RULE

Department of Health
Bureau of Health Services Financing
and
Office of Behavioral Health

Behavioral Health Services
Healthy Louisiana and Coordinated System of Care Waiver
(LAC 50:XXXIII.101,103,301,501, and 701)

The Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health have amended LAC 50:XXXIII.101, §103, §301, §501, and §701 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 XXXIII. Behavioral Health Services
Subpart 1. Healthy Louisiana and Coordinated System of Care Waiver

Chapter 1. Managed Care Organizations and the Coordinated System of Care Contractor

§101. General Provisions

A. – B. ...

C. Managed care organizations shall operate as such, and the CSoC contractor shall operate as a prepaid inpatient health plan (PIHP). The MCOs and the CSoC contractor were procured

through a competitive request for proposal (RFP) process. The MCOs and CSoC contractor shall assist with the state's system reform goals to support individuals with behavioral health and physical health needs in families' homes, communities, schools and jobs.

D. – D.4. ...

E. The CSoC contractor shall be paid on a risk basis for specialized behavioral health services rendered to children/youth enrolled in the Coordinated System of Care Waiver. The MCOs shall be paid on a risk basis for specialized behavioral health and physical health services rendered to adults and children/youth.

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 38:360 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2353 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 43:321 (February 2017), LR 44:

§103. Recipient Participation

A. The following Medicaid recipients shall be mandatory participants for integrated specialized behavioral health and physical health services:

1. – 12. ...

***

B. Mandatory participants shall be automatically enrolled and disenrolled from the MCOs.

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 and Hospitals, Bureau of Health Services Financing, LR 38:361 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:1286 (July 2015), LR 41:2354 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 43:321 (February 2017), LR 44:

Chapter 3. Managed Care Organizations and the Coordinated System of Care Contractor Participation

§301. Participation Requirements and Responsibilities

A. ...

B. MCOs and the CSoC contractor shall:

1. – 4. ...

5. contract only with providers of services who are licensed and/or certified according to state laws, regulations, rules, the provider manual and other notices or directives issued

by the department, meet the state of Louisiana credentialing criteria and enrolled with the Bureau of Health Services Financing, or its designated contractor, after this requirement is implemented;

6. ensure that contracted rehabilitation providers are employed by a rehabilitation agency or clinic licensed and authorized under state law to provide these services;

7. – 10.c. ...

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 38:362 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2355 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 43:322 (February 2017), LR 44:

Chapter 5. Reimbursement

§501. General Provisions

A. For recipients enrolled in one of the MCOs or with the CSoC contractor, the department or its fiscal intermediary shall make monthly capitation payments to the MCOs or CSoC contractor.

1. The capitation rates paid to the MCOs or CSoC contractor shall be actuarially sound rates.

2. The MCOs or CSoC contractor will determine the rates paid to its contracted providers.

a. No payment shall be less than the minimum Medicaid rate.

B. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:363 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 39:317 (February 2013), LR 41:2356 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:

Chapter 7. Grievance and Appeals Process

§701. General Provisions

A. ...

B. An enrollee, an enrollee’s authorized representative or a provider on behalf of an enrollee, with the enrollee’s prior written consent, has 60 calendar days from the date on the notice of action in which to file an appeal.

C. An enrollee, an enrollee’s authorized representative or a provider on behalf of an enrollee, with the enrollee’s prior

written consent, may file a grievance at any time after an occurrence or incident which is the basis for the grievance.

D. – E. ...

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 38:363 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2356 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 43:322 (February 2017), LR 44:

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

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing
and
Office of Behavioral Health

Behavioral Health Services
Substance Use Disorders Services
(LAC 50:XXXIII.14101,14301,14303,14501, and 14701)

The Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health have amended LAC 50:XXXIII.14101, §14301, §14303, §14501, and §14701 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 XXXIII. Behavioral Health Services
Subpart 15. Substance Use Disorders Services

Chapter 141. General Provisions

§14101. Introduction

A. The Medicaid Program hereby adopts provisions to provide coverage under the Medicaid State Plan for substance use disorders (SUD) services rendered to children and adults. These services shall be administered under the authority of the Department of Health (LDH), in collaboration with managed care organizations (MCOs) and the coordinated system of care (CSoC)

contractor, which shall be responsible for the necessary operational and administrative functions to ensure adequate service coordination and delivery. The CSoC contractor shall only manage specialized behavioral health services for children and youth enrolled in the CSoC program.

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 and Hospitals, Bureau of Health Services Financing, LR 38:426 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2357 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:

Chapter 143. Services

§14301. General Provisions

A. ...

B. American Society of Addiction Medicine (ASAM) levels of care require reviews on an ongoing basis, as deemed necessary by the department to document compliance with national standards.

C. Services provided to children and youth must include communication and coordination with the family and/or legal guardian and custodial agency for children in state custody.

Coordination with other child-serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the child's medical record.

1. The agency or individual who has the decision making authority for a child or adolescent in state custody must approve the provision of services to the recipient.

D. Children who are in need of SUD services shall be served within the context of the family and not as an isolated unit.

1. Services shall be:

a. delivered in a culturally and linguistically competent manner; and

b. respectful of the individual receiving services.

2. Services shall be appropriate to individuals of diverse racial, ethnic, religious, sexual, and gender identities, and other cultural and linguistic groups.

3. Services shall also be appropriate for:

a. age;

b. development; and

c. education.

E. Evidence-based practices require prior approval and fidelity reviews on an ongoing basis as determined necessary by the department.

