FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES
RULE TITLE: Rural Health Clinics Alternative Payment Methodology

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

It is anticipated that implementation of this proposed rule will result in estimated state general fund programmatic cost of $61,072 for FY 18-19, $383,617 for FY 19-20 and $409,633 for FY 20-21. It is anticipated that $540 ($270 SGF and $270 FED) will be expended in FY 18-19 for the state's administrative expense for promulgation of this proposed rule and the final rule. The numbers reflected above are based on a blended Federal Medical Assistance Percentage (FMAP) rate of 64.67 percent in FY 18-19 and 65.79 percent in FYs 19-20 and 20-21 for the projected non-expansion population, and an FMAP rate of 93.5 percent in FY 18-19, 91.5 percent in FY 19-20 and 90.0 percent in FY 20-21 for projected expansion population.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the implementation of this proposed Rule will increase federal revenue collections by $179,530 for FY 18-19, $1,148,864 for FY 19-20 and $1,192,509 for FY 20-21. It is anticipated that $270 will be collected in FY 18-19 for the federal share of the expense for promulgation of this proposed rule and the final rule. The numbers reflected above are based on a blended Federal Medical Assistance Percentage (FMAP) rate of 64.67 percent in FY 18-19 and 65.79 percent in FYs 19-20 and 20-21 for the projected non-expansion population, and an FMAP rate of 93.5 percent in FY 18-19, 91.5 percent in FY 19-20 and 90.0 percent in FY 20-21 for projected expansion population.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This proposed Rule amends the provisions governing the reimbursement methodology for rural health clinics (RHCs) in order to implement an alternative payment methodology to allow RHCs to be reimbursed a separate prospective payment system (PPS) rate for behavioral health and dental services which is at the same rate as the existing all-inclusive encounter PPS rate when such services are rendered on the same day as a medical visit. This proposed rule will be beneficial to Medicaid recipients as it reduces the number of RHC visits required to receive behavioral health and dental services. There are no economic costs to RHCs, although there may be a reduction in the number of RHC visits required to receive behavioral health and dental services which could reduce payments to RHCs. However we anticipate the rule will be beneficial to RHCs by allowing them to receive reimbursement for behavioral health and dental services, in addition to the current PPS encounter rate. It is anticipated that implementation of this proposed rule will increase Medicaid programmatic expenditures by approximately $240,062 for FY 18-19, $1,532,481 for FY 19-20 and $1,602,142 for FY 20-21.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This rule has no known effect on competition and employment.

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1812#055

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NOTICE OF INTENT

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

School-Based Health Services
(LAC 50:XV.Chapter 95 and XXXIII.Chapter 41)

The Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health propose to amend LAC 50:XV.Chapter 95 and XXXIII.Chapter 41 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health propose to amend the provisions governing school-based medical services covered in the Early and Periodic Screening, Diagnosis and Treatment Program and school-based behavioral health services in order to: 1) add services categorized as 504 plans, individual health plans or otherwise medically necessary in addition to those covered by an individual education plan, to the services available for school-based Medicaid claiming; 2) amend the reimbursement methodology to expand allowable billing providers for direct/therapy and nursing services; and 3) add applied behavioral analysis, personal care services and transportation to allowable Medicaid billing.

Title 50
PUBLIC HEALTH-MEDICAL ASSISTANCE
Part XV. Services for Special Populations
Subpart 5. Early and Periodic Screening, Diagnosis, and Treatment
Chapter 95. School-Based Health Services
Subchapter A. School-Based Medicaid Medical Direct Services
§9501. General Provisions

A. EPSDT school-based medical services are provided pursuant to an individualized service plan (IEP), a section 504 accommodation plan, an individualized health care plan, an individualized family service plan, or are otherwise medically necessary services provided by a licensed medical provider (physician, optometrist, respiratory therapist, registered nurse, licensed practical nurse, dentist, dental hygienist and chiropractor) within a local education agency (LEA). The goal of these services is to prevent or mitigate disease, enhance care coordination, and reduce costs by preventing the need for tertiary care. Providing these services in the school increases access to health care for children and youth resulting in a more efficient and effective delivery of care.

