RULE

Department of Health
Bureau of Health Services Financing

Early and Periodic Screening, Diagnosis and Treatment
Personal Care Services
(LAC 50:XV.Chapter 73)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XV.Chapter 73 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 XV. Services for Special Populations
Subpart 5. Early and Periodic Screening, Diagnosis, and Treatment

Chapter 73. Personal Care Services

§7301. Introduction

A. Early Periodic Screening, Diagnosis and Treatment (EPSDT) Personal Care Services (PCS)

1. Personal Care Services are services which prevent institutionalization and enable the beneficiary to live in the community. PCS are tasks which are medically necessary when physical or cognitive limitations due to illness or injury necessitate assistance with:

a. eating;

b. toileting;

c. bathing;

d. bed mobility;

e. transferring;

f. dressing;

g. locomotion;

h. personal hygiene; or

i. bladder or bowel requirements.

2. Repealed.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, Bureau of Health Services Financing, LR 21:947 (September 1995), repromulgated for LAC codification, LR 29:177 (February 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 45:

§7303. Services

A. The beneficiary shall be allowed the freedom of choice to select an EPSDT PCS provider.

B. EPSDT personal care services include:

1. basic personal care, including toileting, grooming, bathing and assistance with dressing;

2. assistance with bladder and/or bowel requirements or problems, including helping the beneficiary to and from the bathroom or assisting the beneficiary with bedpan routines, but excluding catheterization;

3. assistance with eating and food, nutrition, and diet activities, including preparation of meals for the beneficiary only;

4. performance of incidental household services essential to the beneficiary’s health and comfort in her/his home. Examples of such activities are changing and washing bed linens and rearranging furniture to enable the beneficiary to move about more easily in his/her own home;

5. accompanying, not transporting the beneficiary to and from his/her physician and/or other medical appointments for necessary medical services; and

6. assistance with locomotion in their place of service, while in bed or from one surface to another. Assisting the beneficiary with transferring and bed mobility.

7. – 8. Repealed.

C. Intent of Services

1. EPSDT PCS shall not be provided to meet childcare needs nor as a substitute for the parent or guardian in the absence of the parent or guardian.

2. EPSDT PCS shall not be used to provide respite care for the primary caregiver.

3. EPSDT PCS provided in an educational setting shall not be reimbursed if these services duplicate services that are provided by or shall be provided by the Department of Education.

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 21:947 (September 1995), repromulgated for LAC codification, LR 29:177 (February 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 45:

§7305. Beneficiary Qualifications

A. Conditions for Provision of EPSDT Personal Care Services

1. The person must be a categorically-eligible Medicaid beneficiary birth through 20 years of age (EPSDT eligible) and have been prescribed medically necessary, age appropriate EPSDT PCS by a practitioner (physician, advance practice nurse, or physician assistant).

2. An EPSDT-eligible shall meet medical necessity criteria as established by the Bureau of Health Services

Financing (BHSF) which shall be based on functional and medical eligibility and impairment in at least two activities of daily living (ADL), as determined by BHSF or its designee.

3. EPSDT PCS shall be prescribed if medically necessary by the beneficiary's attending practitioner initially and every 180 days thereafter (or rolling six months), and when changes in the plan of care occur. The plan of care shall be acceptable only after the practitioner signs and dates the completed form. The practitioner's signature must be an original signature and not a rubber stamp.

4. 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, Bureau of Health Services Financing, LR 21:947 (September 1995), repromulgated for LAC codification, LR 29:177 (February 2003), amended LR 30:253 (February 2004), amended 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 45:

§7307. Prior Authorization

A. EPSDT personal care services are subject to prior authorization (PA) by BHSF or its designee. A face-to-face

medical assessment shall be completed by the practitioner. The beneficiary’s choice of a personal care services provider may assist the practitioner in developing a plan of care which shall be submitted by the practitioner for review/approval by BHSF or its designee. The plan of care shall specify:

1. the specific personal care service(s) to be provided (i.e., activities of daily living for which assistance is needed); and

2. ...

B. Dates of service not included in the plan of care or provided prior to approval of the plan of care by BHSF or its designee are not reimbursable. The beneficiary’s attending practitioner shall review and/or modify the plan of care and sign off on it prior to the plan of care being submitted to BHSF or its designee. A copy of the practitioner’s prescription for EPSDT PCS shall be included with the plan of care at the time of submission for prior authorization and may not be dated after delivery of services has started. A copy of the prescription shall be retained in the EPSDT PCS provider’s files.

C. A new plan of care shall be submitted at least every 180 days (rolling six months) with approval by the beneficiary’s attending practitioner. The plan of care shall reassess the patient’s need for EPSDT PCS, including any updates to information which has changed since the previous assessment was

conducted (with explanation of when and why the change(s) occurred).

