RULE

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

Home and Community-Based Services Waivers
Community Choices Waiver
(LAC 50:XXI.Chapters 81, 85, 86, 93, and 95)

The Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services have amended LAC 50:XXI.Chapters 81, 85, 86, 93, and 95 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 50
PUBLIC HEALTH-MEDICAL ASSISTANCE
Part XXI. Home and Community Based Services Waivers
Subpart 7. Community Choices Waiver

Chapter 81. General Provisions

§8105. Programmatic Allocation of Waiver Opportunities

A. ...

B. Community Choices Waiver opportunities shall be offered to individuals on the registry according to priority groups. The following groups shall have priority for Community Choices Waiver opportunities, in the order listed:

1. – 4. ...

5. individuals who require expedited waiver services, who are approved for the maximum amount of services allowable under LT-PCS and will require institutional placement, unless offered an expedited waiver opportunity;

6. individuals who are not presently receiving home and community-based services (HCBS) under another Medicaid program, including, but not limited to:

a. Program of All-Inclusive Care for the Elderly (PACE);

b. long term—personal care services (LT-PCS); and/or

c. any other 1915(c) waiver; and

7. all other eligible individuals on the CCW registry, by date of first request for services.

C. – D. ...

E. Notwithstanding the priority group provisions, up to 300 Community Choices Waiver opportunities may be granted to qualified individuals who require expedited waiver services. These individuals shall be offered an opportunity on a first-come, first-served basis.

1. To be considered for an expedited waiver opportunity, the individual must, at the time of the request for the expedited opportunity, be approved for the maximum amount of

services allowable under LT-PCS and require institutional placement, unless offered an expedited waiver opportunity.

2. The following criteria shall be considered in determining whether to grant an expedited waiver opportunity:

a. ...

b. the death or incapacitation of an informal caregiver leaves the individual without other supports;

c. ...

d. the individual lives alone and has no access to informal support; or

e. for other reasons, the individual lacks access to adequate informal support to prevent nursing facility placement.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3517 (December 2011), amended LR 39:319 (February 2013), LR 39:1778 (July 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1896 (October 2018), LR 45:756 (June 2019), LR 50:785 (June 2024), LR 51:

Chapter 85. Self-Direction Initiative

§8501. Self-Direction Service Option

A. – C.2.d.vi. ...

D. Employee Qualifications. All employees under the self-direction option must:

1. ...

2. pass required criminal history background and database checks; and

3. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3523 (December 2011), amended LR 39:321 (February 2013), LR 39:1779 (July 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1900 (October 2018), LR: 49:1726 (October 2023), LR 50:787 (June 2024), LR 51:

Chapter 86. Organized Health Care Delivery System

§8601. General Provisions

A. - C. ...

D. Prior to enrollment, an OHCDS must demonstrate the ability to provide all of the CCW services.

1. For ADHC services, the OHCDS must show the ability to provide this service, only if there is a licensed ADHC provider in the service area.

2. – 8. 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 and the Office of Aging and Adult Services, LR 40:792 (April 2014), amended LR 41:2643 (December 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1901 (October 2018), LR 50:787 (June 2024), LR 51:

Chapter 93. Provider Responsibilities

§9301. General Provisions

A. ...

B. All providers (with the exception of Home Delivered Meals providers), Self-Direction (SD) employers and/or Fiscal Employer Agencies (FEAs) must ensure that statewide criminal history background checks are performed on all unlicensed persons working for their agency in accordance with R.S. 40:1203.1 et seq. and/or other applicable state law upon hire.

1. Ensure that the provider or SD employer and/or FEA does not hire unlicensed persons who have a conviction that

bars employment in accordance with R.S. 40:1203.3 or other applicable state law.

a. The provider, SD employer and/or FEA shall have documentation on the final disposition of all charges that bars employment pursuant to applicable state law.

2. Ensure that all employees, including contractors, have not been excluded from participation in the Medicaid programs by checking the databases upon hire and monthly thereafter.

a. The provider, SD employer and/or FEA must maintain documentation of the results of these database checks.

C. The provider shall not request payment unless the participant for whom payment is requested is receiving services in accordance with the Community Choices Waiver program provisions and the services have been prior authorized and actually provided.

