RULE

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

Behavioral Health Services
Statewide Management Organization
LaCHIP Affordable Plan Benefits Administration
(LAC 50:XXXIII.103)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health have amended LAC 50:XXXIII.103 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 1. Statewide Management Organization

Chapter 1. General Provisions

§103. Recipient Participation

A. The following Medicaid recipients shall be mandatory participants in the coordinated behavioral health system of care:

1. - 5. ...

6. children who receive foster care or adoption assistance (Title IV-E), or who are in foster care or who are otherwise in an out-of-home placement;

7. Title XXI SCHIP populations, including:

a. LaCHIP Phases 1 - 4; and

b. LaCHIP Affordable Plan (Phase 5);

8. recipients who receive both Medicare and Medicaid benefits; and

9. recipients enrolled in the LaMOMS program.

B. ...

C. Notwithstanding the provisions of Subsection A of this Section, the following Medicaid recipients are excluded from enrollment in the PIHP/SMO:

1. recipients enrolled in the Medicare Beneficiary Programs (QMB, SLMB, QDWI and QI-1);

2. adults who reside in an intermediate care facility for persons with intellectual disabilities (ICF/ID);

3. recipients of Refugee Cash Assistance;

4. recipients enrolled in the Regular Medically Needy Program;

5. recipients enrolled in the Tuberculosis Infected Individual Program;

6. recipients who receive emergency services only coverage;

7. recipients who receive services through the Program of All-Inclusive Care for the Elderly (PACE);

8. recipients enrolled in the Low Income Subsidy Program;

9. participants in the TAKE CHARGE Family Planning Waiver; and

10. recipients enrolled in the LaMOMS Program.

11. - 12. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:361 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Kathy H. Kliebert

Secretary

RULE

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

Home and Community-Based Services Waivers
Children's Choice Waiver
Electronic Visit Verification
(LAC 50:XXI.11531)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities have adopted LAC 50:XXI.11531 under 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 9. Children's Choice

Chapter 115. Provider Participation Requirements

Subchapter B. Provider Requirements

§11531. Electronic Visit Verification

A. Effective for dates of service on or after August 1, 2015, Children's Choice Waiver providers shall use the electronic visit verification (EVV) system designated by the department for automated

scheduling, time and attendance tracking, and billing for certain home and community-based services.

B. Reimbursement shall only be made to providers with documented use of the EVV system. The services that require use of the EVV system will be published in the Children's Choice Waiver provider manual.

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 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 for Citizens with Developmental Disabilities

Home and Community-Based Services Waivers
New Opportunities Waiver
Electronic Visit Verification
(LAC 50:XXI.Chapter 142)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities have adopted LAC 50:XXI.Chapter 142 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 142. Provider Participation Requirements

§14201. Electronic Visit Verification

A. Effective for dates of service on or after August 1, 2015, New Opportunities Waiver providers shall use the electronic visit verification (EVV) system designated by the department for automated scheduling, time and attendance tracking, and billing for certain home and community-based services.

B. Reimbursement shall only be made to providers with documented use of the EVV system. The services that require use of the EVV system will be published in the NOW provider manual.

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 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 Service Financing
and
Office for Citizens with Developmental Disabilities

Home and Community-Based Services Waivers
Residential Options Waiver
Electronic Visit Verification
(LAC 50:XXI.16705)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities has adopted LAC 50:XXI.16705 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 13. Residential Options Waiver

Chapter 167. Provider Participation

§16705. Electronic Visit Verification

A. Effective for dates of service on or after July 1, 2015, Residential Options Waiver providers shall use the electronic visit verification (EVV) system designated by the department for automated scheduling, time and attendance

tracking, and billing for certain home and community-based services.

B. Reimbursement shall only be made to providers with documented use of the EVV system. The services that require use of the EVV system will be published in the ROW provider manual.

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 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 for Citizens with Developmental Disabilities

Home and Community-Based Services Waivers
Supports Waiver
Electronic Visit Verification
(LAC 50:XXI.5903)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities have adopted LAC 50:XXI.5903 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 5. Supports waiver

Chapter 59. Provider Participation

§5903. Electronic Visit Verification

A. Effective for dates of service on or after August 1, 2015, Supports Waiver providers shall use the electronic visit verification (EVV) system designated by the department for automated scheduling, time and attendance tracking, and billing for certain home and community-based services.

B. Reimbursement shall only be made to providers with

documented use of the EVV system. The services that require use of the EVV system will be published in the Supports Waiver provider manual.

