

RULE

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

**Behavioral Health Services
Healthy Louisiana and Coordinated System of Care Waiver
(LAC 50:XXXIII.Chapters 1, 3 and 7)**

The Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health have amended LAC 50:XXXIII.Chapters 1, 3 and 7 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.

TITLE 50

PUBLIC HEALTH-MEDICAL ASSISTANCE

Part XXXIII. Behavioral Health Services

Subpart 1. Healthy Louisiana and Coordinated System of Care Waiver

Chapter 1. Managed Care Organizations and the Coordinated System of Care Contractor

§101. General Provisions

A. The Medicaid Program hereby adopts provisions to establish a comprehensive system of delivery for specialized behavioral health and physical health services. These services shall be administered through the Healthy Louisiana and Coordinated System of Care (CSoC) Waiver under the authority of

the Department of Health (LDH), in collaboration with managed care organizations (MCOs) and the coordinated system of care (CSoC) contractor, which shall be responsible for the necessary operational and administrative functions to ensure adequate service coordination and delivery.

B. ...

C. Managed care organizations shall operate as such, and the CSoC contractor shall operate as a prepaid inpatient health plan (PIHP). The MCOs were procured through a competitive request for proposal (RFP) process. The CSoC contractor was procured through an emergency process consistent with 45 CFR part 92. The MCOs and CSoC contractor shall assist with the state's system reform goals to support individuals with behavioral health and physical health needs in families' homes, communities, schools and jobs.

D. - E. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:360 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2353 (November 2015), amended by the

Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 43:

§103. Recipient Participation

A. - A.5. ...

6. full dual eligibles (for behavioral health services only and non-emergency medical transportation (NEMT));

7. children residing in an intermediate care facility for persons with intellectual disabilities (for behavioral health services only and NEMT);

8. all enrollees of waiver programs administered by the LDH Office for Citizens with Developmental Disabilities (OCDD) or the LDH Office of Aging and Adult Services (OAAS) (mandatory for behavioral health services only and NEMT);

9. ...

10. adults residing in a nursing facility (for behavioral health services only and NEMT);

11. supplemental security income/transfer of resources/long-term care related adults and children (for behavioral health services only and NEMT); and

12. transfer of resources/long-term care adults and children (for behavioral health services only and NEMT).

* * *

B. ...

C. Notwithstanding the provisions of Subsection A of this Section, the following Medicaid recipients are excluded from enrollment in the MCOs and the CSoC contractor:

1. for adults and children:

- a. Refugee Cash Assistance;
- b. Refugee Medical Assistance;
- c. Spend-Down Medically Needy;
- d. Specified Low-Income Beneficiaries (SLMB)-

only;

- e. Aliens Emergency Services;
- f. Qualified Individuals (QI) 1;
- g. Long-Term Care (LTC) co-insurance;
- h. Qualified Disabled and Working Individuals

(QDWI); and

- i. Qualified Medicare Beneficiaries (QMB)-only;

and

2. adult-only populations excluded from the 1915(b)

waiver:

- a. residents of an ICF/ID;
- b. Program of All Inclusive Care for the

Elderly (PACE); and

- c. Take Charge Plus.

3. - 10. 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, LR 38:361 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:1286 (July 2015), LR 41:2354 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 43:

§107. Enrollee Rights and Responsibilities

A. - A.1.b. ...

c. receive assistance with care coordination from the primary care providers (PCP's) office or the enrollee's behavioral health provider;

d. Repealed.

A.2. - B.8. ...