D. Any provider of services under the Community Choices Waiver shall not refuse to serve any individual who chooses their agency unless there is documentation to support an inability to meet the individual’s health and welfare needs, or all previous efforts to provide service and supports have failed and there is no option but to refuse services.

1. OAAS or its designee must be immediately notified of the circumstances surrounding a refusal by a provider to render services.

2. This requirement can only be waived by OAAS or its designee.

E. Providers must maintain adequate documentation to support service delivery and compliance with the approved POC and will provide said documentation at the request of the department, or its designee.

F. Any provider of services under the Community Choices Waiver shall not interfere with the eligibility, assessment, care plan development, or care plan monitoring processes with use of methods including, but not limited to:

1. harassment;

2. intimidation; or

3. threats against program participants, members of their informal support network, LDH staff or support coordination staff.

G. Any provider of services under the Community Choices Waiver shall have the capacity and resources to provide all aspects of any service they are enrolled to provide in the specified service area.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3524 (December 2011), amended LR 39:322 (February 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1901 (October 2018), LR 50:788 (June 2024), LR 51:

Chapter 95. Reimbursement

§9501. Reimbursement and Rate Requirements

A. – G. ...

H. Personal assistance service providers and Self-Direction employers must pay their direct services workers (DSW) a minimum of $9 per hour.

I. ADHC providers must pay their ADHC direct support workers a minimum of $9 per hour.

J. The state has the authority to set and change provider rates and/or provide lump sum payments to providers based upon funds allocated by the legislature.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3525 (December 2011), amended LR 39:322 (February 2013), LR 39:508, 508 (March 2013),

repromulgated LR 39:1048 (April 2013), amended LR 39:1779 (July 2013), LR 40:793 (April 2014), LR 42:897 (June 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:1902 (October 2018), LR 47:886 (July 2021), LR 49:487 (March 2023), LR 50:788 (June 2024), LR 51:

§9503. Direct Support/Service Worker Wages, Other Benefits, and Workforce Retention Bonus Payments

A. Direct Support/Service Worker Wage Floor and Other Benefits

1. Repealed.

2. - 3. ...

4. All PAS and ADHC providers affected by this rate increase shall be subject to passing 70 percent of their rate increases directly to the direct support/service worker in various forms. These forms include a minimum wage floor of $9 per hour and other wage and non-wage benefits. These wage floor and wage and non-wage benefits are effective for all affected direct support/service workers, including contracted workers, of any working status, whether full-time or part-time.

5. Repealed.

6. ...

B. Direct Support/Service Worker Workforce Bonus Payments

1. Repealed.

2. The PAS and ADHC direct support/service worker who provided services from April 1, 2021 to October 31, 2022 to participants, must receive at least $250 of this $300 monthly bonus payment paid to the provider. This bonus payment is effective for all affected direct support/service workers, including contracted workers, of any working status, whether full-time or part-time.

C. – D.1.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, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 49:684 (April 2023), LR 51:

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.

Michael Harrington, MBA, MA

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Hospital Services
Inpatient Hospital Services
Other Rural Hospitals
(LAC 50:V.Chapter 12)

The Department of Health, Bureau of Health Services Financing has adopted LAC 50:V.Chapter 12 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950, et seq. This Rule is hereby adopted on the day of promulgation.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part V. Hospital Services
Subpart 1. Inpatient Hospitals Services

Chapter 12. Other Rural Hospitals

Subchapter A. General Provisions

§1201. Qualifying Criteria

A. To qualify as an other rural, non-state hospital, the hospital shall meet the following criteria:

1. is a non-state owned hospital;

2. has no more than 60 licensed beds as of October 1, 2024, excluding distinct part psychiatric unit beds, distinct part rehabilitation unit beds, and nursery bassinets;

3. does not qualify as a *rural hospital* as defined in R.S. 40:1189.3;

4. is not located within one of Louisiana's metropolitan statistical areas (MSA) as delineated in OMB Bulletin No. 23-01;

5. has an operational emergency room; and

6. is located in a municipality with a population of less than 23,000 as measured by the 2020 United States Census Bureau.

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 51:

Subchapter B. Reimbursement Methodology

§1225. Other Rural Hospitals

A. The inpatient hospital per diem rates paid to other rural, non-state hospitals shall be as follows.

1. Acute Care Services. The per diem rate for acute care services shall be 85 percent of the small rural hospital acute per diem rate in effect.