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 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

Home Health Program
Rehabilitation Services
Reimbursement Rate Increase
(LAC 50:XIII.Chapter 9)

The Department of Health and Hospitals, Bureau of Health Services Financing has repealed the provisions of the June 20, 1997, May 20, 2001, and the May 20, 2004 Rules governing rehabilitation services, and adopted LAC 50:XIII.Chapter 9 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
Subpart 1. Home Health Services

Chapter 9. Rehabilitation Services

§901. General Provisions

A. The Medicaid Program provides coverage for rehabilitation services rendered in the Home Health Program. Home Health rehabilitation services include:

1. physical therapy;

2. occupational therapy; and

3. speech/language therapy.

B. All home health rehabilitation services must be medically necessary and prior authorized.

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 41:

§903. Reserved.

§905. Reimbursement Methodology

A. The Medicaid Program provides reimbursement for physical therapy, occupational therapy and speech/language therapy covered under the Home Health Program.

B. Effective for dates of service on or after February 13, 2014, reimbursement for physical and occupational therapy services shall be 85 percent of the 2013 Medicare published rate. There shall be no automatic enhanced rate adjustment for physical and occupational therapy services.

C. Speech/language therapy services shall continue to be reimbursed at the flat fee in place as of February 13, 2014 and in accordance with the Medicaid published fee schedule for speech/language therapy services provided in the Home Health Program.

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 41:

Kathy H. Kliebert

Secretary

RULE

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

Nursing Facilities - Standards for Payment
Level of Care Determinations
(LAC 50:II.10156)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services have amended LAC 50:II.10156 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 Administrative Procedure Act, R.S. 49:950 et seq.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE
Part II. Medical Assistance Program
Subpart 3. Standards for Payment
Chapter 101. Standards for Payment for Nursing Facilities

Subchapter G. Levels of Care

§10156. Level of Care Pathways

A. - B. ...

C. The level of care pathways elicit specific information, within a specified look-back period, regarding the individual's:

1. ...

2. receipt of assistance with activities of daily living (ADL);

C.3. - E.2.m. ...

F. Physician Involvement Pathway

1. - 2. ...

3. In order for an individual to be approved under the Physician Involvement Pathway, the individual must have one day of doctor visits and at least four new order changes within the last 14 days or:

a. at least two days of doctor visits and at least two new order changes within the last 14 days; and

F.3.b. - I.1.d. ...

2. In order for an individual to be approved under the behavior pathway, the individual must have:

a. exhibited any one of the following behaviors four to six days of the screening tool's seven-day look-back period, but less than daily:

i. - ii. ...

iii. physically abusive;

iv. socially inappropriate or disruptive; or

b. exhibited any one of the following behaviors daily during the screening tool's seven-day look-back period:

i. - iii. ...

iv. socially inappropriate or disruptive; or

c. experienced delusions or hallucinations within the screening tool's seven-day look-back period that impacted his/her ability to live independently in the community; or

d. exhibited any one of the following behaviors during the assessment tool's three-day look-back period and behavior(s) were not easily altered:

i. wandering;

ii. verbally abusive;

iii. physically abusive;

iv. socially inappropriate or disruptive; or

e. experienced delusions or hallucinations within the assessment tool's three-day look-back period that impacted his/her ability to live independently in the community.

J. - J.3. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:342 (January 2011), amended LR 39:1471 (June 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

Professional Services Program
Immunizations
Reimbursement Methodology
(LAC 50:IX.8305 and 8505)

The Department of Health and Hospitals, Bureau of Health Services Financing has amended LAC 50:IX.8305 and §8505 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 7. Immunizations

Chapter 83. Children's Immunizations

§8305. Reimbursement Methodology

A. - C.3.a. ...

D. Effective for dates of service on or after January 1, 2013 through December 31, 2014, certain vaccine administration services shall be reimbursed at payment rates consistent with the methodologies that apply to such services and physicians under Part B of Title XVIII of the Social Security Act (Medicare) and the Vaccines for Children (VFC) Program.

1. The following vaccine service codes, when covered by the Medicaid Program and provided under the VFC Program, shall be reimbursed at an increased rate:

a. 90471, 90472, 90473 and 90474; or

b. their successor codes as specified by the U.S. Department of Health and Human Services.

