RULE

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

Home and Community Based Behavioral Health Services Waiver
Coordinated System of Care Discharge Criteria
(LAC 50:XXXIII.8103)

The Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health has amended LAC 50:XXXIII.8103 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 9. Home and Community-Based Services Waiver

Chapter 81. General Provision

§8103. Recipient Qualifications

A. – B. ...

C. Recipients shall be discharged from the waiver program if one or more of the following criteria is met:

1. – 4. ...

5. the recipient or his/her parent or guardian disengaged from services, evidenced by lack of face-to-face

contact for a minimum of 60 consecutive calendar days or by failure to cooperate in the re-evaluation assessment at least every 180 days;

6. – 7. ...

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 43:324 (February 2017), LR 44:1895 (October 2018), LR 46:183 (February 2020), LR 50:

Ralph L. Abraham, M.D.

Secretary

RULE

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

Home and Community-Based Services Waivers
Supports Waiver
(LAC 50:XXI.Chapters 53-61)

The Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities have amended LAC 50:XXI.Chapters 53-61 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950, et seq. This Rule is hereby adopted on the day of promulgation.

Title 50
PUBLIC HEALTH-MEDICAL ASSISTANCE
Part XXI. Home and Community-Based Services Waivers
Subpart 5. Supports Waiver

Chapter 53. General Provisions

§5301. Purpose

A. The mission of this waiver is to create options and provide meaningful opportunities that enhance the lives of individuals with intellectual and/or developmental disabilities through employment and day service supports in the community. The goals of the supports waiver are as follows:

1. – 3. ...

B. Allocation of Waiver Opportunities. The Office for Citizens with Developmental Disabilities (OCDD) maintains the developmental disabilities request for services registry (DDRSR), hereafter referred to as “the registry,” which identifies persons with intellectual and/or developmental disabilities who are found eligible for developmental disabilities services using standardized tools, and who request waiver services.

1. – 3. ...

4. OCDD waiver opportunities shall be offered based on the following priority groups:

a. Individuals living at publicly operated intermediate care facilities for the developmentally disabled (ICF/IIDs) or who lived at a publically operated ICF/IID when it was transitioned to a private ICF/IID through a cooperative endeavor agreement (CEA facility), or their alternates. Alternates are defined as individuals living in a private ICF/IID who will give up the private ICF/IID bed to an individual living at a publicly operated ICF/IID or to an individual who was living in a publicly operated ICF/IID when it was transitioned to a private ICF/IID through a cooperative endeavor agreement. Individuals requesting to transition from a publicly operated ICF/IID are awarded a slot when one is requested, and their health and safety can be assured in an OCDD

waiver. This also applies to individuals who were residing in a publicly operated facility at the time the facility was privatized and became a CEA facility.

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, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 32:1604 (September 2006), amended LR 40:2583 (December 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2531 (December 2017), LR 48:1574 (June 2022), LR 50:

Chapter 55. Target Population

§5503. Denial of Admission or Discharge Criteria

A. Beneficiaries shall be denied admission to, or discharged from, the supports waiver if one of the following criteria is met:

1. ...

2. the beneficiary does not meet the requirement for an ICF/IID level of care;

3. – 4. ...

5. the beneficiary is admitted to an ICF/IID or nursing facility with the intent to stay and not to return to waiver services:

a. ...

b. the beneficiary will be discharged from the waiver on the ninety-first day if the participant is still in the ICF/IID or nursing facility;

6. - 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 and the Office for Citizens with Developmental Disabilities, LR 40:2584 (December 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:1575 (June 2022), LR 50:

Chapter 57. Covered Services

§5701. Supported Employment Services

A. Supported employment services consists of intensive, ongoing supports and services necessary for a beneficiary to achieve the desired outcome of employment in a community setting where a majority of the persons employed are without disabilities. Beneficiaries utilizing these services may need ongoing supports for the life of their employment due to the

nature of their disability, and natural supports may not meet this need.

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

1. ...

