfare of a participant;

4. supervision or assistance with health related tasks (any health related procedures governed under the Nurse Practice Act) in accordance with applicable laws governing the delegation of medical tasks/medication administration;

5. supervision or assistance while escorting/ accompanying the individual outside of the home to perform tasks, including instrumental activities of daily living, health maintenance or other needs as identified in the plan of care and to provide the same supervision or assistance as would be rendered in the home; and

6. extension of therapy services to maximize independence when the caregiver has been instructed in the performance of the activities by a licensed therapist or registered nurse.

C. Unless the individual is also the spouse of the participant, the following individuals are prohibited from being paid as a monitored in-home caregiving principal caregiver:

1. the participant’s curator;

2. the participant’s tutor;

3. the participant’s legal guardian;

4. the participant’s responsible representative; or

5. the person to whom the participant has given representative and mandate authority (also known as power of attorney).

D. Participants electing monitored in-home caregiving services shall not receive the following Residential Options Waiver services during the period of time that the participant is receiving monitored in-home caregiving services:

1. community living supports;

2. companion care;

3. host home;

4. shared living (conversion or non-conversion); or

5. adult day health care services.

E. Monitored in-home caregiving providers must be licensed HCBS providers with a monitored in-home caregiving module who employ professional staff, including a registered nurse and a care manager, to support principal caregivers to perform the direct care activities performed in the home. The agency provider must assess and approve the home in which services will be provided, and shall enter into contractual agreements with caregivers who the agency has approved and trained. The agency provider will pay per diem stipends to caregivers.

F. The MIHC provider must use secure, web-based information collection from principal caregivers for the purposes of monitoring participant health and caregiver performance. All protected health information must be transferred, stored, and otherwise utilized in compliance with

applicable federal and state privacy laws. Providers must sign, maintain on file, and comply with the LDH HIPAA business associate addendum.

G. The department shall reimburse for monitored in-home caregiving services based upon a two-tiered model which is designed to address the participant's ROW acuity level.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 45:

Chapter 169. Reimbursement

§16901. Unit of Reimbursement

A. Reimbursement for the following services shall be a prospective flat rate for each approved unit of service provided to the waiver participant. One quarter hour (15 minutes) is the standard unit of service and reimbursement shall not be made for less than one quarter hour of service. This covers both the service provision and administrative costs for these services:

1. – 4.b. ...

5. professional services furnished by a/an:

a. – d. ...

e. social worker;

f. ...

6. supported employment;

a. individual placement;

b. micro-enterprise;

7. adult day health care;

8. pre-vocational service; and

9. day habilitation.

* * *

B. – B.2. ...

C. The following services are reimbursed at a per diem rate:

1. ...

2. companion care services;

3. shared living services;

a. per diem rates are established based on the number of individuals sharing the living service module for both shared living non-conversion and shared living conversion services; and

4. monitored in-home caregiving services.

a. The per diem rate for monitored in-home caregiving services does not include payment for room and board, and federal financial participation is not claimed for room and board.

D. The reimbursement for transportation services is a flat fee based on a capitated rate.

1. – 3.b. Repealed.

E. Nursing services are reimbursed at either an hourly or per visit rate for the allowable procedure codes.

F. Installation of a personal emergency response system (PERS) is reimbursed at a one-time fixed rate and maintenance of the PERS is reimbursed at a monthly rate.

G. Transition expenses from an ICF/ID or nursing facility to a community living setting are reimbursed at the cost of the service(s) up to a lifetime maximum rate of $3,000.

H. Dental services are reimbursed at the Medicaid fee-for-service rate.

I. The assessment performed by the monitored in-home caregiving provider shall be reimbursed at the authorized rate or approved amount of the assessment when the service has been prior authorized by the plan of care.

J. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 33:2456 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 39:1049 (April 2013), LR 41:2168, 2170 (October

2015), LR 42:63 (January 2016), LR 42:900 (June 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2530 (December 2017), LR 45:

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

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Inpatient Hospital Services
Non-Rural, Non-State Hospitals
Reimbursement Rate Adjustment
(LAC 50:V.Chapters 5 and 9)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:V.Chapters 5 and 9 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 50

PUBLIC HEALTH-MEDICAL ASSISTANCE
Part V. Hospitals
Subpart 1. Inpatient Hospital Services

Chapter 5. State Hospitals

Subchapter B. Reimbursement Methodology

§551. Acute Care Hospitals

A. – F.2. ...

G. Effective for dates of service on or after January 1, 2020, the inpatient per diem rate paid to state-owned acute care hospitals, excluding inpatient psychiatric services, shall be calculated based on allowable costs per the latest filed cost

report. Final reimbursement determined based on the allowable costs per the finalized Medicare/Medicaid cost report.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1241 (May 2012), amended LR 38:2772 (November 2012), LR 40:312 (February 2014), LR 40:1941 (October 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 45:

§553. Inpatient Psychiatric Services for State Owned Hospitals

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

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

AUTHORITY NOTE: 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:

Chapter 9. Non-Rural, Non-State Hospitals

Subchapter B. Reimbursement Methodology

§953. Acute Care Hospitals

A. – V.2. ...

W. 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. 40:1300 and public-private partnership hospitals as defined in LAC 50:V.1701-1703 shall be exempt from this rate increase.