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

C. School-based medical services shall be covered for all recipients in the school system who are eligible.

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

§9503. Covered Services

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

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

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

b. Medication Administration. This service is scheduled as part of a health care plan developed by either the treating physician or the school district LEA. Administration of medication will be at the direction of the physician and within the license of the individual provider and must be approved within the district LEA policies.

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

d. Repealed.

2. Immunization Assessments. These services are nursing assessments of health status (immunizations) required by the Office of Public Health. This service requires a medical provider to assess the vaccination status of children in these cohorts once each year. This assessment is limited to the following children:

a. children enrolling in school for the first time;
b. pre-kindergarten children;
c. kindergarten children;
d. children entering sixth grade; or
e. any student 11 years of age regardless of grade.

3. EPSDT Program Periodicity Schedule for Screenings. Qualified individuals employed by a school district may perform any of these screens within their licensure. The results of these screens must be made available as part of the care coordination plan of the district. The screens shall be performed according to the periodicity schedule including any inter-periodic screens.

a. - e. Repealed.

4. EPSDT Medical/Nursing Assessment/Evaluation Services. A licensed health care provider employed by a school district may perform services to protect the health status of children and correct health problems. These services may include health counseling and triage of childhood illnesses and conditions.

a. Consultations are to be face-to-face contact in one-on-one sessions. These are services for which a parent would otherwise seek medical attention at physician or health care provider's office. This service is available to all Medicaid individuals eligible for EPSDT.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:2760 (October 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 45:

§9505. Reimbursement Methodology

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

1. Each LEA shall determine cost annually by using DHH's cost report for medical service cost form based on the direct services cost report.

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

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

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

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

1. ...

2. Develop Direct Cost—The Payroll Cost Base. Total annual salaries and benefits paid, as well as contracted (vendor) payments, shall be obtained initially from each LEA's payroll/benefits and accounts payable system. This data shall be reported on LDH's medical services cost report form for all medical service personnel (i.e. all personnel providing LEA medical treatment services covered under the state plan).

3. ...

4. Determine the Percentage of Time to Provide All Medical Services. A time study which incorporates the CMS-approved Medicaid administrative claiming (MAC) methodology for nursing service personnel shall be used to determine the percentage of time nursing service personnel spend on medical services and general and administrative (G and A) time. This time study will assure that there is no duplicate claiming. The G and A percentage shall be reallocated in a manner consistent with the CMS-approved Medicaid administrative claiming methodology. Total G and

A time shall be allocated to all other activity codes based on the percentage of time spent on each respective activity. To reallocate G and A time to medical services, the percentage of time spent on medical services shall be divided by 100 percent minus the percentage of G and A time. This shall result in a percentage that represents the medical services with appropriate allocation of G and A. This percentage shall be multiplied by total adjusted salary cost as determined Paragraph B.4 above to allocate cost to school-based services. The product represents total direct cost.

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

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

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

C. Reconciliation of LEA Certified Costs and Medicaid Management Information System (MMIS) Paid Claims. Each LEA shall complete the medical services cost report and submit the cost report(s) no later than five months after the fiscal year period ends (June 30), and reconciliation shall be completed within 12 months from the fiscal year end. All filed medical services cost reports shall be subject to desk review by the department's audit contractor. The department shall reconcile the total expenditures (both state and federal share) for each LEA's nursing services. The Medicaid certified cost expenditures from the medical services cost report(s) will be reconciled against the MMIS paid claims data and the department shall issue a notice of final settlement pending audit that denotes the amount due to or from the LEA. This reconciliation is inclusive of all medical services provided by the LEA.

D. ...

1. The financial oversight of all LEAs shall include reviewing the costs reported on the medical services cost reports against the allowable costs, performing desk reviews and conducting limited reviews.

2. The department will make every effort to audit each LEA at least every four years. These activities shall be performed to ensure that audit and final settlement occurs no later than two years from the LEA's fiscal year end for the cost reporting period audited. LEAs may appeal audit findings in accordance with LDH appeal procedures.

3. - 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 39:2761 (October 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 45:

Subchapter B. School-Based EPSDT Transportation Services

§9511. General Provisions

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

B. School-based EPSDT transportation services shall be covered for all recipients in the school system who are eligible for the service.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 45:

§9515. Reimbursement Methodology

A. Payment is based on the most recent school year's actual cost as determined by desk review and/or audit for each LEA provider, which is the parish or city. Each local education agency (LEA) shall determine cost annually by using LDH's cost report for special transportation (transportation cost report) form as approved by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) November 2005.