2. job assessment, discovery and development, placement; and

B.3. – C. ...

D. Transportation is a separate billable component for supported employment services, both individual and group. Transportation may be billed on the same day as a supported employment service is delivered.

E. ...

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

1. ...

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

G. Service Limitations

1. Services for job assessment, discovery and development in individual jobs and self-employment shall not exceed the number of units as defined in a plan of care year and must have a prior authorization.

2. Services for job assessment, discovery and development in group employment shall not exceed the number of units as defined in a plan of care year and must have a prior authorization.

3. Services for individual initial job support, job retention and follow-along shall not exceed the number of units of service as defined in a plan of care year and must have prior authorization. Individual job follow-along services may be delivered virtually.

4. Services for initial job support, job retention and follow-along in group employment shall not exceed the number of units of service as defined in a plan of care year and must have prior authorization.

H. Restrictions

1. Beneficiaries receiving individual and/or group supported employment services may also receive other services in the same service day. However, these services cannot be provided at the same time of the day.

2. All virtual individual supported employment services must be documented and included in the plan of care. Virtual delivery of group supported employment is not allowed.

I. – J. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 32:1605 (September 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:2585 (December 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2532 (December 2017), LR 48: LR 48:1575 (June 2022), LR 50:

§5703. Day Habilitation

A. ...

B. Day habilitation is the overarching service and may be delivered in a combination of these two service types:

1. onsite day habilitation; and

2. community life engagement.

NOTE: Day habilitation services may be delivered virtually and be included in the approved plan of care.

3. Repealed.

C. – D. ...

E. Transportation is a separate billable component for day habilitation services. A day habilitation service must be billed on the same day that transportation is billed. Transportation cannot be billed if the service is delivered virtually.

F. Service Limitations. Services shall not exceed the number of units of service as defined in a plan of care year and must have a prior authorization.

G. Restrictions

1. Beneficiaries receiving day habilitation services may also receive other services on the same day but not at the same time of the day.

2. All virtual delivery of day habilitation services must be on an approved plan of care.

H. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 32:1605 (September 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:2585 (December 2014), amended by Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:1576 (June 2022), LR 50:

§5705. Prevocational Services

A. Prevocational services are individualized, person centered services that assist the beneficiaries in establishing

their path to obtain individualized community employment. This service is time limited and targeted for people who have an interest in becoming employed in individual jobs in the community, but who may need additional skills, information, and experiences to determine their employment goal and become successfully employed. Beneficiaries receiving prevocational services may choose to leave this service at any time or pursue employment opportunities at any time. Career planning must be a major component of prevocational services and should include activities focused on beneficiaries becoming employed to their highest ability.

B. Prevocational services is the overarching service and may be delivered in a combination of these two service types:

1. onsite prevocational; and

2. community career planning.

NOTE: Prevocational services may be delivered virtually.

3. Repealed.

C. – D. ...

E. Prevocational services may also include assistance in personal care with activities of daily living.

F. Transportation is a separate billable component for prevocational services. A prevocational service must be billed on the same day that transportation is billed. Transportation

cannot be billed if the prevocational service is delivered virtually.

G. Service Limitations. Services shall not exceed the number of units of service as defined in a plan of care year and must have a prior authorization.

H. Restrictions

1. Beneficiaries receiving prevocational services may also receive other services on the same day but cannot be provided during the same time of the day.

2. All virtual prevocational services must be included on the approved plan of care.

I. Prevocational services are not available to individuals who are eligible to participate in programs that are available and funded under section 110 of the Rehabilitation Act of 1973 or sections 602 (16) or (17) of the Individuals with Disabilities Education Act [20 U.S.C. 1401 (26 and 29)], as amended, and those covered under the state plan, if applicable.

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, Office for Citizens with Developmental Disabilities, LR 32:1605 (September 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with

Developmental Disabilities, LR 40:2585 (December 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:1577 (June 2022), LR 50:

§5707. Respite

A. Respite care is a service provided on a short-term basis to a beneficiary who is unable to care for himself/herself due to the absence or need for relief of those unpaid persons normally providing care for the beneficiary.

