RULE

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

Adult Behavioral Health Services
(LAC 50:XXXIII.6103, 6301, 6303, and Chapter 65)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health have amended LAC 50:XXXIII.6103, §§6301, 6303 and Chapter 65 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 XXXIII. Behavioral Health Services
Subpart 7. Adult Mental Health Services

Chapter 61. General Provisions

§6103. Recipient Qualifications

A. Individuals over the age of 18, and not otherwise eligible for Medicaid, who meet Medicaid eligibility and clinical criteria established in §6103.B, shall qualify to receive adult behavioral health services.

B. Qualifying individuals who meet one of the following criteria shall be eligible to receive adult behavioral health services.

1. Person with Acute Stabilization Needs

a. The person currently presents with mental health symptoms that are consistent with a diagnosable mental disorder specified within the *Diagnostic and Statistical Manual of Mental Disorders (DSM-V) or the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM),* or subsequent revisions of these documents.

b. …

2. Person with Major Mental Disorder (MMD)

a. The person has at least one diagnosable mental disorder which is commonly associated with higher levels of impairment. These diagnoses may include:

i. schizophrenia spectrum and other psychotic disorders;

ii. bipolar and related disorders; or

iii. depressive disorders.

b. …

c. A person with a primary diagnosis of a substance use disorder without an additional co-occurring qualifying mental health diagnosis shall not meet the criteria for a major mental disorder diagnosis.

3. Persons with Serious Mental Illness (SMI)

a. The person currently has, or at any time during the past year, had a diagnosable qualifying mental health diagnosis of sufficient duration to meet the diagnostic criteria

specified within the DSM-V or the ICD-10-CM, or subsequent revisions of these documents.

b. …

c. A person with a primary diagnosis of a substance use disorder without an additional co-occurring qualifying mental health diagnosis shall not meet the criteria for a SMI diagnosis.

4. …

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 38:358 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 63. Services

§6301. General Provisions

A. – C.4. …

D. Anyone providing behavioral health services must be certified by the department, or its designee, in addition to operating within their scope of practice license.

E. – 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, Bureau of Health Services Financing, LR 38:359 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

§6303. Assessments

A. Each recipient shall undergo an independent assessment prior to receiving behavioral health services. The individual performing the assessment, eligibility, and plan of care shall meet the independent assessment conflict free criteria established by the department.

B. – C. …

D. The evaluation and re-evaluation must be finalized through the SMO using the universal needs assessment criteria and qualified SMO personnel. Needs-based eligibility evaluations are conducted at least every 12 months.

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 38:359 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 65. Provider Participation

§6501. Provider Responsibilities

A. – C. …

D. Anyone providing behavioral health services must be certified by the department, or its designee, in addition to operating within their scope of practice license. To be certified or recertified, providers shall meet the provisions of this Rule, the provider manual and the appropriate statutes. The provider shall create and maintain documents to substantiate that all requirements are met.

E. – E.6. …

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:360 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

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.

Kathy H. Kliebert

Secretary

RULE

Department of Health and Hospitals
Bureau of Health Services Financing

Family Planning Services
(LAC 50:XV.Chapters 251-255)

The Department of Health and Hospitals, Bureau of Health Services Financing has amended LAC 50:XV.Chapters 251-255 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 17. Family Planning Services

Chapter 251. General Provisions

§25101. Purpose

A. Effective July 1, 2014, the Medicaid Program shall provide coverage of family planning services and supplies under the Medicaid State Plan, to a new targeted group of individuals who are otherwise ineligible for Medicaid. This new optional coverage group may also include individuals receiving family planning services through the Section 1115 demonstration waiver, Take Charge Program, if it is determined that they meet the eligibility requirements for the state plan family planning services.

B. The primary goals of family planning services are to:

1. increase access to services which will allow improved reproductive and physical health;

2. improve perinatal outcomes; and

3. reduce the number of unintended pregnancies.

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 40:1097 (June 2014), amended LR 41:

Chapter 253. Eligibility Criteria

§25301. Recipient Qualifications

A. Recipients who qualify for family planning services in the new categorically needy group include individuals of child bearing age who meet the following criteria:

1. women who are not pregnant and have income at or below 138 percent of the federal poverty level; and

2. men who have income at or below 138 percent of the federal poverty level.

