

STATE OF LOUISIANA

PAYMENT OF MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

CITATION Medical and Remedial Care and Services Item 4.b.
42 CFR
447.201 and Early and Periodic Screening, Diagnostic, and Treatment of Individuals under 21 Years
447.304 of Age are Reimbursed as follows:

I. Basic EPSDT Services

Governmental and non-governmental providers are reimbursed the same rate except as otherwise noted in the State Plan and/or approved federal waivers. Fee schedules are published on the Louisiana Medicaid website at https://www.lamedicaid.com/Provweb1/fee_schedules/feeschedulesindex.htm unless stated in the State Plan.

- A. **EPSDT Preventive Screening (Medical, Vision, Hearing, Dental) - Periodic and Interperiodic Screening** (including immunizations) are reimbursed according to the ‘EPSDT Preventive Services Fee Schedule’ and/or the age-appropriate immunization fee schedule minus any third party coverage.
- B. **Eyeglass Services** are reimbursed at the fee schedule for eyeglasses (including cataract eyeglasses and contact lenses) in effect for services provided on or after March 1, 2004.
- C. **Hearing Aid Services** are reimbursed at the lower of:
 - 1. the provider's actual charge for the services, or
 - 2. the allowable fee for similar services covered under the State Plan.
- D. **Rehabilitative Services** provided to recipients up to the age of three are reimbursed at the maximum allowable fee for occupational, physical, speech therapy, audiology, and psychology services according to the State’s established fee schedule which is available on the Office of Citizens with Developmental Disabilities (OCDD) website under the link “EPSDT Early Intervention Services (EarlySteps) at https://ldh.la.gov/assets/docs/OCDD/EarlySteps/Provider_Docs/LAServicesandRates_10012013.pdf.

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G. EPSDT Services Provided by Local Education Agencies

Effective for dates of service on or after March 20, 2019, the following medically necessary services provided by local education agencies (LEAs) are reimbursable when included on a recipient's individualized service plan (IEP), a section 504 accommodation plan, an individualized health care plan, an individualized family service plan, or medical need documentation:

1. medical and remedial care;
2. personal care;
3. rehabilitative;
4. audiology;
5. speech pathology;
6. occupational therapy;
7. speech therapy; and
8. Applied Behavioral Analysis (ABA)

The services are reimbursed according to the following methodology:

Cost Reporting

Settlement payments for EPSDT services provided in a school setting, shall be based on the most recent school year's actual cost as determined by desk review and/or audit for each LEA provider. Each LEA shall determine cost annually by using LDH's cost report for each EPSDT services cost form.

Direct cost shall be the amount of total compensation (salaries, vendor payments and fringe benefits) of current service providers and the direct cost related to the electronic health records to arrive at the total direct costs for services. There are no additional direct costs included. The basis of allocation for direct service compensation cost for employees is LDH's Direct Services Time Study Methodology approved by CMS November 2014. This time study incorporates the CMS approved Medicaid Administrative Claiming (MAC) methodology for direct service employees (excluding vendors) and is used to determine the percentage of time direct service employees spend on direct services and General and Administrative (G and A) time.

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

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To determine EPSDT services cost that may be attributed to Medicaid, the ratio of Medicaid covered students in the LEA is multiplied by total (direct plus indirect) cost. Cost data is subject to certification by each LEA. This serves as the basis for obtaining federal Medicaid funding.

The participating LEAs' actual cost of providing EPSDT services shall be claimed for Medicaid federal financial participation (FFP) based on the following methodology:

1. Employee Cost

a. Develop Direct Cost-The Payroll Cost Base

Total annual salaries and benefits paid are obtained initially from each LEA's Payroll/Benefits system. This data will be reported on LDH's direct services cost report form for all direct service employees that participated in the random moment time study (i.e. all employees providing LEA direct treatment services covered under the State Plan).

b. Adjust the Payroll Cost Base

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

c. Determine the Percentage of Time to Provide All EPSDT Services

A time study, which incorporates the CMS-approved Medicaid Administrative Claiming (MAC) methodology for direct service employees, shall be used to determine the percentage of time EPSDT service providers spend on EPSDT direct services and general and administrative (G and A time). This time study will assure there is no duplicate claiming. The G and A percentage shall be reallocated in a manner consistent with the CMS-approved Medicaid administrative claiming methodology. Total G and A time shall be allocated to all other activity codes based on the percentage of time spent on each respective activity.

