RULE

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

Act 421 Children's Medicaid Option
(LAC 50:XXII.Chapters 81-85)

The Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities have adopted LAC 50:XXII.Chapters 81-85 in the Medical Assistance Program as authorized by R.S. 36:254, 46:977.21-977.25 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 XXII. 1115 Demonstration Waivers
Subpart 9. Act 421 Children's Medicaid Option

Chapter 81. General Provisions

§8101. Purpose

A. The purpose of the Act 421 Children's Medicaid Option (421-CMO) program is to provide Medicaid State Plan services to children with disabilities who meet the eligibility criteria set forth in this Subpart, despite parental or household income that would otherwise exclude them from Medicaid eligibility.

B. The Department of Health (LDH) has expenditure authority under Section 1115 of the Social Security Act (Act) to

claim as medical assistance the costs of services provided under a risk contract to eligible individuals. Through this Section 1115 demonstration, the State is allowed to permit Medicaid managed care organizations (MCOs) to provide Medicaid State Plan services to children with disabilities regardless of their parents' and/or household income. LDH shall, subject to the approval of the Centers for Medicare and Medicaid Services (CMS), institute a program to provide health care services via the State's Medicaid program for the population contemplated under Section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248), subject to additional terms and conditions set forth in this Subpart.

C. 421-CMO enrollees are eligible for all medically necessary Medicaid State Plan services.

D. The number of enrollees in the 421-CMO program is contingent upon the amount appropriated by the Louisiana legislature annually for that purpose.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:977.21-977.25, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Louisiana Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 46:

§8103. Effective Date and Administration

A. Services provided under the 421-CMO program shall begin upon approval of expenditure authority under Section 1115 of the Act by CMS.

B. Upon approval by CMS, enrollment and start of services will commence at the beginning of the first calendar quarter after conclusion of the initial registration period.

C. The 421-CMO program shall be administered as a Section 1115 demonstration waiver under the authority of LDH, in collaboration with the Healthy Louisiana MCOs.

D. The 421-CMO program is a demonstration waiver that will span five years. LDH may request approval for an extension of this Section 1115 demonstration from CMS prior to the expiration date.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:977.21-977.25, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Louisiana Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 46:

§8105. Enrollee Qualifications and Admissions Criteria

A. In order to qualify for the 421-CMO program, an individual must meet both programmatic eligibility and clinical eligibility criteria as set forth in this Subpart.

B. Programmatic eligibility. In order to be programmatically eligible for the 421-CMO program, an individual must meet all of the following criteria:

1. Is 18 years of age or younger (under 19 years of age).

2. Is a U.S. Citizen or qualified alien.

3. Is a Louisiana resident.

4. Has or has applied for a Social Security Number.

5. Has countable resources of $2,000 or less (parental/household resources not considered).

6. Has care needs that can be safely met at home at a lower cost than the cost of services provided in an institutional setting.

7. Maintains pre-existing private health insurance for major medical coverage, either through employer sponsored insurance, the federal marketplace, or other independently purchased commercial health insurance, unless a hardship exception is applied for and granted by LDH.

a. LDH will employ a look-back period of one 180 days to determine pre-existing private health insurance.

b. Lock-out period. If LDH determines that a family or responsible adult has discontinued pre-existing private health insurance, either during the look-back period or at any time during the enrollee’s enrollment in the 421-CMO program, LDH will impose a lock-out.

c. During the lock-out period, the enrollee will be unable to receive services, but will retain his or her enrollment in the 421-CMO program.

d. The lock-out period will end when the enrollee demonstrates new or former pre-existing private health insurance has been re-instated.

e. The lock-out period will extend up to 180 days from discontinuation of pre-existing private health insurance or 421-CMO program offer, whichever date is later.

f. At the conclusion of the 180 day lock-out period, if the enrollee has not re-instated the pre-existing private health insurance, the enrollee will be terminated from the 421-CMO program.

g. If terminated, the individual can re-register for the 421-CMO program and be placed on the 421-CMO registry as a new applicant.

h. Hardship Exception. The enrollee can apply for a hardship exception at any time, including during a lock-out period.

i. A hardship exists when:

(a). private health insurance premiums and any additional deductibles and co-payments or out of pocket healthcare costs for the individual obtaining coverage equal or exceed 5% of the household income;

(b). unemployment resulting in loss of employer-sponsored private insurance for the child; or

(c). an exemption period of 90 days for transition to new employment, after which the enrollee must resume private health insurance.

ii. LDH's grant of a hardship exception will end the lock-out period.

