RULE

Department of Health
Bureau of Health Services Financing
and
Office for Citizens with Developmental Disabilities

Home and Community-Based Services Waivers
New Opportunities Waiver
(LAC 50:XXI.Chapters 137-143)

The Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities have amended LAC 50:XXI.Chapters 137-143 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.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXI. Home and Community-Based Services Waivers
Subpart 11. New Opportunities Waiver

Chapter 137. General Provisions

§13701. Introduction

A. The New Opportunities Waiver (NOW), hereafter referred to as the NOW, is designed to enhance the home and community-based services and supports available to individuals with developmental disabilities, who would otherwise require an intermediate care facility for persons with developmental disabilities (ICF-DD) level of care. The mission of the NOW is to utilize the principle of self-determination and supplement the family and/or community

supports while supporting the dignity, quality of life and security in the everyday life of an individual, and maintaining that individual in the community. Services provided in the NOW are community-based, and are designed to allow an individual experience that mirrors the experiences of individuals without disabilities. These services are not to be restrictive, but liberating, by empowering individuals to experience life in the most fulfilling manner as defined by the individual while still assuring health and safety. In keeping with the principles of self-determination, NOW includes a self-direction service delivery option. This allows for greater flexibility in hiring, training, and general service delivery issues.

B. All NOW services are accessed through the case management agency of the participant’s choice. All services must be prior authorized and delivered in accordance with the approved comprehensive plan of care (CPOC). The CPOC shall be developed using a person-centered process coordinated by the participant’s case manager.

C. ...

D. In order for the NOW provider to bill for services, the participant and the direct service provider, professional or other practitioner rendering service, must be present at the time the service is rendered unless otherwise allowed in rule. The service

must be documented in service notes describing the service rendered and progress towards the participant’s personal outcomes and CPOC.

E. Only the following NOW services shall be provided for, or billed for, the same hours on the same day as any other NOW service:

1. ...

2. supported independent living; and

3. skilled nursing services. Skilled nursing services may be provided with:

a. ...

b. supported independent living;

c. – d. ...

e. prevocational services.

F. – G. ...

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 Community Supports and Services, LR 30:1201 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1647 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:68 (January 2014), amended by the

Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:

§13702. Settings for Home and Community-Based Services

A. NOW participants are expected to be integrated in and have full access to the greater community while receiving services, to the same extent as individuals without disabilities. Providers shall meet the requirements of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services' (CMS) Home and Community-Based Setting Requirements for Home and Community-Based Services (HCBS) Waivers as delineated in LAC 50:XXI.901.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:

§13705. Denial of Admission or Discharge Criteria

A. Individuals shall be denied admission to or discharged from the NOW if one of the following criteria is met:

1. - 5. ...

6. the health and welfare of the participant cannot be assured through the provision of NOW services within the participant's approved comprehensive plan of care;

7. - 8. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1202 (June 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities LR 40:69 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:

Chapter 139. Covered Services

§13901. Individual and Family Support Services

A. Individual and family support (IFS) services are direct support and assistance services, provided in the participant's home or in the community, that allow the participant to achieve and/or maintain increased independence, productivity, enhanced family functioning and inclusion in the community to the same degree as individuals without disabilities. IFS services are also used to provide relief to the primary caregiver. Transportation is included in the reimbursement for these services. Reimbursement for these services includes the development of a service plan for the provision of these services, based on the approved COPC.

1. Individual and family support day (IFS-D) services will be authorized during waking hours for up to 16 hours when

natural supports are unavailable in order to provide continuity of services to the participant. Waking hours are the period of time when the participant is awake and not limited to traditional daytime hours as outlined in the CPOC.

a. Additional hours of IFS-D services beyond the 16 hours can be approved based on documented need, which can include medical or behavioral need, and specified in the approved CPOC.

2. Individual and family support-night (IFS-N) service is direct support and assistance provided during the participant’s sleeping “night” hours. Night hours are considered to be the period of time when the participant is asleep and there is a reduced frequency and intensity of required assistance. IFS-N services are not limited to traditional nighttime hours and are outlined in the CPOC. The IFS-N worker must be immediately available and in the same residence as the participant to be able to respond to the participant’s immediate needs. Documentation of the level of support needed, based on the frequency and intensity of needs, shall be included in the CPOC with supporting documentation in the provider’s services plan. Supporting documentation shall outline the participant’s safety, communication, and response methodology planned for and agreed to by the participant and/or his/her authorized representative identified in his/her circle of support.

The IFS-N worker is expected to remain awake and alert unless otherwise authorized under the procedures noted below.

a. ...

b. The participant's support team shall assess the participant's ability to awaken staff. If it is determined that the participant is able to awaken staff and requests that the IFS-N worker be allowed to sleep, the CPOC shall reflect the participant's request.

c. – d. ...

e. Any allegation of abuse/neglect during sleeping hours will result in the discontinuation of allowance of the staff to sleep until investigation is complete. Valid findings of abuse/neglect during night hours will require immediate revision to the CPOC.