1. Direct cost is limited to the cost of fuel, repairs and maintenance, rentals, contracted vehicle use cost and the amount of total compensation (salaries and fringe benefits) of special transportation employees or contract cost for contract drivers, as allocated to special transportation services for Medicaid recipients based on a ratio explained in Step 4 below.

2. Indirect cost is derived by multiplying the direct cost by the cognizant agency's unrestricted indirect cost rate assigned by the Department of Education to each LEA. There are no additional indirect costs included.

B. The transportation cost report initially provides the total cost of all special transportation services provided, regardless of payer. To determine the amount of special transportation costs that may be attributed to Medicaid, the ratio of Medicaid covered trips to all student trips determined in step 4 below is multiplied by total direct cost. Trip data is derived from transportation logs maintained by drivers for each one-way trip. This ratio functions in lieu of the time study methodology and student ratio used for the direct services cost report. Cost data on the transportation cost report is subject to certification by each parish and serves as the basis for obtaining Federal Medicaid funding.

C. The participating LEA's actual cost of providing specialized transportation services will be claimed for Medicaid FFP based on the methodology described in the steps below. The state will gather actual expenditure information for each LEA through the LEA's payroll/benefits and accounts payable system. These costs are also reflected

in the annual financial report (AFR) that all LEAs are required to certify and submit to the Department of Education. All costs included in the amount of cost to be certified and used subsequently to determine the reconciliation and final settlement amounts as well as interim rates are identified on the CMS approved transportation cost report and are allowed in OMB Circular A-87.

1. Step 1—Develop Direct Cost–Other. The non-federal share of cost for special transportation fuel, repairs and maintenance, rentals, and contract vehicle use cost are obtained from the LEA's accounts payable system and reported on the Transportation Cost Report form.

2. Step 2—Develop Direct Cost-The Payroll Cost Base. Total annual salaries and benefits paid as well as contract cost (vendor payments) for contract drivers are obtained from each LEA's payroll/benefits and accounts payable systems. This data will be reported on the transportation cost report form for all direct service personnel (i.e. all personnel working in special transportation).

3. Step 3—Determine Indirect Cost. Indirect cost is determined by multiplying each LEA's unrestricted indirect rate assigned by the cognizant agency (the Department of Education) by total direct cost as determined under steps 1 and 2. No additional indirect cost is recognized outside of the cognizant agency indirect rate. The sum of direct costs as determined in steps 1 and 2 and indirect cost is total special transportation cost for all students with an IEP.

4. Step 4—Allocate Direct Service Cost to Medicaid. Special transportation drivers shall maintain logs of all students transported on each one-way trip. These logs shall be utilized to aggregate total annual one-way trips which will be reported by each LEA on the special transportation cost report. Total annual one-way trips by Medicaid students will be determined by LDH from the MMIS claims system. To determine the amount of special transportation cost that may be attributed to Medicaid, total cost as determined under step 3 is multiplied by the ratio of one-way trips by Medicaid students to one-way trips for all students transported via special transportation. This results in total cost that may be certified as Medicaid's portion of school based special transportation services cost.

D. Cost Settlement Process. As part of its financial oversight responsibilities, the department will develop audit and review procedures to audit and process final settlements for certain LEAs. The audit plan will include a risk assessment of the LEAs using paid claim data available from the department to determine the appropriate level of oversight. The financial oversight of all LEAs will include reviewing the costs reported on the direct services and transportation cost reports against the allowable costs in accordance with OMB Circular A-87, performing desk reviews and conducting limited reviews. For example, field audits will be performed when the department finds a substantial difference between information on the filed direct services and/or transportation cost reports and Medicaid claims payment data for particular LEAs. These activities will be performed to ensure that audit and final settlement occurs no later than two years from the LEA's fiscal year end for the cost reporting period audited.