8. Is not otherwise eligible for Medicaid or CHIP.

C. Clinical eligibility. In order to be clinically eligible for the 421-CMO program, an individual must meet all of the following criteria:

1. Has a disability, defined as a medically determinable physical or mental impairment (or combination of impairments) that:

a. results in marked and severe functional limitations; and

b. has lasted or is expected to last for at least one year or to result in death.

2. Meets the medical necessity requirement, assessed on an annual basis, for institutional placement in an intermediate care facility for individuals with intellectual disabilities (ICF/IID), a nursing facility, or a hospital.

a. An individual meets ICF/IID level of care when he/she:

i. has obtained a statement of approval from the Office for Citizens with Developmental Disabilities, confirming that he has a developmental disability as defined in R.S. 28:451.2; and

ii. meets the requirements for active treatment of a developmental disability under the supervision of a qualified developmental disability professional, as prescribed on Form 90-L.

b. An individual meets nursing facility level of care when he demonstrates the following, assessed in accordance with the Act 421 Children's Medicaid Option Assessment Tool:

i. the need for skilled nursing and/or therapeutic interventions on a regular and sustained basis; and

ii. substantial functional limitations as compared to same age peer group in two of the following areas: learning, communication, self-care, mobility, social competency, money management (for children 18 and older), work, and meal preparation.

c. An individual meets hospital level of care when he demonstrates the following, assessed in accordance with the Act 421 Children's Medicaid Option Assessment Tool:

i. frequent and complex medical care that requires the use of equipment to prevent life-threatening

situations, with skilled medical care required multiple times during each 24-hour period;

ii. complex skilled medical interventions that are expected to persist for at least six months; and

iii. overall health condition that is highly unstable and presents constant potential for complications or rapid deterioration, with the result that the child requires continuous assessment by professional nurses, parents, or other properly instructed individuals, in order to detect unstable and life-threatening condition and respond promptly with appropriate care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:977.21-977.25, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Louisiana Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 46:

§8107. Admission Denial or Discharge Criteria

A. Individuals shall be denied admission to or discharged from 421-CMO program if any of the following criteria is met:

1. the individual does not meet the programmatic eligibility requirements for the 421-CMO program;

2. the individual does not meet the clinical eligibility requirements for the 421-CMO program;

3. the individual is incarcerated or placed under the jurisdiction of penal authorities, courts or state juvenile justice authorities;

4. the individual resides in another state or has a change of residence to another state;

5. the individual or responsible adult fails to cooperate in the eligibility determination/re-determination process; or

6. the 421-CMO enrollee is admitted to an ICF/IID, nursing facility, or hospital with the intent to not return to 421-CMO services;

a. the enrollee is deemed to intend to return to 421-CMO services when documentation is received from the treating physician that the admission is temporary and shall not exceed ninety (90) days;

b. the enrollee will be discharged from 421-CMO on the ninety-first (91st) day after admission if the enrollee is still in the ICF/IID, nursing facility, or hospital.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:977.21-977.25, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Louisiana Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 46:

§8107. Allocation of Act 421 Children's Medicaid Option Opportunities

A. The Act 421 Children's Medicaid Option request for services registry, hereafter referred to as the 421-CMO registry, shall be used to identify persons who meet ICF/IID, nursing facility, or hospital level of care who are waiting for a 421-CMO program slot. Individuals who are found eligible and who request 421-CMO program services will be added to the 421-CMO registry. Funded 421-CMO program slots will be offered in accordance with this Subpart.