B. Respite may be provided in a licensed respite care facility that is determined to be appropriate by the beneficiary or other responsible party, or may be provided in the beneficiary's home or private place of residence.

C. – D. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 32:1606 (September 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:2586 (December 2014), amended by the Department of Health, Bureau of Health Services Financing

and the Office for Citizens with Developmental Disabilities, LR 48:1577 (June 2022), LR 50:

§5709. Habilitation

A. Habilitation offers services designed to assist the beneficiary in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community settings.

B. Habilitation is provided in the home or community, includes necessary transportation, and is included on the plan of care as determined to be appropriate.

C. Habilitation services may include, but are not limited to:

1. ...

2. travel training activities in the community that promote community independence, to include but not limited to, place of individual employment, church, or other community activity. This does not include group supported employment, day habilitation, or prevocational sites.

D. – E. ...

F. Beneficiaries receiving habilitation may use this service in conjunction with other supports waiver services as long as other services are not provided during the same period in a day.

NOTE: Beneficiaries who are age 18 through 21 may also receive available services as outlined on their plan of care through the Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program, if applicable. Beneficiaries who are age 21 and older may receive available services as outlined on their plan of care through the Long-Term Personal Care Services (LT-PCS) Program, if applicable.

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, Office for Citizens with Developmental Disabilities, LR 32:1606 (September 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:2586 (December 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:1577 (June 2022), LR 50:

§5713. Personal Emergency Response System

A. A personal emergency response system (PERS) is an electronic device connected to the beneficiary’s phone which enables a beneficiary to secure help in the community. The system is programmed to signal a response center staffed by trained professionals when a "help" button is activated.

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, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 32:1607 (September 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:2587 (December 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:1578 (June 2022), LR 50:

§5715. Support Coordination

A. Support coordination is a service that will assist beneficiaries in gaining access to all of their necessary services, as well as medical, social, educational, and other services, regardless of the funding source for the services. Support coordinators shall be responsible for on-going monitoring of the provision of services included in the beneficiary’s approved plan of care.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with

Developmental Disabilities, LR 34:662 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, Office for Citizens with Developmental Disabilities, LR 40:2587 (December 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:1578 (June 2022), LR 50:

§5717. Housing Stabilization Transition Services

A. Housing stabilization transition services enable beneficiaries who are transitioning into a permanent supportive housing unit, including those transitioning from institutions, to secure their own housing. The service is provided while the beneficiary is in an institution and preparing to exit the institution using the waiver. The service includes the following components:

1. conducting a housing assessment to identify the beneficiary's preferences related to housing (i.e., type, location, living alone or with someone else, need for accommodations, and other important preferences), and his/her needs for support to maintain housing, including:

A.1.a. – 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 and the Office for Citizens with Developmental Disabilities, LR 40:81 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:1578 (June 2022), LR 50:

§5721. Dental Services

A. – A.10. ...

B. Dental Service Exclusions

1. ...

2. Non-covered services include but are not limited to the following:

a. – e. ...

f. routine post-operative services — these services are covered as part of the fee for initial treatment provided;

B.2.g. – 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, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:1579 (June 2022), LR 50:

§5723. Community Life Engagement Development

A. Community life engagement development (CLED) facilitates the development of opportunities to assist beneficiaries in becoming involved in the community. The purpose of CLED is to find the opportunities that encourage and foster the development of meaningful relationships in the community reflecting the beneficiary's choices and values. Objectives outlined in the comprehensive plan of care will afford opportunities to increase community inclusion, participation in leisure/recreational activities, and encourage participation in volunteer and civic activities. To utilize this service, the beneficiary may or may not be present. CLED services may be performed by a staff person for up to three waiver beneficiaries who have a common provider agency for day services and supports. Rates shall be adjusted accordingly.