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 38:361 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2354 (November 2015), amended by the

Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 43:

Chapter 3. Managed Care Organizations and the Coordinated System of Care Contractor Participation

§301. Participation Requirements and Responsibilities

A. - B.4. ...

5. contract only with providers of services who are licensed and/or certified, meet the state of Louisiana credentialing criteria and enrolled with the Bureau of Health Services Financing, or its designated contractor, after this requirement is implemented;

B.6. - B.9. ...

a. are developed by the enrollee's primary care provider (PCP) or behavioral health provider with the enrollee's participation and in consultation with any specialists' providing care to the enrollee, with the exception of treatment plans or plans of care developed for recipients in the Home and Community Based Services (HCBS) Waiver. The wraparound agency shall develop plans of care according to wraparound best practice standards for recipients who receive behavioral health services through the HCBS Waiver;

b. ...

c. are in accordance with any applicable state and federal quality assurance and utilization review standards; and

9.d. - 10.c. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:362 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2355 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 43:

§303. Benefits and Services

A. ...

B. The MCO and CSoC contractor:

1. shall ensure that medically necessary services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are being furnished and shall not be more restrictive than services provided under the Medicaid State Plan;

B.2. - C.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, Bureau of Health Services Financing, LR 38:362 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2355 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 43:

Chapter 7. Grievance and Appeals Process

§701. General Provisions

A. ...

B. An enrollee, or a provider on behalf of an enrollee, has 60 calendar days from the date on the notice of action in which to file an appeal.

C. An enrollee may file a grievance at any time after an occurrence or incident which is the basis for the grievance.

D. - E. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:363 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2356 (November 2015), amended by the

Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 43:

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**

**Disproportionate Share Hospital Payments
Inpatient Psychiatric Services
Reimbursement Rate Reduction
(LAC 50:V.2903)**

The Department of Health, Bureau of Health Services Financing has amended LAC 50:V.2903 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.

TITLE 50

PUBLIC HEALTH-MEDICAL ASSISTANCE

Part V. Hospital Services

Subpart 3. Disproportionate Share Hospital Payments

Chapter 29. Public-Private Partnerships

§2903. Reimbursement Methodology

A. Free-Standing Psychiatric Hospitals. Effective for dates of service on or after October 1, 2015, the per diem rate paid to free-standing psychiatric hospitals shall be reduced by 5 percent of the rate in effect on September 30, 2015. The new per diem rate shall be \$552.05 per day.

1. Cost and lengths of stay will be reviewed for reasonableness before payments are made. Payments shall be made on a monthly basis.

2. 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.

B. - 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, Bureau of Health Services Financing, LR 40:2259 (November 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

Rebekah E. Gee MD, MPH

Secretary

RULE

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

**Home and Community-Based Behavioral Health Services Waiver
(LAC 50:XXXIII.Chapters 81-83)**

The Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health have amended LAC 50:XXXIII.Chapters 81-83 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.

Title 50

**PUBLIC HEALTH-MEDICAL ASSISTANCE
Part XXXIII. Behavioral Health Services
Subpart 9. Home and Community-Based Services Waiver**

Chapter 81. General Provisions

§8101. Introduction

A. The Medicaid Program hereby adopts provisions to provide coverage under the Medicaid State Plan for behavioral health services rendered to children with mental illness and severe emotional disturbances (SED) by establishing a home and community-based services (HCBS) waiver. This HCBS waiver shall be administered under the authority of the Department of Health, in collaboration with the coordinated system of care (CSoc)

contractor, which shall be responsible for the necessary operational and administrative functions to ensure adequate service coordination and delivery.

B.- D. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:366 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2361 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 43:

§8103. Recipient Qualifications

A. The target population for the Home and Community-Based Behavioral Health Services Waiver program shall be Medicaid recipients who:

1. are from the age of 5 years old through the age of 20 years old effective March 1, 2017:

a. recipients enrolled in the program prior to this date, who are between the ages of 0 through 4 or 20 through 21, may continue to be served through this waiver as long as they continue to meet the level of care criteria; and

b. prospectively recipients must be at least age 5 through age 20 to receive waiver services;

2. - 3. ...

4. require hospital or nursing facility level of care, as determined by the department's designated assessment tools and criteria;

5. meet financial eligibility criteria; and

6. reside in a home and community-based setting as defined in 42 CFR 441.301(c)(4) and in accordance with the department's policy and procedures.

B. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:366 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2361 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 43:

Chapter 83. Services

§8301. General Provisions

A. - E. ...

F. Services may be provided at a site-based facility, in the community or in the individual's place of residence as outlined in the plan of care. All service locations must meet the home and community-based service setting criteria in 42 CFR 441.301(c) (4) and in accordance with the department's policy and procedures.

G. - G.2. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:367 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2361 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 43:

§8305. Covered Services

A. - C.3. ...

4. services rendered in an institution for mental disease or any other institutional setting as defined in 42 CFR 441.301(c) (4).

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:367 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2362 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 43:

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

Rebekah E. Gee MD, MPH

Secretary

RULE

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

**Home and Community-Based Services Waivers
Adult Day Health Care Waiver
Transportation Costs
(LAC 50:XXI.2905)**

The Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services have amended LAC 50:XXI.2905 under 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.

Title 50

**PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXI. Home and Community-Based Services Waivers
Subpart 3. Adult Day Health Care**

Chapter 29. Reimbursement

§2905. Cost Categories Included in the Cost Report

A. - D.10. ...

E. Transportation Costs

1. ...

2. Payroll Taxes, Transportation—the cost of the employer's portion of Federal Insurance Contribution Act (FICA), Federal Unemployment Tax Act (FUTA), State Unemployment Tax Act (SUTA), and Medicare tax for drivers.

a. - c. Repealed.

3. Employee Benefits, Transportation—the cost of group insurance, pensions, uniform allowances and other employee benefits related to drivers.

4. Workers' Compensation, Transportation—the cost of workers' compensation insurance for drivers.

5. Non-Emergency Medical Transportation—the cost of purchased non-emergency medical transportation services including, but not limited to:

a. payments to employees for use of their personal vehicle(s);

b. ambulance companies; and

c. other transportation companies for transporting patients of the center.

6. Interest Expenses, Vehicles—interest paid or accrued on loans used to purchase vehicles.

7. Property Insurance, Vehicles—the cost of vehicle insurance.

8. Vehicle Expenses—vehicle maintenance and supplies, including gas and oil.

9. Lease, Automotive—the cost of leasing vehicles used for patient care. A mileage log must be maintained. If a leased vehicle is used for both patient care and personal purposes, cost must be allocated based on the mileage log.

10. Total Transportation Costs.

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 Aging and Adult Services, LR 34:2166 (October 2008), repromulgated LR 34:2571 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2626 (September 2011), amended LR 41:381 (February 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 43:

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
Public Hospitals Supplemental Payments
(LAC 50:V.963)**

The Department of Health, Bureau of Health Services Financing proposes has amended LAC 50:V.963 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.

**Title 50
PUBLIC HEALTH-MEDICAL ASSISTANCE
Part V. Hospital Services
Subpart 1. Inpatient Hospital Services**

Chapter 9. Non-Rural, Non-State Hospitals

Subchapter B. Reimbursement Methodology

§963. Public Hospitals

A. - B.1. ...

a. be designated as a major teaching hospital by the department as of July 1, 2015 and have at least 300 licensed acute hospital beds; or

B.1.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, Bureau of Health Services Financing, LR 38:2772 (November 2012), amended LR 38:3181 (December 2012), repromulgated LR 39:95 (January 2013), amended LR 39:1471 (June 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

Rebekah E. Gee MD, MPH

Secretary

RULE

**Department of Health
Bureau of Health Services Financing**

**Intermediate Care Facilities for Persons
with Intellectual Disabilities
Evacuation and Temporary Sheltering Costs
(LAC 50:VII.33103 and 33105)**

The Department of Health, Bureau of Health Services Financing has amended LAC 50:VII.33103 and adopted §33105 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.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part VII. Long-Term Care Services

Subpart 3. Intermediate Care Facilities for Persons with Intellectual Disabilities

Chapter 331. Vendor Payments

§33103. Payment Limitations

A. Temporary Absence of the Client. A client's temporary absence from an ICF/ID will not interrupt the monthly vendor payment to the ICF/ID, provided the following conditions are met:

1. the ICF/ID keeps a bed available for the client's return; and
2. the absence is for one of the following reasons:
 - a. ...

b. leave of absence. A temporary stay outside the ICF/ID provided for in the client's written individual habilitation plan. A leave of absence will not exceed 45 days per fiscal year (July 1 through June 30) and will not exceed 30 consecutive days in any single occurrence. Certain leaves of absence will be excluded from the annual 45-day limit as long as the leave does not exceed the 30-consecutive day limit and is included in the written individual habilitation plan. These exceptions are as follows:

i. - v. ...

