**RULE**

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

**Experimental Procedures**
**Routine Care for Beneficiaries in Clinical Trials**
**(LAC 50:I.305)**

The Department of Health, Bureau of Health Services Financing has amended LAC 50:I.305 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 1. General Provisions**

**Chapter 3. Experimental Procedures**

**§305. Routine Care for Beneficiaries in Clinical Trials**

A. The Medicaid program shall cover routine patient costs for items and services furnished in connection with participation in a qualifying clinical trial in accordance with section 1905(gg) of the Social Security Act.

B. - C. Repealed.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 46:796 (June 2020), amended LR 48:

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**
**Durable Medical Equipment**
**Enteral Formula Reimbursement**
**(LAC 50:XIII.10301)**

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XIII.10301 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 3. Medical Equipment, Supplies and Appliances**

**Chapter 103. Reimbursement Methodology**

**§10301. General Provisions**

A. – F. ...

G. Effective for dates of service on or after October 1, 2022, fees for enteral formulas will be set at 90 percent of 2021 Rural Medicare fees. For enteral formulas without a corresponding Medicare fee, the Medicaid fees will be set at the lowest fee at which the item has been determined to be widely available based on a review of similar formulas, usual and

customary fees charged in the community, and other Medicaid states.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1894 (September 2009), amended LR 36:1247 (June 2010), LR 36:2041 (September 2010), LR 39:1050 (April 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 48:

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**
**Emergency Provisions**
**(LAC 50:XIII.104)**

The Department of Health, Bureau of Health Services Financing has adopted LAC 50:XIII.104 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**

**§104. Emergency Provisions**

A. In the event that the federal or state government declares an emergency or disaster, the Medicaid Program may temporarily allow non-physician practitioners (advanced practice registered nurses and physician assistants) to order and review home health services, including the completion of associated documentation, if such action is deemed necessary to insure sufficient services are available to meet beneficiaries' needs.

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:

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**

**Hospice Services**
**Emergency Services and Inpatient Care**
**(LAC 50:XV.3503 and 4309)**

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XV.3503 and §4309 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 3. Hospice**

**Chapter 35. Recipient Eligibility**

**§3503. Waiver of Payment for Other Services**

A. – E. ...

F. In the event that the federal or state government declares an emergency or disaster, the Medicaid Program may temporarily waive the provision requiring daily visits by the hospice provider to all clients under the age of 21 to facilitate continued care while maintaining the safety of staff and beneficiaries. Visits will still be completed based on

clinical need of the beneficiary, family, and availability of staff, as requested by the family. The use of telemedicine visits as an alternative is allowed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1467 (June 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:129 (January 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 46:1563 (November 2020), LR 48:

**§4309. Limitation on Payments for Inpatient Care**

A. ...

1. During the 12-month period beginning November 1 of each year and ending October 31, the number of inpatient respite care days for any one hospice beneficiary may not exceed five days per occurrence.

2. – 2.b. ...

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

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

Services Financing, LR 28:1472 (June 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:132 (January 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 48:

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**

**Intermediate Care Facilities for**
**Persons with Intellectual Disabilities**
**Complex Care Reimbursements**
**(LAC 50:VII.32915)**

The Department of Health, Bureau of Health Services Financing has amended LAC 50:VII.32915 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

**Title 50**

**PUBLIC HEALTH—MEDICAL ASSISTANCE**
**Part VII. Long Term Care**
**Subpart 3. Intermediate Care Facilities for Persons with Intellectual Disabilities**

**Chapter 329. Reimbursement Methodology**

**Subchapter A. Non-State Facilities**

**§32915. Complex Care Reimbursements**

A. Private (non-state) intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) may receive an add-on payment to the per diem rate for providing complex care to Medicaid beneficiaries, when medically necessary. The add-on payment shall be a flat fee daily amount

and consists of payment for one of the following components alone or in combination:

1. direct service worker add-on;

2. skilled nursing add-on; and

3. equipment add-on;

4. – 7. Repealed.

B. To qualify, beneficiaries must meet medical necessity criteria established by the Medicaid Program. Supporting medical documentation must also be submitted as specified by the Medicaid Program. The duration of approval of the add-on payment(s) is at the sole discretion of the Medicaid Program and shall not exceed one year.

C. Medical necessity of the add-on payment(s) shall be reviewed and re-determined by the Medicaid Program no less than annually from the date of initial approval of each add-on payment. This review shall be performed in the same manner and using the same medical necessity criteria as the initial review.

D. Each add-on payment requires documentation that the enhanced supports are already being provided to the beneficiary, as specified by the Medicaid program.

1. – 2.a.iii. Repealed.

E. One of the following admission requirements must be met in order to qualify for the add-on payment:

1. the beneficiary has been admitted to the facility for more than 30 days with supporting documentation of medical necessity; or

2. the beneficiary is transitioning from another similar agency with supporting documentation of medical necessity.

3. Repealed.

F. The Medicaid Program shall require compliance with all applicable laws, rules, and regulations as a condition of an ICF/IID's qualification for any complex care add-on payment(s) and may evaluate such compliance in its initial annual qualifying reviews.

1. – 2. Repealed.

G. The following additional requirements apply:

1. Beneficiaries receiving enhanced rates must be included in annual surveys to ensure continuation of supports and review of individual outcomes.

2. Fiscal analysis and reporting is required annually.

H. – I.3.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, LR 42:276

(February 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 44:1447 (August 2018), LR 45:273 (February 2019), LR 48:

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