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
42 CFR
447.201 and
447.304

Medical and Remedial Care and Services Item 4.b.

Early and Periodic Screening, Diagnosis, and Treatment of Individuals under 21 Years 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 the following link: http://www.lamedicaid.com/provweb1/fee_schedules/feeschedulesindex.htm unless stated in the State Plan.

A. **Screening (Vision, Hearing, Dental, Medical) - Full and Interperiodic Screening** (including immunizations) is reimbursed according to a schedule of fees available in the EPSDT KidMed Provider Manual minus any third party coverage.

B. **Consultation With Nurse, Dietitian, or Social Worker is** reimbursed according to a schedule of fees available in the EPSDT KidMed Provider Manual minus any third party coverage.

C. **Reserved.**

D. **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.

E. **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.

F. **Rehabilitative Services** provided to recipients up to the age of three are reimbursed at the maximum allowable fee for occupational, physical, and speech therapy services according to the State's established schedule of fees available in the EPSDT Health Services Manual minus any third party coverage.

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G. Rehabilitative School Based Health Services

Local Education Agencies will only be reimbursed for the following IDEA services: audiology, speech pathology, physical therapy, occupational therapy, and psychological services. Services provided by Local Education Agencies to recipients age 3 to 21 that are medically necessary and included on the recipient's Individualized Education Plan (IEP) are reimbursed according to the following methodology.

Effective for dates of service on or after February 13, 2014, reimbursement for physical and occupational therapy services provided by school based health centers (Provider Type 38) shall be 85 percent of the 2013 Medicare published rate. The Medicare published rate shall be the rate in effect on February 13, 2014.

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 found on the Louisiana Medicaid website at the following link: http://www.lamedicaid.com/provweb1/fee_schedules/feeschedulesindex.htm

1. Special Rehabilitation Services Provided by Local Education Agencies

Summary of Payment Methodology

Payment is based on the most recent school year's actual cost as determined by desk review and/or audit for each Local Education Agency (LEA) provider, which is the parish or city. Each LEA shall determine cost annually by using DHH's Cost Report for Direct Service Cost (the Direct Service Cost Report) form as approved by CMS November 2005. Direct cost is limited to the amount of total compensation (salaries and fringe benefits) of current direct service providers as allocated to direct services for Medicaid special education recipients. The basis of allocation for direct service compensation cost is DHH's Direct Services Time Study Methodology approved by CMS November 2005. This time study incorporates the CMS approved Medicaid Administrative Claiming (MAC) methodology for direct service personnel and is used to determine the

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percentage of time direct service personnel spend on direct IDEA/IEP services and General and Administrative (G&A) time.

There are no additional direct costs included in the rate. Indirect cost is derived by multiplying the cognizant agency indirect cost unrestricted rate assigned by the Department of Education to each LEA. There are no additional indirect costs included. The Direct Service Cost Report initially provides the total cost of all school based services provided, regardless of payer. To determine the amount of direct services cost that may be attributed to Medicaid, the ratio of Medicaid covered students with IEPs to all students with IEPs is multiplied by total direct cost. Cost data is subject to certification by each parish. This serves as the basis for obtaining Federal Medicaid funding.

For each of the IDEA related school based services other than specialized transportation services, the participating LEAs' actual cost of providing the services will be claimed for Medicaid FFP based on the methodology described in the steps below. The State will gather actual expenditure information for each LEA through its Payroll/Benefits and Accounts Payable System. These costs are also reflected in the Annual Financial Report (AFR) that all LEAs are required to certify and submit to the Department of Education. All costs included in the amount of cost to be certified and used subsequently to determine reconciliation and final settlement amounts as well as interim rates are identified on the CMS approved Direct Services Cost Report and are allowed in OMB Circular A-87. The State also will use other LEA specific information including the general fund budget and FTE counts.

Step 1: Develop Direct Cost-The Payroll Cost Base
Total annual salaries and benefits paid as well as contracted (vendor) payments are obtained initially from each LEA's Payroll/Benefits and Accounts Payable system. This data will be reported on DHH's Direct Services Cost Report form for all direct service personnel (i.e. all personnel providing LEA direct treatment services covered under the state plan).

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Step 2: Adjust the Payroll Cost Base

The payroll cost base is reduced for amounts reimbursed by other funding sources (e.g. Federal grants). The payroll cost base does not include any amounts for staff whose compensation is 100 percent reimbursed by a funding source other than state/local funds. The application of Step 2 results in total adjusted salary cost.