NOTE: Elopements and unauthorized absences under the individual habilitation plan count against allowable leave days. However, Title XIX eligibility is not affected if the absence does not exceed 30 consecutive days and if the ICF/ID has not discharged the client.

3. ...

4. a period of 24 continuous hours or more shall be considered an absence. Likewise, a temporary leave of absence for hospitalization or a home visit is broken only if the client returns to the ICF/ID for 24 hours or longer;

5. upon admission, a client must remain in the ICF/ID at least 24 continuous hours in order for the ICF/ID to submit a payment claim for a day of service or reserve a bed;

EXAMPLE: A client admitted to an ICF/ID in the morning and transferred to the hospital that afternoon would not be eligible for any vendor payment for ICF/ID services.

6. ...

7. the ICF/ID shall promptly notify DHH of absences beyond the applicable thirty- or seven-day limitations. Payment to the ICF/MR shall be terminated from the thirty-first or eighth day, depending upon the leave of absence. Payment will commence after the individual has been determined eligible for Title XIX benefits and has remained in the ICF/ID for 30 consecutive days;

8. the limit on Title XIX payment for leave days does not mean that further leave days are prohibited when provided for in the individual habilitation plan. After the Title XIX payment limit is met, further leave days may be arranged between the ICF/ID and the client, family or responsible party. Such arrangements may include the following options.

a. The ICF/ID may charge the client, family or responsible party an amount not to exceed the Title XIX daily rate.

b. The ICF/ID may charge the client, family or responsible party a portion of the Title XIX daily rate.

c. The ICF/ID may absorb the cost into its operation costs.

B. Temporary Absence of the Client Due to Evacuations.

When local conditions require evacuation of ICF/ID residents, the following procedures apply.

1. When clients are evacuated to a family's or friend's home at the ICF/ID's request, the ICF/MR shall not submit a claim for a day of service or leave day, and the client's liability shall not be collected.

2. When clients go home at the family's request or on their own initiative, a leave day shall be charged.

3. When clients are admitted to the hospital for the purpose of evacuation of the ICF/ID, Medicaid payment shall not be made for hospital charges.

4. - 5. Repealed.

C. Payment Policy in regard to Date of Admission, Discharge, or Death

1. Medicaid (Title XIX) payments shall be made effective as of the admission date to the ICF/ID. If the client is medically certified as of that date and if either of the following conditions is met:

a. the client is eligible for Medicaid benefits in the ICF/ID (excluding the medically needy); or

b. the client was in a continuous institutional living arrangement (nursing home, hospital, ICF/ID, or a combination of these institutional living arrangements) for 30

consecutive days; the client must also be determined financially eligible for medical assistance.

2. The continuous stay requirement is:

a. ...

b. not interrupted by the client's absence from the ICF/ID when the absence is for hospitalization or leave of absence which is part of the written individual habilitation plan.

3. The client's applicable income is applied toward the ICF/ID fee effective with the date Medicaid payment is to begin.

4. - 5. ...

NOTE: The ICF/ID shall promptly notify LDH/BHSF of admissions, death, and/or all discharges.

D. Advance Deposits

1. An ICF/ID shall neither require nor accept an advance deposit from an individual whose Medicaid (Title XIX) eligibility has been established.

EXCEPTION: An ICF/ID may require an advance deposit for the current month only on that part of the total payment which is the client's liability.

2. ...

E. Retroactive Payment. When individuals enter an ICF/ID before their Medicaid (Title XIX) eligibility has been

established payment for ICF/ID services is made retroactive to the first day of eligibility after admission.