B. IFS services may be shared by up to three waiver participants who may or may not live together and who have a common direct service provider agency. Waiver participants may share IFS services staff when agreed to by the participants and health and welfare can be assured for each participant. The decision to share staff must be reflected on the CPOC and based on an individual-by-individual determination and choice. Reimbursement rates are adjusted accordingly. Shared IFS services, hereafter referred to as shared support services, may be either day or night services.

C. IFS (day or night) services include:

1. - 2.f. ...

3. personal support and assistance in participating in community, employment, health and leisure activities;

C.4. – D.2. ...

3. IFS-D and IFS-N services will not be authorized or provided to the participant while the participant is in a center-based respite facility.

4. Repealed.

E. – E.2. ...

3. An IFS-D or IFS-N worker/shared supports worker shall not work more than 16 hours in a 24-hour period unless there is a documented emergency or a time-limited non-routine need that is documented in the approved CPOC or granted in writing by the OCDD waiver director/designee.

F. – F.3. ...

G. Provider Requirements. Providers must be licensed by the Louisiana Department of Health as a home and community-based services provider and must meet the module specific requirements for the service being provided.

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 Community Supports and Services, LR 30:1202 (June 2004), amended by the

Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 32:2063 (November 2006), LR 33:1647 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:71 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:

§13903. Center-Based Respite Care

A. – C. ...

C. Service Limits. CBR services shall not exceed 720 hours per participant, per CPOC year.

1. ...

D. Provider Requirements. Providers must be licensed by the Department of Health as a home and community-based services provider and must meet the module specific requirements for the service being provided.

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 Community Supports and Services, LR 30:1203 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1648 (August

2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:72 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:

§13905. Community Integration Development

A. Community integration development (CID) facilitates the development of opportunities to assist participants in becoming involved in the community through the creation of natural supports. The purpose of CID is to encourage and foster the development of meaningful relationships in the community reflecting the participant’s choices and values. Objectives outlined in the comprehensive plan of care will afford opportunities to increase community inclusion, participation in leisure/recreational activities, and encourage participation in volunteer and civic activities. Reimbursement for this service includes the development of a service plan. To utilize this service, the participant may or may not be present as identified in the approved CID service plan. CID services may be performed by a shared supports worker for up to three waiver participants who have a common direct service provider agency. Rates shall be adjusted accordingly.

B. ...

C. Service Limitations. Services shall not exceed 60 hours per participant per CPOC year which includes the combination of shared and non-shared community integration development.

D. Provider Qualifications. Providers must be licensed by the Department of Health as a home and community-based services provider and must meet the module specific requirements for the service being provided.

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 Community Supports and Services, LR 30:1203 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1648 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:72 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:

§13907. Supported Independent Living

A. Supported independent living (SIL) assists the participant to acquire, improve or maintain those social and adaptive skills necessary to enable a participant to reside in the community and to participate as independently as possible. SIL

services include assistance and/or training in the performance of tasks such as personal grooming, housekeeping and money management. Payment for this service includes oversight and administration and the development of service plans for the enhancement of socialization with age-appropriate activities that provide enrichment and may promote wellness. The service plan should include initial, introduction, and exploration for positive outcomes for the participant for community integration development. These services also assist the participant in obtaining financial aid, housing, advocacy and self-advocacy training as appropriate, emergency support, trained staff and assisting the participant in accessing other programs for which he/she qualifies. SIL participants must be 18 years or older.

B. Place of Service. Services are provided in the participant's residence and/or in the community. The participant's residence includes his/her apartment or house, provided that he/she does not live in the residence of any legally responsible relative. An exception will be considered when the participant lives in the residence of a spouse or disabled parent, or a parent age 70 or older. Family members who are not *legally responsible relatives* as defined in §13901.D.1, can be SIL workers provided they meet the same qualifications as any other SIL worker.

C. Exclusions

1. Legally responsible persons may not be SIL providers for the individual whom they are legally responsible.

2. SIL shall not include the cost of:

a. – e. ...

3. SIL services cannot be provided in a substitute family care setting.

D. Service Limit. SIL services are limited to one service per day, per CPOC year, except when the participant is in center-based respite. When a participant living in an SIL setting is admitted to a center-based respite facility, the SIL provider shall not bill the SIL per diem beginning with the date of admission to the center-based respite facility and through the date of discharge from the center-based respite facility.

E. Provider Qualifications. Providers must be licensed by the Department of Health as a home and community-based services provider and meet the module specific requirements for the service being provided.

F. Provider Responsibilities

1. Minimum direct services by the SIL agency include two documented contacts per week and one documented face-to-face contact per month by the SIL provider agency in addition to the approved direct support hours. These required contacts must be completed by the SIL agency supervisor so designated by the provider agency due to the experience and expertise relating to the

participants' needs or a licensed/certified professional qualified in the state of Louisiana who meets requirements as defined by 42 CFR §483.430 or any subsequent regulation.