B. Initial Registration

1. There will be an initial registration period lasting one month, during which time registration will occur in two pathways:

a. Online registration forms will be taken from individuals who are not currently on the intellectual/developmental disabilities (I/DD) request for services registry or otherwise enrolled in Medicaid.

b. Children 18 years of age and under (under 19) who are on the I/DD request for services registry and are not currently enrolled in Medicaid or CHIP will be automatically registered for participation.

i. Individuals receiving automatic placement on the 421-CMO registry will receive a preprinted mailed form explaining the 421-CMO program and that they are

automatically registered. The form will provide them with the opportunity to opt out of participation, and if they do not opt out, attest to prioritization needs per the process set forth in this Subpart.

2. LDH will create a numerically ordered 421-CMO registry based on individuals that registered during the initial registration period, placing them in random order.

3. Individuals registered during the initial registration period will receive 421-CMO program offers according to the prioritization process established in this Subpart first. Once priority offers are complete, 421-CMO program offers will then be made in numeric order of the 421-CMO registry.

4. Individuals who do not receive 421-CMO program offers will remain on the 421-CMO registry in the numeric order assigned, with a protected registry date corresponding to the close of the initial registration period.

C. Ongoing Registration. After the initial registration period and slot allocation, subsequent registrants for the 421-CMO program will be assigned a 421-CMO registry date based on the date on which they register and will receive an offer on a first-come, first-served basis unless otherwise prioritized as provided for in this Subpart. 421-CMO program offers will be made upon availability.

D. Prioritization

1. In order to ensure individuals with the most urgent needs receive services, LDH will prioritize 421-CMO program offers to individuals who meet either of the following criteria:

a. The individual has been institutionalized in an ICF/IID, nursing facility, or hospital for 30 of the preceding 90 days. Institutional days do not have to be consecutive.

b. On three or more separate occasions in the preceding 90 days, the individual has been admitted to an ICF/IID, nursing facility, or hospital and remained institutionalized for at least 24 hours.

2. An individual newly registering for 421-CMO program during ongoing registration may request and, if the individual qualifies, receive prioritization in order to receive the next available 421-CMO program offer. In addition, at any time an individual currently on the 421-CMO registry may request and, if the individual qualifies, receive prioritization.

3. Prioritization will be considered valid for a period of 180 days from the date that prioritization is approved while waiting for a 421-CMO program offer. At the expiration of the 180 days, if no 421-CMO program offer has been made, the individual loses prioritization but retains his or her original protected registry date for purposes of receiving a 421-CMO program offer.

a. If an individual’s priority period has expired with no 421-CMO program offer available during that time period, he or she may request to requalify for prioritization.

i. If the individual qualifies without a break in the two priority periods (they are consecutive), he/she shall retain the original prioritization date.

ii. If the individual qualifies with a break in the priority periods, he/she shall receive a new prioritization date.

b. There is no limit on the number of times an individual may qualify for prioritization prior to receiving a 421-CMO program offer.

c. If more than one individual has received prioritization at one time, the next available 421-CMO program offer will be made to the individual with the earliest prioritization date.

4. Once enrolled in the 421-CMO program, enrollees will not be required to demonstrate ongoing need for prioritization. Prioritization is only a method of fast-tracking initial entry into the 421-CMO program for families with the highest urgency of need.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:977.21-977.25, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Louisiana Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 46:

§8109. Eligibility and Enrollment

A. Upon extension of a 421-CMO program offer to an individual, the individual will need to establish programmatic and clinical eligibility by showing he or she meets all eligibility criteria. When eligibility is determined, the individual will be enrolled in the 421-CMO program and with a health and dental plan of their choice.

B. Louisiana Health Insurance Premium Payment Program (LaHIPP)

1. Enrollees in the 421-CMO program shall be enrolled in LaHIPP when cost-effective health plans are available through the individual’s employer or a responsible party's employer-based health plan or other health insurance if the individual is enrolled or eligible for such a health plan.

2. All requirements and coverage through the LaHIPP program shall follow the provisions set forth in LAC 50:III.2311 except that 421-CMO program enrollees enrolled in LaHIPP shall receive their Medicaid benefits through managed care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:977.21-977.25, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Louisiana Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 46:

Chapter 83. Services

§8301. Covered Services

A. The coverage of 421-CMO services under the scope of this demonstration are all services offered under the Louisiana Medicaid State Plan.