F. Timely Filing for Reimbursements. Vendor payments cannot be made if more than 12 months have elapsed between the month of initial services and submittal of a claim for these services. Exceptions for payments of claims over 12 months old can be made with authorization from LDH/BHSF only.

G. Refunds to Clients

1. When the ICF/ID receives vendor payments, it shall refund any fees for services collected from clients, family or responsible party by the end of the month in which vendor payment is received.

2. Advance payments for a client's liability (applicable income) shall be refunded promptly if he/she leaves the ICF/ID.

3. The ICF/ID shall adhere to the following procedures for refunds:

a. The proportionate amount for the remaining days of the month shall be refunded to the client, family, or the responsible party no later than 30 days following the date of discharge. If the client has not yet been certified, the procedures spelled out in §33103.G.1 above shall apply.

b. No penalty shall be charged to the client, family, or responsible party even if the circumstances surrounding the discharge occurred as follows:

i. - ii. ...

iii. within some other "minimum stay" period established by the ICF/ID.

c. ...

H. ICF/ID Refunds to the Department

1. Nonparticipating ICF/ID. Vendor payments made for services performed while an ICF/ID is in a nonparticipating status with the Medicaid Program shall be refunded to the department.

2. Participating ICF/ID. A currently participating Title XIX, ICF/ID shall correct billing or payment errors by use of appropriate adjustment void or patient liability (PLI) adjustment forms.

I. Sitters. An ICF/ID will neither expect nor require a client to have a sitter. However, the ICF/ID shall permit clients, families, or responsible parties directly to employ and pay sitters when indicated, subject to the following limitations:

1. The use of sitters will be entirely at the client's, family's, or responsible party's discretion. However, the ICF/ID shall have the right to approve the selection of a sitter. If the ICF/ID disapproves the selection of the sitter, the ICF/ID will provide written notification to the client, family, and/or responsible party, and to the department stating the reasons for disapproval.

2. - NOTE ...

3. Payment to sitters is the direct responsibility of the ICF/ID facility when:

a. - c. ...

4. A sitter will be expected to abide by the ICF/ID's rules, including health standards and professional ethics.

5. The presence of a sitter does not absolve the ICF/ID of its full responsibility for the client's care.

6. The ICF/ID is not responsible for providing a sitter if one is required while the resident is on home leave.

J. Tips. The ICF/ID shall not permit tips for services rendered by its employees.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:682 (April 1999), LR 31:1082 (May 2005), repromulgated LR 31:2257 (September 2005), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

§33105. Evacuation and Temporary Sheltering Costs

A. Intermediate care facilities for persons with intellectual disabilities required to participate in an evacuation, as directed by the appropriate parish or state official, or which act as a host shelter site may be entitled to reimbursement of its documented and allowable evacuation and temporary sheltering costs.

1. The expense incurred must be in excess of any existing or anticipated reimbursement from any other sources, including the Federal Emergency Management Agency (FEMA) or its successor.

2. ICFs/ID must first apply for evacuation or sheltering reimbursement from all other sources and request that the department apply for FEMA assistance on their behalf.

3. ICFs/ID must submit expense and reimbursement documentation directly related to the evacuation or temporary sheltering of Medicaid residents to the department.

B. Eligible Expenses. Expenses eligible for reimbursement must occur as a result of an evacuation and be reasonable, necessary, and proper. Eligible expenses are subject to audit at the department's discretion and may include the following.

1. Evacuation Expenses. Evacuation expenses include expenses from the date of evacuation to the date of arrival at a temporary shelter or another ICF/ID. Evacuation expenses include:

a. resident transportation and lodging expenses during travel;

b. nursing staff expenses when accompanying residents, including:

i. transportation;

ii. lodging; and

iii. additional direct care expenses, when a direct care expense increase of 10 percent or more is documented:

(a). the direct care expense increase must be based on a comparison to the average of the previous two pay periods or other period comparisons determined acceptable by the department;

c. any additional allowable costs that are directly related to the evacuation and that would normally be allowed under the ICF/ID rate methodology.