3. 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 40:1097 (June 2014), amended LR 41:

Chapter 255. Services

§25501. Covered Services

A. Medicaid covered family planning services include:

1. seven office visits per year for physical examinations or necessary re-visits as it relates to family planning or family planning-related services;

2. contraceptive counseling (including natural family planning), education, follow-ups and referrals;

3. laboratory examinations and tests for the purposes of family planning and management of sexual health;

4. pharmaceutical supplies and devices to prevent conception, including all methods of contraception approved by the Federal Food and Drug Administration; and

a. – c. Repealed.

5. male and female sterilization procedures and follow-up tests provided in accordance with 42 CFR 441, Subpart F.

B. Family planning-related services include the diagnosis and treatment of sexually transmitted diseases or infections, regardless of the purpose of the visit at which the disease or

infection was discovered. Medicaid covered family planning-related services include:

1. diagnostic procedures, drugs and follow-up visits to treat a sexually transmitted disease, infection or disorder identified or diagnosed at a family planning visit (other than HIV/AIDS or hepatitis);

2. annual family planning visits for individuals, both males and females of child bearing age, which may include:

a. a comprehensive patient history;

b. physical, including breast exam;

c. laboratory tests; and

d. contraceptive counseling;

3. vaccine to prevent cervical cancer;

4. treatment of major complications from certain family planning procedures; and

5. transportation services.

C. – C.3 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 40:1098 (June 2014), amended LR 41:

Kathy H. Kliebert

Secretary

RULE

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

Home and Community-Based Services Waivers
Adult Day Health Care
(LAC 50:XXI.Chapter 29)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services have amended LAC 50:XXI.Chapter 29 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 3. Adult Day Health Care

Chapter 29. Reimbursement

§2903. Cost Reporting

A. Cost Centers Components

1. Direct Care Costs. This component reimburses for in-house and contractual direct care staffing, social services and activities (excluding the activities director) and fringe benefits and direct care supplies.

2. Care Related Costs. This component reimburses for in-house and contractual salaries and fringe benefits for supervisory and dietary staff, raw food costs and care related

supplies.

3. Administrative and Operating Costs. This component reimburses for in-house or contractual salaries and related benefits for administrative, housekeeping, laundry and maintenance staff. Also included are:

a. utilities;

b. accounting;

c. dietary supplies;

d. housekeeping and maintenance supplies; and

e. all other administrative and operating type expenditures.

4. Property. This component reimburses for depreciation, interest on capital assets, lease expenses, property taxes and other expenses related to capital assets, excluding property costs related to patient transportation.

5. Transportation. This component reimburses for in-house and contractual driver salaries and related benefits, non-emergency medical transportation, vehicle maintenance and supply expense, motor vehicle depreciation, interest expense related to vehicles, vehicle insurance, and auto leases.

B. Providers of ADHC services are required to file acceptable annual cost reports of all reasonable and allowable costs. An acceptable cost report is one that is prepared in accordance with the requirements of this Section and for which the provider has supporting documentation necessary for

completion of a desk review or audit. The annual cost reports are the basis for determining reimbursement rates. A copy of all reports and statistical data must be retained by the center for no less than five years following the date cost reports are submitted to the Bureau. A chart of accounts and an accounting system on the accrual basis or converted to the accrual basis at year end are required in the cost report preparation process. The Bureau or its designee will perform desk reviews of the cost reports. In addition to the desk review, a representative number of the facilities shall be subject to a full-scope, annual on-site audit. All ADHC cost reports shall be filed with a fiscal year from July 1 through June 30.

1. When a provider ceases to participate in the ADHC Waiver program, the provider must file a cost report covering a period under the program up to the effective date of cessation of participation in the program. Depending on the circumstances involved in the preparation of the provider's final cost report, the provider may file the cost report for a period of not less than one month or not more than 13 months.