1. LEAs may appeal audit findings in accordance with LDH appeal procedures.

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

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

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

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

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

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

5. State Monitoring. If the department becomes aware of potential instances of fraud, misuse or abuse of LEA services and Medicaid funds, it will perform timely audits and investigations to identify and take the necessary actions to remedy and resolve the problem.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 45:

Subchapter C. School-Based Medicaid Personal Care Services

§9521. General Provisions

A. EPSDT school-based personal care services (PCS) are provided by a personal care assistant pursuant to an individualized service plan (IEP), a section 504 accommodation plan, an individualized health care plan, an individualized family service plan, or are otherwise medically necessary within a local education agency (LEA). The goal of these services is to enable the recipient to be treated on an outpatient basis rather than an inpatient basis to the extent that services on an outpatient basis are projected to be more cost effective than services provided on an inpatient basis.

B. All personal care assistants providing school-based personal care services shall not be a member of the recipient's immediate family. (Immediate family includes father, mother, sister, brother, spouse, child, grandparent, in-law, or any individual acting as parent or guardian of the recipient.). Personal care services may be provided by a person of a degree of relationship to the recipient other than immediate family, if the relative is not living in the recipient's home, or, if she/he is living in the recipient's home solely because her/his presence in the home is necessitated by the amount of care required by the recipient. Personal care assistants must meet all training requirements applicable under state law and regulations and successfully complete the applicable examination for certification for PCS.

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

D. Personal care services must meet medical necessity criteria as established by the Bureau of Health Services Financing (BHSF) which shall be based on criteria equivalent to at least an intermediate care facility I (ICF-1) level of care; and the recipient must be impaired in at least two of daily living tasks, as determined by BHSF.

E. Early and periodic screening, diagnosis, and treatment personal care services must be prescribed by the recipient's attending physician initially and every 180 days thereafter (or rolling six months), and when changes in the plan of care occur. The plan of care shall be acceptable for submission to BHSF only after the physician signs and dates the completed form.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 45:

§9523. Covered Services

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

1. basic personal care, toileting and grooming activities, including bathing, care of the hair and assistance with clothing;

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

3. assistance with eating and food, nutrition, and diet activities, including preparation of meals for the recipient only;

4. performance of incidental household services essential to the client's health and comfort in her/his home; and

EXAMPLES: Changing and washing bed linens and rearranging furniture to enable the recipient to move about more easily in his/her own home.

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

B. EPSDT personal care services are not:

1. to be provided to meet childcare needs nor as a substitute for the parent in the absence of the parent;

2. allowable for the purpose of providing respite care to the primary caregiver; and

3. reimbursable when provided in an educational setting if the services duplicate services that are or must be provided by the Department of Education.

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

1. documentation of approval of services by BHSF or its designee;

2. daily notes by PCS provider denoting date of service, services provided (checklist is adequate);

3. total number of hours worked;

4. time period worked;

5. condition of recipient;

6. service provision difficulties;

7. justification for not providing scheduled services; and

8. any other pertinent information.

D. There must be a clear audit trail between:

1. the prescribing physician;

2. the local education agency;

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

4. the services provided and reimbursed by Medicaid.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 45:

§9525. Reimbursement Methodology

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

1. Each LEA shall determine cost annually by using LDH's cost report for personal care service cost form based on the direct services cost report.

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

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

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

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

1. The state shall gather actual expenditure information for each LEA through its payroll/benefits and accounts payable system.

2. Develop Direct Cost-The Payroll Cost Base. Total annual salaries and benefits paid, as well as contracted (vendor) payments, shall be obtained initially from each LEA's payroll/benefits and accounts payable system. This data shall be reported on LDH's personal care services cost report form for all personal care service personnel (i.e. all personnel providing LEA personal care treatment services covered under the state plan).

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

4. Due to the nature of personal care services, 100 percent of the personal care provider's time will be counted as reimbursable. Personal care providers will not be subject to a time study.

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

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

C. Reconciliation of LEA Certified Costs and Medicaid Management Information System (MMIS) Paid Claims. Each LEA shall complete the personal care services cost report and submit the cost report(s) no later than five months after the fiscal year period ends (June 30), and reconciliation shall be completed within 12 months from the fiscal year end. All filed personal care services cost reports shall be subject to desk review by the department's audit contractor. The department shall reconcile the total expenditures (both state and federal share) for each LEA's nursing services. The Medicaid certified cost expenditures from the personal care services cost report(s) will be reconciled against the MMIS paid claims data and the department shall issue a notice of final settlement pending audit that denotes the amount due to or from the LEA. This reconciliation is inclusive of all personal care services provided by the LEA.

