RULE

Department of Health
Bureau of Health Services Financing

Adult Residential Care Providers
Licensing Standards
(LAC 48:I.6831 and 6832)

The Department of Health, Bureau of Health Services Financing has amended LAC 48:I.6831 and 6832 as authorized by R.S. 36:254 and R.S. 40:2166.1-2166.8. 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 48
PUBLIC HEALTH-MEDICAL ASSISTANCE
Part I. General Administration
Subpart 3. Licensing and Certification

Chapter 68. Adult Residential Care Providers

Subchapter B. Administration and Organization

§6831. Visitation by Members of the Clergy During a Declared Public Health Emergency

A. – H. ...

I. Subject to the requirements of §6831.E-G, each ARCP shall allow members of the clergy to visit residents of the ARCP during a declared PHE when a resident, or his legal or designated representative, requests a visit with a member of the clergy, subject to the following conditions and requirements:

1. – 2. ...

3. An ARCP’s policy and procedure on clergy visitation, at a minimum, requires the following:

a. that the ARCP shall give special consideration and priority for clergy visitation to residents receiving end-of-life care;

b. that a clergy member may be screened for infectious agents or infectious diseases, utilizing at least the current screening or testing methods and protocols recommended by the Centers for Disease Control and Prevention (CDC), as applicable; if there is a current Louisiana SHO order or emergency notice that requires more rigorous screening or testing methods, or protocols, then the ARCP shall utilize those methods and protocols;

c. that a clergy member may not be allowed to visit an ARCP resident if such clergy member has obvious signs or symptoms of an infectious agent, or infectious disease, or if such clergy member tests positive for an infectious agent, or infectious disease;

d. that a clergy member may not be allowed to visit an ARCP resident if the clergy member refuses to comply with the provisions of the ARCP’s policy and procedures or refuses to comply with the ARCP’s reasonable time, place, and manner restrictions;

e. that a clergy member may be required to wear PPE as determined appropriate by the ARCP, considering the resident's medical condition or clinical considerations; at the ARCP's discretion PPE may be made available by the ARCP to clergy members.

f. that an ARCP's policy and procedure include provisions for compliance with a Louisiana SHO order or emergency notice and with any governor's executive order or proclamation limiting visitation during a declared PHE;

g. that the resident shall have the right to consensual, nonsexual physical contact such as hand holding or hugging with a member of the clergy; and

h. that an ARCP's policy and procedure include provisions for compliance with any federal law, regulations, requirements, orders, or guidelines regarding visitation in ARCPs issued by any federal government agency during a declared PHE.

4. An ARCP shall submit a written copy of its visitation policies and procedures on clergy member visitation, to the Health Standards Section of the Department of Health (LDH) at the initial licensure survey.

5. After licensure, the facility shall make its visitation policies and procedures available for review by LDH at any time, upon request.

6. An ARCP shall within 24 hours after establishing its written policies and procedures on clergy member visitation, make its written policies and procedures easily accessible from the homepage of its website, if the ARCP has a website.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 47:1500 (October 2021), amended LR 49:

§6832. Visitation by Immediate Family Members and Other Designated Persons During a Declared Public Health Emergency

A. A licensed ARCP shall comply with any federal law, regulation, requirement, order, or guideline regarding visitation in ARCPs issued by any federal government agency during a declared PHE. The provisions of the licensing rules in §6832.B-E shall be preempted by any federal statute, regulation, requirement, order or guideline from a federal government agency that requires an ARCP to restrict resident visitation in a manner that is more restrictive than the rules.

B. – D. ...

E. Subject to the requirements of §6832.A-C, each ARCP shall allow immediate family members and other designated persons to visit a resident of the ARCP during a declared PHE when a resident, or his legal or designated representative,

requests a visit with immediate family members and other designated persons, subject to the following conditions and requirements:

1. – 2. ...

3. An ARCP's policy and procedure on visitation by immediate family members and other designated persons, at a minimum, requires the following:

a. that the ARCP shall give special consideration and priority for visitation by immediate family members and other designated persons to residents receiving end-of-life care;

b. that visitation by immediate family members of the residents and other designated persons may be screened for infectious agents or infectious diseases, utilizing at least the current screening or testing methods and protocols recommended by the CDC, as applicable; if there is a current Louisiana SHO order or emergency notice that requires more rigorous screening or testing methods and protocols, then the ARCP shall utilize those methods and protocols;

c. that an immediate family member or other designated person may not be allowed to visit an ARCP resident if such immediate family member or other designated person has obvious signs or symptoms of an infectious agent or infectious disease, or if such immediate family member or other designated

person tests positive for an infectious agent or infectious disease;

d. that an immediate family member or other designated person may not be allowed to visit an ARCP resident if the immediate family member or other designated persons refuses to comply with the provisions of the ARCP's policy and procedure or refuses to comply with the ARCP's reasonable time, place, and manner restrictions;

e. that immediate family members and other designated persons may be required to wear PPE as determined appropriate by the ARCP, considering the resident's medical condition or clinical consideration; at the ARCP's discretion, PPE may be made available by the ARCP to immediate family members and other designated persons;

f. that an ARCP's policy and procedure include provisions for compliance with a Louisiana SHO order or emergency notice and with any governor's executive order or proclamation limiting visitation during a declared PHE;

g. that the resident and an immediate family member or other designated person shall have the right to consensual, nonsexual physical contact such as hand holding or hugging; and

h. that an ARCP's policy and procedure include provisions for compliance with any federal law, regulations,

requirements, orders, or guidelines regarding visitation in ARCPs issued by any federal government agency during a declared PHE.