2. Non-ICF/ID Facility Temporary Sheltering Expenses. Non-ICF/ID facility temporary sheltering expenses include expenses from the date the Medicaid residents arrive at a non-ICF/ID facility temporary shelter to the date all Medicaid residents leave the shelter. A non-ICF/ID facility temporary shelter includes shelters that are not part of a licensed ICF/ID and are not billing for the residents under the ICF/ID reimbursement methodology or any other Medicaid reimbursement

system. Non-ICF/ID facility temporary sheltering expenses may include:

a. additional nursing staff expenses including:

i. lodging; and

ii. additional direct care expenses, when a direct care expense increase of 10 percent or more is

documented:

(a). the direct care expense increase must be based on a comparison to the average of the previous two pay periods or other period comparisons determined acceptable by the department;

b. care-related expenses incurred in excess of care-related expenses prior to the evacuation;

c. additional medically necessary equipment such as beds and portable ventilators that are not available from the evacuating nursing facility and are rented or purchased specifically for the temporary sheltered residents; and

i. these expenses will be capped at a daily rental fee not to exceed the total purchase price of the item;

ii. the allowable daily rental fee will be determined by the department;

d. any additional allowable costs as determined by the department and that are directly related to the temporary

sheltering and that would normally be allowed under the ICF/ID reimbursement methodology.

3. Host ICF/ID Temporary Sheltering Expenses. Host ICF/ID temporary sheltering expenses include expenses from the date the Medicaid residents are admitted to a licensed ICF/ID to the date all temporary sheltered Medicaid residents are discharged from the ICF/ID, not to exceed a six-month period.

a. The host ICF/ID shall bill for the residents under Medicaid's ICF/ID reimbursement methodology.

b. Additional direct care expenses may be submitted when a direct care expense increase of 10 percent or more is documented.

i. The direct care expense increase must be based on a comparison to the average of the previous two pay periods or other period comparisons determined acceptable by the department.

C. Payment of Eligible Expenses

1. For payment purposes, total eligible Medicaid expenses will be the sum of nonresident-specific eligible expenses multiplied by the facility's Medicaid occupancy percentage plus Medicaid resident-specific expenses.

a. If Medicaid occupancy is not easily verified using the evacuation resident listing, the Medicaid occupancy from the most recently filed cost report will be used.

2. Payments shall be made as quarterly lump-sum payments until all eligible expenses have been submitted and paid. Eligible expense documentation must be submitted to the department by the end of each calendar quarter.

3. All eligible expenses documented and allowed under §33105 will be removed from allowable expenses when the ICF/ID's Medicaid cost report is filed. These expenses will not be included in the allowable cost used to set ICF/ID reimbursement rates in future years.

a. Equipment purchases that are reimbursed on a rental rate under §33105.B.2.c may have their remaining basis included as allowable cost on future costs reports provided that the equipment is in the ICF/ID and being used. If the remaining basis requires capitalization then depreciation will be recognized.

4. Payments shall remain under the upper payment limit cap for ICFs/ID.

D. When an ICF/ID resident is evacuated to a temporary sheltering site (an unlicensed sheltering site or a licensed ICF/ID) for less than 24 hours, the Medicaid vendor payment to the evacuating facility will not be interrupted.

E. When an ICF/ID resident is evacuated to a temporary sheltering site (an unlicensed sheltering site or a licensed NF) for greater than 24 hours, the evacuating ICF/ID may submit the claim for Medicaid vendor payment for a maximum of five days,

provided that the evacuating ICF/ID provides sufficient staff and resources to ensure the delivery of essential care and services to the resident at the temporary shelter site.

F. When an ICF/ID resident is evacuated to a temporary shelter site, which is an unlicensed sheltering site, for greater than five days, the evacuating ICF/ID may submit the claim for Medicaid vendor payment for up to an additional 15 days, provided that the evacuating ICF/ID:

1. has received an extension to stay at the unlicensed shelter site; and
2. provides sufficient staff and resources to ensure the delivery of essential care and services to the resident, and to ensure the needs of the resident are met.