E.1. – F. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:426 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2357 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:

§14303. Covered Services

A. – A.3. ...

B. Service Exclusions. The following services/components shall be excluded from Medicaid reimbursement:

1. – 3. ...

4. services rendered in an institute for mental disease unless provided through Code of Federal Regulations "allowed in lieu of", or a U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) approved waiver; and

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 and Hospitals, Bureau of Health Services Financing, LR 38:426 (February 2012), amended by the Department of Health and

Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2357 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:

Chapter 145. Provider Participation

§14501. Provider Responsibilities

A. – C. ...

D. Anyone providing SUD services must be licensed in accordance with state laws and regulations, in addition to operating within their scope of practice license. Providers shall meet the provisions of this Rule, the provider manual and the appropriate statutes.

E. Residential addiction treatment facilities shall be accredited by an approved accrediting body and maintain such accreditation. Denial, loss of or any negative change in accreditation status must be reported to the MCO in writing within the time limit established by the department.

F. – F.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 Hospitals, Bureau of Health Services Financing, LR 38:427 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2357 (November 2015), amended by the

Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:

Chapter 147. Reimbursement

§14701. General Provisions

A. For recipients enrolled with the CSoC contractor, the department or its fiscal intermediary shall make monthly capitation payments to the CSoC contractor, exclusive of coverage for residential substance use treatment services.

1. The capitation rates paid to the CSoC contractor shall be actuarially sound rates.

2. The CSoC contractor will determine the rates paid to its contracted providers.

a. No payments shall be less than the minimum Medicaid rate.

B. For recipients enrolled in one of the MCOs, the department or its fiscal intermediary shall make monthly capitation payments to the MCOs inclusive of coverage for the provision of residential substance use services for recipients enrolled in CSoC.

1. The capitation rates paid to the MCOs shall be actuarially sound rates.

2. The MCOs will determine the rates paid to its contracted providers.

a. No payment shall be less than the minimum Medicaid rate.

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 38:427 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 39:3301 (December 2013), LR 41:2358 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:

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

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing
and
Office of Behavioral Health

Children's Behavioral Health Services
(LAC 50:XXXIII.Chapters 21-27)

The Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health have amended LAC 50:XXXIII.Chapters 21-27 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 XXXIII. Behavioral Health Services
Subpart 3. Children's Mental Health Services

Chapter 21. General Provisions

§2101. Introduction

A. The Medicaid Program hereby adopts provisions to provide coverage under the Medicaid State Plan for mental health services rendered to children and youth with behavioral health disorders. These services shall be administered under the authority of the Department of Health (LDH), in collaboration with managed care organizations (MCOs) and the coordinated

system of care (CSoC) contractor, which shall be responsible for the necessary operational and administrative functions to ensure adequate service coordination and delivery. The CSoC contractor shall only manage specialized behavioral health services for children and youth enrolled in the coordinated system of care.

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 and Hospitals, Bureau of Health Services Financing, LR 38:364 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2358 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:

Chapter 23. Services

§2301. General Provisions

A. ...

B. Services provided to children and youth must include communication and coordination with the family and/or legal guardian and custodial agency for children in state custody. Coordination with other child-serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the child’s medical record.

1. The agency or individual who has the decision making authority for a child or youth in state custody must request and approve the provision of services to the recipient.

C. Children who are in need of specialized behavioral health services shall be served within the context of the family and not as an isolated unit.

1. Services shall be:

a. delivered in a culturally and linguistically competent manner; and

b. respectful of the individual receiving services.

2. Services shall be appropriate to children and youth of diverse racial, ethnic, religious, sexual, and gender identities and other cultural and linguistic groups.

3. Services shall also be appropriate for:

a. age;

b. development; and

c. education.

D. Evidence-based practices require prior approval and fidelity reviews on an ongoing basis as determined necessary by the department.

1. - 3.c. Repealed.

E. Services may be provided at a site-based facility, in the community or in the individual's place of residence as outlined in the plan of care.

F. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:364 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2358 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:

§2303. Covered Services

A. The following behavioral health services shall be reimbursed under the Medicaid Program:

1. ...

2. rehabilitation services, including community psychiatric support and treatment (CPST) and psychosocial rehabilitation (PSR);

3. - 4. ...

B. Service Exclusions. The following services shall be excluded from Medicaid reimbursement:

1. - 3. ...

4. services rendered in an institute for mental disease other than a psychiatric residential treatment facility (PRTF) or an inpatient psychiatric hospital; and

5. ...

C. - C.4. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:364 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2359 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:

Chapter 25. Provider Participation

§2501. Provider Responsibilities

A. - B. ...

C. Anyone providing specialized behavioral health services shall be licensed in accordance with state laws and regulations, in addition to operating within their scope of practice license. Providers shall meet the provisions of this Rule, the provider manual and the appropriate statutes. The provider shall create and maintain documents to substantiate that all requirements are met.

D. Providers shall maintain case records that include, at a minimum:

1. a copy of the plan of care or treatment plan;

2. the name of the individual;

3. the dates of service;

4. the nature, content and units of services provided;

5. the progress made toward functional improvement; and

6. the goals of the plan of care or treatment plan.

E. - E.6. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:364 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2359 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:

Chapter 27. Reimbursement

§2701. General Provisions

A. For recipients enrolled with one of the MCOs or CSoC contractor, the department or its fiscal intermediary shall make monthly capitation payments to the MCOs or the CSoC contractor.