D. Cost Settlement Process. As part of its financial oversight responsibilities, the department shall develop audit and review procedures to audit and process final settlements for certain LEAs. The audit plan shall include a risk assessment of the LEAs using available paid claims data to determine the appropriate level of oversight.

1. The financial oversight of all LEAs shall include reviewing the costs reported on the personal care services cost reports against the allowable costs, performing desk reviews and conducting limited reviews.

2. The department will make every effort to audit each LEA at least every four years. These activities shall be performed to ensure that audit and final settlement occurs no later than two years from the LEA's fiscal year end for the cost reporting period audited. LEAs may appeal audit findings in accordance with LDH appeal procedures.

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

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

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

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

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 45:

Subchapter D. School-Based Therapy Services

§9531. General Provisions

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

B. Therapists providing school-based therapy services are required to maintain an active therapist license with the state of Louisiana.

C. School-based therapy services shall be covered for all recipients in the school system who are eligible for the service.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 45:

§9533. Covered Services

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

1. Audiology Services. The identification and treatment of children with auditory impairment, using at risk criteria and appropriate audiology screening techniques. Therapists and/or audiologists must meet qualifications established in 42 CFR 440.110(c).

2. Speech Pathology Services. The identification and treatment of children with communicative or oropharyngeal disorders and delays in development of communication skills including diagnosis. Therapists and/or audiologists must meet qualifications established in 42 CFR 440.110(c).

3. Occupational Therapy Services. Addresses the functional needs of a child related to the performance of self-help skills, adaptive behavior, play and sensory, motor and postural development. Therapists must meet qualifications established in 42 CFR 440.110(b).

4. Physical Therapy Services. Designed to improve the child's movement dysfunction. Therapists must meet qualifications established in 42 CFR 440.110(a).

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 45:

§9535. Reimbursement Methodology

A. Local education agencies (LEAs) will only be reimbursed for the following Individuals with Disabilities Education Act (IDEA) services:

1. audiology;
2. speech pathology;
3. physical therapy;
4. occupational therapy; and
5. psychological services.

B. Services provided by local education agencies to recipients ages 3 to 21 that are medically necessary and included on the recipient's individualized service plan (IEP), a section 504 accommodation plan, an individualized health care plan, an individualized family service plan, or are otherwise medically necessary are reimbursed according to the following methodology.

1. Speech/language therapy services shall continue to be reimbursed in accordance with the Medicaid published fee schedule.

C. Cost Reporting. Settlement payments for EPSDT school-based therapy services shall be based on the most recent school year's actual cost as determined by desk review and/or audit for each LEA provider.

1. Each LEA shall determine cost annually by using LDH's cost report for therapy service cost form based on the direct services cost report.

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

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

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

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

1. The state shall gather actual expenditure information for each LEA through its payroll/benefits and accounts payable system.

2. Develop Direct Cost-The Payroll Cost Base. Total annual salaries and benefits paid, as well as contracted (vendor) payments, shall be obtained initially from each LEA's payroll/benefits and accounts payable system. This data shall be reported on LDH's therapy services cost report form for all therapy service personnel (i.e. all personnel providing LEA therapy treatment services covered under the state plan).

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

4. Determine the Percentage of Time to Provide All Therapy Services. A time study which incorporates the CMS-approved Medicaid administrative claiming (MAC) methodology for therapy service personnel shall be used to determine the percentage of time therapy service personnel spend on therapy services and general and administrative (G and A) time. This time study will assure that there is no duplicate claiming. The G and A percentage shall be reallocated in a manner consistent with the CMS-approved Medicaid administrative claiming methodology. Total G and A time shall be allocated to all other activity codes based on the percentage of time spent on each respective activity. To reallocate G and A time to therapy services, the percentage of time spent on therapy services shall be divided by 100 percent minus the percentage of G and A time. This shall result in a percentage that represents the therapy services with appropriate allocation of G and A. This percentage shall be multiplied by total adjusted salary cost as determined Paragraph B.4 above to allocate cost to school based services. The product represents total direct cost.