4. An ARCP shall submit a written copy of its visitation policies and procedures on family members and other designated persons' visitation, to the Health Standards Section of LDH at the initial licensure survey.

5. After licensure, the facility shall make its visitation policies and procedures available for review by LDH at any time, upon request.

6. An ARCP shall within 24 hours after establishing its written policies and procedures on family members and other designated persons' visitation, make its written policies and procedures easily accessible from the homepage of its website, if the ARCP has a website.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 47:1500 (October 2021), amended LR 49:

Ralph L. Abraham, M.D.

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Ambulatory Surgical Centers
Reimbursement Methodology
(LAC 50:XI.7503)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XI.7503 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 XI. Clinic Services
Subpart 11. Ambulatory Surgical Centers

Chapter 75. Reimbursement

§7503. Reimbursement Methodology

A. – G. ...

H. Effective for dates of service after March 20, 2024, an ambulatory surgical center (ASC) shall be reimbursed based on the Louisiana Medicaid Louisiana State University (LSU) enhanced fee schedule, published on the Medicaid provider website at www.lamedicaid.com, if the following conditions are met:

1. The ASC is owned and/or operated by LSU School of Dentistry, LSU Health Sciences Center, or LSU Healthcare network;

2. The ASC is licensed within the state of Louisiana; and

3. The ASC is Medicaid enrolled.

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 35:1889 (September 2009), amended LR 36:2278 (October 2010), LR 37:1572 (June 2011), LR 39:317 (February 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 47:1311 (September 2021), 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

Disproportionate Share Hospital Payments
Northern Area Psychiatric Hospitals
(LAC 50:V.2503 and 2721)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:V.2503 and adopted §2721 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 3. Disproportionate Share Hospital Payments

Chapter 25. Disproportionate Share Hospital Payment Methodologies

§2503. Disproportionate Share Hospital Qualifications

A. – A.11. ...

12. be a major medical center located in the southeastern area of the state as defined in §2719.A;

13. be a psychiatric hospital located in the northern area of the state as defined in §2721.A; and

14. effective July 1, 1994, must also have a Medicaid inpatient utilization rate of at least 1 percent.

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 34:655 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3294 (December 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 43:962 (May 2017), LR 45:1763 (December 2019), LR 50:

Chapter 27. Qualifying Hospitals

§2721. Psychiatric Hospitals Located in the Northern Area of the State

A. Effective for dates of service on or after February 20, 2024, hospitals qualifying for payments as psychiatric hospitals located in the northern area of the state shall meet the following criteria:

1. be a private, non-rural freestanding psychiatric hospital located in Department of Health administrative regions 7 or 8; and

2. have a current executed academic affiliation agreement for purposes of providing graduate medical education and training to at least five documented intern and resident full time equivalents (FTEs) annually.

a. the affiliation agreement must be with a medical school located in Louisiana;

b. the intern and resident FTE count must be included on the Medicare Medicaid cost report annually on worksheet S-3, column 9; and

c. the hospital must be listed as a graduate medical education program training site on the Accreditation Council for Graduate Medical Education website.

B. Payment Methodology. Effective for dates of service on or after February 20, 2024, each qualifying hospital shall be paid a DSH adjustment payment which is the pro rata amount calculated by dividing their hospital specific allowable uncompensated care costs by the total allowable uncompensated care costs for all hospitals qualifying under this category and multiplying by the funding appropriated by the Louisiana Legislature in the applicable state fiscal year for this category of hospitals.

1. Costs, patient specific data and documentation that qualifying criteria is met shall be submitted in a format specified by the department.

2. Costs and lengths of stay shall be reviewed by the department for reasonableness before payments are made.

3. Aggregate DSH payments for hospitals that receive payment from this category, and any other DSH category, shall

not exceed the hospital's specific DSH limit. If payments calculated under this methodology would cause a hospital's aggregate DSH payment to exceed the limit, the payment from this category shall be capped at the hospital's specific DSH limit.

4. A pro rata decrease, necessitated by conditions specified in §2501.B.1 above for hospitals described in this Section, will be calculated based on the ratio determined by dividing the hospital's uncompensated costs by the uncompensated costs for all of the qualifying hospitals described in this Section, then multiplying by the amount of disproportionate share payments calculated in excess of the federal DSH allotment.

a. Additional payments shall only be made after finalization of the Centers for Medicare and Medicaid Services' (CMS) mandated DSH audit for the state fiscal year. Payments shall be limited to the aggregate amount recouped from the qualifying hospitals described in this Section, based on these reported audit results. If the hospitals' aggregate amount of underpayments reported per the audit results exceeds the aggregate amount overpaid, the payment redistribution to underpaid hospitals shall be paid on a pro rata basis calculated using each hospital's amount underpaid, divided by the sum of underpayments for all of the hospitals described in this Section.