2. ...

3. Supported independent living services shall be coordinated with any services listed in the approved CPOC, and may serve to reinforce skills or lessons taught in school, therapy or other settings.

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 Community Supports and Services, LR 30:1204 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1648 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:73 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:

§13909. Substitute Family Care

A. Substitute family care (SFC) provides for day programming, transportation, independent living training, community integration, homemaker, chore, attendant care and companion

services, and medication oversight (to the extent permitted under state law) to participants residing in a substitute family care home that meets all licensing requirements for the substitute family care module. The service is a stand-alone family living arrangement for participants age 18 and older. The SFC house parents assume the direct responsibility for the participant's physical, social, and emotional well-being and growth, including family ties. Only two SFC participants may reside in a single SFC setting at the same time. There shall be no more than three persons living in a substitute family care setting who are unrelated to the SFC provider. Immediate family members (mother, father, brother and/or sister) cannot be substitute family care parents. Reimbursement for this service includes the development of a service plan based on the approved CPOC. Participants living in an SFC home may receive IFS services.

B. – C. ...

1. Repealed.

D. Provider Qualifications. Providers must be licensed by the Department of Health as a home and community-based services provider and must meet the module specific requirements for the service being provided.

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 Community Supports and Services, LR 30:1204 (June 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:73 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:

§13911. Day Habilitation

A. Day habilitation is provided in a community-based setting and provides the participant assistance with social and adaptive skills necessary to enable the participant to participate as independently as possible in the community. These services focus on socialization with meaningful age-appropriate activities which provide enrichment and promote wellness, as indicated in the participant's CPOC. Day habilitation services are provided in a variety of community settings, (i.e. local recreation department, garden clubs, libraries, etc.) other than the person's residence and are not limited to a fixed-site facility.

1. Day habilitation services must be directed by a person-centered service plan and provide the participant choice in how they spend their day. The activities should assist the participant to gain their desired community living experience, including the acquisition, retention or improvement in self-help,

socialization and adaptive skills, and/or to provide the individual an opportunity to contribute to and be a part of his or her community.

a. – f. Repealed.

2. Day habilitation services shall be coordinated with any therapy, prevocational service, or supported employment models that the participant may be receiving. The participant does not receive payment for the activities in which he/she are engaged. The participant must be 18 years of age or older in order to receive day habilitation services.

3. Career planning activities may be a component of the participant’s plan and may be used to develop learning opportunities and career options consistent with the person’s skills and interests.

B. Service Limits. Services can be provided one or more hours per day but not to exceed eight hours per day or 8,320 one quarter hour units of service per CPOC year.

C. Licensing Requirements. Providers must be licensed by the Department of Health and as a home and community-based services provider and must meet the module specific requirements for the service being provided.

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 Community Supports and Services, LR 30:1204 (June 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:73 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:

§13913. Supported Employment

A. Supported employment is competitive work in an integrated work setting, or employment in an integrated work setting in which the participants are working toward competitive work that is consistent with the strengths, resources, priorities, interests, and informed choice of participants for whom competitive employment has not traditionally occurred. The participant must be eligible and assessed to need the service in order to receive supported employment services. The outcome of this service is sustained paid employment and work experience leading to further career development and individual integrated community–based employment for which an individual is compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

B. Individuals eligible for Louisiana Rehabilitation Services (LRS) must access those services prior to utilizing home and community-based waiver supported employment services.

C. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment cannot be provided at worksites that are facility based, or other similar types of vocational services furnished in specialized facilities that are not part of the general workplace. Supported employment includes activities needed by waiver participants to sustain paid work, including supervision and training and is based on an individualized service plan. Supported employment may include assistance and prompting with:

C.1. – D. ...

1. A one-to-one model of supported employment is a placement strategy in which an employment specialist (job coach) places a person into competitive employment, provides training and support and then gradually reduces time and assistance at the work site through formation of natural supports. This service is time limited to six to eight weeks in duration.

2. Follow along services are designed for participants who are in supported employment and have been placed in a work site and only require minimum oversight for follow along at the job site. This service is limited to 24 days per CPOC year.

3. Mobile work crew/enclave is an employment setting in which a group of two or more participants, but no more than eight perform work in a variety of locations under the supervision of a permanent employment specialist (job coach/supervisor). This service is up to eight hours a day, five days per week.

E. Service Exclusions

1. Services shall not be used in conjunction or simultaneously with any other waiver service, except substitute family care, supported independent living, and skilled nursing services.

2. When supported employment services are provided at a work site in which persons without disabilities are employees, payment will be made only for the adaptations, supervision and training required by participants receiving waiver services as a result of his/her disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

3. Services are not available to participants who are eligible and have been accepted to participate in programs funded under Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the Individuals with Disabilities Education Act, 20 U.S.C. 1401(16) and (71).