To reallocate G and A time to EPSDT services, the percentage of time spent on EPSDT services shall be divided by 100 percent minus the percentage of G and A time. This shall result in a percentage that represents the EPSDT services with appropriate allocation of G and A. This percentage shall be multiplied by total adjusted salary cost as determined by the adjusted payroll cost base to allocate cost to school based services. The product represents total direct cost.

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

d. Determine Indirect Cost

Indirect cost shall be determined by multiplying each LEA's indirect unrestricted rate assigned by the cognizant agency (the Department of Education) by total adjusted direct cost. No additional indirect cost shall be recognized outside of the cognizant agency indirect rate. The sum of direct cost and indirect cost shall be the total employer direct service cost for all students receiving EPSDT services.

2 Vendor Cost

a. Develop Direct Cost-The Vendor Cost Base

Total annual vendor costs paid are obtained initially from each LEAs' Accounts Payable system. This data will be reported on LDH's direct services cost report form for all direct service vendors (i.e. all contracted personnel providing LEA direct treatment services covered under the State Plan).

b. Adjust the Vendor Cost Base

The vendor cost base shall be reduced for amounts reimbursed by non-state and local funding sources (e.g. federal grants). The vendor cost base shall not include any amounts for vendor whose cost is 100 percent reimbursed by a funding source other than state/local funds. This results in total adjusted vendor cost.

c. Vendor Rate per service for Providing EPSDT Services

Vendors are not subject to the time study process. Vendors are only at a school to provide the direct services enumerated in the contract. Vendors are not expected to perform general and administrative (G and A) tasks. This rate per service should include all vendor's direct and indirect costs. This rate per service should cover the time spent providing the direct service, administrative time and any other time related to tasks related to that service.

d. Determine Indirect Cost

Indirect cost shall be determined by multiplying each LEA's indirect unrestricted rate assigned by the cognizant agency (the Department of Education) by total adjusted direct cost. No additional indirect cost shall be recognized outside of the cognizant agency indirect rate. The sum of direct cost and indirect cost shall be the total vendor direct service cost for all students receiving EPSDT services.

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3. Personal Care Service Employee/Vendor
 - a. Develop Direct Cost-The Payroll Cost Base
Total annual salaries and benefits paid are obtained initially from each LEA's Payroll system. Vendor costs are obtained from vendor invoices and the LEA's accounts payable system. This data will be reported on LDH's direct services cost report form for all PCS employees or vendors (i.e. all employees/vendors providing LEA personal care services covered under the State Plan).
 - b. Adjust the Payroll/Vendor Cost Base
The payroll/vendor cost base shall be reduced for amounts reimbursed by non-state and local funding sources (e.g. federal grants). The payroll/vendor cost base shall not include any amounts for costs 100 percent reimbursed by a funding source other than state/local funds. This results in total adjusted salary/vendor cost.
 - c. Determine Indirect Cost
Indirect cost shall be determined by multiplying each LEA's indirect unrestricted rate assigned by the cognizant agency (the Department of Education) by total adjusted direct cost. No additional indirect cost shall be recognized outside of the cognizant agency indirect rate. The sum of direct cost and indirect cost shall be the total direct service cost for all students receiving EPSDT services.
4. Applied Behavioral Analysis
Applied Behavioral Analysis (ABA)-based services provided by individuals working within the scope of their license are reimbursable by Medicaid. ABA services will be reimbursed using the EPSDT cost based methodology for employees and vendors as described in 1 and 2 above. _

Allocate Direct Service Cost to Medicaid

To determine the amount of cost that may be attributed to Medicaid, total direct service cost (employee and vendor) shall be multiplied by the ratio of Medicaid enrolled students in the LEA to all students in the LEA. This results in total cost that may be certified as Medicaid's portion of school-based EPSDT services cost. The Medicaid enrolled student ratio is calculated one time in each cost report year. This calculation is based on the statewide student count performed in October each year.