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

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

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

E. Reconciliation of LEA Certified Costs and Medicaid Management Information System (MMIS) Paid Claims. Each LEA shall complete the therapy services cost report and submit the cost report(s) no later than five months after the fiscal year period ends (June 30), and reconciliation shall be completed within 12 months from the fiscal year end. All filed therapy services cost reports shall be subject to desk review by the department's audit contractor. The department shall reconcile the total expenditures (both state and federal share) for each LEA's therapy services. The Medicaid certified cost expenditures from the therapy services cost report(s) will be reconciled against the MMIS paid claims data and the department shall issue a notice of final settlement pending audit that denotes the amount due to or from the LEA. This reconciliation is inclusive of all therapy services provided by the LEA.

F. Cost Settlement Process. As part of its financial oversight responsibilities, the department shall develop audit and review procedures to audit and process final settlements for certain LEAs. The audit plan shall include a risk

assessment of the LEAs using available paid claims data to determine the appropriate level of oversight.

1. The financial oversight of all LEAs shall include reviewing the costs reported on the therapy services cost reports against the allowable costs, performing desk reviews and conducting limited reviews.

2. The department will make every effort to audit each LEA at least every four years. These activities shall be performed to ensure that audit and final settlement occurs no later than two years from the LEA's fiscal year end for the cost reporting period audited. LEAs may appeal audit findings in accordance with LDH appeal procedures.

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

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

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

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

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 45:

Part XXXIII. Behavioral Health Services

Subpart 5. School Based Behavioral Health Services

Chapter 41. General Provisions

§4101. Introduction

A. The Medicaid Program hereby adopts provisions to provide coverage under the Medicaid state plan for school based behavioral health services rendered to children and youth with behavioral health disorders. These services shall be administered under the authority of the Department of Health.

B. The school based behavioral health services rendered to children with emotional or behavioral disorders are medically necessary behavioral health services provided to Medicaid recipients in accordance with an individualized service plan, a section 504 accommodation plan pursuant to 34 C.F.R. §104.36, an individualized health care plan, an individualized family service plan, or are otherwise medically necessary.

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 38:400 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2171 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 45:

§4103. Recipient Qualifications

A. ...

B. Qualifying children and adolescents must have been determined eligible for Medicaid and behavioral health services covered under Part B of the Individuals with Disabilities Education Act (IDEA), with a written service plan (an IEP, section 504 plan, individualized health care plan (IHP), or an individualized family service plan (IFSP)) which contains medically necessary services recommended by a physician or other licensed practitioner, within the scope of his or practice under state law.

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 38:400 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2172 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 45:

Chapter 43. Services

§4301. General Provisions

A. The Medicaid Program shall provide coverage for behavioral health services pursuant to §1905(a) of the Social Security Act which are addressed in the IEP, section 504 plan, IHP, IFSP or otherwise medically necessary, and that correct or ameliorate a child's health condition.

B. Services must be performed by qualified providers who provide school based behavioral health services as part of their respective area of practice (e.g. psychologist providing a behavioral health evaluation). Services rendered by certified school psychologists must be supervised consistent with R.S. 17:7.1.

1. Applied behavior analysis-based (ABA) services rendered in school-based settings must be provided by, or under the supervision of, a behavior analyst who is currently licensed by the Louisiana Behavior Analyst Board, or a licensed psychologist or licensed medical psychologist, hereafter referred to as the licensed professional. Payment for services must be billed by the licensed professional

C. - 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 38:400 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2172 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 45:

§4303. Covered Services

A. ...

B. The following school based behavioral health services shall be reimbursed under the Medicaid Program:

1. ...

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

3. addiction services; and

4. environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct

observation, measurement and functional analysis of the relations between environment and behavior.

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 38:400 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:384 (February 2015), LR 41:2172 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 45:

§4305. Service Limitations and Exclusions

A. The Medicaid Program shall not cover school based behavioral health services performed solely for educational purposes (e.g. academic testing). Services that are not reflected in the IEP, section 504 plan, IHP or IFSP (as determined by the assessment and evaluation) shall not be covered.

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 38:401 (February 2012), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 45:

Chapter 45. Provider Participation

§4501. Local Education Agency Responsibilities

A. - D. ...

E. Anyone providing behavioral health services must be operating within the scope of practice of their applicable license. The provider shall create and maintain documents to substantiate that all requirements are met.