F. Service Limits

1. One-to-one intensive services shall not exceed 1,280 one quarter hour units per CPOC year. Services shall be limited to eight hours a day, five days a week, for six to eight weeks.

2. Follow along services shall not exceed 24 days per CPOC year.

3. Mobile crew/enclave services shall not exceed 8,320 one quarter hour units of service per CPOC year, without additional documentation. This is eight hours per day, five days per week.

G. Licensing Requirements. The provider must possess a valid certificate of compliance as a community rehabilitation provider (CRP) from Louisiana Rehabilitation Services or be licensed by the Department of Health as a home and community-based services provider and must meet the module specific requirements for the service being provided.

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 Community Supports and Services, LR 30:1205 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1649 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:74 (January 2014), amended by the

Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:

§13915. Transportation for Day Habilitation and Supported Employment Models

A. Transportation provided for the participant to the site of the day habilitation or supported employment model, or between the day habilitation and supported employment model site (if the participant receives services in more than one place) is reimbursable when day habilitation or supported employment model has been provided. Reimbursement may be made for a one-way trip. There is a maximum fee per day that can be charged for transportation regardless of the number of trips per day.

B. Licensing Requirements. Providers must be licensed by the Department of Health as a home and community-based services provider and meet the module specific requirements for the service being provided. The licensed provider must carry $1,000,000 liability insurance on the vehicles used in transporting the participants.

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 Community Supports and Services, LR 30:1205 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office

for Citizens with Developmental Disabilities, LR 32:2064 (November 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:74 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:

§13917. Prevocational Services

A. Prevocational services are intended to prepare a participant for paid employment or volunteer opportunities in the community to the participant's highest level. Prevocational services allow the individual to develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings.

1. Prevocational services are intended to develop and teach general skills such as;

a. the ability to communicate effectively with supervisors, co-workers, and customers;

b. accepted community workplace conduct and dress;

c. the ability to follow directions and attend to tasks;

d. workplace problem solving skills and general workplace safety; and

e. mobility training.

2. Prevocational services are provided in a variety of locations in the community and are not limited to a fixed-site facility. Participants receiving prevocational services must have an employment related goal as part of their CPOC and service plan. The general habilitation activities must support their employment goals. Prevocational services are designed to create a path to integrated community based employment for which an individual is compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Assistance with personal care may be a component of prevocational services, but may not comprise the entirety of the service.

B. Prevocational services are provided on a regularly scheduled basis and may be scheduled on a comprehensive plan of care for one or more days per week and may be prior authorized for up to 8,320 units of service in a plan year with appropriate documentation. A standard unit is one quarter hour.

1. – 8. Repealed.

C. Exclusions. The following service exclusions apply to prevocational services.

1. ...

D. Service Limits. Services shall not exceed eight hours a day, five days a week, and cannot exceed 8,320 one quarter hour units of service per CPOC year. Additionally, prevocational

services are time limited to four years, after which the participant should be able to transition into employment. Exceptions to the four year limitation may be approved at the discretion of OCDD program office.

E. Licensing Requirements. Providers must be licensed by the Department of Health as a home and community-based services provider and must meet the module specific requirements for the service being provided.

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 Community Supports and Services, LR 30:1205 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1649 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:75 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:

§13919. Environmental Accessibility Adaptations

A. – C. ...

1. Any service covered under the Medicaid state plan shall not be authorized by NOW. The environmental accessibility

adaptation(s) must be delivered, installed, operational and accepted by the participant/authorized representative in the CPOC year for which it was approved. The environmental accessibility adaptation(s) must be billed and reimbursed according to the Medicaid billing guidelines established by LDH policy. A written itemized detailed bid, including drawings with the dimensions of the existing and proposed floor plans relating to the modification, must be obtained and submitted for prior authorization. Modifications may be applied to rental or leased property with the written approval of the landlord and approval of the human services authority or district. Reimbursement shall not be paid until receipt of written documentation that the job has been completed to the satisfaction of the participant.

2. – 5. ...

6. Excluded are those vehicle adaptations which are of general utility or for maintenance of the vehicle. Car seats are not considered a vehicle adaptation.

D. Service Limits. There is a cap of $7,000 per three year period for a participant for environmental accessibility adaptations. On a case-by-case basis, with supporting documentation and based on need, a participant may be able to exceed this cap with the prior approval of OCDD central office.

E. – E.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, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1206 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1649 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:75 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:

§13921. Specialized Medical Equipment and Supplies

A. – D. ...

E. Service Limitations. There is a cap of $1,000 per three year period for a participant for specialized equipment and supplies. On a case-by-case basis, with supporting documentation and based on need, a participant may be able to exceed this cap with the prior approval of OCDD central office.