Reconciliation of LEA Certified Costs and Medicaid Management Information System (MMIS) Paid Claims

Each LEA shall complete and submit the applicable services cost report(s) no later than five months after the fiscal year period ends (June 30), and reconciliation should be completed within 12 months from the fiscal year end.

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All filed cost reports shall be subject to desk review by the Department’s audit contractor. The Department shall reconcile the total expenditures (both state and federal share) for each LEA’s services. The Medicaid certified cost expenditures from the cost report(s) will be reconciled against the MMIS paid claims data and the Department shall issue a notice of final settlement, after all reviews, that denotes the amount due to or from the LEA. This reconciliation is inclusive of all services provided by the LEA.

Cost Settlement Process

As part of its financial oversight responsibilities, the Department shall develop risk assessment and audit plan to ensure cost reasonableness and accuracy in accordance with current CMS guidelines. Based on the audit plan, the Department will develop agreed upon procedures to review and process all final settlements to LEAs. The agreed upon procedures will be performed to review cost reports submitted by LEAs.

- a. The financial oversight of all LEAs shall include reviewing the costs reported on each EPSDT services cost report against the allowable costs, performing desk reviews and conducting limited reviews.
- b. The Department shall make every effort to audit each LEA at least every four years. These activities shall be performed to ensure that audit and final settlement occurs no later than two years from the LEA’s fiscal year end for the cost reporting period audited. LEAs may appeal audit findings in accordance with LDH appeal procedures.
- c. The Department shall adjust the affected LEA’s payments no less than annually, when any reconciliation or final settlement results in significant underpayments or overpayments to any LEA.

If the actual certified costs of an LEA’s Medicaid services exceed interim Medicaid payments, the Department will pay this difference to the LEA in accordance with the final actual certification agreement. If the actual certified costs of an LEA’s Medicaid services for any program cost report are less than interim Medicaid payments, the Department will reduce all school based Medicaid reimbursements from the current and following cost report years’ settlement until the amount due is reduced to zero.

All costs described within this methodology are for eligible 1905(a) Medicaid services provided by Medicaid qualified practitioners that have been approved under Attachment 3.1-A and whose reimbursement methodology has been comprehensively described here in the Medicaid State Plan.

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Specialized Transportation Services Provided by Local Education Agencies

General Provisions

A special transportation trip is only billable to Medicaid on the same day that a Medicaid enrolled child receives a Medicaid service included in the student's IEP/IFSP. The need for specialized transportation must be documented in the child's IEP/IFSP. The transportation shall be provided on a specially adapted bus.

Reimbursement Methodology

Effective for dates of service on or after March 20, 2019, medically necessary specialized transportation that is included on the student's IEP/IFSP, provided by LEAs to recipients under age 21 is reimbursed according to the following methodology:

Cost Reporting

Reimbursement for specialized transportation services shall be based on the LEA's actual cost reported as determined by desk review and/or audit for each LEA.

Each LEA shall determine cost annually by using LDH's Specialized Transportation cost report form. Direct cost shall be the cost of fuel, repairs and maintenance, rentals, contracted vehicle use cost and the amount of total compensation (salaries, vendor payments and fringe benefits) of specialized transportation employees or contract cost for contract drivers, as allocated to specialized transportation services for Medicaid recipients. There are no additional direct costs included in the rate.