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

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

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), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1389 (July 2017), repromulgated LR 43:1757 (September 2017), amended LR 43:2533 (December 2017), repromulgated LR 44:1445 (August 2018), amended LR 45:

§955. Long-Term Hospitals

A. – L. ...

M. 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.

AUTHORITY NOTE: Promulgated in accordance 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:

§959. Inpatient Psychiatric Hospital Services

A. – N.2. ...

O. 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 indexing to 32 percent of the small rural hospital prospective per diem rate in effect on January 1, 2019.

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

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

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

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), amended LR 44:1446 (August 2018), LR 45:

§961. Inpatient Rehabilitation Hospital Services

A. ...

* * *

B. – B.2. ...

3. Effective for dates of service on or after January 1, 2020, the prospective per diem rate paid to non-rural, non-state free-standing rehabilitation hospitals shall be

indexed to 37 percent of the small rural hospital prospective per diem rate in effect on January 1, 2019.

4. Rehabilitation hospitals whose per diem rates as of January 1, 2019, excluding the graduate medical education portion of the per diem, are greater than 37 percent of the January 1, 2019 small rural hospital rate shall not be increased.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:2533 (December 2017), amended LR 44:1446 (August 2018), LR 45:

§967. Children's Specialty Hospitals

A. – M. ...

N. Effective for dates of service on or after January 1, 2020, the inpatient per diem rates paid to children's specialty hospitals for acute, neonatal intensive care units, pediatric intensive care units and burn units' services shall be increased by 3.2 percent of the per diem rate on file as of December 31, 2019.

O. Effective for dates of service on or after January 1, 2020, the prospective per diem rate paid to distinct part psychiatric units within children's specialty hospitals shall be

increased by indexing to 32 percent of the small rural hospital prospective per diem rate in effect on January 1, 2019

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2562 (November 2010), amended LR 37:2162, 2162 (July 2011), LR 38:2773 (November 2012), LR 39:3097 (November 2013), LR 40:312 (February 2014), repromulgated LR 40:1940 (October 2014), amended LR 40:1941 (October 2014), LR 42:275 (February 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 43:964 (May 2017), LR 45:

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

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Managed Care for Physical and Behavioral Health
Reimbursement Methodology
Kick and Lump Sum Payments
(LAC 50:I.3509)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:I.3509 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 35. Managed Care Organization Participation Criteria

§3509. Reimbursement Methodology

A. ...

1. The department will establish monthly capitation rates within an actuarially sound rate range certified by its actuaries. Consistent with all applicable federal rules and regulations, the rate range will initially be developed using fee-for-service claims data, Bayou Health shared savings claims data, Bayou Health managed care organization encounter data, Louisiana Behavioral Health Partnership (LBHP) encounter data,

financial data reported by Bayou Health managed care organizations and the LBHP statewide management organization, supplemental ad hoc data, and actuarial analyses with appropriate adjustments.

2. As the Bayou Health managed care program matures and fee-for-service, shared savings and LBHP data are no longer available, there will be increasing reliance on Bayou Health managed care organization encounter data and/or financial data to set future rates, subject to comparable adjustments.

3. – 4.d. ...

5. Kick Payments. MCOs may be reimbursed a one-time supplemental lump sum payment, hereafter referred to as a "kick payment", for the provision of certain services that meet specific conditions, in an amount determined by the department's actuaries.

a. The kick payment is intended to cover the cost of a specific care event or treatment. Payment will be made to the MCO upon submission of satisfactory evidence of the event or treatment.

b. Only one kick payment will be made per event or treatment.

c. Repealed.

6. ...

7. The department, or its fiscal intermediary, may reimburse an MCO's monthly capitation payments or kick payments

in the aggregate on a lump sum basis when administratively necessary.

B. – M.1. ...

2. If three attempts to contract with the provider prior to the delivery of the medically necessary service have not been documented, the MCO shall reimburse the provider the published Medicaid fee-for-service rate in effect on the date of service.