G. When an ICF/ID resident is evacuated to a temporary shelter site, which is a licensed ICF/ID, for greater than 5 days, the evacuating ICF/ID may submit the claim for Medicaid vendor payment for an additional period, not to exceed 55 days, provided that:

1. the host/receiving ICF/ID has sufficient licensed and certified bed capacity for the resident, or the host/receiving ICF/ID has received departmental and/or CMS approval to exceed the licensed and certified bed capacity for a specified period; and
2. the evacuating ICF/ID provides sufficient staff and resources to ensure the delivery of essential care and

services to the resident, and to ensure the needs of the resident are met.

H. If an ICF/ID resident is evacuated to a temporary shelter site which is a licensed ICF/ID, the receiving/host ICF/ID may submit claims for Medicaid vendor payment under the following conditions:

1. beginning day 2 and continuing during the "sheltering period" and any extension period, if the evacuating nursing home does not provide sufficient staff and resources to ensure the delivery of essential care and services to the resident and to ensure the needs of the residents are met;

2. upon admission of the evacuated residents to the host/receiving ICF/ID; or

3. upon obtaining approval of a temporary hardship exception from the department, if the evacuating ICF/ID is not submitting claims for Medicaid vendor payment.

I. Only one ICF/ID may submit the claims and be reimbursed by the Medicaid Program for each Medicaid resident for the same date of service.

J. An ICF/ID may not submit claims for Medicaid vendor payment for non-admitted residents beyond the expiration of its extension to exceed licensed (and/or certified) bed capacity or expiration of its temporary hardship exception.

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:

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**

**Nursing Facilities
Evacuation and Temporary Sheltering Costs
(LAC 50:II.20019)**

The Department of Health, Bureau of Health Services Financing has amended LAC 50:II.20019 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.

Title 50

**PUBLIC HEALTH—MEDICAL ASSISTANCE
Part II. Nursing Facilities
Subpart 5. Reimbursement**

Chapter 200. Reimbursement Methodology

§20019. Evacuation and Temporary Sheltering Costs

[Formerly LAC 50:VII.1319]

A. - B.1.b.iii.(a). ...

c. any additional allowable costs as defined in the CMS Publication 15-1-21, last modified 9/28/2012, that are directly related to the evacuation and that would normally be allowed under the nursing facility case-mix rate.

2. - 2.a.ii.(a). ...

b. care-related expenses as defined in LAC

50:II.20005 and incurred in excess of care-related expenses prior to the evacuation;

c. - c.ii. ...

d. any additional allowable costs as defined in the CMS Publication 15-1-21, last modified 9/28/2012, that are directly related to the temporary sheltering and that would normally be allowed under the nursing facility case-mix rate.

3. -3.b.i. ...

C. Payment of Eligible Expenses

1. - 2. ...

3. All eligible expenses documented and allowed under §20019 will be removed from allowable expenses when the nursing facility's Medicaid cost report is filed. These expenses will not be included in the allowable cost used to set case-mix reimbursement rates in future years.

a. Equipment purchases that are reimbursed on a rental rate under §20019.B.2.c may have their remaining basis included as allowable cost on future costs reports provided that the equipment is in the nursing facility and being used. If the remaining basis requires capitalization under CMS Publication 15-1-21 guidelines, last modified 9/28/2012, then depreciation will be recognized.

4. ...

D. When a nursing facility (NF) resident is evacuated to

a temporary shelter site (an unlicensed sheltering site or a licensed NF) for less than 24 hours, the Medicaid vendor payment to the evacuating facility will not be interrupted.

E. When a NF resident is evacuated to a temporary shelter site (an unlicensed sheltering site or a licensed NF) for greater than 24 hours, the evacuating nursing facility may submit the claim for Medicaid vendor payment for a maximum of five days, provided that the evacuating nursing facility provides sufficient staff and resources to ensure the delivery of essential care and services to the resident at the temporary shelter site.