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

To determine the amount of specialized transportation cost that may be attributed to Medicaid, total cost is multiplied by the ratio of one-way Medicaid eligible trips to one-way trips for all students transported via specialized transportation. This results in total cost that may be certified as Medicaid's portion of school-based specialized transportation services cost.

Specialized transportation trip data is derived from transportation logs maintained by drivers for each one-way trip. Cost data on the specialized transportation cost report is subject to certification by each parish.

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For specialized transportation services, the participating LEAs' actual cost of providing specialized transportation paid with state and local funds shall be claimed for Medicaid federal financial participation (FFP) based on the following methodology:

Step 1—Develop Direct Cost—Other

Cost for specialized transportation fuel, repairs and maintenance, rentals, and contract vehicle use cost are obtained from the LEA's accounts payable system and reported on the Specialized Transportation Cost Report form.

Step 2—Develop Direct Cost-The Payroll Cost Base

Total annual salaries and benefits paid as well as contract cost (vendor payments) for contract drivers are obtained from each LEA's payroll/benefits and accounts payable systems. This data will be reported on the specialized transportation cost report form for all direct service personnel (i.e. all personnel working in specialized transportation).

Step 3—Determine Indirect Cost

Indirect cost is determined by multiplying each LEA's unrestricted indirect rate assigned by the cognizant agency (the Department of Education) by total direct cost. No additional indirect cost is recognized outside of the cognizant agency indirect rate.

Step 4 – Total Cost

The sum of direct costs and indirect cost is total specialized transportation direct cost for all students with an IEP/IFSP indicating medical need.

Step 5—Allocate Specialized Transportation Cost to Medicaid

Specialized transportation drivers shall maintain logs of all students transported on each one-way trip. These logs shall be utilized to aggregate total annual one-way trips which will be reported by each LEA on the specialized transportation cost report.

To determine the amount of specialized transportation cost that may be attributed to Medicaid, total cost is multiplied by the ratio of one-way Medicaid eligible trips to one-way trips for all students transported via specialized transportation. This results in total cost that may be certified as Medicaid's portion of school-based specialized transportation services cost.

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Medicaid One-way Trip Ratios for Specialized Transportation

Numerator - The number of one-way trips for Medicaid enrolled children who received specialized transportation to and from the IEP/ISFP service destination will be claimed as a Medicaid eligible trip when the child receives a Medicaid service included in an IEP/IFSP on a particular day and specialized transportation is specifically listed in the IEP or IFSP.

Denominator - The total number of one-way trips for all children that ride a specialized transportation bus.

Calculation - Medicaid trip ratio x Specialized transportation costs [(direct services) + (direct services x indirect rate)]

Reimbursement of LEA Certified Costs

Each LEA shall complete and submit the Specialized Transportation cost report no later than five months after the fiscal year end (June 30), and reconciliation shall be completed within 12 months from the fiscal year end. All filed cost reports shall be subject to desk review or audit by the Department's audit contractor.

The financial oversight of all LEAs will include reviewing the costs reported on the specialized transportation cost reports against the allowable costs in accordance with 2 CFR 200, performing desk reviews and conducting limited reviews. The Department shall issue a notice of final reimbursement, after all reviews, which denotes the amount due to the LEA.

Cost Reimbursement Process

As part of its financial oversight responsibilities, the Department shall develop risk assessment and audit plan to ensure cost reasonableness and accuracy in accordance with the current CMS guidelines. Based on the audit plan, the Department will develop agreed upon procedures to review and process all reimbursements to LEAs. The agreed upon procedures will be performed to review cost reports submitted by LEAs.

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- a. The financial oversight of all LEAs shall include reviewing the costs reported on the Specialized Transportation cost report against the allowable costs, performing desk reviews and conducting limited reviews.
- b. The Department shall make every effort to audit each LEA at least every four years. These activities shall be performed to ensure that audit and final reimbursement occurs no later than two years from the LEA's fiscal year end for the cost reporting period audited. LEAs may appeal audit findings in accordance with LDH appeal procedures.