2. Qualifying Criteria. Reimbursement shall be limited to specified services furnished by a physician, either a doctor of osteopathy or a medical doctor or under the personal supervision of a physician, who attests to a specialty or subspecialty designation in family medicine, general internal medicine or pediatrics, and also attests to meeting one or more of the following criteria:

a. certification as a specialist or subspecialist within family medicine, general internal medicine or pediatric medicine by the American Board of Medical Specialists (ABMS), the American Board of Physician Specialties (ABPS), or the American Osteopathic Association (AOA); or

b. specified evaluation and management and vaccine services that equal at least 60 percent of total Medicaid codes paid during the most recently completed calendar year, or for newly eligible physicians the prior month.

3. Payment Methodology. For vaccine administration services provided under the Vaccines for Children Program in

calendar years 2013 and 2014, the reimbursement shall be the lesser of the:

a. regional maximum administration fee; or

b. Medicare fee schedule rate in calendar years 2013 or 2014 that reflects the mean value over all parishes (counties) of the rate for each of the specified code(s) or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor multiplied by the calendar year 2013 and 2014 relative value units in accordance with 42 CFR 447.405 as approved by the Centers for Medicare and Medicaid Services.

4. The department shall make a payment to the provider for the difference between the Medicaid rate and the increased rate, if any.

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 35:71 (January 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Public Health, LR 39:96 (January 2013), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Chapter 85. Adult Immunizations

§8505. Reimbursement Methodology

A. - B.3.a. ...

C. Effective for dates of service on or after January 1, 2013 through December 31, 2014, certain vaccine administration services shall be reimbursed at payment rates consistent with the methodology that applies to such services and physicians under Part B of Title XVIII of the Social Security Act (Medicare).

1. The following vaccine service codes, when covered by the Medicaid Program, shall be reimbursed at an increased rate:

a. 90471, 90472, 90473 and 90474; or

b. their successor codes as specified by the U.S. Department of Health and Human Services.

2. Qualifying Criteria. Reimbursement shall be limited to specified services furnished by a physician, either a doctor of osteopathy or a medical doctor or under the personal supervision of a physician, who attests to a specialty or subspecialty designation in family medicine, general internal medicine or pediatrics, and also attests to meeting one or more of the following criteria:

a. certification as a specialist or subspecialist within family medicine, general internal medicine or pediatric medicine by the American Board of Medical Specialists (ABMS), the American Board of Physician Specialties (ABPS), or the American Osteopathic Association (AOA); or

b. specified evaluation and management and vaccine services that equal at least 60 percent of total Medicaid codes paid during the most recently completed calendar year, or for newly eligible physicians the prior month.

3. Payment Methodology. For vaccine administration services provided in calendar years 2013 and 2014, the reimbursement shall be the lesser of the:

a. Medicare fee schedule rate in calendar years 2013 or 2014 that reflects the mean value over all parishes (counties) of the rate for each of the specified code(s) or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor multiplied by the calendar year 2013 and 2014 relative value units in accordance with 42 CFR 447.405 as approved by the Centers for Medicare and Medicaid Services; or

b. provider's actual billed charges for the service.

4. The department shall make a payment to the provider for the difference between the Medicaid rate and the increased rate, if any.

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

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

Office of Public Health, LR 39:97 (January 2013), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Kathy H. Kliebert

Secretary

RULE

Department of Health and Hospitals
Bureau of Health Services Financing

Professional Services Program
Physician Services
Reimbursement Methodology
(LAC 50:IX.15113)

The Department of Health and Hospitals, Bureau of Health Services Financing has amended LAC 50:IX.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 B. Physician Services

§15113. Reimbursement Methodology

A. - I.3. …

J. Effective for dates of service on or after January 1, 2013 through December 31, 2014, certain physician services shall be reimbursed at payment rates consistent with the methodology that applies to such services and physicians under part B of title XVIII of the Social Security Act (Medicare).

1. The following physician service codes, when covered by the Medicaid Program, shall be reimbursed at an increased rate:

a. evaluation and management codes 99201 through 99499; or

b. their successor codes as specified by the U.S. Department of Health and Human Services.

2. Qualifying Criteria. Reimbursement shall be limited to specified services furnished by or under the personal supervision of a physician, either a doctor of osteopathy or a medical doctor, who attests to a specialty or subspecialty designation in family medicine, general internal medicine or pediatrics, and who also attests to meeting one or more of the following criteria:

a. certification as a specialist or subspecialist in family medicine, general internal medicine or pediatric medicine by the American Board of Medical Specialists (ABMS), the American Board of Physician Specialties (ABPS), or the American Osteopathic Association (AOA); or

b. specified evaluation and management and vaccine services that equal at least 60 percent of total Medicaid codes paid during the most recently completed calendar year, or for newly eligible physicians the prior month.

