**RULE**

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

**Medicaid Eligibility**
**Twelve-Month Continuous Eligibility**
**(LAC 50:III.2525)**

The Department of Health, Bureau of Health Services Financing has amended LAC 50:III.2525 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 III. Eligibility**
**Subpart 3. Eligibility Groups and Factors**

**Chapter 23. Eligibility Factors**

**§2525. Twelve-Month Continuous Eligibility**

A. – B. ...

C. Twelve months of continuous eligibility is not available to the following children:

1. children excepted from continuous eligibility under 42 CFR §435.926(d);

2. children enrolled in the Medically Needy Program;

3. children enrolled in the LaCHIP Affordable Plan who obtain creditable coverage;

4. children enrolled in the Act 421 Medicaid Children’s Option who discontinue pre-existing health insurance coverage;

5. children whose parent/guardian fails to pay a monthly premium, if applicable; or

6. children whose parent/guardian fails to provide verification of citizenship or immigration status after a reasonable opportunity has been allowed.

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 34:253 (February 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 47:

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

Dr. Courtney N. Phillips

Secretary

**RULE**

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

**School-Based Health Services**
**(LAC 50:XV.Chapter 95)**

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XV.Chapter 95 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. The 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 95. School-Based Health Services**

**Subchapter A. School-Based Medicaid Medical Direct Services**

**§9501. General Provisions**

A. EPSDT school-based medical services are provided pursuant to an individualized service plan (IEP), a section 504 accommodation plan, an individualized health care plan, or are otherwise medically necessary services provided by a licensed medical provider (physician, optometrist, respiratory therapist, registered nurse, licensed practical nurse, dentist, and dental

hygienist) within a local education agency (LEA). The goal of these services is to prevent or mitigate disease, enhance care coordination, and reduce costs by preventing the need for tertiary care. Providing these services in the school increases access to health care for children and youth resulting in a more efficient and effective delivery of care.

B. All participating LEAs are required to maintain an active status with Medicaid. Should an LEA’s Medicaid provider number become inactive or one LEA from a group that shares a tax identification becomes inactive, it may cause the entire cost report to be denied and the cost settlement forfeited.

C. All medical service providers providing school-based medical services are required to maintain an active license that is necessary for the applicable service within the state of Louisiana.

D. School-based medical services shall be covered for all recipients in the school system who are eligible according to Subsection A above.

E. Effective for the fiscal year ended June 30, 2021 cost report year, the individual cost settlement amounts for each program (therapy services, behavioral health services, nursing services, personal care services and other medical direct services) will be combined into one cost settlement for the LEA. Settlement letters will be sent to the LEA with the individual

final cost reports for its records. Medicaid administrative claiming (MAC) cost reports are derived by using the MAC-related time study results and cost related to each of the EPSDT programs. All costs will have been certified by the LEA with the EPSDT cost report, so no additional signatures or certifications are required for MAC. Therefore, MAC cost reports shall remain separate.

F. LEAs that terminate business must notify the Louisiana Medicaid fiscal intermediary, immediately. Instructions will need to be provided to Department of Health/Rate Setting and Audit and/or Department of Education as to the final disposition of cost settlements and previous dollars owed to or from Louisiana Medicaid.

1. For LEAs that transfer to new management companies and owe the department, the new owners shall assume all obligations of repayment for the new LEA. Overpayments will be recouped from future earnings of the new management company.

2. For separating LEAs that are owed reimbursements, the department will cut a supplemental check to the LEA or the new management company. However, failure to provide instructions to the department within 10 days of closure may result in forfeiture of payment.

G. Dollars owed will be assessed to all future cost settlements for the LEA and will be applied to the earliest cost

report year with an overpayment. For example, if an LEA has an overpayment for nursing services and an amount due to them for therapy services, the payment for therapy services will be applied to the LEA’s overpayment for the nursing services. The net balance from this offset will:

1. be used to offset overpayments in other periods (from oldest period moving forward to the current period);

2. create a net overpayment that will be carried forward and offset against future billings and/or payments; and

3. be remitted to the LEA.