State Monitoring

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

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I. Dental Services

Effective for dates of service on or after July 1, 2023, EPSDT dental services shall be reimbursed based on the Louisiana Medicaid fee schedule.

The reimbursement rates in the fee schedule target aggregate reimbursement by dental service category, equal to a specific percentage of the 2022 National Dental Advisory Services (NDAS) Comprehensive Fee Report 70th percentile, as listed within subparts (a) through (d).

- (a) Category I dental service rates for diagnostic and preventive services are established at approximately 57.2 percent of the NDAS.
- (b) Category II dental service rates for basic dental services are established at approximately 52.9 percent of the NDAS.
- (c) Category III dental service rates for major dental services are established at approximately 61.2 percent of the NDAS.
- (d) Category IV dental service rates for orthodontic services are established at approximately 38.5 percent of the NDAS.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of EPSDT dental services. All rates in the fee schedule are published on the Medicaid provider website at www.lamedicaid.com.

The agency's fee schedule rate was set as of July 1, 2019 and is effective for services provided on or after that date. Effective July 1, 2023, payments for dental and denture services as defined at Attachment 3.1-A Page 4 and Attachment 3.1-B Page 4, shall be paid based on a the Louisiana Medicaid fee schedule.

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CITATION

42 CFR
447.304
447.200-205
and Section
1905(r)(5) of
the Act

Medical and Remedial Care and Services
Item 4.b.(contd.)

II. The following services that are not otherwise covered under the Louisiana State Plan will be reimbursed when provided to an EPSDT beneficiary:

A. Hospice Services

Effective for the dates of service on or after May 1, 2012, reimbursement for hospice services are pursuant to the methodology as outlined under Attachment 4.19-B, Item 18.

B. Personal Care Services

Personal Care Services (PCS) for EPSDT eligibles shall be paid the lesser of billed charges or the maximum unit rate set by the Department. The maximum rate is a prospective flat rate for each approved unit of service that is provided to the beneficiary. One quarter hour is the standard unit of service, excluding travel time to arrive at the beneficiary's home.

Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental and non-governmental providers of personal care services. The agency's fee schedule rate was set as of February 20, 2023 and is effective for services provided on or after that date. All rates are published on the agency's website at www.lamedicaid.com

C. Chiropractors

Reimbursement Methodology

Chiropractors are reimbursed under the same methodology used to reimburse physicians. Reimbursement is made at the lower of the provider's billed charge for the services or the maximum allowable fee for chiropractic services under the Department's provider reimbursement fee schedule.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and non-governmental providers of chiropractor services. The agency's fee schedule rate was set as of January 1, 2024, and is effective for services provided on or after that date. All rates are published on the agency's website at www.lamedicaid.com

STATE OF LOUISIANA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED
IN SECTION 1902(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS
FOLLOWS:

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EPSDT Rehabilitation and Other Licensed Practitioner's Behavioral Health Services

Methods and Standards for Establishing Payment Rates

Effective for dates of service on or after March 1, 2012, reimbursements for services are based upon a Medicaid fee schedule established by LDH.

The reimbursement rates for physician services rendered under the Louisiana Behavioral Health Partnership (LBHP) shall be a flat fee for each covered service as specified on the established Medicaid fee schedule.

The reimbursement rates shall be based on a percentage of the Louisiana Medicare Region 99 allowable for a specified year. If a Medicare fee exists for a defined covered procedure code, then Louisiana will pay Psychologists and ARNPs at 80% of the LBHP physician rates. If a Medicare fee exists for a defined covered procedure code, then Louisiana will pay LCSWs, LPCs, LMFTs, and LAC's as well as qualified unlicensed practitioners delivering Community Psychiatric Support and Treatment at 70% of the LBHP physician rates.

Where Medicare fees do not exist for a covered code, the fee development methodology will build fees considering each component of provider costs as outlined below. These reimbursement methodologies will produce rates sufficient to enlist enough providers so that services under the Plan are available to individuals at least to the extent that these services are available to the general population, as required by 42 CFR 447.204.