1. The capitation rates paid to MCOs or the CSoC contractor shall be actuarially sound rates.

2. The MCOs or the CSoC contractor will determine the rates paid to its contracted providers.

a. No payment shall be less than the minimum Medicaid rate.

B. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:365 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 39:317 (February 2013), LR 41:2359 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services

(CMS), if it is determined that submission to CMS for review and approval is required.

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Disproportionate Share Hospital Payments
Major Medical Centers
Specialized Burn Care Units
(LAC 50:V.2717)

The Department of Health, Bureau of Health Services Financing has adopted LAC 50:V.2717 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 27. Qualifying Hospitals

§2717. Major Medical Centers with Specialized Burn Care Units Located in the Southwestern Area of the State

A. Effective for dates of service on or after June 30, 2018, hospitals qualifying for payments as major medical centers located in the southwestern area of the state shall meet the following criteria:

1. be a private, non-rural hospital located in Department of Health administrative region 4;

2. have at least 175 inpatient beds as reported on the Medicare/Medicaid cost report, Worksheet S-3, column 2, lines 1-18, for the state fiscal year ending June 30, 2017. For qualification purposes, inpatient beds shall exclude nursery and Medicare-designated distinct part psychiatric unit beds;

3. have a burn intensive care unit that is reported on the Medicare/Medicaid cost report, Worksheet S-3, line 10, columns 1-8, for the state fiscal year ending June 30, 2017;

4. does not qualify as a Louisiana low-income academic hospital under the provisions of §3101; and

5. does not qualify as a party to a low income and needy care collaboration agreement with the Department of Health under the provisions of §2713.

B. Payment Methodology. Effective for dates of service on or after June 30, 2018, 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.

b. Payments shall be limited to the aggregate amount recouped from the qualifying hospitals described in this Section, based on the reported DSH audit results.

c. 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 44:

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Federally-Qualified Health Centers
Reimbursement Methodology
Long-Acting Reversible Contraceptives
(LAC 50:XI.10703)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XI.10703 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 XI. Clinic Services
Subpart 13. Federally-Qualified Health Centers

Chapter 107. Reimbursement Methodology

§10703. Alternate Payment Methodology

A. – C. ...

D. Effective for dates of service on or after January 1, 2019, FQHCs shall be reimbursed a separate payment outside of the prospective payment system (PPS) rate for the following services:

1. Long-Acting Reversible Contraceptives (LARCs)

a. Reimbursement for LARCs shall be at the lesser of, the rate on file or the actual acquisition cost for entities participating in the 340B program. Federally qualified health centers eligible for 340B pricing must bill Medicaid at their 340B actual acquisition cost for reimbursement.

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 34:1033 (June 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

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

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Healthcare Services Provider Fees
Emergency Ground Ambulance and Hospital Provider Fees
(LAC 48:I.4001)

The Department of Health, Bureau of Health Services Financing has amended LAC 48:I.4001 as authorized by R.S. 36:254 and R.S. 46:2625. 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 1. General

Chapter 40. Provider Fees

§4001. Specific Fees

A. – D. ...

E. Emergency Ground Ambulance Services. Effective August 1, 2016, a fee shall be imposed on emergency ground ambulance service providers in accordance with R.S. 46:2626.

1. – 3. ...

a. the maximum fee allowable in any year shall not exceed the percentage of net patient service revenues permitted by federal regulation pursuant to 42 CFR 433.68 as determined by the department, as reported by the provider and

subject to audit for the previous fiscal year of the provider. The department will arrive at net patient services revenue by using net operating revenue as defined in R.S. 46:2626.

E.4. ...

F. Hospital Services

1. – 4. ...

5. No licensed facility, which is prohibited from participating in the Medicare Program set forth in 42 U.S.C. 1396, shall be assessed or levied any fee for the hospital stabilization authorized in Article VII, Section 10.13 of the Constitution of Louisiana. This provision is specifically subject to the approval of any waiver required by the Centers for Medicare and Medicaid Services and approval by the Department of Health.

AUTHORITY NOTE: Promulgated in accordance with Chapter 45 of Title 46 as enacted in 1992, 46:2601-2605, redesignated as Chapter 47 of Title 46, containing R.S. 46:2621 to 46:2625 and P.L. 102-234.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Management and Finance, LR 19:347 (March 1993), amended LR 20:51 (January 1994), LR 26:1478 (July 2000), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 33:100

(January 2007), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1887, 1888 (November 2016), LR 43:73 (January 2017), repromulgated LR 43:323 (February 2017), amended LR 44:1015 (June 2018), LR 44:

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing
and
Office of Behavioral Health

Home and Community-Based Behavioral Health Services Waiver
(LAC 50:XXXIII.8103, 8501 and 8701)

The Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health have amended LAC 50:XXXIII.8103, §8501 and §8701 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 XXXIII. Behavioral Health Services
Subpart 9. Home and Community-Based Services Waiver

Chapter 81. General Provisions

§8103. Recipient Qualifications

A. The target population for the Home and Community-Based Behavioral Health Services Waiver program shall be Medicaid recipients who:

1. are from the age of 5 years old through the age of 20 years old effective March 1, 2017:

a. ...

b. prospectively enrolled recipients must be at least age 5 through age 20 to receive waiver services;

A.2. - 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 and Hospitals, Bureau of Health Services Financing, LR 38:366 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2361 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 43:324 (February 2017), LR 44:

Chapter 85. Provider Participation

§8501. Provider Responsibilities

A. – C. ...

D. Anyone providing behavioral health services must be licensed in accordance with state laws and regulations, in addition to operating within their scope of practice license. Providers requiring certification in accordance with federal or state laws, regulations, rules, the provider manual, or other notices or directives issued by the department must be appropriately certified. To be certified or recertified, providers shall meet the provisions of this Rule, the provider

manual and the appropriate statutes. The provider shall create and maintain documents to substantiate that all requirements are met.