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 39:2760 (October 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1298 (August 2016), LR 45:561 (April 2019), LR 47:

**§9503. Covered Services**

A. The following school-based medical services shall be covered.

1. Chronic Medical Condition Management and Care Coordination. This is care based on one of the following criteria.

a. The child has a chronic medical condition or disability requiring implementation of a health plan/protocol (e.g., children with asthma, diabetes, or cerebral palsy). There must be a written health care plan based on a health assessment performed by the medical services provider. The date of the completion of the plan and the name of the person completing the plan must be included in the written plan. Each health care service required and the schedule for its provision must be described in the plan.

b. ...

c. Implementation of Physician’s Orders. These services shall only be provided as a result of receipt of a written plan of care from the child’s physician or included in the student’s IEP, IHP, 504 plan, or are otherwise medically necessary for students with disabilities.

2. – 4.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 and Hospitals, Bureau of Health Services Financing, LR 39:2760 (October 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 45:562 (April 2019), LR 47:

**§9505. Reimbursement Methodology**

A. Payment for EPSDT school-based medical services shall be based on the most recent school year’s actual costs as determined by desk review and/or audit for each LEA provider.

1. ...

2. Direct costs shall be limited to the amount of total compensation (salaries, vendor payments and fringe benefits) of current medical service providers as allocated to medical services for Medicaid recipients. The direct costs related to the electronic health record shall be added to the compensation costs to arrive at the total direct costs for medical services. There are no additional direct costs included in the rate.

3. Indirect costs shall be derived by multiplying the cognizant agency indirect cost unrestricted rate assigned by the Department of Education to each LEA by the allowable costs. There are no additional indirect costs included.

4. To determine the amount of medical services costs that may be attributed to Medicaid; the ratio of total Medicaid students in the LEA to all students in the LEA is multiplied by total direct cost. Cost data are subject to certification by each LEA. This serves as the basis for obtaining federal Medicaid funding.

B. For the medical services, the participating LEA’s actual cost of providing the services shall be claimed for

Medicaid federal financial participation (FFP) based on the following methodology.

1. – 2. ...

3. Adjust the Payroll Cost Base. The payroll cost base shall be reduced for amounts reimbursed by other funding sources (e.g., federal grants). The payroll cost base shall not include any amounts for staff whose compensation is 100 percent reimbursed by a funding source other than state/local funds. This application results in total adjusted salary cost.

4. ...

a. A sufficient amount of medical service personnel’s time shall be sampled to ensure results that will have a confidence level of at least 95 percent with a precision of plus or minus five percent overall.

b. Time study moments are to be completed and submitted by all participating LEA participants. Participants will have 48 hours from the time of the moment to complete each moment. Reminder emails will be sent to the participant and the Medicaid coordinator each morning until the moment expires. Once a time study moment has expired, it will no longer be able to be completed and will be deemed not returned. Any LEA that fails to return at least 85 percent of its moments from the time study for two quarters in a cost report year for any program, will be suspended from that program for the entire cost report year.

c. The time study percentage used for cost reimbursement calculation is an average of the four quarterly statewide time study results for each school based Medicaid program. LEAs must participate in all four time study quarters to be reimbursed all costs for the fiscal year. Any LEA that does not submit a cost report for any program for which any billings were submitted will be required to pay back any billing dollars received for that cost report year. This will be handled in the school based claiming cost settlement process.

5. Determine Indirect Costs. Indirect costs shall be determined by multiplying each LEA's indirect unrestricted rate assigned by the cognizant agency (the Department of Education) by total adjusted direct costs as determined under Paragraph B.3 above. No additional indirect costs shall be recognized outside of the cognizant agency's indirect rate. The sum of direct costs and indirect costs shall be the total direct service cost for all students receiving medical services.

6. Allocate Direct Service Costs to Medicaid. To determine the costs that may be attributed to Medicaid, total cost as determined under Paragraph B.5 above shall be multiplied by the ratio of Medicaid students in the LEA to all students in the LEA. This results in total cost that may be certified as Medicaid's portion of school-based medical services cost.

C. – D.2. ...

3. LEAs must bill for all Medicaid services provided. Medicaid eligibility will automatically terminate if there are no claim submissions within an 18 month period. Ineligible LEAs will have all interim claims denied and cost reports for all the programs in which the LEA participated may be rejected.