B. All 421-CMO services must be medically necessary. The medical necessity for services shall be determined by a licensed professional or physician who is acting within the scope of his/her professional license and applicable state law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:977.21-977.25, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Louisiana Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 46:

§8303. Service Delivery

A. Louisiana’s Act 421 Children’s Medicaid Option delivery system is based on an integrated managed care model for physical and behavioral health services. Under this demonstration, Healthy Louisiana will continue to operate as approved in Section 1932(a) state plan authority for managed care and concurrent 1915(b) demonstration.

B. Enrollees in the 421-CMO program shall be mandatorily enrolled in Healthy Louisiana and in a dental benefits prepaid ambulatory health plan. They shall have the opportunity to choose a health and dental plan upon application. If they do not choose a plan, one will be automatically assigned to them upon enrollment per the current methodology outlined in the Medicaid State Plan.

C. Enrollees shall be designated as a special health care needs group, entitling recipients to receive case management and enhanced care coordination through their managed care plan.

D. All of the covered services under the 421-CMO program shall be delivered in accordance with the Medicaid State Plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:977.21-977.25, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Louisiana Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 46:

Chapter 85. Reimbursement

§8501. Reimbursement Methodology

A. For 421-CMO program enrollees, LDH or its fiscal intermediary shall make monthly capitation payments to the managed care organizations (MCOs) and dental benefits prepaid ambulatory health plans for the provision of all covered services. The capitation rates paid to the MCOs and dental

benefits prepaid ambulatory health plans shall be actuarially sound rates, and the MCOs and dental benefits prepaid ambulatory health plans will determine the rates paid to its contracted providers. No payment shall be less than the minimum Medicaid fee-for-service fee schedule on file.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:977.21-977.25, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Louisiana Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 46:

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.

Dr. Courtney N. Phillips

Secretary

RULE

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

Adult Mental Health Services
Peer Support Services
(LAC 50:XXXIII.6307)

The Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health have adopted LAC 50:XXXIII.6307 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 XXXIII. Behavioral Health Services
Subpart 7. Adult Mental Health Services

Chapter 63. Services

§6307. Covered Services

A. The following mental health services shall be reimbursed under the Medicaid Program:

1. ...

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

A.3. - B.3. ...

AUTHORITY NOTE: Promulgated in accordance with R.S.

36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:359 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 42:61 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1015 (June 2018), LR 46:795 (June 2020), repromulgated LR 46:952 (July 2020), amended LR 46:

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.

Dr. Courtney N. Phillips

Secretary

RULE

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

Home and Community-Based Services Waivers
New Opportunities Waiver
Individual and Family Support Payments
(LAC 50:XXI.13701,13902,13927,13933, and 14301)

The Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities have amended LAC 50:XXI.13701, §13927, and §14301, adopted §13902, and repealed §13933 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 11. New Opportunities Waiver

Chapter 137. General Provisions

§13701. Introduction

A. – D. ...

E. Only the following NOW services shall be provided for, or billed for, during the same hours on the same day as any other NOW service:

1. ...

2. supported independent living; and

3. skilled nursing services.

a. Skilled nursing services may only be provided with:

i. substitute family care;

ii. supported independent living;

iii. day habilitation;

iv. supported employment (all three modules); and/or

v. prevocational services

4. – 4.e. Repealed.

F. – 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 of the Secretary, Bureau of Community Supports and Services, LR 30:1201 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1647 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:68 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:50 (January 2018), LR 45:42 (January 2019), LR 46:

Chapter 139. Covered Services

§13902 Individual and Family Support Supplemental Payments

A. Supplemental payments will be made to licensed HCBS providers with a PCA module who support individuals currently receiving qualified waiver services who have complex medical and/or behavioral needs and are at a higher risk of institutionalization.

1. The integration of the supplemental payment provides additional funding to licensed HCBS providers with a PCA module who provide supports that focus on the prevention of deteriorating or worsening medical or behavioral conditions for individuals with complex needs.

2. The provider will be required to complete a screening tool and submit initial documentation as outlined in the program manual prior to qualifying for any supplemental payment. The supplemental payment will be re-evaluated annually to determine ongoing need per program requirements.

3. The PCA providers must be licensed home and community-based services (HCBS) providers with a personal care attendant module in order to receive the supplemental payment, in addition to the criteria listed in §13902 B.