E. – E.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 Hospitals, Bureau of Health Services Financing, LR 38:368 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2362 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:

Chapter 87. Reimbursement

§8701. Reimbursement Methodology

A. The department or its fiscal intermediary shall make monthly capitation payments to the CSoC contractor.

1. The capitation rates paid to the CSoC contractor shall be actuarially sound rates.

2. The CSoC contractor will make payments to its contracted providers.

a. No payment shall be less than the minimum Medicaid rate.

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 38:368 (February 2012), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:

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

Rebekah E. Gee MD, MPH

Secretary

RULE

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

Home and Community-Based Services Waivers
Community Choices Waiver
(LAC 50:XXI.Chapters 81-87 and 93)

The Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services have amended LAC 50:XXI.Chapters 81-87 and 93 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 50

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

Chapter 81. General Provisions

§8101. Introduction

A. The target population for the Community Choices Waiver includes individuals who:

1. are 65 years of age or older; or

2. are 21-64 years of age with a physical disability; and

3. meet nursing facility level of care requirements.

4. Repealed.

B. – D.2. ...

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. This includes but is not limited to:

a. – 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, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3517 (December 2011), amended 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:

§8103. Request for Services Registry

A. The Department of Health (LDH) is responsible for the request for services registry, hereafter referred to as “the registry,” for the Community Choices Waiver. An individual who wishes to have his or her name placed on the registry must contact a toll-free telephone number which shall be maintained by the department.

B. Individuals who desire their name to be placed on the Community Choices Waiver registry shall be screened to determine whether they meet:

1. nursing facility level or care; and

2. are members of the target population as identified in the federally-approved waiver document.

C. Only individuals who pass the screen required in §8103.B.1-2 shall be added to the registry.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3517 (December 2011), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§8105. Programmatic Allocation of Waiver Opportunities

A. ...

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

1. individuals with substantiated cases of abuse or neglect referred by protective services who, without Community

Choices Waiver services, would require institutional placement to prevent further abuse or neglect;

2. – 3. ...

4. individuals admitted to or residing in a nursing facility who have Medicaid as the sole payer source for the nursing facility stay;

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

a. Adult Day Health Care (ADHC) Waiver;

b. New Opportunities Waiver (NOW);

c. Supports Waiver, and/or

d. Residential Options Waiver (ROW); and

B.6. – C. ...

D. Notwithstanding the priority group provisions, 75 Community Choices Waiver opportunities are reserved for qualifying individuals who have been diagnosed with Amyotrophic Lateral Sclerosis (ALS). Qualifying individuals who have been diagnosed with ALS shall be offered an opportunity on a first-come, first-serve basis.

E. Notwithstanding the priority group provisions, up to 300 Community Choices Waiver opportunities may be granted to qualified individuals who require emergency waiver services.

These individuals shall be offered an opportunity on a first-come, first-serve basis.

1. To be considered for an expedited waiver opportunity, the individual must, at the time of the request for the expedited opportunity, be approved for the maximum amount of services allowable under the long–term personal care services and require institutional placement, unless offered an expedited waiver opportunity.

2. – 2.e. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3517 (December 2011), amended LR 39:319 (February 2013), LR 39:1778 (July 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§8107. Resource Assessment Process

A. Each Community Choices Waiver applicant/participant shall be assessed using the uniform International Resident Assessment Instrument (interRAI) designed to verify that an individual meets nursing facility level of care and to assess multiple key domains of function, health, social support and service use. The interRAI assessment generates a score that

assigns the individual to a resource utilization group (RUG-III/HC).

B. The following seven primary RUG-III/HC categories and subcategories will be utilized to determine the assistance needed for various activities of daily living (ADLs) and instrumental activities of daily living (IADLs).

1. Special Rehabilitation. Individuals in this category have had at least 120 minutes of rehabilitation therapy (physical, occupational and/or speech) within the seven days prior to their interRAI assessment.

2. – 2.c. ...

3. Special Care. Individuals in this category have a medium to high level of need for assistance with ADLs and have one or more of the following conditions or require one or more of the following treatments:

a. – f. ...

g. intravenous (IV) medications; or

B.3.h. – C.1. ...

2. The applicant/participant may qualify for an increase in the annual services budget amount upon showing that:

a. one or more answers are incorrect as recorded on the assessment (except for the answers in the identification information, personal intake and initial history, assessment date and reason, and/or signature sections); or

b. ...

D. Each Community Choices Waiver participant shall be re-assessed at least annually.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3518 (December 2011), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

Chapter 83. Covered Services

§8301. Support Coordination

A. Support coordination services assist participants in gaining access to needed waiver and other state plan services, as well as needed medical, social, educational, housing, and other services, regardless of the funding source for these services. Support coordination agencies shall be required to perform the following core elements of support coordination services:

1. intake;

2. assessment and re-assessment;

3. plan of care development and revision;

4. follow-up/monitoring;

5. critical incident management; and

6. transition/discharge and closure.

7. – 12. Repealed.