2. Psychiatric Services. The per diem rate for psychiatric services shall be 85 percent of the small rural hospital psychiatric per diem rate in effect.

3. Neonatal Intensive Care Unit (NICU) Services. The per diem rate for NICU services shall be 85 percent of the small rural hospital NICU per diem rate in effect.

4. Nursery Boarder Baby Services. The per diem rate for nursery boarder baby services shall be 85 percent of the small rural hospital nursery boarder baby per diem rate in effect.

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 51:

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.

Michael Harrington, MBA, MA

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Hospital Services
Outpatient Hospital Services
Other Rural Hospitals
(LAC 50:V.Chapter 79)

The Department of Health, Bureau of Health Services Financing has adopted LAC 50:V.Chapter 79 in the Medical Assistance program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part V. Hospital Services
Subpart 5. Outpatient Hospital Services

Chapter 79. Other Rural Hospitals

§7901. Qualifying Criteria

A. In order to qualify as an other rural, non-state hospital, the hospital shall meet the following criteria:

1. is a non-state owned hospital;

2. has no more than 60 licensed beds as of October 1, 2024, excluding distinct part psychiatric unit beds, distinct part rehabilitation unit beds, and nursery bassinets;

3. does not qualify as a *rural hospital* as defined in R.S. 40:1189.3;

4. is not located within one of Louisiana's metropolitan statistical areas (MSA) as delineated in the OMB Bulletin No. 23-01;

5. has an operational emergency room; and

6. is located in a municipality with a population of less than 23,000 as measured by the 2020 United States Census.

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 51:

§7903. Reimbursement Methodology

A. The reimbursement rates paid to other rural, non-state hospitals for outpatient hospital services shall be as follows.

1. Surgery Services. The reimbursement amount for outpatient hospital surgery services shall be an interim payment equal to the Medicaid fee schedule amount on file for each service, and a final reimbursement amount of 95 percent of allowable Medicaid cost as calculated through the cost report settlement process.

2. Clinic Services. The reimbursement amount for outpatient hospital facility fees for clinic services shall be an interim payment equal to the Medicaid fee schedule amount on

file for each service, and a final reimbursement amount of 95 percent of allowable Medicaid cost as calculated through the cost report settlement process.

3. Laboratory Services. The reimbursement amount for outpatient clinical diagnostic laboratory services shall be the Medicaid fee schedule amount on file for each service.

4. Rehabilitation Services. The reimbursement amount for outpatient rehabilitation services shall be an interim payment equal to the Medicaid fee schedule amount on file for each service, and a final reimbursement amount of 95 percent of allowable Medicaid cost as calculated through the cost report settlement process.

5. Other Outpatient Hospital Services. The reimbursement amount for outpatient hospital services other than surgery services, clinic services, clinical diagnostic laboratory services, and rehabilitation services shall be an interim payment equal to 95 percent of allowable Medicaid cost as calculated through the cost report settlement process.

B. If a qualifying hospital’s outpatient cost is greater in subsequent cost reporting periods than the initial implementation year cost report period’s cost, outpatient costs shall be subjected to a cap prior to determination of cost settlement amount. Calculation of reimbursable costs shall be as follows.

1. An average cost per Medicaid outpatient unduplicated encounter per day shall be established using Medicaid cost report and paid claims data from the initial cost report period of implementation. The average unduplicated encounter cost per day shall be calculated by dividing the total outpatient allowable costs for all Medicaid outpatient services by the number of paid unduplicated encounters per day. Clinical diagnostic laboratory services and vaccines are not included in this calculation.

2. To determine the capped limit for each subsequent year’s allowable cost settlement reimbursement, the base year outpatient unduplicated encounter per day cost shall be multiplied by the unduplicated encounters from the applicable subsequent cost reporting period’s Medicaid paid claims data and then increased by 3 percent cumulatively for each year subsequent to the initial implementation year.

3. Final reimbursement shall be 95 percent multiplied by the lesser of capped cost amount calculated per §7903.B.2 or allowable reimbursable cost calculated per §7903.A.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 51:

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.

Michael Harrington, MBA, MA

Secretary