D. Amendments or changes in the plan of care shall be submitted as they occur and shall be treated as a new plan of care which begins a new six-month service period. Revisions of the plan of care may be necessary because of changes that occur in the beneficiary's medical condition which warrant an additional type of service, a change in frequency of service or a change in duration of service. Documentation for a revised plan of care is the same as for a new plan of care. Both a new start date and reassessment date shall be established at the time of reassessment. The EPSDT PCS provider may not initiate services or changes in services under the plan of care prior to approval by BHSF or its designee.

E. Beneficiaries who have been designated by BHSF as chronic needs are exempt from the standard prior authorization process. Although a new request for prior authorization shall still be submitted every 180 days, the EPSDT PCS provider shall only be required to submit a PA request form accompanied by a statement from a practitioner verifying that the beneficiary's condition has not improved and the services currently approved must be continued. Only BHSF or its designee can grant the designation of a chronic needs case to a 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, Bureau of Health Services Financing, LR 21:947 (September 1995), repromulgated for LAC codification, LR 29:177 (February 2003), amended LR 30:253 (February 2004), amended by the Department of Health, Bureau of Health Services Financing, LR 45:

§7309. Place of Service

A. EPSDT PCS shall be provided if medically necessary in the beneficiary's home or in another location outside of the beneficiary's home. The beneficiary's home is defined as the beneficiary's own home, which includes the following:

1. – 3. ...

4. a foster home; or

5. a supervised living facility.

6. – 6.a. Repealed.

B. Institutions such as hospitals, institutions for mental disease, nursing facilities, intermediate care facilities for individuals with intellectual disabilities, or residential treatment centers are not considered a beneficiary's home.

C. Medicaid prohibits multiple professional disciplines from being present in the beneficiary's residential setting at the same time. However, multiple professionals may provide

services to multiple beneficiaries in the same residential setting when it is medically necessary. This includes but is not limited to nurses, home health aides, and therapists. BHSF or its designee will determine medical necessity for fee-for-service beneficiaries.

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 21:948 (September 1995), repromulgated for LAC codification, LR 29:178 (February 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 45:

§7311. Service Limits

A. EPSDT PCS are not subject to service limits. The units of service approved shall be based on the physical requirements of the beneficiary and medical necessity for the covered 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 21:947 (September 1995) repromulgated for LAC codification, LR 29:178 (February 2003), amended LR 30:253

(February 2004), amended by the Department of Health, Bureau of Health Services Financing, LR 45:

§7313. Standards for Payment

A. EPSDT PCS shall only be provided to EPSDT beneficiaries and only by a staff member of a licensed personal care services agency enrolled as a Medicaid provider. A copy of the current PCS license must accompany the Medicaid application for enrollment as a PCS provider and copies of current licenses shall be submitted to Provider Enrollment thereafter as they are issued, for inclusion in the enrollment record. The provider's record shall always include a current PCS license at all times. Medicaid enrollment is limited to providers located in Louisiana and certain out-of-state providers located only in the trade areas of Arkansas, Mississippi, and Texas.

B. The unit of service billed by EPSDT PCS providers shall be one-quarter hour, exclusive of travel time to arrive at the beneficiary's home. The entire 15 minutes of the unit of time shall have been spent providing services in order to bill a unit.

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 21:947 (September 1995), repromulgated

for LAC codification, LR 29:178 (February 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 45:

§7315. Provider Qualifications

A. Personal care services shall be provided by a licensed personal care services agency which is duly enrolled as a Medicaid provider. Staff assigned to provide personal care services to a beneficiary shall not be a member of the beneficiary's immediate family. Immediate family is defined as the father, mother, sister, brother, spouse, child, grandparent, in-law, or any individual acting as parent or guardian of the beneficiary. Personal care services may be provided by a person of a degree of relationship to the beneficiary other than immediate family, only if the relative is not living in the beneficiary's home, or, if she/he is living in the beneficiary's home solely because her/his presence in the home is necessitated by the amount of care required by the beneficiary.

B. An unrelated staff member of a licensed personal care services provider may not live in the same home as 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, Bureau of Health

Services Financing, LR 21:947 (September 1995), repromulgated for LAC codification, LR 29:178 (February 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 45:

§7317. Provider Responsibilities

A. The licensed PCS agency is responsible for ensuring that all direct service workers providing EPSDT PCS meet all training requirements applicable under state law and regulations. The direct service worker must successfully complete the applicable examination for certification for PCS. Documentation of the direct service worker's completion of all applicable requirements shall be maintained by the EPSDT PCS provider.

B. The agency shall use an electronic visit verification (EVV) system for time and attendance tracking and billing for EPSDT PCS.