B. ...

1. When participants choose to self-direct their waiver services, the support coordinators are responsible for informing participants about:

a. ...

b. how their activities as an employer are coordinated with the fiscal agent; and

1.c. - 2. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3519 (December 2011), amended LR 39:319 (February 2013), LR 39:1778 (July 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§8302. Long-Term Personal Care Services

A. Community Choices Waiver participants cannot also receive long-term personal care services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:320 (February 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§8303. Transition Intensive Support Coordination

A. Transition intensive support coordination services assist participants who are currently residing in nursing facilities in gaining access to needed waiver and other state plan services, as well as needed medical, social, housing, educational and other services, regardless of the funding source for these services. Support coordinators shall initiate and oversee the process for assessment and reassessment, as well as be responsible for ongoing monitoring of the provision of services included in the participant’s approved POC.

1. – 2. ...

B. Support coordinators may assist persons to transition for up to six months while the individual still resides in the facility.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3519 (December 2011),

amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§8305. Environmental Accessibility Adaptations

A. Environmental accessibility adaptations are necessary physical adaptations that will be made to the home to reasonably assure the health and welfare of the participant, or enable the participant to function with greater independence in the home.

1. There must be an identified need for environmental accessibility adaptations as indicated by:

a. the interRAI assessment; or

b. supporting documentation of the need.

2. A credentialed environmental accessibility adaptation assessor must complete a written report that includes:

a. verification of the need for the adaptation(s);

b. draft job specifications; and

c. cost estimates for completion of the environmental accessibility adaptation(s).

3. The work must be completed by an enrolled, licensed contractor.

4. Environmental accessibility adaptation(s) shall meet all job specifications as outlined in the written report

before payment is made to the contractor that performed the environmental accessibility adaptation(s).

a. If final inspection, either by OAAS staff or the assessor, reveals that the adaptation(s) is substandard, the costs of correcting the work will be the responsibility of the party in error.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3519 (December 2011), amended LR 39:320 (February 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§8307. Personal Assistance Services

A. Personal assistance services (PAS) provide assistance and/or supervision necessary for the participant with functional impairments to remain safely in the community. PAS include the following services and supports based on the approved POC:

1. supervision or assistance in performing activities of daily living (ADL);

2. supervision or assistance in performing instrumental activities of daily living (IADL);

A.3. – B. ...

C. The provision of PAS services outside of the participant’s home does not include trips outside of the borders of the state without prior written approval by OAAS or its designee.

D. PAS may be provided through the “a.m.” and “p.m.” delivery option defined as follows:

1. – 2. ...

3. a minimum four hours break between the “a.m.” and the “p.m.” portions of this PAS delivery method;

4. – 6. ...

7. "a.m." and/or "p.m." PAS may not be provided on the same calendar day as other PAS delivery methods;

D.8. – F. ...

G. Every PAS provider shall ensure that each waiver participant who receives PAS has a written individualized back-up staffing plan and agreement for use in the event that the assigned PAS worker is unable to provide support due to unplanned circumstances, including emergencies which arise during a shift.

H. Every PAS provider shall ensure timely completion of the emergency plan for each waiver participant they serve.

I. – I.6. ...

J. Participants are not permitted to receive PAS while living in a home or property owned, operated, or controlled by

an owner, operator, agent, or employee of a licensed provider of long-term care services and providers are prohibited from providing and billing for services under these circumstances. Participants may not live in the home of a direct support worker unless that worker is related by blood or marriage to the participant.

1. ...

K. It is permissible for the PAS allotment to be used flexibly within a prior authorized week in accordance with the participant's preferences and personal schedule and with proper documentation.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3519 (December 2011), amended LR 39:320 (February 2013), LR 39:1778 (July 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:

§8309. Transition Services

A. ...

B. Allowable expenses are those necessary to enable the individual to establish a basic household (excluding expenses for room and board) including, but not limited to:

1. ...

2. specific set up fees or deposits;

3. activities to assess need, arrange for and procure needed resources;

4. essential furnishings to establish basic living arrangements; and

5. health and welfare assurances.

C. ...

D. These services do not include monthly rental, mortgage expenses, food, recurring monthly utility charges and household appliances and/or items intended for purely diversional/recreational purposes. These services may not be used to pay for furnishing or to set-up living arrangements that are owned or leased by a waiver provider.

E. ...

F. Funds are available up to the lifetime maximum amount identified in the federally-approved waiver document.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the

Office of Aging and Adult Services, LR 37:3520 (December 2011), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§8311. Adult Day Health Care Services

A. ...

B. ADHC services include those core service requirements identified in the ADHC licensing standards (LAC 48.I.4243), in addition to:

1. medical care management; and

2. transportation to and from medical and social activities (if the participant is accompanied by the ADHC center staff).

3. – 8. Repealed.

C. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3521 (December 2011), amended LR 39:321 (February 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§8313. Caregiver Temporary Support Services

A. – H. ...

I. Caregiver temporary support may be provided for the relief of the principal caregiver for participants who receive monitored in-home caregiving (MIHC) services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3521 (December 2011), amended LR 39:321 (February 2013), LR 40:792 (April 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§8315. Assistive Devices and Medical Supplies

A. Assistive devices and medical supplies are specialized medical equipment and supplies which include:

1. devices, controls, appliances or nutritional supplements that enable participants to increase their ability to perform activities of daily living; or

2. devices, controls, appliances or nutritional supplements that enable participants to perceive, control, or communicate with the environment in which they live or provide emergency response;

3. items, supplies and services necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items;

4. supplies and services necessary to assure health and welfare;

5 other durable and non-durable medical equipment and medical supplies that are necessary, but not available under the state plan;

6. personal emergency response systems (PERS);

7. other in-home monitoring and medication management devices and technology;

8. routine maintenance or repair of specialized equipment; and

9. batteries, extended warranties, and service contracts that are cost effective and assure health and welfare.