B. Determination Process: A PCA provider can qualify for a supplemental payment if the individual currently receiving qualified waiver services has a complex medical and/or behavioral need.

1. Complex Medical

a. Individuals must require at least two of the following non-complex tasks delegated by a registered nurse to a non-licensed direct service worker:

i. suctioning of a clean, well-healed, uncomplicated mature tracheostomy in an individual who has no cardiopulmonary problems and is able to cooperate with the person performing the suctioning (excludes deep suctioning);

ii. care of a mature tracheostomy site;

iii. removing/cleaning/replacing inner tracheostomy cannula for mature tracheostomy;

iv. providing routine nutrition, hydration or medication through an established gastrostomy or jejunostomy tube (excludes nasogastric tube);

v. clean intermittent urinary catheterization;

vi. obtaining a urinary specimen from a port of an indwelling urinary catheter;

vii. changing a colostomy appliance;

viii. ensuring proper placement of nasal cannula (excludes initiation/changing of flow rate;

ix. capillary blood glucose testing;

x. simple wound care (including non-sterile/clean dressing removal/application); or

xi. other delegable non-complex tasks as approved by OCDD in accordance with LAC 48:1 Chapter 92 Subchapter D.

2. Behavioral

a. The individual meets two of the following items:

i. specific behavioral programming/procedures are required, or the individual receives behavioral health treatment/therapy and needs staff assistance on a daily basis to complete therapeutic homework or use skills/coping mechanisms being addressed in therapy;

ii. staff must sometimes intervene physically with the individual beyond a simple touch prompt or redirect, or the individual's environment must be carefully structured based on professionally driven guidance/assessment to avoid behavior problems or minimize symptoms; or

iii. a supervised period of time away, outside of the individual's weekly routine, such as work, school or participation in his/her community, is needed at least once per week; and

b. the individual requires one of the following due to the items listed in a.-a.iii above:

i. higher credentialed staff (college degree, specialized licensing, such as registered behavior technician [RBT], applied behavior analysis [ABA], etc.), who

have advanced behavioral training for working with individuals with severe behavioral health symptoms or significant experience working with this population; or

ii. the need for higher qualified supervision of the direct support of staff (master's degree, additional certification, such as board certified behavior analyst [BCBA], etc.).

C. The supplemental payment is not allowed for waiver participants who do not receive individual and family support (IFS) services.

D. The supplemental payment may not be approved for waiver participants receiving IFS hours in addition to 12 or more hours of skilled nursing per day.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 46:

§13927. Skilled Nursing Services

A. – B. ...

C. Provider Qualifications. The provider must be licensed by the Department of Health as a home health agency.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1208 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1651 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:77 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:56 (January 2018), LR 46:

§13933 Complex Care

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 and the Office for Citizens with Developmental Disabilities, LR 45:43 (January 2019), repealed LR 46:

Chapter 143. Reimbursement

§14301. Unit of Reimbursement

A. – B.3. ...

C. The following services are paid through a per diem:

1.- 4. ...

5. individual and family support supplemental payment.

D. – F. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1209 (June 2004), amended by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 34:252 (February 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 35:1851 (September 2009), LR 36:1247 (June 2010), LR 37:2158 (July 2011), LR 39:1049 (April 2013), LR 40:80 (January 2014), LR 42:898 (June 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:58 (January 2018), LR 45:44 (January 2019), LR 46:

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.

Dr. Courtney N. Phillips

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Hospital Licensing Standards
(LAC 48:II.9301)

The Department of Health, Bureau of Health Services Financing has amended LAC 48:II.9301 as authorized by R.S. 36:254 and R.S. 40:2100-2115. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950, et seq. This Rule is hereby adopted on the day of promulgation.

Title 48

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

Chapter 93. Hospitals

Subchapter A. General Provisions

§9301. Purpose

A. – B. ...

C. Primarily Engaged

1. Except as provided in §9301.C.2, hospitals shall be *primarily engaged*, as defined by this Rule and determined by the Department of Health, in providing inpatient hospital services to inpatients, by or under the supervision of licensed physicians. Inpatient hospital services are services defined in

this licensing rule and are provided to inpatients of the hospital as one of the following:

a. – b. ...