C. ...

D. Annual Reporting. Cost reports are to be filed on or before the last day of September following the close of the cost reporting period. Should the due date fall on a Saturday, Sunday, or an official state or federal holiday, the due date shall be the following business day. The cost report forms and

schedules must be filed with one copy of the following documents:

1. a cost report grouping schedule. This schedule should include all trial balance accounts grouped by cost report line item. All subtotals should agree to a specific line item on the cost report. This grouping schedule should be done for the balance sheet, income statement and expenses;

2. a depreciation schedule. The depreciation schedule which reconciles to the depreciation expense reported on the cost report must be submitted. If the center files a home office cost report, copies of the home office depreciation schedules must also be submitted with the home office cost report. All hospital based facilities must submit a copy of a depreciation schedule that clearly shows and totals assets that are hospital only, ADHC only and shared assets;

3. – 5. ...

6. For management services provided by a related party or home office, a description of the basis used to allocate the costs to providers in the group and to non-provider activities and copies of the cost allocation worksheet, if applicable. Costs of related management/home offices must be reported on a separate cost report that includes an allocation schedule; and

D.7. – F. ...

G. Accounting Basis. The cost report must be prepared on

the accrual basis of accounting. If a center is on a cash basis, it will be necessary to convert from a cash basis to an accrual basis for cost reporting purposes. Particular attention must be given to an accurate accrual of all costs at the year-end for appropriate recordation of costs in the applicable cost reporting period. Care must be given to the proper allocation of costs for contracts to the period covered by such contracts. Amounts earned although not actually received and amounts owed to creditors but not paid must be included in the appropriate cost reporting period.

H. ...

I. Attendance Records

1. Attendance data reported on the cost report must be supportable by daily attendance records. Such information must be adequate and available for auditing.

a. – b. Repealed

2. Daily attendance records should include the time of each client’s arrival and departure from the facility. The attendance records should document the presence or absence of each client on each day the facility is open. The facility’s attendance records should document all admissions and discharges on the attendance records. Attendance records should be kept for all clients that attend the adult day facility. This includes Medicaid, Veteran’s Administration, insurance, private, waiver and other clients. The attendance of all clients should

be documented regardless of whether a payment is received on behalf of the client. Supporting documentation such as admission documents, discharge summaries, nurse's progress notes, sign-in/out logs, etc. should be maintained to support services provided to each client.

3. – 4. Repealed.

J. Employee Record

1. The provider shall retain written verification of hours worked by individual employees.

a. Records may be sign-in sheets or time cards, but shall indicate the date and hours worked.

b. Records shall include all employees even on a contractual or consultant basis.

c. – d. Repealed.

2. Verification of employee orientation and in-service training.

3. Verification of the employee's communicable disease screening.

K. Billing Records

1. The provider shall maintain billing records in accordance with recognized fiscal and accounting procedures. Individual records shall be maintained for each client. These records shall meet the following criteria.

a. Records shall clearly detail each charge and each payment made on behalf of the client.

b. Records shall be current and shall clearly reveal to whom charges were made and for whom payments were received.

c. Records shall itemize each billing entry.

d. Records shall show the amount of each payment received and the date received.

2. The provider shall maintain supporting fiscal documents and other records necessary to ensure that claims are made in accordance with federal and state requirements.

L. Non-acceptable Descriptions. “Miscellaneous”, “other” and “various”, without further detailed explanation, are not acceptable descriptions for cost reporting purposes. If any of these are used as descriptions in the cost report, a request for information will not be made and the related line item expense will be automatically disallowed. The provider will not be allowed to submit the proper detail of the expense at a later date, and an appeal of the disallowance of the costs may not be made.

1. – 2. Repealed.

M. Exceptions. Limited exceptions to the cost report filing requirements will be considered on an individual provider basis upon written request from the provider to the Bureau of Health Services Financing, Rate and Audit Review Section. If an exception is allowed, the provider must attach a statement describing fully the nature of the exception for which prior

written permission was requested and granted. Exceptions which may be allowed with written approval are as follows.

1. If the center has been purchased or established during the reporting period, a partial year cost report may be filed in lieu of the required 12-month report.

2. If the center experiences unavoidable difficulties in preparing the cost report by the prescribed due date, an extension may be requested prior to the due date. Requests for exception must contain a full statement of the cause of the difficulties that rendered timely preparation of the cost report impossible.

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 Aging and Adult Services, LR 34:2164 (October 2008), repromulgated LR 34:2569 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and Office of Aging and Adult Services, LR 37:3626 (September 2011), amended LR 41:

§2905. Cost Categories Included in the Cost Report

A. Direct Care (DC) Costs

1. - 13. ...