M.3. – N.2.a. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1587 (June 2011), amended LR 39:92 (January 2013), LR 41:937 (May 2015), LR 41:2367 (November 2015), LR 42:755 (May 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 45:

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

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Medicaid Eligibility
Medicare Savings Programs
(LAC 50:III.10703 and 10705)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:III.10703 and §10705 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 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 III. Eligibility
Subpart 5. Financial Eligibility

Chapter 107. Resources

§10703. General Provisions

A. – C.1.b. ...

2. – 2.a. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2867 (December 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:

§10705. Resource Disregards

A. – B.1. ...

C. All resources shall be disregarded in eligibility determinations for all Medicare Savings Programs.

1. – 2. Repealed.

D. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:1899 (September 2009), amended LR 36:2867 (December 2010), LR 41:949 (May 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 45:

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

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Outpatient Hospital Services
Non-Rural, Non-State Hospitals
Reimbursement Rate Adjustment
(LAC 50:V.Chapters 53-61)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:V.Chapters 53-61 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 V. Hospitals
Subpart 5. Outpatient Hospitals

Chapter 53. Outpatient Surgery

Subchapter B. Reimbursement Methodology

§5313. Non-Rural, Non-State Hospitals

A. – K.1. ...

L. Effective for dates of service on or after January 1, 2020, the reimbursement rates paid to non-rural, non-state hospitals for outpatient surgery shall be increased by 3.2 percent of the rates on file as of December 31, 2019.

1. Hospitals participating in public-private partnerships as defined in §6701 shall be exempted from this rate increase.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Service Financing, LR 35:1900 (September 2009), amended LR 36:1250 (June 2010), LR 36:2041 (September 2010), LR 37:3266 (November 2011), LR 40:313 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:964 (May 2017), LR 43:2534 (December 2017), LR 44:2166 (December 2018), LR 45:

§5317. Children's Specialty Hospitals

A. – I.1. ...

J. Effective for dates of service on or after January 1, 2020, the reimbursement rates paid to children's specialty hospitals for outpatient surgery shall be increased by 3.2 percent of the rates on file as of December 31, 2019.

1. Final reimbursement shall be 100 percent of allowable cost as calculated through the cost report settlement process.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2042 (September 2010), amended LR 37:3266 (November 2011), LR 40:313 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:965 (May 2017), LR 43:2534 (December 2017), LR 44:2167 (December 2018), LR 45:

§5319. State-Owned Hospitals

A. – B. ...

C. Effective for dates of service on or after January 1, 2020, the reimbursement rates paid to state-owned hospitals for outpatient surgery shall be increased by 14.67 percent of the fee schedule rates on file as of December 31, 2019.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:2773 (November 2012), amended LR 40:314 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 45:

Chapter 55. Clinic Services

Subchapter B. Reimbursement Methodology

§5513. Non-Rural, Non-State Hospitals

A. – K.1. ...

L. Effective for dates of service on or after January 1, 2020, the reimbursement rates paid to non-rural, non-state hospitals for outpatient clinic services shall be increased by 3.2 percent of the rates on file as of December 31, 2019.

1. Hospitals participating in public-private partnerships as defined in §6701 shall be exempted from this rate increase.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Service Financing, LR 35:1900 (September 2009), amended LR 36:1250 (June 2010), LR 36:2042 (September 2010), LR 37:3266 (November 2011), LR 40:313 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:965 (May 2017), LR 43:2535 (December 2017), LR 44:2167 (December 2018), LR 45:

§5517. Children's Specialty Hospitals

A. – I. ...

J. Effective for dates of service on or after January 1, 2020, the reimbursement rates paid to children's specialty hospitals for outpatient hospital clinic services shall be increased by 3.2 percent of the rates on file as of December 31, 2019.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2042 (September 2010), amended LR 37:3266 (November 2011), LR 40:313 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:965 (May 2017), LR 43:2535 (December 2017), LR 44:2167 (December 2018), LR 45:

§5519. State-Owned Hospitals

A. – B. ...

C. Effective for dates of service on or after January 1, 2020, the reimbursement rates paid to state-owned hospitals for outpatient clinic services shall be increased by 14.67 percent of the fee schedule rates on file as of December 31, 2019.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:2774 (November 2012), amended LR 40:314 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 45:

Chapter 57. Laboratory Services

Subchapter B. Reimbursement Methodology

§5713. Non-Rural, Non-State Hospitals

A. – K.2. ...

L. Effective for dates of service on or after January 1, 2020, the reimbursement rates paid to non-rural, non-state hospitals for outpatient laboratory services shall be increased by 3.2 percent of the rates on file as of December 31, 2019.

1. In accordance with Section 1903(i)(7) of the Social Security Act, payments for Medicaid clinical diagnostic laboratory services shall be limited to the amount that Medicare pays on a per test basis. If this or any other rate adjustment causes the Medicaid calculated rate to exceed the Medicare payment rate for a clinical laboratory test, the rate shall be adjusted to the lower Medicare payment rate.

