RULE

Department of Health
Bureau of Health Services Financing

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

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

Title 50

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

Chapter 8. American Rescue Plan Act Funding

§801. Nursing Recruitment and Retention Payments

A. General Provisions

1. Nurses that provide extended home health (EHH) services may be eligible to receive recruitment and retention bonuses through April 2024.

2. A nurse is defined as an individual who possesses and maintains a valid license as a licensed practical nurse (LPN) or registered nurse (RN).

3. All payments shall be administered by the home health agency (HHA) that employs the nurse. If a nurse is employed at multiple agencies, only one HHA may pay the recruitment and retention payment.

4. HHAs shall submit an invoice and supporting documentation for each nurse that meets the requirements outlined in this Chapter on a monthly basis and shall comply with all other requirements established by LDH to receive a payment.

5. HHAs shall disburse the entire payment to the nurse and are prohibited from reducing the payment in any way.

6. HHAs that provide the required documentation, comply with all applicable requirements, and have at least one nurse a month receiving a bonus payment will be eligible to invoice LDH for an administrative fee of $2,500 each month.

B. Recruitment

1. Recruitment is the hiring of a new nurse who commits to providing a minimum of 120 hours of EHH services to beneficiaries under the age of 21 who are in a Medicaid waiver program in each calendar month.

2. A one-time, lump sum payment of $5,000 may be paid to any nurse who is hired by the HHA and commits to providing a minimum of 120 hours of EHH services to beneficiaries in a waiver program and has not received the retention lump sum bonus payment outlined in this Chapter.

3. Each nurse may only receive the lump sum recruitment bonus payment once.

C. Retention

1. Existing nurses who commit to providing a minimum of 120 hours of EHH services to eligible waiver beneficiaries in a calendar month and have not received the recruitment or retention lump sum bonus payment will receive a $5,000 retention bonus.

2. Nurses who receive the recruitment or retention lump sum bonus payment shall be eligible to receive a monthly payment of $200 if they provided at least 120 hours of EHH services to eligible waiver beneficiaries during the previous calendar month.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 49:

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

Home Health Program
Authorizing Authority and Emergency Provisions
(LAC 50:XIII.Chapter 1)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XIII.Chapter 1 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 XIII. Home Health Program
Subpart 1. Home Health Services

Chapter 1. General Provisions

§101. Definitions

[Formerly LAC 50:XIX.101]

A. The following words and terms, when used in this Subpart 1, shall have the following meanings, unless the context clearly indicates otherwise:

Authorized Healthcare Provider—a physician, nurse practitioner, clinical nurse specialist, or physician assistant licensed, certified, registered, or otherwise authorized to order home healthcare services consistent with Louisiana law.

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Home Health Services—patient care services provided in the patient's home or place of residence under the order of an authorized healthcare provider that are necessary for the diagnosis and treatment of the patient's illness or injury, including one or more of the following services:

a. – e. ...

f. medical supplies, equipment and appliances suitable for use in the patient's home or place of residence.

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Physical Therapy Services—rehabilitative services necessary for the treatment of the patient's illness or injury or, restoration and maintenance of function affected by the patient's illness or injury. These services are provided with the expectation, based on the authorized healthcare provider's assessment of the patient's rehabilitative potential, that:

a. – b. ...

Place of Residence—location where normal life activities take place but does not include a hospital, intermediate care facility for individuals with intellectual disabilities, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

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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 30:431 (March 2004), amended by the Department of Health, Bureau of Health Services Financing, LR 44:59 (January 2018), LR 49:

§103. Requirements for Home Health Services

[Formerly LAC 50:XIX.103]

A. Home health services shall be based on an expectation that the care and services are medically reasonable and appropriate for the treatment of an illness or injury, and that the services can be performed adequately by the agency in the recipient's home or place of residence. For initial ordering of home health services, the authorized healthcare provider must document a face-to-face encounter that is related to the primary reason the recipient requires home health services. This face-to-face encounter must occur no more than 90 days before or 30 days after the start of services. For the initial ordering of medical supplies, equipment and appliances, the authorized healthcare provider must document that a face-to-face encounter that is related to the primary reason the recipient requires medical equipment occurred no more than six months prior to the start of services. A written plan of care for services shall be evaluated and signed by the authorized healthcare provider every 60 days. This plan of care shall be maintained in the recipient's medical records by the home health agency.