F. ...

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 Community

Supports and Services, LR 30:1207 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1649 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:75 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:

§13925. Professional Services

A. Professional services are services designed to increase the participant’s independence, participation and productivity in the home, work and community. Participants, up to the age of 21, who participate in NOW must access these services through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Professional services may only be furnished and reimbursed through NOW when the services are not covered under the Medicaid State Plan. Professional services must be delivered with the participant present and be provided based on the approved CPOC and an individualized service plan. Service intensity, frequency and duration will be determined by individual need. Professional services may be utilized to:

1. – 4. ...

5. provide necessary information to the participant, family, caregivers and/or team to assist in the implementation of plans according to the approved CPOC.

B. – B.1. ...

2. Social work services are highly specialized direct counseling services furnished by a licensed clinical social worker and designed to meet the unique counseling needs of individuals with development disabilities. Counseling may address areas such as human sexuality, depression, anxiety disorders, and social skills. Services must only address those personnel outcomes and goals listed in the approved CPOC.

3. ...

C. Service Limits. There shall be a $2,250 cap per participant per CPOC year for the combined range of professional services in the same day but not at the same time. Additional services may be prior authorized if the participant reaches the cap before the expiration of the comprehensive plan of care and the participant’s health and safety is at risk.

D. – E.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, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1207 (June 2004), amended by the

Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1650 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:76 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:

§13927. Skilled Nursing Services

A. Skilled nursing services are medically necessary nursing services ordered by a physician and provided by a licensed registered nurse or a licensed practical nurse. Skilled nursing services shall be provided by a licensed, enrolled home health agency and require an individual nursing service plan. These services must be included in the participant’s approved CPOC. All Medicaid state plan services must be utilized before accessing this service. Participants, up to the age of 21, must access these services as outlined on the CPOC through the Home Health Program.

B. When there is more than one participant in the home receiving skilled nursing services, services may be shared and payment must be coordinated with the service authorization system and each participant’s approved CPOC. Nursing consultations are offered on an individual basis only.

C. Provider Qualifications. The provider must be licensed by the Department of Health as a home and community-based services

provider and must meet the module specific requirements for the service being provided.

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 Community Supports and Services, LR 30:1208 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1651 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:77 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:

§13929. One Time Transitional Expenses

A. One-time transitional expenses are those allowable expenses incurred by participants who are being transitioned from an ICF-DD to his/her own home or apartment of their choice in the community of their choice. *Own home* shall mean the participant's own place of residence and does not include any family members home or substitute family care homes. The participants must be allowed choice in the items purchased.

B. – D. ...

E. Provider Qualifications. This service shall only be provided by the Department of Health, Office for Citizens with Developmental Disabilities (OCDD) with coordination of appropriate entities.

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 Community Supports and Services, LR 30:1208 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1651 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:77 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:

§13931. Adult Companion Care

A. Adult companion care services assist the participant to achieve and/or maintain the outcomes of increased independence, productivity and inclusion in the community. These services are designed for an individual who lives independently and can manage his/her own household with limited supports. The companion is a principal care provider chosen by the participant, who provides services in the participant’s home and lives with the participant

as a roommate. Adult companion care services are furnished through a licensed provider organization as outlined in the participant's CPOC. This service includes:

1. providing assistance with all of the activities of daily living as indicated in the participant's CPOC;

2. – 3. ...

B. Adult companion care services are arranged by provider organizations that are subject to licensure. The setting is the participant's home which should have been freely chosen by the participant from among non-disability specific settings and not owned or controlled by the provider. The companion is an employee or contractor of the provider organization and is responsible for providing limited, daily direct services to the participant.

1. ...

2. Services may not be provided by a family member who is the participant's spouse or legal guardian.

C. ...

1. The provider organization shall develop a written agreement as part of the participant's CPOC which defines all of the shared responsibilities between the companion and the participant. The written agreement shall include, but is not limited to:

2.a. – 3.b. ...

c. contacting the companion a minimum of once per week or as specified in the participant’s comprehensive plan of care; and

3.d. – 4.a. ...

b. inclusion of any other expenses must be negotiated between the participant and the companion. These negotiations must be facilitated by the provider and the resulting agreement must be included in the written agreement and in the participant’s CPOC.

D. Companion Responsibilities

1. The companion is responsible for:

a. participating in, and abiding by, the CPOC;

D.1.b. – E. ...

1. Adult companion care services may be authorized for up to 365 days per year as documented in the participant’s CPOC.

F. Service Exclusions

1. ...

2. Participants receiving adult companion care services are not eligible for receiving the following services:

a. supported independent living;

b. - d. ...

G. Provider Qualifications. Providers must be licensed by the Department of Health as a home and community-based services

provider and must meet the module specific requirements for the service being provided.

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 for Citizens with Developmental Disabilities, LR 40:77 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:

§13933. Remote Assistance

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 for Citizens with Developmental Disabilities, LR 40:78 (January 2014), repealed by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:

§13935. Housing Stabilization Transition Service

A. Housing stabilization transition service enables participants who are transitioning into a permanent supportive housing unit, including those transitioning from institutions, to

secure their own housing. The service is provided while the participant is in an institution and preparing to exit the institution using the waiver. The setting for the permanent supportive housing must be integrated in the greater community, and support full access to the greater community by the participant. The service includes the following components:

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

a. access to housing of the participant's choice, including non-disability specific settings;

1.b– 3.c. ...