2. Hospitals participating in public-private partnerships as defined in §6701 shall be exempted from this rate increase.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Service Financing, LR 35:1900 (September 2009), amended LR 36:1250 (June 2010), LR 36:2042 (September 2010), LR 37:3266 (November 2011), LR 40:313 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:965 (May 2017), LR 43:2535 (December 2017), LR 44:2167 (December 2018), LR 45:

§5719. Children's Specialty Hospitals

A. – I.1. ...

J. Effective for dates of service on or after January 1, 2020, the reimbursement rates paid to children's specialty hospitals for outpatient clinical diagnostic laboratory services shall be increased by 3.2 percent of the rates on file as of December 31, 2019.

1. In accordance with Section 1903(i)(7) of the Social Security Act, payments for Medicaid clinical diagnostic laboratory services shall be limited to the amount that Medicare pays on a per test basis. If this or any other rate adjustment causes the Medicaid calculated rate to exceed the Medicare payment rate for a clinical laboratory test, the rate shall be adjusted to the lower Medicare payment rate.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2043 (September 2010), amended LR 37:3267 (November 2011), LR 40:314 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:965 (May 2017), LR 43:2535 (December 2017), LR 44:2167 (December 2018), LR 45:

Chapter 59. Rehabilitation Services

Subchapter B. Reimbursement Methodology

§5913. Non-Rural, Non-State Hospitals

A. – E.1. ...

F. Effective for dates of service on or after January 1, 2020, the reimbursement rates paid to non-rural, non-state hospitals for outpatient rehabilitation services shall be increased by 3.2 percent of the rates on file as of December 31, 2019.

1. Hospitals participating in public-private partnerships as defined in §6701 shall be exempted from this rate increase.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Service Financing, LR 35:1900 (September 2009), amended LR 36:1250 (June 2010), LR 36:2043 (September 2010), LR 44:2167 (December 2018), LR 45:

§5917. Children's Specialty Hospitals

A. – C.1. ...

D. Effective for dates of service on or after January 1, 2020, the reimbursement rates paid to children's specialty hospitals for outpatient rehabilitation services shall be increased by 3.2 percent of the rates on file as of December 31, 2019.

1. Final reimbursement shall be 100 percent of allowable cost as calculated through the cost report settlement process.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2043 (September 2010), amended by the Department of Health, Bureau of Health Services Financing LR 44:2168 (December 2018), LR 45:

§5919. State-Owned Hospitals

A. – A.2. ...

B. Effective for dates of service on or after January 1, 2020, the reimbursement rates paid to state hospitals for outpatient rehabilitation services shall be increased by 3.2 percent of the rates on file as of December 31, 2019.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:2774 (November 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 45:

Chapter 61. Other Outpatient Hospital Services

Subchapter B. Reimbursement Methodology

§6115. Non-Rural, Non-State Hospitals

A. – K.1. ...

L. Effective for dates of service on or after January 1, 2020, the reimbursement rates paid to non-rural, non-state hospitals for outpatient hospital services, other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services and outpatient hospital facility fees, shall be increased by 3.2 percent of the rates in effect as of December 31, 2019.

1. Final reimbursement shall be 85.84 percent of allowable cost as calculated through the cost report settlement process.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Service Financing, LR 35:1900 (September 2009), amended LR 36:1250 (June 2010), LR 36:2043 (September 2010), LR 37:3267 (November 2011), LR 40:314 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:965 (May 2017), LR 43:2535 (December 2017), LR 44:2168 (December 2018), LR 45:

§6119. Children’s Specialty Hospitals

A. – I.1. ...

J. Effective for dates of service on or after January 1, 2020, the reimbursement fees paid to children’s specialty

hospitals for outpatient hospital services, other than rehabilitation services and outpatient hospital facility fees, shall be increased by 3.2 percent of the rates in effect as of December 31, 2019.

1. Final reimbursement shall be 100 percent of allowable cost as calculated through the cost report settlement process.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2044 (September 2010), amended LR 37:3267 (November 2011), LR 40:314 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:965 (May 2017), LR 43:2535 (December 2017), LR 44:2168 (December 2018), LR 45:

§6127. State-Owned Hospitals

A. – C. ...

D. Effective for dates of service on or after January 1, 2020, the reimbursement rates paid to state hospitals for outpatient hospital services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services and outpatient hospital facility fees shall be increased by 11 percent of the rates in effect on December 31,

2019. Final reimbursement shall be at 100 percent of allowable cost through the cost settlement process.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 35:957 (May 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:2774 (November 2012), LR 40:315 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 45:

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

Rebekah E. Gee MD, MPH

Secretary