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
and
Office of Aging and Adult Services

Home and Community-Based Services Waivers
Adult Day Health Care Waiver
(LAC 50:XXI.2101,2103,2301,2703,2901, and 2903)

The Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services has amended LAC 50:XXI.2101, §2102, §2301, §2703 and §2901 and adopted §2903 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. 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 3. Adult Day Health Care Waiver

Chapter 21. General Provisions

§2101. Introduction

A. – D.2.b. ...

3. No individual, unless granted an exception by OAAS, may concurrently serve as a responsible representative for more than two participants in OAAS-operated Medicaid home and community-based service programs including:

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

b. – d. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 11:623 (June 1985), repromulgated LR 13:181 (March 1987),amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 23:1149 (September 1997), repromulgated LR 30:2034 (September 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2161 (October 2008), repromulgated LR 34:2565 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2494 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:2162 (December 2018), LR 50:

§2103. Program Description

A. ...

B. The target population for the ADHC Waiver Program includes individuals who:

1. ...

2. are 22 to 64 years old and with a physical disability; and

3. ...

C. The long-range goal for all adult day health care participants is the delay or prevention of long-term care facility placement. The more immediate goals of the Adult Day Health Care Waiver are to:

1. – 2. ...

3. restore and rehabilitate the individual to the highest possible level of functioning as may be practicable under the circumstances;

4. – 6. ...

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 Human Resources, Office of Family Security, LR 8:145 (March 1982), amended LR 11:623 (June 1985), repromulgated LR 13:181 (March 1987), amended by the Department of Health and Hospitals, Office of the Secretary, LR 14:793 (November 1988), amended by the Bureau of Health Services Financing, LR 23:1149 (September 1997), repromulgated LR 30:2034 (September 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2161 (October 2008), repromulgated LR 34:2566 (December 2008), amended by the Department of Health and

Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2624 (September 2011), LR 39:2495 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

Chapter 23. Services

§2301. Covered Services

A. – A.4.b. ...

c. These services do not include monthly rental charges, mortgage expenses, food, recurring monthly utilities charges, household appliances, and/or items intended for purely diversional/recreational purposes.

A.4.d. – A.5.b.iii. ...

6. ADHC Health Status Monitoring (HSM). This service monitors the status of participants that are unable to attend the ADHC on their scheduled day as outlined in the approved plan of care.

a. The ADHC provider may utilize this service and contact the participant via telephone to check in on the participant and provide follow-up on any need identified during the telephone contact.

7. Home Delivered Meals (HDMs). These services assist in meeting the nutritional needs of a participant in

support of the maintenance of self-sufficiency and enhancing the quality of life.

a. Up to two nutritionally balanced meals per day may be delivered to the home of an eligible participant who is unable to prepare their own meals, and/or has no responsible caregiver in the home on days that the participant is not scheduled to attend the ADHC center.

b. Each meal shall provide a minimum of one-third of the current recommended dietary allowance (RDA) for the participant as adopted by the United States Department of Agriculture. The provision of HDMs does not provide a full nutritional regimen.

8. Activity and Sensor Monitoring (ASM). This is a computerized system that monitors the participant’s in-home movement and activity for health, welfare, and safety purposes.

a. The provider agency is responsible for monitoring electronically-generated information, for responding as needed, and for equipment maintenance.

b. ASM must meet applicable manufacturing, design and installation standards.

c. ASM must be prior authorized and no experimental items shall be authorized.

9. Personal Emergency Response System (PERS). This is an electronic device which enables participants to secure

help in an emergency. PERS is appropriate for participants who are cognitively and/or physically able to operate the system and who are alone for significant periods of time.

a. PERS must meet applicable manufacturing, design, and installation standards.

b. PERS must be prior authorized and no experimental items shall be authorized.

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 Human Resources, Office of Family Security, LR 11:623 (June 1985), amended LR 13:181 (March 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 23:1149 (September 1997), amended LR 25:1100 (June 1999), repromulgated LR 30:2036 (September 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2162 (October 2008), repromulgated LR 34:2566 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2625 (September 2011), LR 39:2495 (September 2013), LR 40:791 (April 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:2163 (December 2018), LR 49:486 (March 2023), LR 50:

Chapter 27. Provider Responsibilities

§2703. Reporting Requirements

A. – B. ...

C. Support coordinators shall provide the participant's approved POC to the providers listed on the POC in a timely manner.

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 of Aging and Adult Services, LR 34:2164 (October 2008), repromulgated LR 34:2568 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2497 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:2165 (December 2018), LR 50:

Chapter 29. Reimbursement

§2901. Reimbursement and Rate Requirements

A. Adult day health care services shall be reimbursed according to LAC 50:XXI.709.

1. – 5. Repealed.

B. The following services shall be reimbursed at the authorized rate or approved amount of the installation, device/equipment, and when the service has been prior approved by the plan of care:

1. home delivered meals (not to exceed the maximum limit set by OAAS);

2. activity and sensor monitoring;

3. transition services (not to exceed the maximum lifetime limit set by OAAS);

4. personal emergency response system; and

5. assistive technology.