3. Payment Methodology. For primary care services provided in calendar years 2013 and 2014, the reimbursement shall be the lesser of the:

a. Medicare Part B fee schedule rate in calendar years 2013 or 2014 that is applicable to the place of service and reflects the mean value over all parishes (counties) of the rate for each of the specified or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor multiplied by the calendar year 2013 and 2014 relative value units in accordance with 42 CFR 447.405. If there is no applicable rate established by Medicare, the reimbursement shall be the rate specified in a fee schedule established and announced by the Centers for Medicare and Medicaid Services (CMS); or

b. provider's actual billed charge for the service.

4. The department shall make payment to the provider for the difference between the Medicaid rate and the increased rate, if any.

K. - M. …

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:

Kathy H. Kliebert

Secretary

RULE

Department of Health and Hospitals
Bureau of Health Services Financing

State Children's Health Insurance Program
LaCHIP Affordable Plan Benefits Administration
(LAC 50:III.Chapter 205)

The Department of Health and Hospitals, Bureau of Health Services Financing has amended LAC 50:III.20501 and §§20505-20507 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XXI 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 III. Eligibility
Subpart 11. State Children's Health Insurance Program

Chapter 205. Louisiana Children's Health Insurance Program (LaCHIP) - Phase V

§20501. General Provisions

A. …

B. The Department retains the oversight and management of this LaCHIP expansion with health care benefits provided through the BAYOU HEALTH Program and behavioral health services provided through the Louisiana Behavioral Health Partnership (LBHP).

C. Phase five is a cost-sharing program. Families who are enrolled in phase five of LaCHIP will be responsible for paying premiums.

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

HISTORICAL NOTE: Repromulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:660 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§20505. Covered Services

A. Children covered in phase five of the LaCHIP expansion shall receive health care benefits through an array of covered services offered by health plans participating in the BAYOU HEALTH Program, and behavioral health services administered by the Statewide Management Organization under the LBHP. The following services shall be included:

1. - 8. …

9. inpatient and outpatient behavioral health services other than those listed in any other provisions of §20503:

9.a. - 10. …

11. nursing care services;

a. Repealed.

12. …

13. inpatient substance abuse treatment services, including residential substance abuse treatment services:

a. inpatient admissions must be pre-certified. Emergency services are covered if, upon review, presentation is

determined to be life-threatening, resulting in admission to inpatient, partial hospital or intensive outpatient level of care;

b. …

14. outpatient substance abuse treatment services:

a. all services must be pre-certified;

b. …

15. case management services;

a. Repealed.

16. - 16.a. …

17. hospice care:

a. Repealed.

18. medical transportation; and

a. Repealed.

19. …

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

HISTORICAL NOTE: Repromulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:660 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§20507. Cost Sharing

A. Phase five of LaCHIP is a cost-sharing program with premiums limited to no more than 5 percent of the family's annual income.

B. The following cost-sharing criteria shall apply.

1. - 1.a. …

2. - 3.e. Repealed.

C. Non-payment of premiums may result in disenrollment from LaCHIP. Recipients shall be allowed a 60-day grace period prior to disenrollment for non-payment.

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

HISTORICAL NOTE: Repromulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:661 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Kathy H. Kliebert

Secretary

RULE

Department of Health and Hospitals
Bureau of Health Services Financing

State Children's Health Insurance Program
Modified Adjusted Gross Income
(LAC 50:III.20103)

The Department of Health and Hospitals, Bureau of Health Services Financing has amended LAC 50:III.20103 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XXI 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 III. Eligibility

Subpart 11. State Children's Health Insurance Program

Chapter 201. Louisiana Children's Health Insurance Program (LaCHIP) - Phases 1-3

§20103. Eligibility Criteria

A. - A.1. ...

2. are from families with income at or below 217 percent of the federal poverty level; and

A.3. - D.1.f. ...

E. Effective December 31, 2013 eligibility for LaCHIP shall be determined by modified adjusted gross income (MAGI) methodology in accordance with section 1004(a)(2) of the Patient

Protection and Affordable Care Act (ACA) of 2010 and section 36B (d)(2)(B) of the *Internal Revenue Code*.