These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act 42 CFR 447.200, regarding payments and consistent with economy, efficiency and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained.

The Medicaid fee schedule will be equal to or less than the maximum allowable under the same Medicare rate, where there is a comparable Medicare rate.

The following services are excluded from coverage benefits and are excluded from Medicaid reimbursement:

1. components that are not provided to, or directed exclusively toward the treatment of, Medicaid eligible children and youth;
2. services provided at a work site which are job tasks oriented and not directly related to the treatment of the needs of children and youth;

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3. any services or components in which the basic nature are to supplant housekeeping, homemaking, or basic services for the convenience of children and youth receiving services;
4. services rendered in an institution for mental disease (IMD), other than a psychiatric residential treatment facility (PRTF) or an inpatient psychiatric hospital; and
5. the cost of room and board associated with crisis stabilization.

Except as otherwise noted in the Plan, the State-developed fee schedule is the same for both governmental and private individual providers and the fee schedule and any annual/periodic adjustments to the fee schedule will be published in the Louisiana Register. The Agency's fee schedule rate was set as of March 1, 2012 and is effective for services provided on or after that date. All rates are published on the agency's website at www.lamedicaid.com.

The fee development methodology will primarily be composed of provider cost modeling, though Louisiana provider compensation studies, but may also include cost data and fees from similar State Medicaid programs. The following list outlines the major components of the cost model to be used in fee development:

1. Staffing Assumptions and Staff Wages;
2. Employee-Related Expenses – Benefits, Employer Taxes (e.g., FICA, unemployment, and workers compensation);
3. Program-Related Expenses (e.g., supplies);
4. Provider Overhead Expenses; and
5. Program Billable Units.

The fee schedule rates will be developed as the ratio of total annual modeled provider costs to the estimated annual billable units.

Effective for dates of service on or after December 1, 2015, children's mental health services shall be reimbursed as follows:

Reimbursements for services shall be based upon the established Medicaid fee schedule for specialized behavioral health services rendered to recipients enrolled with the Coordinated System of Care (CSoc) contractor. The fee schedule is published on the Medicaid provider website at www.lamedicaid.com.

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EPSDT Rehabilitation and Other Licensed Practitioner’s Behavioral Health Services

Methods and Standards for Establishing Payment Rates

Therapeutic Group Home Reimbursement

Each provider of Therapeutic Group Home (TGH) services shall enter into a contract with one or more of the managed care organizations (MCOs) in order to receive reimbursement for Medicaid covered services. Providers shall meet the provisions herein, the provider manual, and the appropriate statutes. For recipients enrolled in one of the MCOs, the Department or its fiscal intermediary shall make monthly capitation payments to the MCOs. The capitation rates paid to the MCOs shall be actuarially sound rates and the MCOs will determine the rates paid to its contracted providers. No payment shall be less than the minimum Medicaid rate.

TGH services shall be inclusive of, but not limited to the allowable cost of clinical and related services, psychiatric supports, integration with community resources, the skill-building provided by unlicensed practitioners, and allowable and non-allowable costs components, as defined by the Department. Services provided by psychologists and licensed mental health practitioners shall be billed to the MCO separately. All psychiatric supports and therapeutic services delivered by licensed mental health professionals (LMHPs) must be billed separately and not included in the per diem rate (Qualifications for LMHPs are listed in Attachment 3.1-A, Item 4.b, Page 8a). The facility is expected to provide recreational activities for all enrolled children but not use Medicaid funding for payment of such non-Medicaid activities. Definitions of allowable and non-allowable costs are defined by the Department.

The TGH provider types and associated reimbursement are as follows:

In-State Therapeutic Group Homes Reimbursement Rates

- A. In-State publicly and privately owned and operated TGHs shall be reimbursed according to the MCO established rate within their contract.