C. ADHC health status monitoring services shall be reimbursed as a per diem rate.

1. – 5.b. Repealed.

D. The following services shall be reimbursed at an established monthly rate:

1. support coordination;

a. – d. Repealed.

2. transition intensive support coordination; and

3. monthly monitoring/maintenance for PERS and/or ASM services.

E. Reimbursement shall not be made for ADHC Waiver services provided prior to the department’s approval of the POC and release of prior authorization for the services.

F. 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, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 49:683 (April 2023), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

§2903. Adult Day Health Care (ADHC) Direct Support Worker Wages, Other Benefits, and Workforce Retention Bonus Payments

[Formerly LAC 50:XXI.2901]

A. Establishment of ADHC Direct Support Worker Wage Floor and Other Benefits

1. ADHC providers that were providing ADHC services on or after October 1, 2021 and employing ADHC direct support workers will receive a rate increase. The ADHC reimbursement rates shall be rebased resulting in an average increase of $4.31 per hour (rates differ based on facility specific transportation rate).

2. For direct support workers employed at the ADHC centers on or after October 1, 2021, 70 percent of the ADHC provider rate increases shall be passed directly to the ADHC

direct support workers in the form of a minimum wage floor of $9 per hour and in other wage and non-wage benefits.

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

4. The ADHC provider rate increases, wage floor, and/or wage and non-wage benefits will end March 31, 2025 or when the state’s funding authorized under section 9817 of the American Rescue Plan Act of 2021 (Pub. L. No. 117-002) is exhausted.

5. The Department of Health (LDH) reserves the right to adjust the ADHC direct support worker wage floor and/or wage and non-wage benefits as needed through appropriate rulemaking promulgation consistent with the Administrative Procedure Act.

B. Establishment of Direct Support Worker Workforce Bonus Payments

1. ADHC providers who provided services from April 1, 2021 to October 31, 2022 shall receive bonus payments of $300 per month for each ADHC direct support worker that worked with participants for those months.

2. The ADHC direct support 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 ADHC direct support workers of any working status, whether full-time or part-time.

C. Audit Procedures for ADHC Direct Support Worker Wage Floor, Other Benefits, and Workforce Bonus Payments

1. The wage enhancements, wage and non-wage benefits and bonus payments reimbursed to ADHC providers shall be subject to audit by LDH.

2. ADHC providers shall provide to LDH or its representative all requested documentation to verify that they are in compliance with the ADHC direct support worker wage floor, wage and non-wage benefits and/or bonus payments.

3. This documentation may include, but is not limited to, payroll records, wage and salary sheets, check stubs, copies of unemployment insurance files, etc.

4. ADHC providers shall produce the requested documentation upon request and within the timeframe provided by LDH.

5. Non-compliance or failure to demonstrate that the wage enhancement, wage and non-wage benefits and bonus payments

were paid directly to ADHC direct support workers may result in the following:

a. sanctions; or

b. disenrollment from the Medicaid Program.

D. Sanctions for ADHC Direct Support Worker Wage Floor, Other Benefits and Workforce Bonus Payments

1. The ADHC provider will be subject to sanctions or penalties for failure to comply with this Rule or with requests issued by LDH pursuant to this Rule. The severity of such action will depend on the following factors:

a. failure to pass 70 percent of the ADHC provider rate increases directly to the ADHC direct support workers in the form of a floor minimum of $9 per hour and in other wage and non-wage benefits and/or the $250 monthly bonus payments;

b. the number of employees identified that the ADHC provider has not passed 70 percent of the ADHC provider rate increases directly to the ADHC direct support workers in the form of a floor minimum of $9 per hour and in other wage and non-wage benefits and/or the $250 monthly bonus payments;

c. the persistent failure to not pass 70 percent of the ADHC provider rate increases directly to the ADHC direct support workers in the form of a floor minimum of $9 per

hour and in other wage and non-wage benefits and/or the $250 monthly bonus payments; or

d. failure to provide LDH with any requested documentation or information related to or for the purpose of verifying compliance with this Rule.

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 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

Inpatient Hospital Services
Teaching Hospitals
(LAC 50:V.1301 and §1303)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:V.1301 and §1303 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 13. Teaching Hospitals

Subchapter A. General Provisions

§1301. Major Teaching Hospitals

A. The Louisiana Medical Assistance Program's recognition of a major teaching hospital is limited to facilities having a documented affiliation agreement for the purpose of providing graduate medical education training with a Louisiana medical school accredited by the Liaison Committee on Medical Education (LCME) or by the Commission on Osteopathic College Accreditation (COCA). A major teaching hospital shall meet one of the following criteria:

1. – 2. ...

B. For the purposes of recognition as a major teaching hospital, a facility shall be considered a "major participant" in a graduate medical education program if it meets the following criteria. The facility must participate in residency programs that:

1. require residents to rotate for a required experience; and

2. - 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, LR 39:324 (February 2013), amended LR 40:1697 (September 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 49:70 (January 2023), LR 50:

§1303. Minor Teaching Hospitals

A. The Louisiana Medical Assistance Program's recognition of a minor teaching hospital is limited to facilities having a documented affiliation agreement for the purposes of providing graduate medical education training with a Louisiana medical school accredited by the LCME or by the COCA. A minor teaching hospital shall meet the following criteria:

1. – 2. ...