4. participating in the development of the comprehensive plan of care and incorporating elements of the housing support plan; and

A.5. – C.1. ...

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 for Citizens with Developmental Disabilities, LR 40:78 (January 2014), amended by the Department of Health, Bureau of Health

Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:

§13937. Housing Stabilization Service

A. Housing stabilization service enables waiver participants to maintain their own housing as set forth in the participant's approved CPOC. Services must be provided in the home or a community setting. This service includes the following components:

1. – 1.h. ...

2. participating in the development of the CPOC, incorporating elements of the housing support plan;

A.3. – C.1. ...

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 for Citizens with Developmental Disabilities, LR 40:79 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:

Chapter 141. Self-Direction Initiative

§14101. Self-Direction Service Delivery Option

A. ...

B. Participant Responsibilities. Waiver participants choosing the self-directed service delivery option must understand

the rights, risks and responsibilities of managing his/her own care and individual budget. If the participant is unable to make decisions independently, he/she must have an authorized representative who understands the rights, risks and responsibilities of managing his/her care and supports within his/her individual budget. Responsibilities of the participant or authorized representative include:

1. - 2. ...

3. participation in the development and management of the approved personal purchasing plan:

a. this annual budget is determined by the recommended service hours listed in the participant’s CPOC to meet his/her needs;

b. ...

C. Termination of the Self-Direction Service Delivery Option. Termination of participation in the self-direction service delivery option requires a revision of the CPOC, the elimination of the fiscal agent and the selection of the Medicaid-enrolled waiver service provider(s) of choice.

1. Voluntary Termination. The waiver participant may choose at any time to withdraw from the self-direction service delivery option and return to the traditional provider agency management of services.

2. – 2.d.iv. ...

D. All services rendered shall be prior approved and in accordance with the comprehensive plan of care.

E. All services must be documented in service notes, which describes the services rendered and progress towards the participant's personal outcomes and his/her comprehensive plan of care.

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 Community Supports and Services, LR 30:1209 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1651 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:79 (January 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:

Chapter 142. Provider Participation Requirements

§14202. Incident Reporting, Tracking and Follow-up

A. The direct service provider is responsible for responding to, reviewing, and remediating incidents that occur to the participants they support. Direct service providers must comply

with any other rules promulgated by the LDH regarding incident reporting and response.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 44:

Chapter 143. Reimbursement

§14301. Unit of Reimbursement

A. Reimbursement for services shall be a prospective flat rate for each approved unit of service provided to the participant. One quarter hour (15 minutes) is the standard unit of service and reimbursement shall not be made for less than 15 minutes (one quarter hour) of service. This covers both service provision and administrative costs for the following services:

1. - 3. ...

4. prevocational services;

5. individual and family support-day and night:

5.a. – 10. ...

B. The following services are to be paid at cost, based on the need of the participant and when the service has been prior authorized and on the CPOC:

1. – 3. ...

C. The following services are paid through a per diem:

1. ...

2. supported independent living;

C.3. - E. ...

F. Direct Support Professionals Wages. The minimum rate paid to direct support professionals shall be the federal minimum wage in effect at the time.

G. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1209 (June 2004), amended by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 34:252 (February 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 35:1851 (September 2009), LR 36:1247 (June 2010), LR 37:2158 (July 2011), LR 39:1049 (April 2013), LR 40:80 (January 2014), LR 42:898 (June 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, 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

Home Health Program
Home Health Encounters and Services
(LAC 50:XIII.Chapters 1-5)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XIII.Chapters 1-5 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50
PUBLIC HEALTH MEDICAL ASSISTANCE
Part XIII. Home Health Program
Subpart 1. Home Health Services

Chapter 1. General Provisions

§101. Definitions

[Formerly LAC 50:XIX.101]

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

***

Home Health Services—patient care services provided in the patient's residential setting or any setting in which normal life activities take place under the order of a physician that are necessary for the diagnosis and treatment of the patient's

illness or injury, including one or more of the following services:

a. – e. ...

f. medical supplies, equipment and appliances suitable for use in any setting in which normal life activities take place.

NOTE: Medical supplies, equipment and appliances for home health are reimbursed through the Durable Medical Equipment Program and must be prior authorized.