1. EPSDT PCS providers identified by BHSF shall use:

a. the (EVV) system designated by the department; or

b. an alternate system that:

i. has successfully passed the data integration process to connect to the designated EVV system; and

ii. is approved by the department.

2. Reimbursement for services may be withheld or denied if an EPSDT PCS provider:

a. fails to use the EVV system; or

b. uses the system not in compliance with Medicaid’s policies and procedures for EVV.

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 21:947 (September 1995), repromulgated for LAC codification, LR 29:178 (February 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 45:

§7319. EPSDT PCS Provider Responsibilities

A. Documentation

1. Documentation for EPSDT PCS provided shall include at a minimum, the following:

a. ...

b. daily notes by PCS provider denoting date of service and services provided (checklist is adequate);

c. – d. ...

e. health condition of beneficiary;

f. – h. ...

2. There shall be a clear audit trail between:

a. the prescribing practitioner;

b. ...

c. the person providing the personal care services to the beneficiary; and

d. ...

B. Agencies providing EPSDT PCS shall conform to all applicable Medicaid regulations as well as all applicable laws and regulations by federal, state, and local governmental entities including, but not limited to:

1. – 6. ...

7. Workman’s Compensation; and

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, Office of the Secretary, Bureau of Health Services Financing, LR 21:947 (September 1995), repromulgated for LAC codification, LR 29:178 (February 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 45:

§7321. Reimbursement

A. Reimbursement for EPSDT PCS shall be the lesser of billed charges or the maximum unit rate set by the department. The maximum rate is a flat rate for each approved unit of

service provided to the beneficiary. This rate shall be adjusted as necessary by the department.

1. One quarter hour (15 minutes) is the standard unit of service, exclusive of travel time to arrive at the beneficiary's home.

2. ...

B. Personal Care Workers Wage Enhancement

1. An hourly wage enhancement payment in the amount of $2 will be reimbursed to providers for full-time equivalent (FTE) personal care workers who provide services to Medicaid beneficiaries.

a. At least 75 percent of the wage enhancement shall be paid to personal care workers as wages. If less than 100 percent of the enhancement is paid in wages, the remainder, up to 25 percent shall be used to pay employer-related taxes, insurance and employee benefits.

b. The minimum hourly rate paid to personal care workers shall be the current minimum wage plus 75 percent of the wage enhancement.

2. – 7.d. 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, Bureau of Health

Services Financing, LR 29:179 (February 2003), amended LR 33:2202 (October 2007), repromulgated LR 33:2425 (November 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2561 (November 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 45:

§7323. Nonreimbursable Services

A. The following services are not appropriate for personal care and are not reimbursable as EPSDT personal care services:

1. – 4. ...

5. administration of medicine (an EPSDT PCS direct service worker may only remind/prompt about self-administered medication to an EPSDT eligible beneficiary who is over the age of 18);

6. cleaning of the home in an area not occupied by the beneficiary;

a. Repealed.

7. laundry, other than that incidental to the care of the beneficiary;

a. Repealed.

EXAMPLE: Laundering of clothing and bedding for the entire household, as opposed to simple laundering of the beneficiary's clothing or bedding.

8. shopping for groceries or household items other than items required specifically for the health and maintenance of the beneficiary, and not for items used by the rest of the household;

9. ...

10. teaching a family member or friend how to care for a beneficiary who requires frequent changes of clothing or linens due to total or partial incontinence for which no bowel or bladder training program for the patient is possible;

11. – 15. ...

16. specialized aide procedures such as:

a. rehabilitation of the beneficiary (exercise or performance of simple procedures as an extension of physical therapy services);

b. measuring/recording the beneficiary's vital signs (temperature, pulse, respirations and/or blood pressure, etc.) or intake/output of fluids;

c. ...

d. special procedures such as:

i. – viii. ...

ix. weight measurement; and

x. ...

17. – 29. ...

B. – D. 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, Bureau of Health Services Financing, LR 21:947 (September 1995), repromulgated for LAC codification, LR 29:179 (February 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 45:

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

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Pharmacy Benefits Management Program
State Supplemental Rebate Agreement Program
(LAC 50:XXIX.Chapter 11)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XXIX.Chapter 11 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 XXIX. Pharmacy

Chapter 11. State Supplemental Rebate Agreement Program

§1101. General Provisions

A. The Centers for Medicare and Medicaid Services approved LDH to enter into state supplemental rebate agreements with pharmaceutical manufacturer(s). LDH may enter into an agreement with a pharmaceutical manufacturer to obtain a rebate(s) in addition to federal rebates pursuant to 42 U.S.C. 1396r. Participation by a pharmaceutical manufacturer in a state supplemental rebate agreement with the department is voluntary.

B. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:966 (May 2017), amended LR 45:

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

Rebekah E. Gee MD, MPH

Secretary