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EPSDT Rehabilitation and Other Licensed Practitioner’s Behavioral Health Services

Methods and Standards for Establishing Payment Rates (continued)

- A. Out-of-State Therapeutic Group Home Reimbursement Rates
Out-of-State therapeutic group homes shall be reimbursed for their services according to the rate established by the MCO.
- B. Payments to out-of-state TGH facilities that provide covered services shall not be subject to TGH cost reporting requirements.

Therapeutic Group Home Cost Reporting Requirements

All in-state Medicaid participating TGH providers are required to file an annual Medicaid cost report according to the Department’s specifications and departmental guides and manuals.

- A. Costs reports must be submitted annually. The due date for filing annual cost reports is the last day of the fifth month following the facility’s fiscal year end. Separate cost reports must be filed for the facilities central/home office when costs of that entity are reported on the facilities cost report. If the facility experiences unavoidable difficulties in preparing the cost report by the prescribed due date, a filing extension may be requested. A filing extension must be submitted to Medicaid prior to the cost report due date.
- B. Facilities filing a reasonable extension request will be granted an additional 30 days to file their cost report.

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TN 11-0010

STATE OF LOUISIANA

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR
SERVICE LISTED IN SECTION 1902(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE
PLAN ARE DESCRIBED AS FOLLOWS:

**EPSDT Rehabilitation and Other Licensed Practitioner’s Behavioral Health Services
Methods and Standards for Establishing Payment Rates (continued)**

New Therapeutic Group Homes and Change of Ownership of Existing Facilities

- A. Changes of ownership (CHOW) exist if the beds of a new owner have previously been certified to participate in the Medicaid program under the previous owner’s provider agreement. The acceptance of a CHOW will be determined solely by LDH Reimbursement will continue to be based on the Medicaid reimbursement rate. The rate adjustment process will be determined using the previous owners cost report information for the applicable time periods.
- B. New providers are those entities whose beds have not previously been certified to participate in the Medicaid program. New providers will be reimbursed, depending on provider type, in accordance with the Therapeutic Group Home Unit of Service section of the State Plan.

Therapeutic Group Home Providers with Disclaimed Cost Reports or Non-Filer Status

- A. Providers with disclaimed cost reports are those providers that receive a disclaimer of opinion from the LDH audit contractor after conclusion of the audit process.
- B. Providers with non-filer status are those providers that fail to file a complete cost report in accordance with the Therapeutic Group Home (TGH) Cost Reporting Requirements section of the State Plan.
- C. Providers with disclaimed cost reports, or providers with non-filer status will not receive any additional reimbursement through the rate adjustment process. These providers will however be subject to the recoupment of Medicaid payments equal to the provider with the greatest recoupment of Medicaid payments in the State of Louisiana for the applicable fiscal year.

Effective for dates of service on or after July 1, 2012, the reimbursement rates for the following behavioral health services provided to children/adolescents shall be reduced by 1.44 percent of the rates in effect on June 30, 2012:

- 1. Therapeutic services;
- 2. Rehabilitation services; and
- 3. Crisis intervention services.

Effective for dates of service on or after January 20, 2013, supplemental Medicaid payments for state-owned and operated behavioral health providers shall be made in accordance with the payment methodology as described under **Attachment 4.19-B, Item 13d, page 8.**

Unlicensed Practitioners

Reimbursement for the TGH is based on a daily rate for the skill building provided by unlicensed practitioners as defined in the provider qualifications under Attachment 3.1-A, Item 4.b, Page 9F.

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PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

Medical and Remedial Care and Services

Item 4.b. (continued)

CITATION
42 CFR 447.201

III. EPSDT Early Intervention Services

Physical therapy, occupational therapy, speech therapy, audiology services, and psychological services for infants and toddlers ages birth to three years are reimbursed according to the published fee schedules which correspond to the following three settings:

1. Natural environment-which may include a child's home or settings in the community where children of the same age with no disabilities or special needs participate;
2. Special purpose facility/inclusive child care settings such as care centers, nursery schools, or preschools where at least 50 percent of the children have no disabilities or developmental delays; and
3. Center-based special purpose facility- where only children with disabilities or developmental delays are served.