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 38:401 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:385 (February 2015), LR 41:2172 (October 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 45:

Chapter 47. Payments

§4701. Reimbursement Methodology

A. Payments for school based behavioral health services shall be based on the most recent school year's actual cost as determined by desk review and/or audit for each LEA provider.

1. Each LEA shall determine cost annually by using LDH's cost report for behavioral health service cost form based on the direct services cost report.

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

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

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

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

1. The state shall gather actual expenditure information for each LEA through its payroll/benefits and accounts payable system.

2. Develop Direct Cost-The Payroll Cost Base. Total annual salaries and benefits paid, as well as contracted (vendor) payments, shall be obtained initially from each LEA's payroll/benefits and accounts payable system. This data shall be reported on LDH's behavioral health services cost report form for all behavioral health service personnel (i.e. all personnel providing LEA behavioral health treatment services covered under the state plan).

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

4. Determine the Percentage of Time to Provide All behavioral health Services. A time study which incorporates the CMS-approved Medicaid administrative claiming (MAC) methodology for nursing service personnel shall be used to determine the percentage of time nursing service personnel spend on behavioral health services and general and administrative (G and A) time. This time study will assure that there is no duplicate claiming. The G and A percentage shall be reallocated in a manner consistent with the CMS-approved Medicaid administrative claiming methodology. Total G and A time shall be allocated to all other activity codes based on the percentage of time spent on each respective activity. To reallocate G and A time to behavioral health services, the percentage of time spent on behavioral health services shall be divided by 100 percent minus the percentage of G and A time. This shall result in a percentage that represents the behavioral health services with appropriate allocation of G and A. This percentage shall be multiplied by total adjusted salary cost as determined Paragraph B.4 above to allocate cost to school based services. The product represents total direct cost.

a. A sufficient number of behavioral health service personnel's time shall be sampled to ensure results that will have a confidence level of at least 95 percent with a precision of plus or minus 5 percent overall.

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

service cost for all students receiving behavioral health services.

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

C. Reconciliation of LEA Certified Costs and Medicaid Management Information System (MMIS) Paid Claims. Each LEA shall complete the behavioral health services cost report and submit the cost report(s) no later than five months after the fiscal year period ends (June 30), and reconciliation shall be completed within 12 months from the fiscal year end. All filed behavioral health services cost reports shall be subject to desk review by the department's audit contractor. The department shall reconcile the total expenditures (both state and federal share) for each LEA's nursing services. The Medicaid certified cost expenditures from the behavioral health services cost report(s) will be reconciled against the MMIS paid claims data and the department shall issue a notice of final settlement pending audit that denotes the amount due to or from the LEA. This reconciliation is inclusive of all behavioral health services provided by the LEA.

1. – 2. Repealed.

D. Cost Settlement Process. As part of its financial oversight responsibilities, the department shall develop audit and review procedures to audit and process final settlements for certain LEAs. The audit plan shall include a risk assessment of the LEAs using available paid claims data to determine the appropriate level of oversight.

1. The financial oversight of all LEAs shall include reviewing the costs reported on the behavioral health services cost reports against the allowable costs, performing desk reviews and conducting limited reviews.

2. The department will make every effort to audit each LEA at least every four years. These activities shall be performed to ensure that audit and final settlement occurs no later than two years from the LEA's fiscal year end for the cost reporting period audited. LEAs may appeal audit findings in accordance with LDH appeal procedures.

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

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

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

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

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

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

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 38:401 (February 2012), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 45:

§4703. Cost Calculations

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 38:401 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2172 (October 2015), repealed by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 45:

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.

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have a positive on family functioning, stability and autonomy as described in R.S. 49:972 by increasing access to school-based medical and behavioral health services.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have a positive impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973 by increasing access to school-based medical and behavioral health services.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct or indirect cost to the provider to provide the same level of service. However, this proposed Rule may have a positive impact on the provider's ability to provide the same level of service as described in HCR 170 due to increased payments in state fiscal year 20-21 for provision of these school-based medical and behavioral health services.

Public Comments

Interested persons may submit written comments about the proposed Rule to Jen Steele, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Steele is responsible for responding to inquiries regarding this

proposed Rule. The deadline for submitting written comments is at close of business, 4:30 p.m., on January 29, 2019.