4. The department shall adjust the affected LEA's payments no less than annually, when any reconciliation or final settlement results in significant underpayments or overpayments to any LEA. By performing the reconciliation and final settlement process, there shall be no instances where total Medicaid payments for services exceed 100 percent of actual, certified expenditures for providing LEA services for each LEA.

a. – c. Repealed.

5. If the interim payments exceed the actual, certified costs of an LEA's Medicaid services, the department shall recoup the overpayment in one of the following methods:

a. offset all future claim payments from the affected LEA until the amount of the overpayment is recovered;

b. recoup an agreed upon percentage from future claims payments to the LEA to ensure recovery of the overpayment within one year; or

c. recoup an agreed upon dollar amount from future claims payments to the LEA to ensure recovery of the overpayment within one year.

6. If the actual certified costs of an LEA’s Medicaid services exceed interim Medicaid payments, the department will pay this difference to the LEA in accordance with the final actual certification agreement.

7. Cost reports must be submitted annually. The due date for filing annual cost reports is November 30. There shall be no automatic extension of the due date for filing of cost reports. If an LEA experiences unavoidable difficulties in preparing its cost report by the prescribed due date, one 30-day extension may be permitted, upon written request submitted to the department prior to the due date. The request must explain in detail why the extension is necessary. Extensions beyond 30 days may be approved for situations beyond the LEA’s control. Cost reports that have not been received by the due date will be deemed non-compliant and may be subject to a non-refundable reduction of 5 percent of the total cost settlement. This reduction may be increased an additional 5 percent each month until the completed cost report is submitted or the penalties total 100 percent. LEAs that have not filed their cost report by six months or more beyond the due date cannot bill for services until the cost report is filed.

8. Type 1 and 3 charter schools in Orleans Parish will be required to submit acceptable documentation (board minutes, letter from the school board, etc.) that authorizes the charter to act as its own LEA, upon enrollment. Likewise, in order to receive a cost settlement, confirmation that the authorization is still in good standing with the school board will be required to accompany the submission of the cost report. Failure to provide this documentation at the time the cost report is filed may cause the cost report to be rejected and not be considered as timely filed.

9. Vendors will be reimbursed based on a rate per service. This rate shall include all of the vendor’s direct and indirect costs. This service rate should cover the time spent providing the direct service, administrative time and any other time related to tasks related to that service. Vendors will not be subject to the time study process due to them only being at a school to provide the direct services enumerated in the contract. Vendors will not be expected to perform any additional general and administrative (G and A) tasks for the LEA.

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 39:2761

(October 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 45:562 (April 2019), LR 47:

**Subchapter B. School-Based EPSDT Transportation Services**

**§9511. General Provisions**

A. A special transportation trip is only billable to Medicaid on the same day that a Medicaid-eligible child is receiving IDEA services included in the child's individualized service plan (IEP), a section 504 accommodation plan, an individualized health care plan (IHP), or are otherwise medically necessary and the transportation is provided in a vehicle that is part of special transportation in the LEA's annual financial report certified and submitted to the Department of Education. The need for transportation must be documented in the child's IEP, IHP, 504 plan, or are otherwise medically necessary.

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, Bureau of Health Services Financing, LR 45:563 (April 2019), amended LR 47:

**Subchapter C. School-Based Medicaid Personal Care Services**

**§9521. General Provisions**

A. EPSDT school-based personal care services (PCS) are provided by a personal care assistant pursuant to an individualized service plan (IEP), a section 504 accommodation plan, an individualized health care plan, or are otherwise medically necessary within a local education agency (LEA).

B. School-based personal care services shall be covered for all Medicaid recipients in the school system.

C. Personal care services must meet medical necessity criteria.

D. Early and periodic screening, diagnosis, and treatment personal care services must be prescribed by a licensed practitioner within the scope of their practice initially and every 180 days thereafter (or rolling six months) and when changes in the plan of care occur.

E. 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 45:564 (April 2019), amended LR 47:

**§9523. Covered Services**

A. The following school-based personal care services shall be covered:

1. basic personal care, toileting, diapering, and grooming activities;

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

3. assistance with eating and food, nutrition, and diet activities;

4. accompanying, but not transporting, the recipient to and from his/her physician and/or medical facility for necessary medical services; and

EXAMPLES: Repealed.

5. provides assistance with transfers, positioning and repositioning.