B. For the purposes of recognition as a minor teaching hospital, a facility is considered to "participate significantly" in a graduate medical education program if it meets the following criteria. The facility must participate in residency programs that:

1. require residents to rotate for a required experience; and

2. – 3.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 39:324 (February 2013), amended LR 40:1698 (September 2014), amended LR 40:1698 (September 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 49:70 (January 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

Intermediate Care Facilities for Persons with Developmental Disabilities
Licensing Standards
(LAC 48:I.8531 and 8591)

The Department of Health, Bureau of Health Services Financing has amended LAC 48:I.8531 and §8591 as authorized by R.S. 36:254 and R.S. 40:2180-2180.5. 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 48

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

Chapter 85. Intermediate Care Facilities for Persons with Developmental Disabilities

Subchapter B. Administration and Organization

§8531. Governing Body

A. – I.10. ...

J. The ICF/DD is not required to admit registered sex offenders; however, if the ICF/DD admits a registered sex offender, as described in R.S. 15:542, or current law, then the ICF/DD shall develop policies and procedures to ensure that residents, their family members including at a minimum, their

primary and secondary contact, and/or their responsible parties, any authorized representative, or guardians are notified upon admission of sex offenders living in the facilities. Such policies and procedures must include provisions for addressing the safety and well-being of other residents, staff, and visitors, subject to 42 C.F.R. §483.420, or current law. The requirement of notification shall continue for as long as the information is considered a public record.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:3190 (December 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 50:

Subchapter F. Provider Responsibilities

§8591. Visitation by Close Family Members of a Resident During a Declared Public Health Emergency

A. – F. ...

G. Subject to compliance with the requirements of §8591.B-D, each ICF/DD shall allow close family members of the residents to visit a resident of the ICF/DD during a declared PHE when a resident, or his legal or designated representative, requests a visit with close family members of the resident, subject to the following conditions and requirements:

1. – 2. ...

3. An ICF/DD's policy and procedure on visitation by close family members shall, at a minimum, require the following:

a. that the ICF/DD shall give special consideration and priority for visitation by close family members and other designated persons to residents receiving end-of-life care;

b. that visitation by close family members and other designated persons may be screened for infectious agents or infectious diseases and will pass such screening prior to each visitation, utilizing at least the current screening or testing methods and protocols recommended by the Centers for Disease Control and Prevention, as applicable; if there is a current Louisiana SHO order or emergency notice that requires more rigorous screening or testing methods and protocols, then the ICF/DD shall utilize those methods and protocols;

c. that a close family member or other designated person may not be allowed to visit an ICF/DD resident if such close family member or other designated person has obvious signs or symptoms of an infectious agent or infectious disease, or if such close family member or other designated person tests positive for an infectious agent or infectious disease;

d. that a close family member or other designated person may not be allowed to visit an ICF/DD resident if the close family member and other designated person refuses to comply with the provisions of the ICF/DD's policy and procedure or refuses to comply with the ICF/DD's reasonable time, place, and manner restrictions;

e. that close family members and other designated persons may be required to wear personal protective equipment as determined appropriate by the ICF/DD, considering the resident's medical condition or clinical considerations;

e.i. – f. ...

g. that an ICF/DD's policy and procedure include provisions for compliance with any federal law, regulations, requirements, orders, or guidelines issued by any federal government agency regarding visitation in ICF/DDs during a declared PHE;

h. that the resident and close family members shall have the right to consensual, nonsexual physical contact such as hand holding or hugging; and

i. that includes provisions for off-site visitation, allowing a close family member to visit an ICF/DD resident away from the facility campus; the policy and procedure shall include requirements for allowing the resident to return to the facility upon certain conditions, such as meeting testing

and isolation requirements recommended by the CDC, the Centers for Medicare and Medicaid Services (CMS), a Louisiana SHO order or emergency notice, or a governor’s executive order or proclamation.

4. An ICF/DD shall submit a written copy of its visitation policies and procedures on close family member visitation, to the Health Standards Section surveyors of the LDH at the initial licensure survey.

5. After licensure, an ICF/DD shall make its visitation policies and procedures available for review by the Department of Health at any time, upon request.

6. An ICF/DD shall within 24 hours after establishing its written policies and procedures on close family member visitation, make its written policies and procedures easily accessible from the home page of its website.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2180-2180.5.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 47:1308 (September 2021), amended LR 50:

Ralph L. Abraham, M.D.

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Intermediate Care Facilities for Persons with Intellectual Disabilities
Leave of Absence Days
(LAC 50:VII.33103)

The Department of Health, Bureau of Health Services Financing has amended LAC 50: VII.33103 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 VII. Long Term Care
Subpart 3. Intermediate Care Facilities for Persons with Intellectual Disabilities

Chapter 331. Vendor Payments

§33103. Payment Limitations

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

1. ...