B. Home health services shall be provided in the recipient’s home or place of residence.

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 30:431 (March 2004), amended by the Department of Health, Bureau of Health Services Financing, LR 44:59 (January 2018), LR 49:

§104. Emergency Provisions

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 48:2293 (September 2022), repealed LR 49:

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

Medicaid Eligibility
Resource Disregards
(LAC 50:III.10705)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:III.10705 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 III. Eligibility
Subpart 5. Financial Eligibility

Chapter 107. Resources

§10705. Resource Disregards

A. – D. ...

E. Disregard from resources unspent funds received as a class member pursuant to a class settlement in the case of *Nancy Anderson, et al. v. Bob Dean Jr., et al.*, 24th Judicial District Court, Parish of Jefferson. No. 820-839.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:1899 (September 2009), amended LR 36:2867 (December 2010), LR 41:949 (May 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 45:1772 (December 2019), LR 46:1393 (October 2020), LR 49:

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

Medical Transportation Program
Non-Emergency Medical Transportation
American Rescue Plan Act
(LAC 50:XXVII.Chapter 5)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XXVII.Chapter 5 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 50

PUBLIC HEALTH-MEDICAL ASSISTANCE
Part XXVII. Medical Transportation Program

Chapter 5. Non-Emergency Medical Transportation

Subchapter A. General Provisions

§505. Requirements for Coverage

A. Payment shall only be authorized for the least costly means of transportation available. The least costly means of transportation shall be determined by the department or its designee and considered the beneficiary’s choice of transportation, the level of service required to safely

transport the beneficiary (e.g., ambulatory, wheelchair, transfer), and the following hierarchy:

1. – 3. ...

4. for-profit providers enrolled in the Medicaid Program.

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, Bureau of Health Services Financing, LR 47:1639 (November 2021), amended LR 49:

Subchapter C. Provider Responsibilities

§517. Provider Enrollment

A. – C. ...

D. All NEMT providers must agree to cover the entire parish or parishes for which he or she provides non-emergency medical transportation services.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 47:1639 (November 2021), amended LR 49:

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

§531. Non-Emergency Medical Transportation Bonus Payments

A. General Provisions

1. Non-emergency medical transportation (NEMT) providers that are fully credentialed in the Medicaid Program may be eligible to receive a bonus payment under the Department of Health's (LDH) American Rescue Plan Act (ARPA) NEMT Program until the program's federal funds are exhausted or through the conclusion of the program in March 2024.

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

3. A NEMT provider is a provider of NEMT services and for the purpose of this bonus payment, includes non-profit and for-profit providers.

4. LDH will administer all payments for the LDH ARPA NEMT Program.

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

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

b. create an account with LAGov to ensure eligibility of payment,

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

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

e. submit a monthly attestation to certify the accuracy of the submitted supporting and credentialing documentation.

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

a. the provider is a no-show;

b. no NEMT vehicle is available;

c. no NEMT driver is available; or

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

B. Payments

1. Transportation providers that meet the requirements for both the LDH ARPA NEMT Program and Medicaid Program will receive a single lump sum payment of $500 per vehicle, for a maximum of three vehicles, totaling a maximum payment of $1,500 per month. Transportation providers must meet all requirements on a monthly basis for payment eligibility.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 49:

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
and
Office of Aging and Adult Services

Personal Care Services
Long Term Care
(LAC 50:XV.12901 and 12903)

The Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services have amended LAC 50:XV.12901 and 12903 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 50

PUBLIC HEALTH-MEDICAL ASSISTANCE
Part XV. Services for Special Populations
Subpart 9. Personal Care Services

Chapter 129. Long Term Care

§12901. General Provisions

A. The purpose of long term-personal care services (LT-PCS) is to assist individuals with functional impairments with their daily living activities. LT-PCS must be provided in accordance with an approved service plan and supporting documentation. In addition, LT-PCS must be coordinated with the

other Medicaid and non-Medicaid services being provided to the participant and will be considered in conjunction with those other services.

B. Each individual requesting or receiving long term-personal care services (LT-PCS) shall undergo a functional eligibility screening utilizing an eligibility screening tool called the level of care eligibility tool (LOCET), or a subsequent eligibility tool designated by the Office of Aging and Adult Services (OAAS).

C. Each LT-PCS applicant/participant shall be assessed using a uniform interRAI home care assessment tool or a subsequent assessment tool designated by OAAS. The assessment is designed to verify that an individual meets eligibility qualifications and to determine resource allocation while identifying an individual’s need for support in performance of activities of daily living (ADLs). The assessment generates a score which measures the individual’s degree of self-performance of the following activities of daily living:

1. bed mobility;
2. toilet transfer;
3. toilet use; and
4. eating.