Occupational Therapy Services—medically prescribed treatment to improve, maintain or restore a function which has been impaired by illness or injury or, when the function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning

***

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:431 (March 2004), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

§103. Requirements for Home Health Services

[Formerly LAC 50:XIX.103]

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

B. Home health services shall be provided in the recipient’s residential setting or any setting in which normal life activities take place, other than a hospital, nursing facility, intermediate care facility for individuals with

intellectual disabilities or any setting in which payment is, or could be, made under Medicaid for inpatient services that include room and board.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:431 (March 2004), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

Chapter 3. Medical Necessity

§301. General Provisions

[Formerly LAC 50:XIX.301]

A. - A.5.f. ...

B. Home health skilled nursing and aide services are considered medically reasonable and appropriate when the recipient's medical condition and medical records accurately justify the medical necessity for services to be provided in their residential setting or any setting in which normal life activities take place, other than a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities or any setting in which payment is, or could be made, under Medicaid for inpatient services that include room and board rather than in a physician's office, clinic, or other

outpatient setting according to guidelines as stated in this Subpart.

C. – D.3. ...

E. Home health services will be authorized upon medical necessity determination based on the state's medical necessity criteria pursuant to LAC 50:I.1101.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:431 (March 2004), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

§303. Provisions for Infants and Toddlers

[Formerly LAC 50:XIX.303]

A. – C.2. ...

3. failure or lack of cooperation by the child's legal guardian(s) to obtain the required medical services in an outpatient setting.

NOTE: The fact that an infant or toddler cannot ambulate or travel without assistance from another is not a factor in determining medical necessity for 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, Office of the Secretary, Bureau of Health Services Financing, LR 30:432 (March 2004), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

§305. Extended Nursing Services for Ages 0-21

A. Extended nursing services may be provided to a Medicaid recipient who is age birth through 21 when it is determined to be medically necessary for the recipient to receive a minimum of three continuous hours per day of nursing services. Medical necessity for extended nursing services exists when the recipient has a medically complex condition characterized by multiple, significant medical problems that require nursing care as defined by the Louisiana Nurse Practice Act.

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, Office of the Secretary, Bureau of Health Services Financing, LR 32:406 (March 2006), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

Chapter 5. Retrospective Review

§501. Home Health Visits

[Formerly LAC 50:XIX.501]

A. Home health services provided to recipients are subject to post-payment review in order to determine if the recipient's condition warrants high utilization.

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 and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:432 (March 2004), 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

Inpatient Hospital Services
Office of Public Health Newborn Screening Payments
(LAC 50:V.115)

The Department of Health, Bureau of Health Services Financing has adopted LAC 50:V.115 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.

Title 50
PUBLIC HEALTH-MEDICAL ASSISTANCE
Part V. Hospital Services
Subpart 1. Inpatient Hospitals Services

Chapter 1. General Provisions

§115. Office of Public Health Newborn Screenings

A. The Department of Health, Bureau of Health Services Financing shall provide reimbursement to the Office of Public Health (OPH) through the Medical Assistance Program for newborn screenings performed by OPH on specimens taken from children in acute care hospital settings.

B. Reimbursement

1. Effective for dates of service on or after August 5, 2017, claims submitted by OPH to the Medicaid Program for the provision of legislatively-mandated inpatient hospital newborn screenings shall be reimbursed outside of the acute hospital per

diem rate for the inpatient stay.

a. The hospital shall not include any costs related to newborn screening services provided and billed by OPH in its Medicaid cost report(s).

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 44:

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Intermediate Care Facilities for Persons with Intellectual Disabilities—Public Facilities Transitional Rate Extension
(LAC 50:VII.32969)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:VII.32969 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.

Title 50

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

Chapter 329. Reimbursement Methodology

Subchapter C. Public Facilities

§32969. Transitional Rates for Public Facilities

A. – B. ...

1. The department may extend the period of transition for an additional year, if deemed necessary, for an active CEA facility that is:

a. a large facility of 100 beds or more;

b. serves a medically fragile population; and

c. provides continuous (24-hour) nursing coverage.

C. – F.4. ...

G. Reserved.

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 39:326 (February 2013), amended LR 40:2588 (December 2014), amended 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

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

The Department of Health, Bureau of Health Services Financing has amended LAC 50:VII.33103 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50

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

Chapter 331. Vendor Payments

§33103. Payment Limitations

A. – A.2.a. ...

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

included in the written individual habilitation plan. These exceptions are as follows:

i. – iv. ...

v. official state holidays; and

vi. two days for bereavement of close family members.

(a). *Close Family Members*-parent, step-parent, child, step-child, brother, step-brother, sister, step-sister, spouse, mother-in-law, father-in-law, grand-parent, or grand-child.

* * *

A.3. – J. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 13:578 (October 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 25:682 (April 1999), LR 31:1082 (May 2005), repromulgated LR 31:2257 (September 2005), amended by the Department of Health, Bureau of Health Services Financing, LR 43:325 (February 2017), LR 44:

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Managed Care for Physical and Behavioral Health
Applied Behavior Analysis-Based Therapy Services Integration
(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.

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. - C.4. ...

D. The following is a summary listing of the core benefits and services that an MCO is required to provide:

1. - 12. ...