F. When a NF resident is evacuated to a temporary shelter site, which is an unlicensed sheltering site, for greater than five days, the evacuating nursing facility may submit the claim for Medicaid vendor payment for up to an additional 15 days, provided that the evacuating nursing facility:

1. has received an extension to stay at the unlicensed shelter site; and
2. provides sufficient staff and resources to ensure the delivery of essential care and services to the resident, and to ensure the needs of the resident are met.

G. When a NF resident is evacuated to a temporary shelter site, which is a licensed nursing home, for greater than five days, the evacuating nursing facility may submit the claim for

Medicaid vendor payment for an additional period, not to exceed 55 days, provided that:

1. the host/receiving nursing home has sufficient licensed and certified bed capacity for the resident, or the host/receiving nursing home has received departmental and/or CMS approval to exceed the licensed and certified bed capacity for a specified period; and

2. the evacuating nursing facility provides sufficient staff and resources to ensure the delivery of essential care and services to the resident, and to ensure the needs of the resident are met.

H. If a NF resident is evacuated to a temporary shelter site which is a licensed NF, the receiving/host nursing home may submit claims for Medicaid vendor payment under the following conditions:

1. beginning day two and continuing during the "sheltering period" and any extension period, if the evacuating nursing home does not provide sufficient staff and resources to ensure the delivery of essential care and services to the resident and to ensure the needs of the residents are met;

2. upon admission of the evacuated residents to the host/receiving nursing facility; or

3. upon obtaining approval of a temporary hardship exception from the department, if the evacuating NF is not

submitting claims for Medicaid vendor payment.

I. Only one nursing facility may submit the claims and be reimbursed by the Medicaid Program for each Medicaid resident for the same date of service.

J. A nursing facility may not submit claims for Medicaid vendor payment for non-admitted residents beyond the expiration of its extension to exceed licensed (and/or certified) bed capacity or expiration of its temporary hardship exception.

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 34:879 (May 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

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**

**Psychiatric Residential Treatment Facilities
Licensing Standards
(LAC 48:I.9047)**

The Department of Health, Bureau of Health Services Financing has amended LAC 48:I.9047 as authorized by R.S. 40:2009. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 48

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

**Chapter 90. Psychiatric Residential Treatment Facilities
(under 21)**

Subchapter D. Human Resources

§9047. Personnel Requirements

A. - A.4. ...

B. The facility shall maintain a minimum ratio of one staff person for four residents (1:4) between the hours of 6 a.m. and 10 p.m. The staff for purposes of this ratio shall consist of direct care staff (i.e. licensed practical nurse (LPN), MHS, MHP, LMHP, etc.).

C. The facility shall maintain a minimum ratio of one

staff person for six residents (1:6) between 10 p.m. and 6 a.m. Staff shall always be awake while on duty. The staff for purposes of this ratio shall consist of direct care staff (i.e. LPN, MHS, MHP, LMHP, etc.).

D. Staffing ratios listed above are a minimum standard. The PRTF must have written policies and procedures that:

1. demonstrate how the staffing pattern will be adjusted when necessary to meet the individual needs and acuity of youth as those fluctuate over time;

2. document how the PRTF continuously monitors the appropriateness of its staffing pattern to ensure the safety of both youth and staff;

- a. This documentation shall include specific methods used by the PRTF to monitor metrics such as restraints and seclusions and other adverse incidents, and documentation of how the PRTF uses this monitoring to make ongoing decisions about staffing patterns; and

3. document how the PRTF continuously monitors the appropriateness of its staffing pattern to ensure that youth receive appropriate, individualized care and treatment and therapeutic interactions;

- a. This documentation shall include specific methods used by the PRTF to monitor metrics such as clinical progress and outcomes, and documentation of how the PRTF uses

this monitoring to make ongoing decisions about staffing patterns.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:385 (February 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

Rebekah E. Gee MD, MPH

Secretary