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

1. daily notes by PCS provider denoting date of service;

2. services provided;

3. total number of hours worked;

4. time period worked;

5. condition of recipient;

6. service provision difficulties;

7. justification for not providing scheduled services; and

8. any other pertinent information.

C. There must be a clear audit trail between:

1. the prescribing physician;

2. the local education agency;

3. the individual providing the personal care services to the recipient; and

4. the services provided and reimbursed by Medicaid.

C.5 – D.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, Bureau of Health Services Financing, LR 45:565 (April 2019), amended LR 47:

**§9525. Reimbursement Methodology**

A. – A.4. ...

B. For the personal care services, the participating LEAs' actual cost of providing the services shall be claimed for Medicaid federal financial participation (FFP) based on the following methodology:

B.1. – D.5. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 45:565 (April 2019), amended LR 47:

**Subchapter D. School-Based Therapy Services**

**§9531. General Provisions**

A. EPSDT school-based therapy services are provided pursuant to an individualized education plan (IEP), a section 504 accommodation plan, an individualized health care plan, or are otherwise medically necessary within a local education agency (LEA). School-based services include physical therapy, occupational therapy and other services, including services provided by audiologists and services for individuals with speech, hearing and language disorders, performed by, or under the direction of, providers who meet the qualifications set forth in the speech language pathologist licensing requirement.

B. Professionals providing school-based therapy services are required to meet the requirements of licensure for their discipline according to the state of Louisiana.

C. Licensed master social workers practicing under the supervision of a licensed clinical social worker; and certified school psychologists practicing under the supervision of a licensed psychologist that has the authority to practice in the community/outside of schools will be required to show proof of verification when the cost report is monitored.

D. School-based services shall be covered for all recipients who are eligible for EPSDT in accordance with §9501.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, Bureau of Health Services Financing, LR 45:566 (April 2019), amended LR 46:343 (March 2020), LR 47:

**§9533. Covered Services**

A. The following school-based therapy services shall be covered:

1. – 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, Bureau of Health Services Financing, LR 45:566 (April 2019), amended by the Department of Health, Bureau of Health Services Financing, LR 46:343 (March 2020), LR 47:

**§9535. Reimbursement Methodology**

A. – D.4.a ...

b. Time study moments participation will be handled in accordance with §9505.B.4.b.

D.5. – F.2. ...

3. LEA Medicaid ineligibility will be handled in accordance with §9505.D.3.

4. The department shall adjust the affected LEA’s payments no less than annually, when any reconciliation or final settlement results in significant underpayments or overpayments to any LEA. By performing the reconciliation and final settlement process, there shall be no instances where total Medicaid payments for services exceed 100 percent of actual, certified expenditures for providing LEA services for each LEA.

a. – c. Repealed.

5. If the interim payments exceed the actual certified costs of an LEA’s Medicaid services the department shall recoup the overpayment in one of the following methods:

a. offset all future claim payments from the affected LEA until the amount of the overpayment is recovered;

b. recoup an agreed upon percentage from future claims payments to the LEA to ensure recovery of the overpayment within one year; or

c. recoup an agreed upon dollar amount from future claims payments to the LEA to ensure recovery of the overpayment within one year.

6. If the actual certified costs of an LEA’s Medicaid services exceed interim Medicaid payments, the

department will pay this difference to the LEA in accordance with the final actual certification agreement.

7. Cost report compliance will be handled in accordance with Section 9505.D.7.

8. Vendors' reimbursement will be handled in accordance with §9505.D.9.

9. Type 1 and 3 charter schools in Orleans Parish will be handled in accordance with §9505.D.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, Bureau of Health Services Financing, LR 45:567 (April 2019), amended by the Department of Health, Bureau of Health Services Financing, LR 46:343 (March 2020), LR 47:

**Subchapter E. School-Based Applied Behavior Analysis-Based Services**

**§9541. General Provisions**

A. ...

B. ABA services provided by local education agencies (LEAs) to eligible Medicaid recipients must be medically necessary and included on the recipient's individualized service plan (IEP), a section 504 accommodation plan, an individualized health care plan or medical need documentation.

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, Bureau of Health Services Financing, LR 46:185 (February 2020), amended LR 47:

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

Dr. Courtney N. Phillips

Secretary