14. Drugs, Over-the-Counter and Non-Legend- cost of over-the-counter and non-legend drugs provided by the center to

its residents. This is for drugs not covered by Medicaid.

15. - 16. ...

17. Recreational Supplies, DC-cost of items used in the recreational activities of the center.

18. Other Supplies, DC—cost of items used in the direct care of residents which are not patient-specific such as prep supplies, alcohol pads, betadine solution in bulk, tongue depressors, cotton balls, thermometers, blood pressure cuffs and under-pads and diapers (reusable and disposable).

19. Allocated Costs, Hospital Based—the amount of costs that have been allocated through the step-down process from a hospital or state institution as direct care costs when those costs include allocated overhead.

20. Miscellaneous, DC—costs incurred in providing direct care services that cannot be assigned to any other direct care line item on the cost report.

21. Total Direct Care Costs—sum of the above line items.

B. Care Related (CR) Costs

1. – 7. ...

8. Contract, Dietary—cost of dietary services and personnel hired through contract that are not employees of the center.

9. – 15. ...

16. Supplies, CR—the costs of supplies used for

rendering care related services to the clients of the center. All personal care related items such as shampoo and soap administered by all staff must be included on this line.

17. ...

18. Miscellaneous, CR—costs incurred in providing care related care services that cannot be assigned to any other care related line item on the cost report.

19. Total Care Related Costs—the sum of the care related cost line items.

C. Administrative and Operating Costs (AOC)

1. – 24. ...

25. Interest Expense, Non-Capital interest paid on short term borrowing for center operations.

26. ...

27. Legal Fees—only actual and reasonable attorney fees incurred for non-litigation legal services related to client care are allowed.

28. Linen Supplies—cost of sheets, blankets, pillows, and gowns.

29. Management Fees and Home Office Costs—the cost of purchased management services or home office costs incurred that are allocable to the provider. Costs for related management/home office must also be reported on a separate cost report that includes an allocation schedule.

30. Office Supplies and Subscriptions—cost of

consumable goods used in the business office such as:

a. pencils, paper and computer supplies;

b. cost of printing forms and stationery including, but not limited to, nursing and medical forms, accounting and census forms, charge tickets, center letterhead and billing forms;

c. cost of subscribing to newspapers, magazines and periodicals.

31. Postage-cost of postage, including stamps, metered postage, freight charges, and courier services.

a. – c. Repealed.

32. Repairs and Maintenance—supplies and services, including electricians, plumbers, extended service agreements, etc., used to repair and maintain the center building, furniture and equipment except vehicles. This includes computer software maintenance.

33. Taxes and Licenses—the cost of taxes and licenses paid that are not included on any other line of the cost report. This includes tags for vehicles, licenses for center staff (including nurse aide re-certifications) and buildings.

34. Telephone and Communications—cost of telephone services, internet and fax services.

35. Travel—cost of travel (airfare, lodging, meals, etc.) by the administrator and other authorized personnel to attend professional and continuing educational seminars and

meetings or to conduct center business. Commuting expenses and travel allowances are not allowable.

36. Utilities—cost of water, sewer, gas, electric, cable TV and garbage collection services.

37. Allocated Costs, Hospital Based—costs that have been allocated through the step-down process from a hospital as administrative and operating costs.

38. Advertising–costs of employment advertising and soliciting bids. Costs related to promotional advertising are not allowable.

39. Maintenance Supplies-supplies used to repair and maintain the center building, furniture and equipment except vehicles.

40. Miscellaneous—costs incurred in providing center services that cannot be assigned to any other line item on the cost report. Examples of miscellaneous expenses are small equipment purchases, all employees' physicals and shots, nominal gifts to all employees, such as a turkey or ham at Christmas, and flowers purchased for the enjoyment of the clients. Items reported on this line must be specifically identified.

41. Total Administrative and Operating Costs.

D. Property and Equipment

1. – 2. ...

3. Interest Expense, Capital—interest paid or accrued on notes, mortgages, and other loans, the proceeds of

which were used to purchase the center's land, buildings and/or furniture, and equipment, excluding vehicles.