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

HISTORICAL NOTE: Repromulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:659 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Kathy H. Kliebert

Secretary

RULE

Department of Health and Hospitals
Bureau of Health Services Financing

Therapeutic Group Homes
Licensing Standards
(LAC 48:I.Chapter 62)

The Department of Health and Hospitals, Bureau of Health Services Financing has amended LAC 48:I.Chapter 62 in the Medical Assistance Program as authorized by R.S. 36:254 and R.S. 40:2009. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 48

PUBLIC HEALTH-GENERAL
Part I. General Administration
Subpart 3. Licensing

Chapter 62. Therapeutic Group Homes

Subchapter A. General Provisions

§6203. Definitions

Active Treatment-implementation of a professionally developed and supervised comprehensive treatment plan that is developed no later than seven days after admission and designed to achieve the client's discharge from inpatient status within the shortest practicable time. To be considered active treatment, the services must contribute to the achievement of the goals listed in the comprehensive treatment plan. Tutoring, attending school, and transportation are not considered active treatment. Recreational activities can be considered active

treatment when such activities are community based, structured and integrated within the surrounding community.

***

Therapeutic Group Home (TGH)-a facility that provides community-based residential services to clients under the age of 21 in a home-like setting of no greater than 10 beds under the supervision and oversight of a psychiatrist or psychologist.

***

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:402 (February 2012), amended LR 41:

Subchapter B. Licensing

§6213. Changes in Licensee Information or Personnel

A. - C.1. ...

2. A TGH that is under provisional licensure, license revocation, or denial of license renewal may not undergo a CHOW.

D. - E. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:405 (February 2012), amended LR 41:

§6219. Licensing Surveys

A. - D. ...

E. If deficiencies have been cited during a licensing survey, regardless of whether an acceptable plan of correction is required, the department may issue appropriate sanctions, including, but not limited to:

1. ...

2. directed plans of correction;

3. provisional licensure;

4. denial of renewal; and/or

5. license revocations.

F. - F.2 ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:406 (February 2012), amended LR 41:

§6221. Complaint Surveys

A. - J.1. ...

a. The offer of the administrative appeal, if appropriate, as determined by the Health Standards Section, shall be included in the notification letter of the results of the informal reconsideration results. The right to administrative appeal shall only be deemed appropriate and thereby afforded upon completion of the informal

reconsideration.

2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:407 (February 2012), amended LR 41:

§6223. Statement of Deficiencies

A. - C.1. ...

2. The written request for informal reconsideration of the deficiencies shall be submitted to the Health Standards Section and will be considered timely if received by HSS within 10 calendar days of the provider's receipt of the statement of deficiencies.

3. - 5. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:407 (February 2012), amended LR 41:

§6225. Cessation of Business

A. Except as provided in §6295 of this chapter, a license shall be immediately null and void if a TGH ceases to operate.

1. - 3. Repealed.

B. A cessation of business is deemed to be effective the

date on which the TGH stopped offering or providing services to the community.

C. Upon the cessation of business, the provider shall immediately return the original license to the Department.

D. Cessation of business is deemed to be a voluntary action on the part of the provider. The provider does not have a right to appeal a cessation of business.

E. Prior to the effective date of the closure or cessation of business, the TGH shall:

1. give 30 days' advance written notice to:

a. HSS;

b. the prescribing physician; and

c. the parent(s) or legal guardian or legal representative of each client; and

2. provide for an orderly discharge and transition of all of the clients in the facility.

F. In addition to the advance notice of voluntary closure, the TGH shall submit a written plan for the disposition of client medical records for approval by the department. The plan shall include the following:

1. the effective date of the voluntary closure;

2. provisions that comply with federal and state laws on storage, maintenance, access, and confidentiality of the closed provider's clients' medical records;

3. an appointed custodian(s) who shall provide the

following:

a. access to records and copies of records to the client or authorized representative, upon presentation of proper authorization(s); and

b. physical and environmental security that protects the records against fire, water, intrusion, unauthorized access, loss and destruction; and

4. public notice regarding access to records, in the newspaper with the largest circulation in close proximity to the closing provider, at least 15 days prior to the effective date of closure.

G. If a TGH fails to follow these procedures, the owners, managers, officers, directors, and administrators may be prohibited from opening, managing, directing, operating, or owning a TGH for a period of two years.