B. This service includes medical equipment, not available under the state plan, that is necessary to address participant functional limitations and necessary medical supplies not available under the state plan.

C. Where applicable, participant must use Medicaid State Plan, Medicare, or other available payers first. The participant’s preference for a certain brand or supplier is not grounds for declining another payer in order to access waiver services.

D. All services must be based on a verified need of the participant and the service must have a direct or remedial benefit to the participant with specific goals and outcomes.

This benefit must be determined by an independent assessment on any items whose cost exceeds the amount identified in the federally-approved waiver document and on all communication devices, mobility devices, and environmental controls. Independent assessments are done by individuals who have no fiduciary relationship with the manufacturer, supplier, or vendor of the item.

E. All items must reduce reliance on other Medicaid State Plan or waiver services.

F. All items must meet applicable standards of manufacture, design, and installation.

G. All items must be prior authorized and no experimental items shall be authorized.

H. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3521 (December 2011), amended LR 39:321 (February 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§8319. Non-Medical Transportation

Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3522 (December 2011), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§8323. Skilled Maintenance Therapy

A. Skilled maintenance therapy is therapy services that may be received by participants in the home or rehabilitation center.

B. ...

C. Therapy services provided to participants are not necessarily tied to an episode of illness or injury and instead focus primarily on the person’s functional need for maintenance of, or reducing the decline in, the participant’s ability to carry out activities of daily living.

D. – H. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3522 (December 2011), amended LR 39:321 (February 2013), amended by the Department of

Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§8325. Housing Transition or Crisis Intervention Services

A. Housing transition or crisis intervention services enable participants who are transitioning into a permanent supportive housing (PSH) unit, including those transitioning from institutions, to secure their own housing or provide assistance at any time the participant's housing is placed at risk (e.g., eviction, loss of roommate or income). The service includes the following components:

1. conducting a housing assessment identifying the participant's preferences related to housing (type, location, living alone or with someone else, accommodations needed, and other important preferences), and identifying his/her needs for support to maintain housing, including:

a. ...

b. becoming familiar with neighborhood, resources, and neighbors;

c. meeting the terms of a lease;

d. eviction prevention;

e. budgeting for housing/living expenses;

f. obtaining/accessing sources of income necessary for rent;

g. home management; and

h. ...

2. assisting the participant to view and secure housing as needed. This may include arranging or providing transportation. The participant shall be assisted in securing supporting documents/records, completing/submitting applications, securing/seeking waiver of deposits, and locating furnishings;

3. – 5. ...

6. communicating with the landlord or property manager regarding:

a. accommodations needed by the participant;

b. components of emergency procedures involving the landlord or property manager; and

c. needs to assist with issues that may place the participant’s ability to access or remain in housing at risk.

B. – C. ...

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 39:1779 (July 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§8327. Housing Stabilization Services

A. Housing stabilization services enable waiver participants to, once housed, successfully maintain tenancy and residence in their own housing as set forth in the participant's approved plan of care. Services must be provided in the home or a community setting. This service includes the following components:

1. ...

2. providing supports and interventions designed to maintain ongoing successful and stable tenancy and residence;

3. serving as point of contact for the landlord or property manager regarding any accommodations needed by the participant, any components of emergency procedures involving the landlord or property manager and to assist with issues that may place the participant's housing at risk; and

A.4. - 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 and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:1779 (July 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§8329. Monitored In-Home Caregiving Services

A. ...

B. The principal caregiver is responsible for supporting the participant to maximize the highest level of independence possible by providing necessary care and supports that may include:

1. – 4. ...

5. supervision or assistance while escorting/ accompanying the individual outside of the home to perform services indicated in the plan of care and to provide the same level of supervision or assistance as would be rendered in the home; and

B.6. – C.5. ...

D. Participants electing monitored in-home caregiving services shall not receive the following Community Choices Waiver services during the period of time that the participant is receiving monitored in-home caregiving services:

1. – 3. ...

E. Monitored in-home caregiving providers must be licensed HCBS providers with a monitored in-home caregiving module who employ professional staff, including a registered nurse and a care manager, to support principal caregivers to perform the direct care activities performed in the home. The provider must assess and approve the home in which services will be provided, and shall enter into contractual agreements with

caregivers who the agency has approved and trained. The provider will pay per diem stipends to caregivers.

F. The MIHC provider must use secure, web-based information collection from principal caregivers for the purposes of monitoring participant health and caregiver performance. All protected health information (PHI) must be transferred, stored, and otherwise utilized in compliance with applicable federal and state privacy laws. Providers must sign, maintain on file, and comply with the LDH HIPAA business associate addendum.

G. The department shall reimburse for monitored in-home caregiving services based upon a tiered model which is designed to address the participant’s acuity.

1. – 2.d. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 40:792 (April 2014), amended LR 41:2642 (December 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

Chapter 85. Self-Direction Initiative

§8501. Self-Direction Service Option

A. The self-direction initiative is a voluntary, self-determination option which allows the participant to coordinate the delivery of personal assistance services through an individual direct support professional rather than through a licensed, enrolled provider. Selection of this option requires that the participant utilize a payment mechanism approved by the department to manage the required fiscal functions that are usually handled by a traditional direct service provider.