4. Property Insurance—cost of fire and casualty insurance on center buildings, and equipment, excluding vehicles. Hospital-based facilities and state-owned facilities must allocate property insurance based on the number of square feet.

5. Property Taxes—taxes levied on the center's buildings and equipment. Hospital-based facilities and state-owned facilities must allocate property insurance based on the number of square feet.

6. – 8. ...

9. Miscellaneous, Property—any capital costs related to the facility that cannot be assigned to any other property and equipment line item on the cost report.

10. Total Property and Equipment.

E. – 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 Aging and Adult Services, LR 34:2164 (October 2008), repromulgated LR 34:2571 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3626 (September 2011), amended LR 41:

§2909. Nonallowable Costs

A. – C.5. ...

D. Specific nonallowable costs (this is not an all-inclusive listing):

1. - 17. ...

18. penalties and sanctions—penalties and sanctions assessed by the Centers for Medicare and Medicaid Services, DHH, the Internal Revenue Service or the State Tax Commission; insufficient funds charges;

19. – 20. ...

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 Aging and Adult Services, LR 34:2169 (October 2008), repromulgated LR 34:2573 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 41:

§2915. Provider Reimbursement

A. Cost Determination Definitions

Adjustment Factor—Repealed.

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Base Rate Components—Repealed.

a. – e. Repealed.

Index Factor-computed by dividing the value of the index for December of the year preceding the rate year by the value of the index one year earlier (December of the second preceding year).

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Rate Component-the rate is the summation of the following:

a. direct care;

b. care related costs;

c. administrative and operating costs;

d. property costs; and

e. transportation costs.

B. Rate Determination

1. The base rate is calculated based on the most recent audited or desk reviewed cost for all ADHC providers filing acceptable full year cost reports. The rates are based on cost components appropriate for an economic and efficient ADHC providing quality service. The client per quarter hour rates represent the best judgment of the state to provide reasonable and adequate reimbursement required to cover the costs of economic and efficient ADHC.

2. For rate periods between rebasing, the rates will be trended forward using the index factor contingent upon appropriation by the legislature.

3. The median costs for each component are

multiplied in accordance with §2915.B.4 then by the appropriate index factors for each successive year to determine base rate components. For subsequent years, the components thus computed become the base rate components to be multiplied by the appropriate index factors, unless they are adjusted as provided in §2915.B.6 below. Application of an inflationary adjustment to reimbursement rates in non-rebasing years shall apply only when the state legislature allocates funds for this purpose. The inflationary adjustment shall be made prorating allocated funds based on the weight of the rate components.

4. – 5. ...

6. Formulae. Each median cost component shall be calculated as follows.

a. Direct Care Cost Component. Direct care allowable quarter hour costs from all acceptable full year cost reports, except those for which an audit disclaimer has been issued, shall be arrayed from lowest to highest. The cost at the midpoint of the array shall be the median cost. Should there be an even number of arrayed cost, an average of the two midpoint centers shall be the median cost. The median cost shall be trended forward by dividing the value of the Consumer Price Index-Medical Services (South Region) index for December of the year preceding the rate year by the value of the index for the December of the year preceding the cost report year. The direct care rate component shall be set at 115 percent of the inflated

median.

b. Care Related Cost Component. Care related allowable quarter hour costs from all acceptable full year cost reports, except those for which an audit disclaimer has been issued, shall be arrayed from lowest to highest. The cost of the center at the midpoint of the array shall be the median cost. Should there be an even number of arrayed cost, an average of the two midpoint centers shall be the median cost. The median cost shall be trended forward by the value of the Consumer Price Index-All Items (South Region) index for December of the year preceding the rate year by the value of the index for the December of the year preceding the cost report year. The care related rate component shall be set at 105 percent of the inflated median.

c. Administrative and Operating Cost Component. Administrative and operating allowable quarter hour cost from all acceptable full year cost reports, except those for which an audit disclaimer has been issued, shall be arrayed from lowest to highest. The cost of the midpoint of the array shall be the median cost. Should there be an even number of arrayed cost, an average of the two midpoint centers shall be the median cost. The median cost shall be trended forward by dividing the value of the CPI-All Items (South Region) index for December of the year preceding the base rate year by the value of the index for the December of the year preceding the cost report year. The

administrative and operating rate component shall be set at 105 percent of the inflated median.