H. Once the TGH has ceased doing business, the TGH shall not provide services until the provider has obtained a new initial license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:407 (February 2012), amended LR 41:

§6227. Denial of License, Revocation of License, or Denial of License Renewal

A. - C.3. ...

D. Revocation of License or Denial of License Renewal. A TGH license may be revoked or may be denied renewal for any of the following reasons, including but not limited to:

1. - 15. ...

16. failure to repay an identified overpayment to the department or failure to enter into a payment agreement to repay such overpayment;

17. failure to timely pay outstanding fees, fines, sanctions, or other debts owed to the department; or

18. failure to maintain accreditation, or for a new TGH that has applied for accreditation, the failure to obtain accreditation.

19. Repealed.

E. If a TGH license is revoked or renewal is denied or the license is surrendered in lieu of an adverse action, any owner, officer, member, director, manager, or administrator of such TGH may be prohibited from opening, managing, directing, operating, or owning another TGH for a period of two years from the date of the final disposition of the revocation, denial action, or surrender.

F. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health

and Hospitals, Bureau of Health Services Financing, LR 38:408 (February 2012), amended LR 41:

§6229. Notice and Appeal of License Denial, License Revocation, License Non-Renewal, and Appeal of Provisional License

A. - B. ...

1. The TGH provider shall request the informal reconsideration within 15 calendar days of the receipt of the notice of the license denial, license revocation, or license non-renewal. The request for informal reconsideration must be in writing and shall be forwarded to the Health Standards Section.

B.2. - D. ...

E. If a timely administrative appeal has been filed by the provider on a license denial, license non-renewal, or license revocation, the DAL or its successor shall conduct the hearing pursuant to the Louisiana Administrative Procedure Act.

E.1. - G.2. ...

3. The provider shall request the informal reconsideration in writing, which shall be received by the HSS within five days of receipt of the notice of the results of the follow-up survey from the department.

a. Repealed

4. The provider shall request the administrative appeal within 15 days of receipt of the notice of the results of the follow-up survey from the department. The request for

administrative appeal shall be in writing and shall be submitted to the Division of Administrative Law, or its successor.

a. Repealed

H. - H.1. ...

I. If a timely administrative appeal has been filed by a provider with a provisional initial license that has expired or by an existing provider whose provisional license has expired under the provisions of this Chapter, the DAL or its successor shall conduct the hearing pursuant to the Louisiana Administrative Procedure Act.

1. - 2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:409 (February 2012), amended LR 41:

Subchapter D. Provider Responsibilities

§6247. Staffing Requirements

A. - C.2. ...

3. A ratio of not less than one staff to five clients is maintained at all times; however, two staff must be on duty at all times with at least one being direct care staff when there is a client present.

D. - D.3. ...

4. Therapist. Each therapist shall be available at

least three hours per week for individual and group therapy and two hours per month for family therapy.

5. Direct Care Staff. The ratio of direct care staff to clients served shall be 1:5 with a minimum of two staff on duty per shift for a 10 bed capacity. This ratio may need to be increased based on the assessed level of acuity of the youth or if treatment interventions are delivered in the community and offsite.

E. - G. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:413 (February 2012), amended LR 41:

§6249. Personnel Qualifications and Responsibilities

A. - A.1.a.ii.(c). ...

b. A supervising practitioner's responsibilities shall include, but are not limited to:

i. reviewing the referral PTA and completing an initial diagnostic assessment at admission or within 72 hours of admission and prior to service delivery;

ii. - iv. ...

v. at least every 28 days or more often as necessary, providing:

1.b.v.(a). - 6.b.viii. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:414 (February 2012), amended LR 41:

Subchapter F. Services

§6267. Comprehensive Treatment Plan

A. Within seven days of admission, a comprehensive treatment plan shall be developed by the established multidisciplinary team of staff providing services for the client. Each treatment team member shall sign and indicate their attendance and involvement in the treatment team meeting. The treatment team review shall be directed and supervised by the supervising practitioner at a minimum of every 28 days.

B. - G.5. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:418 (February 2012), amended LR 41:

§6269. Client Services

A. - A.4. ...

B. The TGH is required to provide at least 16 hours of active treatment per week to each client. This treatment shall be provided and/or monitored by qualified staff.

C. The TGH shall have a written plan for insuring that a range of daily indoor and outdoor recreational and leisure opportunities are provided for clients. Such opportunities shall be based on both the individual interests and needs of the client and the composition of the living group.

C.1. - G.4. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:419 (February 2012), amended LR 41:

Kathy H. Kliebert

Secretary