B. Transportation costs are included in the reimbursement for CLED services.

C. Service Limitations. Services shall not exceed the number of units as defined in the beneficiary's plan of care and must have a prior authorization.

D. Provider Qualifications. Providers must be licensed by the Department of Health as a home and community-based services provider and must meet the module specific requirements for the service being provided.

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 50:

§5725. Specialized Medical Equipment and Supplies

A. Incontinence briefs and supplies are available for a beneficiary, 21 years or older, who has a physician’s order and requires the use of incontinence briefs and supplies.

B. Service Restrictions

1. This service is for those who are 21 years of age or older.

2. This service requires a physician’s order.

C. Service Limitations

1. The cost cannot exceed $2,500 in a single plan of care year.

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 50:

Chapter 59. Provider Participation

§5901. General Provisions

A. ...

B. If the transportation component for supported employment, day habilitation, and/or prevocational services is provided by the provider, the provider must have insurance coverage that meets current home and community-based services providers licensing standards on any vehicles used in transporting a beneficiary.

C. In addition to meeting the requirements cited in this §5901.A and B, providers must meet the following requirements for the provision of designated services.

1. – 7. ...

8. Specialized Medical Equipment and Supplies. Providers of this service must be enrolled to participate in the Medicaid Program as a provider of assistive technology, specialized medical equipment, and supplies.

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, Office for Citizens with Developmental Disabilities, LR 32:1607 (September 2006), LR 34:662 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, Office for Citizens with Developmental Disabilities, LR 40:2587 (December 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with

Developmental Disabilities, LR 43:2532 (December 2017), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 43:2532 (December 2017), LR 48:1579 (June 2022), LR 50:

§5903. Electronic Visit Verification

A. ...

B. Reimbursement shall only be made to providers with use of the EVV system. The services that require use of the EVV system include the following: in home respite, center-based respite, habilitation, day habilitation, prevocational services, and supported employment services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 41:1288 (July 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:1579 (June 2022), LR 50:

Chapter 61. Reimbursement

§6101. Unit of Reimbursement

A. The reimbursement for all services will be paid on a per claim basis. The reimbursement rate covers both service provision and administration. Services which utilize a

prospective flat rate of one-quarter hour (15 minutes) will not be paid for the provision of less than one-quarter hour of service.

B. Supported Employment Services. Reimbursement shall be a prospective flat rate for each approved unit of service provided to the beneficiary. A standard unit of service in both individual and group supported employment services is one-quarter hour (15 minutes). A standard unit for individual ongoing follow along and job assessment is a fee for service rate.

C. – J. ...

K. Community Life Engagement Development. Reimbursement shall be a prospective flat rate for each approved unit of service provided to the beneficiary. One-quarter hour (15 minutes) is the standard unit of service.

L. Transportation. Reimbursement shall be a prospective flat rate for each approved unit of service provided to the beneficiary. A standard unit is a daily rate.

M. Specialized Medical Equipment and Supplies. Reimbursement shall be a prospective flat rate for each approved unit of service provided to the beneficiary.

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, Office for Citizens with Developmental Disabilities, LR 32:1607 (September 2006), amended LR 34:662 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 36:2281 (October 2010), LR 37:2158 (July 2011), LR 39:1050 (April 2013), LR 40:82 (January 2014), LR 40:2587 (December 2014), LR 42:900 (June 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:43 (January 2022), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:43 (January 2022), LR 48:1579 (June 2022), LR 49:1072 (June 2023), LR 50:

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.

Ralph L. Abraham, M.D.

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Home Health Program
American Rescue Plan Act
(LAC 50:XIII.801)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XIII.801 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 50
PUBLIC HEALTH-GENERAL
Part XIII. Home Health Program
Subpart 1. Home Health Services

Chapter 8. American Rescue Plan Act Funding

§801. Nursing Recruitment and Retention Payments

A. General Provisions

1. Nurses that provide extended home health (EHH) services may be eligible to receive recruitment and retention bonuses through March 2025.

2. – 4. ...