Step 3: Determine the Percentage of Time to Provide All Direct Services

A time study which incorporates the CMS-approved Medicaid Administrative Claiming (MAC) methodology for direct service personnel is used to determine the percentage of time direct service personnel spend on direct IDEA/IEP services and General and Administrative (G&A) time. This time study will assure that there is no duplicate claiming. The G&A percentage is reallocated in a manner consistent with the CMS approved Medicaid Administrative Claiming methodology. Total G&A time is allocated to all other activity codes based on the percentage of time spent on each respective activity.

To reallocate G&A time to direct IDEA/IEP services, the percentage of time spent on direct IDEA/IEP services is divided by 100 percent minus the percentage of time spent on G&A. This will result in a percentage that represents the IDEA/IEP services with appropriate allocation of G&A. This percentage is multiplied by total adjusted salary cost as determined in Step 2 to allocate cost to school based services The product represents total direct cost.

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

Step 4: Determine Indirect Cost

Indirect cost is determined by multiplying each LEA's indirect unrestricted rate assigned by the cognizant agency (the Department of Education) by total adjusted direct cost as determined under Step 3. No additional indirect cost is recognized outside of the cognizant agency indirect rate. The sum of direct cost and indirect cost is total direct service cost for all students with an IEP.

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Step 5: Allocate Direct Service Cost to Medicaid

To determine the amount of cost that may be attributed to Medicaid, total cost as determined under Step 4 is multiplied by the ratio of Medicaid recipients with an IEP to all students with an IEP. This results in total cost that may be certified as Medicaid's portion of school based services cost.

2. **Special Transportation Services Provided by Local Education Agencies**

A special transportation trip is only billable to Medicaid on the same day that a Medicaid-eligible child is receiving IDEA services included in the child's IEP and the transportation is provided in a vehicle that is part of special transportation in the LEA's Annual Financial Report certified and submitted to the Department of Education. The need for transportation must be documented in the child's IEP.

Summary of Payment Methodology

Payment is based on the most recent school year's actual cost as determined by desk review and/or audit for each LEA provider, which is the parish or city. Each LEA shall determine cost annually by using DHH's Cost Report for Special Transportation (Transportation Cost Report) form as approved by CMS November 2005. Direct cost is limited to the cost of Fuel, Repairs and Maintenance, Rentals, Contracted Vehicle Use Cost and the amount of total compensation (salaries and fringe benefits) of special transportation employees or contract cost for contract drivers, as allocated to special transportation services for Medicaid recipients based on a ratio explained in Step 4 below. Indirect cost is derived by multiplying the direct cost by the cognizant agency's unrestricted indirect cost rate assigned by the Department of Education to each LEA. There are no additional indirect costs included.

The Transportation Cost Report initially provides the total cost of all special transportation services provided, regardless of payer. To determine the amount of special transportation costs that may be attributed to Medicaid, the ratio of Medicaid covered trips to all student trips determined in Step 4 below is multiplied by total direct cost. Trip data is derived from transportation logs maintained by drivers for each one-way

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trip. This ratio functions in lieu of the time study methodology and student ratio used for the Direct Services Cost Report. Cost data on the Transportation Cost Report is subject to certification by each parish and serves as the basis for obtaining Federal Medicaid funding.

The participating LEA's actual cost of providing specialized transportation services will be claimed for Medicaid FFP based on the methodology described in the steps below. The State will gather actual expenditure information for each LEA through the LEA's Payroll/Benefits and Accounts Payable System. These costs are also reflected in the Annual Financial Report (AFR) that all LEAs are required to certify and submit to the Department of Education. All costs included in the amount of cost to be certified and used subsequently to determine the reconciliation and final settlement amounts as well as interim rates are identified on the CMS approved Transportation Cost Report and are allowed in OMB Circular A-87

Step 1: Develop Direct Cost - Other

The non-federal share of cost for Special Transportation Fuel, Repairs and Maintenance, Rentals, and Contract Vehicle Use Cost are obtained from the LEA's Accounts Payable System and reported on the Transportation Cost Report form.

Step 2: Develop Direct Cost-The Payroll Cost Base

Total annual salaries and benefits paid as well as contract cost (vendor payments) for contract drivers are obtained from each LEA's Payroll/Benefits and Accounts Payable Systems. This data will be reported on the Transportation Cost Report form for all direct service personnel (i.e. all personnel working in special transportation).