Public Hearing

Interested persons may submit a written request to conduct a public hearing either by U.S. mail to the Office of the Secretary ATTN: LDH Rulemaking Coordinator, Post Office Box 629, Baton Rouge, LA 70821-0629, fax to (225) 342-5568, or email to stanley.bordelon@la.gov; however, such request must be received no later than 4:30 p.m. on January 9, 2019. If the criteria set forth in R.S. 49:953(A)(2)(a) are satisfied, LDH will conduct a public hearing at 9:30 a.m. on January 24, 2019 in Room 173 of the Bienville Building, which is located at 628 North Fourth Street, Baton Rouge, LA. To confirm whether or not a public hearing will be held, interested persons should first call Stanley Bordelon at (225) 219-3454 after January 9, 2019. If a public hearing is to be held, all interested persons are invited to attend and present data, views, comments, or arguments, orally or in writing. In the event of a hearing, parking is available to the public in the Galvez Parking Garage which is located between North Sixth and North Fifth/North and Main Streets (cater-corner from the Bienville Building). Validated parking for the Galvez Garage may be available to public hearing attendees when the parking ticket is presented to LDH staff at the hearing.

Rebekah E. Gee MD, MPH
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES
RULE TITLE: School-Based Health Services

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

It is anticipated that the implementation of this proposed rule will result in estimated state general fund programmatic costs of $2,646 for FY 18-19 and federal by $23,144,004 for FY 20-21. The state match for the school based claiming program in FY 20-21 shall be funded through Certified Public Expenditures of non-state funds from local governmental entities to the department to secure federal match to fund the increase in payments. It is anticipated that $5,292 ($2,646 SGF and $2,646 FED) will be expended in FY 18-19 for the state's administrative expense for promulgation of this proposed rule and the final rule. The numbers reflected above are based on a blended Federal Medical Assistance Percentage (FMAP) rate of 65.79 percent for FY 20-21 and 90.0 percent in FY 20-21 for the projected expansion population.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the implementation of this proposed rule will increase federal revenue collections by approximately $2,646 for FY 18-19 and $23,144,004 for FY 20-21. It is anticipated that $2,646 will be expended in FY 18-19 for the federal administrative expenses for promulgation of this proposed rule and the final rule. The numbers reflected above are based on a blended Federal Medical Assistance Percentage (FMAP) rate of 65.79 percent for FY 20-21 and 90.0 percent in FY 20-21 for the projected expansion population.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This proposed Rule amends the provisions governing school-based medical services covered in the Early and Periodic, Diagnosis and Treatment (EPSDT) Program and school-based behavioral health services in order to: 1) add services categorized as 504 plans, individual health plans or otherwise medically necessary in addition to those covered by an individual education plan, to the services available for school-based Medicaid claiming; 2) amend the reimbursement methodology for school-based health services to expand the allowable billing providers for behavioral health, direct/therapy services and nursing services; and 3) add Applied Behavioral Analysis, Personal Care Services and transportation to allowable Medicaid billing. Providers of medical and behavioral health school-based services will benefit from implementation of this proposed Rule since the additional services are currently being provided in school settings, but no Medicaid reimbursement is being claimed. This proposed rule will allow Local Education Authorities (LEAs) to be reimbursed for these expenses. It is anticipated that implementation of this proposed rule will increase programmatic expenditures for school-based health services by approximately $23,144,004 for FY 20-21.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

It is anticipated that the implementation of this proposed rule will not have an effect on competition and employment.

Jen Steele
Medicaid Director
1812#056

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health
Bureau of Health Services Financing

Telemedicine
Claim Submissions
(LAC 50:I.503)

The Department of Health, Bureau of Health Services Financing proposes to amend LAC 50:I.503 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to the Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health, Bureau of Health Services Financing proposes to amend the provisions governing telemedicine in order to revise the procedures for claim submissions to comply with recommendations by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services and align with current managed care organization practices.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part I. Administration
Subpart 1. General Provisions
Chapter 5. Telemedicine
§503. Claim Submissions

A. Medicaid covered services provided via an interactive audio and video telecommunications system (telemedicine) shall be identified on claim submissions by appending the Health Insurance Portability and Accountability Act (HIPAA) of 1996 compliant place of service (POS) or modifier to the appropriate procedure code, in line with current policy.