2. the absence is for one of the following reasons:

a. hospitalization, which does not exceed seven days per hospitalization for treatment of an acute condition; or

b. leave of absence. A temporary stay outside the ICF/ID provided for in the client's written individual habilitation plan. A leave of absence will not exceed 60 days per fiscal year (July 1 through June 30) and will not exceed 45 consecutive days in any single occurrence. Certain leaves of absence will be excluded from the annual 60-day limit as long as the leave does not exceed the 45-consecutive day limit and is included in the written individual habilitation plan. These exceptions are as follows:

i. – iii. ...

vi. trial discharge leave – 14 days per occurrence;

v. – v.i.(a) ...

c. the following leaves of absence will be excluded from both the annual 60-day limit and the 45-consecutive day limit as long as the leave of absence is included in the written individual habilitation plan:

i. ...

NOTE: Elopements and unauthorized absences under the written individual habilitation plan count against allowable leave days. However, Title XIX eligibility is not

affected if the absence does not exceed 30 consecutive days and if the ICF/ID has not discharged the client.

3. – 6. ...

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

A.8. – J. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:682 (April 1999), LR 31:1082 (May 2005), repromulgated LR 31:2257 (September 2005), amended by the Department of Health, Bureau of Health Services Financing, LR 43:325 (February 2017), LR 44:61 (January 2018), amended by the House of Representatives, 2020 Second Extraordinary Session, LR 46:1640 (November 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

RULE

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

Program of All Inclusive Care for the Elderly
Personal Care Attendant Services
(LAC 50:XXIII.Chapters 1-11)

The Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services has amended LAC 50:XXIII.Chapters 1-11 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 XXIII. Program of All Inclusive Care for the Elderly

Chapter 1. General Provisions

§101. Purpose and Scope

A. The Department of Health, Bureau of Health Services Financing implemented the Program of All Inclusive Care for the Elderly (PACE) in accordance with federal regulations at 42 CFR 460 et seq. These regulations set forth:

1. – 5. ...

B. The purpose of the Program of All Inclusive Care for the Elderly is to provide prepaid, capitated, comprehensive health care services designed to meet the following objectives:

1. enhance the quality of life and autonomy for enrolled participants;

2. maximize the dignity of, and respect for, enrolled participants;

3. enable enrolled participants to live in the community as long as medically and socially feasible; and

4. preserve and support the enrolled participant’s family unit.

C. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:244 (February 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

§103. Organization Application and Evaluation

A. A PACE organization shall be licensed as an adult day health care (ADHC) provider.

B. If a PACE organization uses their own staff to provide personal care attendant (PCA) services to PACE participants, the PACE organization shall acquire a home and community–based services (HCBS) license under the PCA module.

C. The Department of Health (LDH) shall grant appropriate waivers of ADHC and HCBS PCA licensing requirements in instances where licensing regulations conflict with federal PACE requirements and when such waivers are determined to have no adverse effect on participants' health, safety, and quality of life.

D. A PACE organization shall not be required to be licensed as a health maintenance organization under the Louisiana regulations for risk-based entities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:245 (February 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

§105. Administrative Requirements

A. A PACE organization must have a fiscally sound operation, as demonstrated by:

1. total assets greater than total unsubordinated liabilities;

2. sufficient cash flow and adequate liquidity to meet obligations as they become due; and

3. a net operating surplus or a financial plan for solvency that is satisfactory to the Centers for Medicaid and Medicare Services (CMS) and the Department of Health.

B. A PACE organization shall operate under the control of an identifiable governing body such as a board of directors, which must include at least one community representative. The following advisory committees shall also be established to advise the board of directors:

1. – 2. ...

3. Restraint Committee; and

4. any other committees as required by CMS and/or LDH.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:245 (February 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

Chapter 3. Services

§301. Medicare and Medicaid Coordination

A. If a Medicare beneficiary or Medicaid participant chooses to enroll in a PACE program:

1. – 2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:245 (February 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

§303. Services Provided

A. The PACE benefit package for all participants, regardless of the source of payment, must include:

1 – 3. ...

4. social services;

5. behavioral health services;

a. - c. Repealed.

6. restorative therapies, including:

a. physical therapy;

b. occupational therapy; and

c. speech-language pathology services;

7. personal care and supportive services;

8. nutrition counseling;

9. recreational therapy;

10. transportation;

11. meals;

a. - y. Repealed.

12. medical specialty services including, but not limited to:

a. anesthesiology;

b. audiology;

c. cardiology;

d. dentistry;

e. dermatology;

f. gastroenterology;

g. gynecology;

h. internal medicine;

i. nephrology;

j. neurosurgery;

k. oncology;

l. ophthalmology;

m. oral surgery;

n. orthopedic surgery;

o. otorhinolaryngology;

p. plastic surgery;

q. pharmacy consulting services;

r. podiatry;

s. psychiatry;

t. pulmonary disease;

u. radiology;

v. rheumatology;

w. general surgery;

x. thoracic and vascular surgery; and

y. urology;

13. laboratory tests, x-rays, and other diagnostic procedures;

14. drugs and biologicals;

a. – d. Repealed.