B. – C. ...

1. Voluntary Termination. A waiver participant may choose at any time to withdraw from the self-direction service option and return to the traditional direct service provider.

2. Involuntary Termination. The department may terminate the self-direction service option for a participant and require him/her to receive provider-managed services under the following circumstances:

a. – c. ...

d. the participant or responsible representative:

i. – ii. ...

iii. fails to provide required documentation;

iv. fails to cooperate with the department fiscal agent or support coordinator;

v. ...

vi. fails to receive self-directed services for 90 calendar days or more.

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

1. be at least 18 years of age on the date of hire;

2. pass required criminal background checks; and

3. be able to complete the tasks identified in the plan of care.

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, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3523 (December 2011), amended LR 39:321 (February 2013), LR 39:1779 (July 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

Chapter 86. Organized Health Care Delivery System

§8601. General Provisions

A. – B. ...

C. The OHCDS must attest that all applicable provider qualifications are met.

D. Prior to enrollment, an OHCDS must show the ability to provide all of the following community choices services :

1. personal assistance services (PAS);

2. home delivered meals;

3. skilled maintenance therapy;

4. nursing;

5. caregiver temporary support services;

6. assistive devices and medical supplies;

7. environmental accessibility adaptations (EAA); and

8. adult day health care (only if there is a licensed ADHC provider in the service area).

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 40:792 (April 2014), amended LR 41:2643 (December 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

Chapter 87. Plan of Care

§8701. Plan of Care

A. The applicant and support coordinator have the flexibility to construct a plan of care that serves the

participant’s health and welfare needs. The service package provided under the POC shall include services covered under the Community Choices Waiver in addition to services covered under the Medicaid state plan (not to exceed the established service limits for either waiver or state plan services) as well as other services, regardless of the funding source for these services. All services approved pursuant to the POC shall be medically necessary and provided in a cost-effective manner. The POC shall be developed using a person-centered process coordinated by the support coordinator.

B. Reimbursement shall not be made for services provided prior to the department’s, or its designee’s, approval of the POC.

C. – C.2. ...

3. total cost of waiver services covered by the POC.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3524 (December 2011), amended LR 39:321 (February 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

Chapter 89. Admission and Discharge Criteria

§8901. Admission Criteria

A. Admission to the Community Choices Waiver program shall be determined in accordance with the following criteria:

1. – 4. ...

5. reasonable assurance that the health and welfare of the participant can be maintained in the community with the provision of Community Choices Waiver services.

B. Failure of the individual to cooperate in the eligibility determination, plan of care development process or to meet any of the criteria above shall result in denial of admission to the Community Choices Waiver.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3524 (December 2011), amended LR 39:322 (February 2013); amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§8903. Admission Denial or Discharge Criteria

A. Admission shall be denied or the participant shall be discharged from the Community Choices Waiver program if any of the following conditions are determined.

1. The individual does not meet the target population criteria as specified in the federally approved waiver document.

2. The individual does not meet the criteria for Medicaid financial eligibility.

3. The individual does not meet the criteria for nursing facility level of care.

4. ...

5. Continuity of services is interrupted as a result of the participant not receiving and/or refusing community choices waiver services (exclusive of support coordination services) for a period of 30 consecutive days.

EXCEPTION: An exception may be granted by OAAS to delay discharge if interruption is due to an acute care hospital, rehabilitation hospital, or nursing facility admission.

6. The health and welfare of the individual cannot be reasonably assured through the provision of Community Choices Waiver services.

7. – 8. ...

9. It is not cost effective or appropriate to serve the individual in the Community Choices Waiver.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3524 (December 2011), amended LR 39:322 (February 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

Chapter 93. Provider Responsibilities

§9301. General Provisions

A. ...

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

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

1. – 2. ...

D. Providers must maintain adequate documentation to support service delivery and compliance with the approved POC

and will provide said documentation at the request of the department, or its designee.

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

1. – 2. ...

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3524 (December 2011), amended LR 39:322 (February 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§9303. Reporting Requirements

A. Support coordinators and direct service providers are obligated to immediately report any changes to the department that could affect the waiver participant's eligibility including, but not limited to, those changes cited in the denial or discharge criteria.

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 and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3525 (December 2011), amended LR 39:322 (February 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

Chapter 95. Reimbursement

§9501. Unit of Reimbursement

A. – A.6. ...

B. The following services shall be reimbursed at the authorized rate or approved amount of the assessment, inspection, installation/fitting, maintenance, repairs, adaptation, device, equipment, or supply item and when the service has been prior authorized by the plan of care:

1. ...

2. environmental accessibility adaption assessment and inspections;

3. assistive devices and medical supplies;

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

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

6. monitored in-home caregiving (MIHC) assessment; and

7. certain nursing, and skilled maintenance therapy procedures

C. – D.3. ...

E. The following services shall be reimbursed on a per-visit basis:

1. certain nursing and skilled maintenance therapy procedures; and

2. personal assistance services furnished via “a.m. and p.m.” delivery method.