D. Based on the individual’s ADL Index score, they are assigned and are eligible for a set allocation of weekly service hours associated with that score.

1. If the individual is allocated less than 32 hours per week and believes that they are entitled to more hours, the individual or their responsible representative may request a fair hearing to appeal the decision.

2. The individual may qualify for more hours if it can be demonstrated that:

a. one or more answers to the questions involving the ADLs used in the ADL Index score are incorrect as recorded on the assessment; or

b. they need additional hours to avoid entering into a nursing facility.

E. Requests for LT-PCS shall be accepted from the following individuals:

1. a Medicaid participant who wants to receive LT-PCS;

2. an individual who is legally responsible for a participant who may be in need of LT-PCS; or

3. a responsible representative designated by the participant to act on his/her behalf in requesting LT-PCS.

F. Each individual who requests LT-PCS has the option to designate a responsible representative. For purposes of these

provisions, a responsible representative shall be defined as the person designated by the individual to act on his/her behalf in the process of accessing and/or maintaining LT-PCS.

1. The appropriate form authorized by OAAS shall be used to designate a responsible representative.

a. The written designation of a responsible representative does not give legal authority for that individual to independently handle the participant’s business without his/her involvement.

b. The written designation is valid until revoked by the participant. To revoke the written designation, the revocation must be submitted in writing to OAAS or its designee.

2. The functions of a responsible representative are to:

a. assist or represent, as needed, the participant in the assessment, care plan development and service delivery processes; and

b. to aid the participant in obtaining all necessary documentation for these processes.

3. No individual may concurrently serve as a responsible representative for more than two participants in OAAS-operated Medicaid home and community-based services. This includes but is not limited to:

a. ...

b. long term-personal care services;

c. – d. ...

G. The Department of Health may remove an LT-PCS provider from the LT-PCS provider freedom of choice list and offer freedom of choice to LT-PCS participants when:

1. one or more of the following departmental proceedings are pending against an LT-PCS participant’s service provider:

1.a. – 3. ...

H. The department may offer participants the freedom to choose another provider if/when the owner(s), operator(s), or member(s) of the governing body of the provider agency is/are under investigation related to:

1. – 8. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:911 (June 2003), amended LR 30:2831 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 32:2082 (November 2006), LR 34:2577 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services

Financing and the Office of Aging and Adult Services, LR 35:2450 (November 2009), LR 39:2506 (September 2013), LR 41:540 (March 2015), LR 42:902 (June 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services and the Office for Citizens with Developmental Disabilities, LR 43:1980 (October 2017), LR 49:

§12903. Covered Services

A. *LT-PCS* are defined as those services that provide assistance with the distinct tasks associated with the performance of the activities of daily living (ADLs) and the instrumental activities of daily living (IADLs). Assistance may be either the actual performance of the personal care task for the individual or supervision and prompting so the individual performs the task by themselves.

1. ADLs are those personal, functional activities required by the participant. ADLs include tasks such as:

a. eating;

b. bathing;

c. dressing;

d. grooming/personal hygiene;

e. transferring;

f. ambulation;

g. toileting; and

h. bed mobility.

2. IADLs are those activities that are considered essential but may not require performance on a daily basis. IADLs include tasks such as:

a. light housekeeping;

b. food preparation and storage;

c. shopping;

d. laundry;

e. assistance with scheduling medical appointments when necessary;

f. accompanying to medical appointments when necessary;

g. assistance with accessing transportation;

h. medication reminders; and

i. medically non-complex tasks where the direct service worker has received the proper training pursuant to R.S. 37:1031-1034.

3. Emergency and non-emergency medical transportation is a covered Medicaid service and is available to all participants. Non-medical transportation is not a required component of LT-PCS. However, providers may choose to furnish transportation for participants during the course of providing LT-PCS. If transportation is furnished, the provider agency must accept any liability for their employee transporting a participant. It is the responsibility of the provider agency to

ensure that the employee has a current, valid driver's license and automobile liability insurance.

4. Constant or intermittent supervision and/or sitter services are not a component of LT-PCS.

5. For participants receiving LT-PCS with the Adult Day Health Care (ADHC) Waiver, LT-PCS may be provided by one worker for up to three LT-PCS participants who live together, and who have a common direct service provider.

A.6. – 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 and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:912 (June 2003), amended LR 30:2831 (December 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2578 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2507 (September 2013), LR 42:902 (June 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 42:1931 (November 2016), LR 47:593 (May 2021), LR 49:

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