15. prosthetics, orthotics, durable medical equipment, corrective vision devices, such as:

a. eyeglasses and lenses;

b. hearing aids;

c. dentures;

d. repair and maintenance of these items; and

e. wheelchairs, including custom wheelchairs that are medically necessary;

f. – l. Repealed.

16. acute inpatient care, including:

a. ambulance;

b. emergency room care and treatment room services;

c. semi-private room and board;

d. general medical and nursing services;

e. medical surgical/intensive care/coronary care unit;

f. laboratory tests, x-rays, and other diagnostic procedures;

g. drugs and biological;

h. blood and blood derivatives;

i. surgical care, including the use of anesthesia;

j. use of oxygen;

k. physical, occupational, recreational therapies, and speech-language pathology services;

l. social services; and

m. psychiatric treatment;

17. nursing facility care, including:

a. semi-private room and board;

b. physician and skilled nursing services;

c. custodial care;

d. personal care and assistance;

e. drugs and biologicals;

f. physical, occupational, recreational therapies, and speech-language pathology, if necessary;

g. social services; and

h. medical supplies and appliances;

18. other services determined necessary by the interdisciplinary team to improve and maintain the participant’s overall health status.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:245 (February 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

§305. Excluded Services

A. Services excluded from coverage are:

1. ...

2. private room and private duty nursing services in an inpatient facility (unless medically necessary), and nonmedical items for personal convenience such as telephone charges and radio or television rental (unless specifically authorized by the interdisciplinary team as part of the participant’s plan of care);

3. – 5.b. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:246 (February 2004) amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

§307. Conditions of Service

A. – B. ...

C. These services must be furnished in, at least, the PACE center, the home, and inpatient facilities.

D. – E. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:246 (February 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

Chapter 5. Participant Enrollment

§501. Eligibility

A. In order to be eligible for services from a PACE site an applicant must:

1. ...

2. be determined by the state administering agency to meet nursing facility level of care, as established by the Department of Health;

3. - 4. ...

B. Eligibility to enroll in a PACE program is not restricted to an individual who is either a Medicare beneficiary or Medicaid participant. A potential participant may be, but is not required to be, any or all of the following:

1. – 3. ...

C. The determination whether a potential participant can be cared for in the community at the time of enrollment without jeopardizing his or her safety is based on the PACE organization’s evaluation of the potential participant. The following are issues to consider when making this determination.

1. The potential participant does not have the capability to call for emergency assistance or does not have the capability to determine when emergency assistance is needed.

2. A physician, familiar with the potential participant’s health and social history, has documented a condition for the potential participant that requires 24-hour/7-days per week of skilled care.

3. The potential participant’s residence:

a. has been condemned; or

b. has been determined unsafe by habitation by PACE provider (detailed documentation of specifics required); or

c. poses a threat to PACE program staff due to:

i. physical condition and integrity of dwelling; or

ii. evidence of abuse and/or neglect from other household members; or

iii. criminal activities or behavior; or

iv. illegal drug use; or

v. brandishing of weapons; or

vi. dangerous pets/animals.

4. The potential participant exhibits health concerns that involve dangerous behavior(s) which would pose a threat to him/her, other PACE participants, or PACE program staff.

5. The potential participant whose current medical treatment or regimen requires 24-hour supervision and whose care is more appropriately provided in an institutional setting (hospital or skilled nursing facility).

6. Repealed.

D. If the PACE organization determines that an applicant’s health and safety cannot be ensured with the

services that PACE can provide, the PACE organization shall submit the following within five working days to the Office of Aging and Adult Services (OAAS):

1. justification for the determination that health and safety cannot be ensured; and

2. any and all assessments and medical records use to make the determination;

E. If OAAS agrees with the PACE organization, OAAS will provide documentation to the PACE organization in writing acknowledging the health and safety concern.

1. – 2. Repealed.

F. If the potential participant is denied enrollment because the potential participant's health or safety would be jeopardized by living in a community setting, the PACE organization must meet the following requirements:

1. notify the potential participant in writing of the reason for denial with notification of appeal rights through the state fair hearing process;

2. refer the potential participant to alternative services, as appropriate;

3. maintain supporting documentation of the reason for denial; and

4. notify CMS and OAAS in the form and manner specified by CMS and make the documentation available for review.

G. If OAAS disagrees with the PACE organization, OAAS will provide the PACE organization with specific information as to why OAAS believes that with PACE services in place, a plan of care can be developed that is adequate to ensure the participant's health, social, and welfare needs. In addition, OAAS will provide suggestions for services that would be beneficial to the participant.

H. A PACE organization shall assess the potential participant to ensure that he or she can be cared for appropriately in a community setting and that he or she meets all requirements for PACE eligibility.

I. Reevaluation of Eligibility

1. LDH shall annually reevaluate whether the participant continues to meet level of care for nursing facility services. LDH may permanently waive the annual recertification of level of care requirements for a participant if it determines that there is no reasonable expectation of improvement or significant change in the participant's condition because of the severity of a chronic condition or the degree of impairment of functional capacity.