Step 3: Determine Indirect Cost

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

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Step 4: Allocate Direct Service Cost to Medicaid

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

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3. **Reconciliation of LEA Certified Costs and MMIS Paid Claims**

Each LEA will complete the Direct Services and Transportation Cost Reports as applicable and submit the cost report(s) no later than 5 months after the June 30 fiscal year period ends and reconciliation will be completed within 12 months from the Fiscal Year End. All filed Direct Services and Transportation cost reports shall be subject to desk review by the Bureau's audit contractor. The Bureau of Health Services Financing (the Bureau) will reconcile the total expenditures (both State and federal share) for each LEA's IDEA/IEP direct services and special transportation services. The Medicaid certified cost expenditures from the Direct Services and Transportation cost report(s) will be reconciled against the MMIS paid claims data and the Bureau shall issue a notice of final settlement pending audit that denotes the amount due to or from the LEA. This reconciliation is inclusive of both direct services and transportation services provided by the LEA.

4. **Cost Settlement Process**

As part of its financial oversight responsibilities, the Bureau will develop audit and review procedures to audit and process final settlements for certain LEAs The audit plan will include a risk assessment of the LEAs using paid claim data available from the Bureau to determine the appropriate level of oversight. The financial oversight of all LEAs will include reviewing the costs reported on the Direct Services and Transportation Cost Reports against the allowable costs in accordance with OMB Circular A-87, performing desk reviews and conducting limited reviews. For example, field audits will be performed when the Bureau finds a substantial difference between information on the filed

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Direct Services and/or Transportation Cost Reports and Medicaid claims payment data for particular LEAs. These activities will be performed to ensure that audit and final settlement occurs no later than 2 years from the LEA's fiscal year end for the cost reporting period audited. LEAs may appeal audit findings in accordance with DHH Appeal procedures.

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

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

   1) Offset all future claim payments from the affected LEA until the amount of the overpayment is recovered;
   2) Recoup an agreed upon percentage from future claims payments to the LEA to ensure recovery of the overpayment within one year; or
   3) Recoup an agreed upon dollar amount from future claims payments to the LEA to ensure recovery of the overpayment within one year.

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

5. **Billing**

Each LEA will submit claims/billings in accordance with the Medicaid EPSDT Health Services manual and will be paid an interim rate (i.e., rates for a period that are provisional in nature pending the completion of a reconciliation and cost settlement for that period) for approved claims.

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6. **State Monitoring**
If the Bureau 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 problems.

H. EPSDT Services Provided by Office of Public Health
For the following EPSDT services the Office of Public Health is paid an enhanced fee as follows:

Consultation EPSDT, By Nurse	$19.88
Consultation EPSDT, By Nutritionist	$19.88
Consultation EPSDT, By Social Worker	$19.88
Lead Poisoning Follow-up	$45.56
Physician Diagnosis and Treatment	$51.62
Clinic Visit for Handicapped Child	$84.68
Diagnosis/Treatment by Physician/Nurse	$51.62
Speech and Hearing Evaluation	$50.27
Initial Screen by Physician	$73.95
Initial Screen by Nurse	$73.95
Periodic Screen by Nurse	$73.95
Interperiodic Screen-child	$46.40
Interperiodic Screen-adolescent	$65.25
Vision Screen	$5.80
Vaccines	$13.70
Screening, Pure Tone, Air only	$5.22

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I. Dental Services

Effective for dates of service on and after December 24, 2008, the reimbursement fees for EPSDT dental services are increased to the following percentages of the 2008 National Dental Advisory Service Comprehensive Fee Report 70th percentile rate, unless otherwise stated. The reimbursement fees are increased to:

1. 80 percent for all oral examinations;
2. 75 percent for the following services:
   a. radiograph – periapical and panoramic film;
   b. prophylaxis;
   c. topical application of fluoride or fluoride varnish; and
   d. removal of impacted tooth;
3. 70 percent for the following services:
   a. radiograph – complete series, occlusal film and bitewings;
   b. sealant, per tooth;
   c. space maintainer, fixed (unilateral or bilateral;
   d. amalgam , primary or permanent;
   e. resin-based composite and resin-based composite crown, anterior;
   f. prefabricated stainless steel or resin crown;
   g. core buildup, including pins;
   h. pin retention;
   i. prefabricated post and core, in addition to crown;
   j. extraction or surgical removal of erupted tooth;
   k. removal of impacted tooth (soft tissue or partially bony); and
   l. palliative (emergency) treatment of dental pain; and
   m. surgical removal of residual tooth roots; and
4. 65 percent for the following dental services:
   a. oral/facial images;
   b. diagnostic casts;
   c. re-cementation of space maintainer or crown;
   d. removal of fixed space maintainer;
   e. all endodontic procedures except unspecified endodontic procedure, by report;
   f. all periodontic procedures except unspecified periodontal procedure, by report;
   g. fluoride gel carrier;

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PAYMENT OF MEDICAL AND REMEDIAL CARE AND SERVICES

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SUPERSEDES: TN- 08-26

h. all fixed prosthodontic procedures except unspecified fixed prosthodontic procedure, by report;
i. tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth;
j. surgical access of an unerupted tooth;
k. biopsy of oral tissue;
l. transseptal fiberotomy/supra crestal fiberotomy;
m. aveolplasty in conjunction with extractions;
n. incision and drainage of abscess;
o. occlusal orthotic device;
p. suture of recent small wounds;
q. frenulectomy;
r. fixed appliance therapy; and
s. all adjunctive general services except:
   i. palliative (emergency) treatment of dental pain, and
   ii. unspecificed adjunctive procedure, by report.