2. Exemptions. The following licensed hospitals are not subject to the primarily engaged provisions and/or requirements of this Chapter:

a. a licensed hospital designated as a psychiatric hospital or a critical access hospital as defined by the Code of Federal Regulations;

b. a licensed hospital designated as a rural hospital as defined by R.S. 40:1189.3; and

c. a licensed hospital currently certified and enrolled as a Medicare/Medicaid certified hospital which has not been determined out of compliance with the federal definition of *primarily engaged*; if a hospital is currently Medicare/Medicaid certified, and has been determined to be currently meeting the federal definition of *primarily engaged*, it shall be exempt from compliance with the following provisions in this section regarding primarily engaged.

C.3. – E.9. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April

1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2399 (November 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 45:1474 (October 2019), LR 46:

Dr. Courtney N. Phillips

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. Hospital Services
Subpart 1. Inpatient Hospitals Services

Chapter 5. State Hospitals

Subchapter B. Reimbursement Methodology

§553. Inpatient Psychiatric Services for State Owned Hospitals

A. – A.1. ...

B. Effective for dates of service on or after January 1, 2021, the prospective per diem rate paid to state owned free-standing psychiatric hospitals, and distinct part psychiatric units within state owned acute care hospitals, shall be

increased by 3.2 percent of the per diem rate on file as of December 31, 2020.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 45:1770 (December 2019), amended LR 46:

Chapter 9. Non-Rural, Non-State Hospitals

Subchapter B. Reimbursement Methodology

§953. Acute Care Hospitals

A. – W.2. ...

X. 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. 40:1300 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 45:1770 (December 2019), LR:46:

§955. Long-Term Hospitals

A. – M. ...

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

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

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:

§959. Inpatient Psychiatric Hospital Services

A. – O.2. ...

P. 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 on file as of December 31, 2020.

1. 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 45:1771 (December 2019), LR 46:

§961. Inpatient Rehabilitation Hospital Services

A. – B.4. ...

5. Effective for dates of service on or after January 1, 2021, the inpatient per diem rate paid to non-rural, non-state free-standing rehabilitation hospitals shall be increased by 3.2 percent of the per diem rate on file as of December 31, 2020.

AUTHORITY NOTE: 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 45:1771 (December 2019), LR 46:

§967. Children’s Specialty Hospitals

A. – O. ...

P. Effective for dates of service on or after January 1, 2021, the inpatient per diem rates paid to children’s specialty hospitals for acute, neonatal intensive care units, pediatric intensive care units and burn units’ services shall be increased

by 3.2 percent of the per diem rate on file as of December 31, 2020.

Q. Effective for dates of service on or after January 1, 2021, the inpatient per diem rates paid to distinct part psychiatric units within children's specialty hospitals shall be increased by 3.2 percent of the per diem rate on file as of December 31, 2020.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 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 45:1771 (December 2019), LR 46:

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.

Dr. Courtney N. Phillips

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Nursing Facilities
Optional State Assessment
(LAC 50:II.10123 and 20001)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:II.10123 and 20001 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 II. Nursing Facilities
Subpart 3. Standards for Payment

Chapter 101. Standards for Payment for Nursing Facilities

Subchapter D. Resident Care Services

§10123. Comprehensive Assessment

A. – G.4.c. ...

H. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

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

Services Financing, LR 22:34 (January 1996), amended by the Department of Health, Bureau of Health Services Financing, LR 46:695 (May 2020), LR 46:

Subpart 5. Reimbursement

Chapter 200. Reimbursement Methodology

§20001. General Provisions

A. Definitions

***

Minimum Data Set (MDS)—a core set of screening and assessment data, including common definitions and coding categories that form the foundation of the comprehensive assessment for all residents of long-term care nursing facility providers certified to participate in the Medicaid Program. The items in the MDS standardize communication about resident problems, strengths, and conditions within nursing facility providers, between nursing facility providers, and between nursing facility providers and outside agencies. The Louisiana system will employ the current required MDS assessment as approved by the Centers for Medicare and Medicaid Services (CMS).