2. LDH may determine that a PACE participant who no longer meets the state Medicaid nursing facility level of care requirements be deemed to continue to be eligible for the PACE program until the next annual reevaluation, if, in the absence of continued coverage under this program, the participant reasonably would be expected to meet the nursing facility level of care requirement within the next six months.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:247 (February 2004), LR 33:850 (May 2007), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

§503. Enrollment

A. Enrollment Period

1. ...

2. Enrollment continues until the participants' death, regardless of changes in health status, unless either of the following actions occurs:

a. – b. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:247 (February 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

§505. Disenrollment

A. A PACE organization shall submit proposed denial of enrollment determinations of applicants for health and safety reasons and all involuntary disenrollments of participants to LDH for review prior to notifying applicants/participants of such adverse decisions. The Department shall review denials of PACE enrollment eligibility and disenrollments in a timely manner.

B. Involuntary Disenrollment

1. A participant may be involuntarily disenrolled for any of the following reasons:

a. a participant fails to pay, or to make satisfactory arrangements to pay, any premium due to the PACE organization after a 30 calendar day grace period;

b. ...

c. the participant moves out of the PACE program service area or is out of the service area for more than 30 consecutive days, unless the PACE organization and/or LDH agrees to a longer absence due to extenuating circumstances;

d. ...

e. the PACE program agreement with CMS and LDH is not renewed or is terminated;

f. – g. ...

2. The following are considered disruptive or threatening behavior for purposes of involuntary disenrollment:

a. behavior that jeopardizes his or her health or safety, or the health or safety of others;

b. consistent refusal to comply with his or her individual plan of care or the terms of the PACE enrollment agreement by a participant with decision-making capacity, but not if the behavior is related to a mental or physical condition of the participant. Noncompliant behavior includes repeated noncompliance with medical advice and/or repeated failure to keep appointments; or

3. if a PACE organization proposes to disenroll a participant based on the disruptive or threatening behavior of the participant or the participant’s caregiver, the organization shall document the following information in the participant’s medical record:

a. the reasons for the proposal to disenroll the participant; and

b. all efforts made to remedy the situation and the outcome of the use of those efforts.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:247 (February 2004), LR 33:850 (May 2007), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

Chapter 7. Quality Assessment and Performance Improvement

§701. Organization Responsibilities

A. – B. ...

C. A PACE organization must take actions that result in improvements to its performance in all types of care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:248 (February 2004), amended by the

Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

§703. Quality Assessment and Performance Improvement Plan

A. – B. ...

C. At a minimum, the plan must specify how the PACE organization proposes to meet the following requirements:

1. identify areas to improve or maintain the delivery of services and care of the participants;

2. – 3. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:248 (February 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

§705. Minimum Requirements

A. A PACE organization’s quality assessment and performance improvement program shall include, but is not limited to, the use of objective measures to demonstrate improved performance with regard to:

1. – 2. ...

3. outcome measures that are derived from data collected during assessments, including data on the following:

a. physiological wellbeing;

b. – c. ...

d. social/behavioral functioning; and

e. quality of life of participants;

4. effectiveness and safety of staff-provided and contracted services, including:

a. ...

b. promptness of service delivery; and

A.4.c. – D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:248 (February 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

§707. Internal Activities

A. A PACE organization must do the following:

1. – 3. ...

4. set priorities for performance improvement, considering prevalence and severity of identified problems, and

give priority to improvement activities that affect clinical outcomes; and

A.5. – C.2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:248 (February 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

§711. Committees with Community Input

A. A PACE organization must establish one or more committees with community input to:

1. ...

2. address the implementation of, and results from, the quality assessment and performance improvement plan; and

3. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:249 (February 2004), amended by the

Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

Chapter 9. Sanctions

§901. Violations

A. Sanctions may be imposed against a PACE organization if it commits one or more of the following violations:

1. fails to provide medically necessary items and services to a participant that are covered PACE services, and that failure has adversely affected (or has substantial likelihood of adversely affecting) the participant;

2. involuntarily disenrolls a participant in violation of 42 CFR 460.164;

3. discriminates in the enrollment or disenrollment of Medicare beneficiaries or Medicaid participants, or both, who are eligible to enroll in a PACE program on the basis of a participant’s health status or need for health care services;

4. engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment, except as permitted by Section 460.150, by Medicare beneficiaries or Medicaid participants whose medical condition or history indicates a need for substantial future medical services;

5. ...

6. misrepresents, falsifies, or fails to disclose information that is furnished to:

6.a. – 9. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:249 (February 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

§903. Imposition of Sanctions by CMS

A. CMS may impose the following sanctions for violations specified in §901:

1. – 4. ...

B. CMS or the state may determine that the PACE organization is not in substantial compliance with PACE requirements, and may take one or more of the following actions:

1. – 3. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health

Services Financing, LR 30:249 (February 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

Chapter 11. Appeals

§1101. Participant Rights, Grievances, and Appeals

A. – B. ...

C. Medicaid-eligible participants who appeal through Medicaid shall be heard by the Division of Administrative Law (DAL) within the timeframes applicable to processing Medicaid appeals except in cases where federal PACE requirements require a more expeditious decision. The PACE organization shall prepare the Summary of Evidence in preparation for the appeal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and 42 CFR 460 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:249 (February 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 50:

Ralph L. Abraham, JD

Secretary