d. Property Cost Component. The property allowable quarter hour costs from all acceptable full year cost reports, except those for which an audit disclaimer has been issued, shall be arrayed from lowest to highest. The cost at the midpoint of the array shall be the median cost. Should there be an even number of arrayed cost, an average of the two midpoint centers shall be the median cost. This will be the rate component. Inflation will not be added to property costs.

e. Transportation Cost Component. The transportation allowable quarter hour costs from all acceptable full year cost reports, except those for which an audit disclaimer has been issued, will be calculated on a provider by provider basis. Should a provider not have filed an acceptable full year cost report, the provider’s transportation cost will be reimbursed as follows:

i. New provider, as described in §2915.E.1, will be reimbursed in an amount equal to the statewide allowable quarter hour median transportation costs.

(a). In order to calculate the statewide allowable quarter hour median transportation costs, all acceptable full year cost reports, except those for which an audit disclaimer has been issued, shall be arrayed from lowest to highest. The cost at the midpoint of the array shall be the

median cost. Should there be an even number of arrayed cost, an average of the two midpoint centers shall be the median cost. This will be the rate component. Inflation will not be added to transportation costs.

ii. Providers that have gone through a change of ownership (CHOW), as described in §2915.E.2, will be reimbursed for transportation costs based upon the previous owner's specific allowable quarter hour transportation costs for the period of time between the effective date of the CHOW and the first succeeding base year in which the new owner could possibly file an allowable 12-month cost report. Thereafter, the new owner's data will be used to determine the provider's rate following the procedures specified in this Rule.

iii. Providers that have been issued an audit disclaimer, or have a non-filer status, as described in §2915.E.3, will be reimbursed for transportation costs at a rate equal to the lowest allowable quarter hour transportation cost (excluding providers with no transportation costs) in the state as of the most recent audited and/or desk reviewed rate database.

iv. For rate periods between rebasing years, if a provider discontinues transportation services and reported no transportation costs on the most recently audited or desk reviewed cost report, no facility specific transportation rate will be added to the facility's total rate for the rate

year.

7. Budgetary Constraint Rate Adjustment. Effective for the rate period July 1, 2011 to July 1, 2012, the allowable quarter hour rate components for direct care, care related, administrative and operating, property, and transportation shall be reduced by 10.8563 percent.

a. – e. Repealed.

8. Interim Adjustments to Rates. If an unanticipated change in conditions occurs that affects the cost of at least 50 percent of the enrolled ADHC providers by an average of five percent or more, the rate may be changed. The Department will determine whether or not the rates should be changed when requested to do so by 25 percent or more of the enrolled providers, or an organization representing at least 25 percent of the enrolled providers. The burden of proof as to the extent and cost effect of the unanticipated change will rest with the entities requesting the change. The Department may initiate a rate change without a request to do so. Changes to the rates may be temporary adjustments or base rate adjustments as described below.

a. Temporary Adjustments. Temporary adjustments do not affect the base rate used to calculate new rates.

i. Changes Reflected in the Economic Indices. Temporary adjustments may be made when changes which

will eventually be reflected in the economic indices, such as a change in the minimum wage, a change in FICA or a utility rate change, occur after the end of the period covered by the indices, i.e., after the December preceding the rate calculation. Temporary adjustments are effective only until the next annual base rate calculation.

ii. Lump Sum Adjustments. Lump sum adjustments may be made when the event causing the adjustment requires a substantial financial outlay, such as a change in certification standards mandating additional equipment or furnishings. Such adjustments shall be subject to the Bureau's review and approval of costs prior to reimbursement.

b. Base Rate Adjustment. A base rate adjustment will result in a new base rate component value that will be used to calculate the new rate for the next fiscal year. A base rate adjustment may be made when the event causing the adjustment is not one that would be reflected in the indices.

9. Provider Specific Adjustment. When services required by these provisions are not made available to the recipient by the provider, the Department may adjust the prospective payment rate of that specific provider by an amount that is proportional to the cost of providing the service. This adjustment to the rate will be retroactive to the date that is determined by the Department that the provider last provided the service and shall remain in effect until the Department

validates, and accepts in writing, an affidavit that the provider is then providing the service and will continue to provide that service

9.a. - 10. Repealed.