5. HHAs shall disburse the entire payment to the nurse and are prohibited from reducing the payment for any purpose other than required state or federal withholdings.

A.6. – C.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, Bureau of Health Services Financing, LR 49:875 (May 2023), amended LR 50:

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.

Ralph L. Abraham, M.D.

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Medicaid Eligibility
Incurred Medical and Remedial Care Expenses
(LAC 50:III.941)

The Department of Health, Bureau of Health Services Financing has adopted LAC 50:III.941 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 III. Eligibility
Subpart 1. General Administration

Chapter 9. Financial Eligibility

Subchapter D. Incurred Medical

§941. Incurred Medical and Remedial Care Expenses

A. In accordance with 42 C.F.R. Part 435 Subparts H and I, certain medical and remedial care expenses incurred by institutionalized individuals and individuals receiving home and community-based services furnished under a waiver, subject to the reasonable limits specified herein, are deducted from the individual’s income in the calculation of patient liability.

B. Reasonable limits imposed are:

1. For medically necessary care, services, and items not paid under the Medicaid State Plan or, if covered under the Medicaid State Plan, denied due to service limitations.

a. The medical or remedial care must be:

i. recognized under state law;

ii. medically necessary as verified by an independent licensed physician or medical director; and

iii. incurred no earlier than three months preceding the month in which it is reported to the state; and

b. The medical or remedial care cannot be:

i. for cosmetic or elective purposes, except when medically necessary as verified by an independent licensed physician or medical director; and/or

ii. for payment of a medical or dental service plan that has not been approved by the Department of Insurance in accordance with the Louisiana Insurance Code, Title 22 of the *Louisiana Revised Statutes*.

2. The deduction for medical and remedial care expenses that were incurred as a result of imposition of transfer of assets penalty period is limited to $0.

3. The deduction for medical and remedial care expenses that were incurred as a result of the individual’s equity interest in the home exceeding the limit established under 42 U.S.C. §139p(f) is limited to $0.

4. The deduction for medical or remedial care expenses that were incurred during a period when the individual is not subject to patient liability is limited to $0.

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 50:

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.

Ralph L. Abraham, M.D.

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Medical Transportation Program
Emergency Medical Transportation
(LAC 50:XXVII.Chapter 3)

The Department of Health, Bureau of Health Services Financing has amended LAC 50: XXVII.Chapter 3 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 XXVII. Medical Transportation Program

Chapter 3. Emergency Medical Transportation

Subchapter A. Reserved.

Subchapter B. Ground Transportation

§325. Reimbursement

A. The Medicaid reimbursement for ground ambulance services is the rate established in the state fee schedule for emergency ambulance transport, basic life support, advanced life support and mileage, oxygen, intravenous fluids, and disposable supplies administered during the emergency ambulance transport minus the amount paid by any liable third party coverage.

B. – J. ...

K. Effective for dates of service on or after July 1, 2023, the reimbursement rates for emergency ground ambulance transportation services shall be reimbursed based on the Louisiana Medicaid fee schedule.

EXCEPTION: Except as otherwise noted in the plan, state-developed fee schedule rates are established separately for governmental, New Orleans-based governmental, and private providers of ambulance transportation services to account for cost variability across these provider types and to maintain access to care through alignment with historic payment levels.

1. The agency's fee schedule rate, set as of July 1, 2023, is effective for services provided on or after that date. All rates are published on the agency's website at: https://www.lamedicaid.com.

2. The fee schedule was established as a function of historical rates in effect as of January 1, 2023 plus an enhancement which was calculated to achieve total fee schedule reimbursement as a percentage of average commercial rates (ACR), with the clarifications listed within Subparagraph a through c below:

a. governmental ambulance providers include those ambulance providers who are owned or operated by a public organization such as state, federal, parish, or city entities;

b. New Orleans-based governmental ambulance providers include ambulance providers located within the city of New Orleans; and

c. private ambulance transportation providers include corporations, limited liability companies, partnerships, or sole proprietors. Private providers must comply with all state laws and the regulations of any governing state agency, commission, or local entity to which they are subject as a condition of enrollment and continued participation in the Medicaid program.