***

B. – C.7. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 46:2742, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1473 (June 2002), repromulgated LR 28:1790 (August 2002), amended LR 28:2537 (December 2002), LR 32:2262 (December 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:825 (March 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1522 (September 2016), LR 43:525 (March 2017), LR 43:2187 (November 2017), LR 46:695 (May 2020), LR 46:

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.

Dr. Courtney N. Phillips

Secretary

NOTICE OF INTENT

Department of Health
Bureau of Health Services Financing

Nursing Facilities
Reimbursement Methodology
(LAC 50:II.20005)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:II.20005 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 II. Nursing Facilities
Subpart 5. Reimbursement

Chapter 200. Reimbursement Methodology

§20005. Rate Determination

A. – D.3.b. ...

i. Each nursing facility's actual square footage per bed is multiplied by the January 1, 2003 new value per square foot, plus $9.75 for land. The square footage used shall not be less than 300 square feet or more than 450 square feet per licensed bed. If 15 percent or more of the nursing facility’s licensed beds are private rooms compared to the total

licensed beds of the nursing facility, then the maximum square footage used shall not be more than 550 square feet per licensed bed. To this value add the product of total licensed beds times $4,000 for equipment, sum this amount and trend it forward using the capital index. This trended value shall be depreciated, except for the portion related to land, at 1.25 percent per year according to the weighted age of the facility. Bed additions, replacements and renovations shall lower the weighted age of the facility. The maximum age of a nursing facility shall be 30 years. Therefore, nursing facilities shall not be depreciated to an amount less than 62.5 percent or [100 percent minus (1.25 percent*30)] of the new bed value. There shall be no recapture of depreciation.

D.3.b.ii. – Q. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1791 (August 2002), amended LR 31:1596 (July 2005), LR 32:2263 (December 2006), LR 33:2203 (October 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:325 (February 2010), repromulgated LR 36:520 (March 2010), amended LR 36:1556 (July 2010), LR 36:1782 (August 2010), LR 36:2566 (November 2010), LR

37:902 (March 2011), LR 37:1174 (April 2011), LR 37:2631 (September 2011), LR 38:1241 (May 2012), LR 39:1286 (May 2013), LR 39:3097, 3097 (November 2013), LR 41:707 (April 2015), LR 41:949 (May 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:82 (January 2017), LR 43:526 (March 2017), LR 46:

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.

Dr. Courtney N. Phillips

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Outpatient Hospital Services
Non-Rural, Non-State Hospitals
Reimbursement Rate Adjustment
(LAC 50:V.5313,5319, and 5715)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:V.5313, §5319, and §5715 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 5. Outpatient Hospital Services

Chapter 53. Outpatient Surgery

Subchapter B. Reimbursement Methodology

5313. Non-Rural, Non-State Hospitals

A. - L.1. ...

M. Effective for dates of service on or after January 1, 2021, the reimbursement rates paid to non-rural, non-state hospitals for outpatient surgery shall be increased by 3.2 percent of the rates on file as of December 31, 2020.

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Service Financing, LR 35:1900 (September 2009), amended LR 36:1250 (June 2010), LR 36:2041 (September 2010), LR 37:3266 (November 2011), LR 40:313 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:964 (May 2017), LR 43:2534 (December 2017), LR 44:2166 (December 2018), LR 45:1773 (December 2019), LR 46:

§5319. State-Owned Hospitals

A. – C. ...

D. Effective for dates of services on or after January 1, 2021, the reimbursement rates paid to state-owned hospitals for outpatient surgery shall be increased by 3.2 percent of the fee schedule rates on file as of December 31, 2020.

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

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

the Department of Health, Bureau of Health Services Financing, LR 45:1773 (December 2019), LR 46:

Chapter 57. Laboratory Services

Subchapter B. Reimbursement Methodology

§5715. State-Owned Hospitals

A. - B. ...

C. Effective for dates of service on or after January 1, 2021, the reimbursement rates paid to state-owned hospitals for outpatient laboratory services shall be reimbursed at 100 per cent of the current Medicare clinical laboratory fee schedule.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Service Financing, LR 35:956 (May 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:315 (February 2014), LR 46:

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.

Dr. Courtney N. Phillips

Secretary