C. Cost Settlement. The direct care cost component shall be subject to cost settlement. The direct care floor shall be equal to 70 percent of the median direct care rate component trended forward for direct care services (plus 70 percent of any direct care incentive added to the rate). The Medicaid Program will recover the difference between the direct care floor and the actual direct care amount expended. If a provider receives an audit disclaimer, the cost settlement for that year will be based on the difference between the direct care floor and the lowest direct care per diem of all facilities in the most recent audited and/or desk reviewed database. If the lowest direct care per diem of all facilities in the most recent audited and/or desk reviewed database is lower than 50 percent of the direct care rate paid for that year, 50 percent of the direct care rate paid will be used as the provider’s direct care per diem for settlement purposes.

D. ...

E. New Facilities, Changes of Ownership of Existing Facilities, and Existing Facilities with Disclaimer or Non-Filer Status

1. New Facilities are those entities whose beds

have not previously been certified to participate, or otherwise have participated, in the Medicaid program. New facilities will be reimbursed in accordance with this Rule and receiving the direct care, care related, administrative and operating, property rate components as determined in §2915.B.1 - §2915.B.6. These new facilities will also receive the state-wide average transportation rate component, as calculated in §2915.B. 6.e.i.(a), effective the preceding July 1.

2. A change of ownership exists if the beds of the new owner have previously been certified to participate, or otherwise have participated, in the Medicaid program under the previous owner’s provider agreement. Rates paid to facilities that have undergone a change in ownership will be based upon the rate paid to the previous owner for all rate components. Thereafter, the new owner’s data will be used to determine the facility’s rate following the procedures in this rule.

3. Existing providers that have been issued an audit disclaimer, or are a provider who has failed to file a complete cost report in accordance with §2903, will be reimbursed based upon the statewide allowable quarter hour median costs for the direct care, care related, administrative and operating, and property rate components as determined in §2915.B.1 - §2915.B.7. No inflation or median adjustment factor will be included in these components. The transportation component will be reimbursed as described in §2915.B.6.e.iii.

F. Effective for dates of service on or after July 1, 2012, the reimbursement rates for ADHC services shall be reduced by 1.5 percent of the rates in effect on June 30, 2012.

1. The provider-specific transportation component shall be excluded from this rate reduction.

F.2. – G.1 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 Aging and Adult Services, LR 34:2170 (October 2008), repromulgated LR 34:2575 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2157 (July 2011), LR 37:2627 (September 2011), repromulgated LR 38:1594 (July 2012), amended LR 39:507 (March 2013), LR 41:

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.

Kathy H. Kliebert

Secretary

RULE

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

School Based Behavioral Health Services
(LAC 50:XXXIII.4303 and 4501)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health have amended LAC 50:XXXIII.4301 and §4501 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 XXXIII. Behavioral Health Services
Subpart 5. School Based Behavioral Health Services

Chapter 43. Services

§4303. Covered Services

A. ...

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

1. therapeutic services, including diagnosis and treatment;

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

3. addiction services.

C. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:400 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 45. Provider Participation

§4501. Local Education Agency Responsibilities

A. – B. ...

C. Each provider of behavioral health services shall enter into a contract with the Statewide Management Organization in order to receive reimbursement for Medicaid covered services.

D. All services shall be delivered in accordance with federal and state laws and regulations, the provisions of this Rule, the provider manual, and other notices or directives issued by the department.

E. Providers of behavioral health services shall ensure that all services are authorized and any services that exceed established limitations beyond the initial authorization are approved for re-authorization prior to service delivery.

F. Anyone providing behavioral health services must be certified by the department, or its designee, in addition to operating within their scope of practice license. To be certified or recertified, providers shall meet the provisions of this Rule, the provider manual and the appropriate statutes. The provider shall create and maintain documents to substantiate that all requirements are met.

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

1. a copy of the treatment plan,;

2. the name of the individual;

3. the dates of service;

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

5. the progress made toward functional improvement; and

6. the goals of the treatment plan.

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:

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.

Kathy H. Kliebert

Secretary