Effective for dates of service on or after February 1, 2005, the reimbursement for early intervention services rendered to infants and toddlers ages birth to three years shall be the lower of billed charges or 75 percent of the rates (a 25 percent reduction) in effect on January 31, 2005.

Effective for dates of service on or after September 1, 2008, the fee schedule used to reimburse certain health services rendered in a natural environment shall be increased by 25 percent of the rate in effect on August 31, 2008.

Effective for dates of service on or after January 1, 2011, the reimbursement for certain Medicaid-covered health services rendered in the EarlySteps program shall be reduced by two percent of the rate in effect on December 31, 2010. The following services rendered in the natural environment shall be reimbursed at the reduced rate:

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

Services rendered in special purpose facilities/inclusive child care and center-based special purpose facilities shall be excluded from this rate reduction.

Effective for dates of service on or after August 3, 2022, reimbursement for Medicaid-covered health services rendered in the EarlySteps program shall be increased by 30 percent of the rate in effect on January 1, 2011. The increased rate shall be applied to services provided in the following settings:

1. Natural environment that includes a child's home and settings in the community where children of the same age with no disabilities or special needs participate;
2. Special purpose facility/inclusive child care settings such as a child care centers, nursery schools, or preschools where at least 50 percent of the children have no disabilities or developmental delays, and

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

3. Center-based special purpose facility that is a facility where only children with disabilities or developmental delays are served.

The following services shall be reimbursed at the increased rate:

1. Audiology services;
2. Speech language pathology services;
3. Occupational therapy;
4. Physical therapy; and
5. Psychological services.

Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental and private providers of EPSDT EarlySteps services. The agency's fee schedule was set as of July 1, 2022 and is effective for services rendered on or after that date. All rates are published on the agency's website at www.lamedicaid.com.

STATE OF LOUISIANA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

Pediatric Day Health Care Program

Reimbursement for pediatric day health care (PDHC) services shall be a statewide fixed per diem rate which is based on the number of hours that a qualified beneficiary attends the PDHC facility.

1. A full day of service is more than six hours, not to exceed a maximum of 12 hours per day.
2. A partial day of service is six hours or less per day.

Reimbursement shall only be made for services authorized by the Medicaid program or its approved designee.

Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental and private providers of PDHC services. The agency's fee schedule rate was set as of August 10, 2022, and is effective for services provided on or after that date. All rates are published on the agency's website at www.lamedicaid.com.

STATE OF LOUISIANA

PAYMENT OF MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

Other Licensed Practitioners - Licensed Behavior Analysts

Reimbursement Methodology

Effective for dates of service on or after February 1, 2014, the Medicaid Program shall provide reimbursement to licensed behavior analysts who are enrolled with the Medicaid program and in good standing with the Louisiana Behavior Analyst Board. Reimbursement shall only be made for services billed by a licensed behavior analyst, licensed psychologist, or medical psychologist.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of behavioral analysis. The agency's fee schedule rate was set as of February 1, 2014 and is effective for services provided on or after that date. All rates are published on the Medicaid provider website using the following link:

http://www.lamedicaid.com/provweb1/fee_schedules/feeschedulesindex.htm

Effective for dates of service on or after January 1, 2017, new provider rates and codes went into effect.

Effective February 13, 2017, the Registered Line Technician (tech) therapy rate was increased.

Reimbursement shall only be made for services authorized by the Medicaid program or its designee.

Reimbursement shall not be made to, or on behalf of, services rendered by a parent, a legal guardian, or legally responsible person.

Effective for dates of service on or after January 20, 2018, applied behavior analysis-based therapy will be included with the specialized behavioral health services provided by managed care organizations (MCOs) that participate in the Healthy Louisiana program.

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