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 34:878 (May 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:1248 (June 2010), LR 36:2564 (November 2010), LR 37:3029 (October 2011), LR 39:1285 (May 2013), LR 40:1379 (July 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 50:

§327. Supplemental Payments for Ambulance Providers

A. Effective for dates of service on or after September 20, 2011, quarterly supplemental payments shall be issued to qualifying ambulance providers for emergency medical

transportation services rendered during the quarter if the department has received an appropriation from the legislature for these payments.

B. – H. ...

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 40:1530 (August 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 50:

§331. Enhanced Reimbursements for Qualifying Emergency Ground Ambulance Service Providers

A. Emergency Medical Transportation

1. Qualifying emergency ambulance service providers assessed a fee as outlined in LAC 48:I.4001.E.1.a-b shall receive enhanced reimbursement for emergency ground ambulance transportation services rendered during the quarter through the Supplemental Payment Program described in the Medicaid State Plan if the department has received an appropriation from the legislature for these payments.

2. Effective for dates of service on or after July 1, 2019, qualifying emergency ambulance service providers assessed a fee as outlined in LAC 48:I.4001.E.1.a-d shall receive enhanced reimbursement for non-emergency ground

ambulance transportation services rendered during the quarter through the Supplemental Payment Program described in the Medicaid State Plan if the department has received an appropriation from the legislature for these payments.

B. – E.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, Bureau of Health Services Financing, LR 42:1890 (November 2016), amended LR 45:1598 (November 2019), LR 50:

Subchapter C. Aircraft Transportation

§351. Standards for Participation

A. Rotor winged (helicopters) and fixed winged emergency aircraft must be certified by the Department of Health, Bureau of Health Services Financing in order to receive Medicaid reimbursement. All air ambulance services must be provided in accordance with state laws and regulations governing the administration of these services.

B. ...

C. Prior Approval. Prior approval shall not be required for emergency air ambulance transportation services, including mileage. Approval shall be done during post payment review and shall not be completed prior to service delivery. Claims for payment of emergency air ambulance transportation services are

received and reviewed retrospectively. The clinical documentation for each emergency air ambulance transportation service shall not be required for submission concurrent with the claim. If required, clinical documentation shall be required post claim submission.

1. Air ambulance claims will be reviewed and a determination will be made based on the following requirements. Air ambulance services are covered only if:

a. speedy admission of the beneficiary is essential and the point of pick-up of the beneficiary is inaccessible by a land vehicle; or

b. great distance or other obstacles are involved in getting the beneficiary to the nearest hospital with appropriate services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 35:70 (January 2009), amended by the Department of Health, Bureau of Health Services Financing, LR 50:

§353. Reimbursement

A.- B. ...

C. If a ground ambulance must be used for part of the transport, the ground ambulance provider will be reimbursed separately according to the provisions governing emergency ground transportation.

D. – I.2. ...

J. The reimbursement rates for emergency and non-emergency, rotor winged and fixed winged air ambulance transportation services shall be reimbursed based on the Louisiana Medicaid fee schedule. These rates include both in state and out-of-state air ambulance transportation. The agency's fee schedule rate was set as of January 1, 2022 and is effective for services provided on or after that date. All rates are published on the agency's website at: https://www.lamedicaid.com.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 35:70 (January 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2564 (November 2010), amended LR 37:3029 (October 2011), LR 39:1285 (May 2013), LR 40:1379 (July 2014), LR 42:277 (February 2016), amended by the Department of Health, Bureau of Health Service Financing, LR 50:

§355. Supplemental Payments for Ambulance Providers

A. Effective for dates of service on or after September 20, 2011, quarterly supplemental payments shall be issued to qualifying ambulance providers for emergency medical air transportation services rendered during the quarter if the department has received an appropriation from the legislature for these payments.