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

F.1. – H. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3525 (December 2011), amended LR 39:322 (February 2013), LR 39:508, 508 (March 2013), repromulgated LR 39:1048 (April 2013), amended LR 39:1779 (July 2013), LR 40:793 (April 2014), LR 42:897 (June 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

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

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Managed Care for Physical and Behavioral Health
Skilled Nursing Facility Services
(LAC 50:I.3507)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:I.3507 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 I. Administration
Subpart 3. Managed Care for Physical and Behavioral Health

Chapter 35. Managed Care Organization Participation Criteria

§3507. Benefits and Services

A. – F.1. ...

G. Excluded Services

1. The following services will continue to be reimbursed by the Medicaid Program on a fee-for-service basis, with the exception of dental services which will be reimbursed through a dental benefits prepaid ambulatory health plan under the authority of a 1915(b) waiver. The MCO shall provide any

appropriate referral that is medically necessary. The department shall have the right to incorporate these services at a later date if the member capitation rates have been adjusted to incorporate the cost of such service. Excluded services include:

a. – c. ...

d. nursing facility services;

EXCEPTION: Skilled nursing facility services may be utilized for members who transition from acute care hospital services as a step-down continuum of care.

G.1.e. – H.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 and Hospitals, Bureau of Health Services Financing, LR 37:1585 (June 2011), amended LR 39:92 (January 2013), repromulgated LR 39:318 (February 2013), LR 41:936 (May 2015), LR 41:2367 (November 2015), LR 42:755 (May 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 44:61 (January 2018), LR 44:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services

(CMS), if it is determined that submission to CMS for review and approval is required.

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Outpatient Hospital Services
Duration of Outpatient Status
(LAC 50:V.5107)

The Department of Health, Bureau of Health Services Financing has repealed LAC 50:V.5107 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

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

Chapter 51. General Provisions

§5107. Duration of Outpatient Status

Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1600 (June 2011), repealed by the Department of Health, Bureau of Health Services Financing, LR 44:

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

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Rural Health Clinics
Reimbursement Methodology
Long-Acting Reversible Contraceptives
(LAC 50:XI.16703)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XI.16703 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 XI. Clinic Services
Subpart 15. Rural Health Clinics

Chapter 167. Reimbursement Methodology

§16703. Alternate Payment Methodology

A. – C. ...

D. Effective for dates of service on or after January 1, 2019, RHCs shall be reimbursed a separate payment outside of the PPS rate for the following services:

1. Long-Acting Reversible Contraceptives (LARCs)

a. Reimbursement for LARCs shall be at the lesser of, the rate on file or the actual acquisition cost for

entities participating in the 340B program. Rural health clinics eligible for 340B pricing must bill Medicaid at their 340B actual acquisition cost for reimbursement.

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 32:1905 (October 2006), repromulgated LR 32:2267 (December 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:2632 (September 2011), LR 40:83 (January 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

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

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing
and
Office of Behavioral Health

Therapeutic Group Homes
(LAC 50:XXXIII.Chapters 121-127)

The Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health have amended LAC 50:XXXIII.Chapters 121-127 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 XXXIII. Behavioral Health Services
Subpart 13. Therapeutic Group Homes

Chapter 121. General Provisions

§12101. Introduction

A. The Medicaid Program hereby adopts provisions to provide coverage under the Medicaid state plan for behavioral health services rendered to children and youth in a therapeutic group home (TGH). These services shall be administered under the authority of the Department of Health (LDH), in collaboration with managed care organizations (MCOs) and the coordinated

system of care (CSoC) contractor for children and youth enrolled in the CSoC program, which shall be responsible for the necessary operational and administrative functions to ensure adequate service coordination and delivery.

B. - C. ...

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 38:427 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2371 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:

Chapter 123. Services

§12303. Covered Services

A. - A.4 ...

B. Service Exclusions. The following services/components shall be excluded from Medicaid reimbursement:

1. - 3. ...

4. services rendered in an institution for mental disease;

5. - 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 Hospitals, Bureau of Health Services Financing, LR 38:428 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2371 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:

Chapter 125. Provider Participation

§12501. Provider Responsibilities

A. Each provider of TGH services shall enter into a contract with one or more of the MCOs in order to receive reimbursement for Medicaid covered services. Providers shall meet the provisions of this Rule, the provider manual, and the appropriate statutes.

B. - C. ...

D. Anyone providing TGH services shall be licensed in accordance with state laws and regulations, in addition to operating within their scope of practice license.

E. TGH facilities shall be accredited by an approved accrediting body and maintain such accreditation. Denial, loss of or any negative change in accreditation status must be

reported to their contracted MCOs in writing within the time limit established by the department.

F. - G.2. ...

H. For TGH facilities that provide care for sexually deviant behaviors, substance use, or dually diagnosed individuals, the facility shall submit documentation to their contracted MCOs regarding the appropriateness of the research-based, trauma-informed programming and training, as well as compliance with ASAM level of care being provided.

I. - J. ...

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 38:428 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2371 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:

Chapter 127. Reimbursement

§12701. General Provisions

A. The department or its fiscal intermediary shall make monthly capitation payments to the MCOs. The capitation rates paid to the MCOs shall be actuarially sound rates and the MCOs

will determine the rates paid to its contracted providers. No payment shall be less than the minimum Medicaid rate.

A.1. - D. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:429 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2372 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:

§12705. In-State Therapeutic Group Homes

A. In-state publicly and privately owned and operated therapeutic group homes shall be reimbursed according to the MCO established rate within their contract.

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 38:429 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR:41:2372 (November 2015), amended by the

Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:

§12707. Out-of-State Therapeutic Group Homes

A. Out-of-state therapeutic group homes shall be reimbursed for their services according to the rate established by the MCO.

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 and Hospitals, Bureau of Health Services Financing, LR 38:429 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2372 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:

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

Rebekah E. Gee MD, MPH

Secretary