13. basic and specialized behavioral health services, including applied behavior analysis (ABA)-based

therapy services, excluding Coordinated System of Care services;

D.14. - F.1. ...

G. Excluded Services

1. - 1.e. ...

f. targeted case management services; and

g. all OAAS/OCDD home and community-based §1915(c) waiver services.

h. Repealed.

H. - 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 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

Professional Services Program
State-Owned or Operated Professional Services Practices
Enhanced Reimbursement Rates
(LAC 50:IX.15110 and 15113)

The Department of Health, Bureau of Health Services Financing has adopted LAC 50:IX.15110, and amended §15113, 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.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE
Part IX. Professional Services Program
Subpart 15. Reimbursement

Chapter 151. Reimbursement Methodology

Subchapter A. General Provisions

§15110. State-Owned or Operated Professional Services Practices

A. Qualifying Criteria. Effective for dates of service on or after February 1, 2018, in order to qualify to receive enhanced rate payments for services rendered to Medicaid recipients under these provisions, physicians and other eligible professional service practitioners must be:

1. licensed by the state of Louisiana;

2. enrolled as a Louisiana Medicaid provider; and

3. employed by, or under contract to provide services in affiliation with, a state-owned or operated entity, such as a state-operated hospital or other state entity, including a state academic health system, which:

a. has been designated by the department as an essential provider. Essential providers include:

i. LSU School of Medicine – New Orleans;

ii. LSU School of Medicine – Shreveport; and

iii. LSU state-operated hospitals (Lallie Kemp Regional Medical Center and Villa Feliciana Geriatric Hospital).

B. State-owned or operating entities shall identify to the department which professional service practitioners/groups qualify for the enhanced rate payments.

C. Payment Methodology

1. Effective for dates of service on or after February 1, 2018, payments shall be made at the community rate level for services rendered by physicians and other eligible professional service practitioners who qualify under the provisions of §15110.A.

a. *Community Rate Level*-the rates paid by commercial payers for the same service.

b. The provider's average commercial rate (ACR) demonstration will be updated at least every three years.

c. Enhanced rates are based on average commercial rates effective during the state fiscal year proceeding the fiscal

year in which the ACR is calculated for each service designated by a current procedural terminology (CPT) code recognized by the Medicaid program as a covered service.

2. For services rendered by physicians and other professional services practitioners, in affiliation with a state-owned or operated entity, the department will collect from the state-owned or operated entity its current commercial rates/fee schedules by CPT code for their top three commercial payers by volume.

3. The department will calculate the average commercial rate for each CPT code for each professional services practice that provides services in affiliation with a state-owned or operated entity.

4. The department will extract from its paid claims history file, for the preceding fiscal year, all paid claims for those physicians and professional practitioners who will qualify for the enhanced reimbursement rates. The department will align the average commercial rate for each CPT code to each Medicaid claim for the physician or professional services practitioner/practice plan and calculate the average commercial payments for the claims.

5. The department will also align the same paid Medicaid claims with the Medicare rates for each CPT code for the physician or professional services practitioner and calculate the

Medicare payment amounts for those claims. The Medicare rates will be the most currently available national non-facility rates.

6. The department will calculate an overall Medicare to commercial conversion factor by dividing the total amount of the average commercial payments for the claims by the total Medicare payments for the claims.

7. This conversion factor will be applied to the current Medicare rates for all procedure codes payable for Medicaid to create the enhanced reimbursement rate.

D. Payment to physician-employed physician assistants and registered nurse practitioners shall be 80 percent of the maximum allowable rate paid to physicians.

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:

Subchapter B. Physician Services

§15113. Reimbursement Methodology

A. - M. ...

N. Effective for dates of service on or after February 1, 2018, physicians, who qualify under the provisions of §15110 for services rendered in affiliation with a state-owned or operated entity that has been designated as an essential provider, shall receive enhanced reimbursement rates up to the community rate level for qualifying services as determined in §15110.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 36:1252 (June 2010), amended LR 36:2282 (October 2010), LR 37:904 (March 2011), LR 39:3300, 3301 (December 2013), LR 41:541 (March 2015), LR 41:1119 (June 2015), LR 41:1291 (July 2015), 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

Targeted Case Management
Reimbursement Methodology
Early and Periodic Screening, Diagnosis and Treatment
(LAC 50:XV.10701)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XV.10701 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.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XV. Services for Special Populations
Subpart 7. Targeted Case Management

Chapter 107. Reimbursement

§10701. Reimbursement

A. - K.2. ...

L. Effective for dates of service on or after April 1, 2018, case management services provided to participants in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program shall be reimbursed at a flat rate for each approved unit of service. The standard unit of service is equivalent to one month.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:1040 (May 2004), amended LR 31:2032 (August 2005), LR 35:73 (January 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1903 (September 2009), LR 36:1783 (August 2010), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Public Health, LR 39:97 (January 2013), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3302 (December 2013), LR 40:1700, 1701 (September 2014), LR 41:1490, 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