B. – H. ...

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 40:1531 (August 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 50:

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.

Ralph L. Abraham, M.D.

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Medical Transportation Program
Non-Emergency Medical Transportation
American Rescue Plan Act
(LAC 50:XXVII.531)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XXVII.531 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 50
PUBLIC HEALTH-GENERAL
Part XXVII. Medical Transportation Program

Chapter 5. Non-Emergency Medical Transportation

Subchapter E. Non-Emergency Medical Transportation American Rescue Plan Act

§531. Non-Emergency Medical Transportation Bonus Payments

A. ...

1. Non-emergency medical transportation (NEMT) providers that are fully credentialed in the Medicaid Program may be eligible to receive a bonus payment under the Department of Health’s (LDH) American Rescue Plan Act (ARPA) NEMT Program

until the program's federal funds are exhausted or through the conclusion of the program.

2. Fully credentialed NEMT providers who meet all eligibility requirements are entitled to a monthly disbursement of $500 per vehicle, for up to three vehicles per month, totaling a maximum payment of $1,500 per month per transportation provider. The managed care organization (MCO) will determine eligibility for monthly payments based on the NEMT provider's ongoing compliance for all provider, driver, and vehicle requirements set forth by the Medicaid Program and the LDH ARPA NEMT Program.

3. ...

4. The MCO will provide a weekly report to LDH containing all newly acquired NEMT providers. LDH will assign each active NEMT provider to an affiliated MCO.

5. The MCO will administer all payments for the LDH ARPA NEMT Program.

a. – e. Repealed.

6. In order to receive payments under the LDH ARPA NEMT Program, the NEMT provider shall do the following:

a. accede to all provisions of the LDH ARPA NEMT Program and execute a contractual agreement with the MCO, solely for the distribution of ARPA funds;

b. maintain ongoing compliance for all provider, driver, and vehicle requirements set forth by the Medicaid Program;

c. submit reporting and credentialing documentation for all drivers and vehicles within their individual company used for NEMT services on a monthly basis. Failure to meet both LDH and the MCO's time requirements shall result in loss of the monthly bonus payment; and

d. submit a monthly attestation to the MCO which certifies the accuracy of the submitted supporting and credentialing documentation.

7. NEMT services are ineligible and shall not be submitted as a completed service if the status of the NEMT service rendered results in one of the following:

a. the provider is a no-show;

b. no NEMT vehicle is available;

c. no NEMT driver is available; or

d. the NEMT provider is late which causes the beneficiary to miss his or her scheduled Medicaid covered service.

B. – B.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, Bureau of Health Services Financing, LR 49:877 (May 2023), amended by the Department of Health, Bureau of Health Services Financing, LR 50:

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.

Ralph L. Abraham, M.D.

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 R.S. 46:2742 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. Effective for assessments with assessment reference dates of October 1, 2023 and after, the department mandates the use of the optional state assessment (OSA) item set. The OSA item set is required to be completed in conjunction with each assessment and at each assessment interval detailed within this Section. The OSA item set must have an assessment reference date

that is identical to that of the assessment it was performed in conjunction with.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and R.S. 46:2742.

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 46:1684 (December 2020), LR 50:

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), or as mandated by the Department of Health through the use of the optional state assessment (OSA).

***

Optional State Assessment (OSA)—assessment required by Louisiana Medicaid to report on Medicaid-covered stays. Allows nursing facility providers using RUG-III or RUG-IV models as the basis for Medicaid payment to do so until the legacy payment model (RUG-III) ends.

***

Patient Driven Payment Model (PDPM)—the proposed new Medicare payment rule for skilled nursing facilities. The PDPM identifies and adjusts different case-mix components for the varied needs and characteristics of a resident’s care and then combines these with a non-case-mix component to determine the full skilled nursing facilities (SNF) prospective payment system (PPS) per diem rate for that resident.

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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 46:1684 (December 2020), LR 50:

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.

Ralph L. Abraham, M.D.

Secretary