The reimbursement for all other covered dental procedures shall remain at the rate on file as of December 23, 2008.

Effective for dates of service on or after January 22, 2010, the reimbursement fees for EPSDT dental services are reduced to the following percentages of the 2008 National Dental Advisory Service Comprehensive Fee Report 70th percentile, unless otherwise stated.

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1. 73 percent for diagnostic oral evaluation services;

2. 70 percent for the following periodic, diagnostic and preventive services:
   a) radiographs – periapical, first film;
   b) radiographs- periapical, each additional film;
   c) radiographs- panoramic film;
   d) prophylaxis- adult and child;
   e) topical application of fluoride, 0-15 years of age (prophylaxis not included; and
   f) topical fluoride varnish, therapeutic application for moderate to high caries risk patients (under 6 years of age); and

3. 65 percent for the remainder of the dental services.

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Effective for dates of service on or after August 1, 2010, the reimbursement fees for EPSDT dental services are reduced to the following percentages of the 2009 National Dental Advisory Service Comprehensive Fee Report 70th percentile, unless otherwise stated.

1. 69 percent for the following oral evaluation services:
   a) periodic oral examination;
   b) oral examination- patients under three years of age; and
   c) comprehensive oral examination- new patients;

2. 65 percent for the following annual and periodic, diagnostic and preventive services:
   a) radiographs – periapical, first film;
   b) radiographs- periapical, each additional film;
   c) radiographs- panoramic film;
   d) prophylaxis- adult and child;
   e) topical application of fluoride, adult and child (prophylaxis not included; and
   f) topical fluoride varnish, therapeutic application for moderate to high caries risk patients (under 6 years of age); and

3. 50 percent for the following diagnostic and adjunctive general services:
   a) oral/facial image
   b) non-intravenous conscious sedation; and
   c) hospital call; and;

4. 58 percent for the remainder of the dental services.

Removable prosthodontics and orthodontic services are excluded from the August 1, 2010 rate reduction.

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Effective for dates of service on or after January 1, 2011, the reimbursement fees for EPSDT dental services are reduced to the following percentages of the 2009 National Dental Advisory Service Comprehensive Fee Report 70th percentile, unless otherwise stated.

1. 67.5 percent for the following oral evaluation services:
   a) periodic oral examination;
   b) oral examination- patients under three years of age; and
   c) comprehensive oral examination- new patients;

2. 63.5 percent for the following annual and periodic, diagnostic and preventive services:
   a) radiographs – periapical, first film;
   b) radiographs- periapical, each additional film;
   c) radiographs- panoramic film;
   d) prophylaxis- adult and child;
   e) topical application of fluoride, adult and child (prophylaxis not included; and
   f) topical fluoride varnish, therapeutic application for moderate to high caries risk patients (under 6 years of age); and

3. 50 percent for the following diagnostic and adjunctive general services:
   a) oral/facial image
   b) non-intravenous conscious sedation; and
   c) hospital call; and;

4. 57 percent for the remainder of the dental services.

Removable prosthodontics and orthodontic services are excluded from the December 1, 2010 rate reduction.

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Effective for dates of service on or after July 1, 2012, the reimbursement fees for EPSDT dental services shall be reduced to the following percentages of the 2009 National Dental Advisory Service Comprehensive Fee Report 70th percentile, unless otherwise:

1. 65 percent for the following oral evaluation services:
   a) periodic oral examination;
   b) oral examination- patients under three years of age; and
   c) comprehensive oral examination- new patients;

2. 62 percent for the following annual and periodic diagnostic and preventive services:
   a) radiographs – periapical, first film;
   b) radiographs- periapical, each additional film;
   c) radiographs- panoramic film;
   d) diagnostic casts;
   e) prophylaxis- adult and child;
   f) topical application of fluoride, adult and child (prophylaxis not included); and
   g) topical fluoride varnish, therapeutic application for moderate to high caries risk patients (under 6 years of age);

3. 45 percent for the following diagnostic and adjunctive general services:
   a) oral/facial image;
   b) non-intravenous conscious sedation; and
   c) hospital call; and

4. 56 percent for the remainder of the dental services.

Removable prosthodontics and orthodontic services are excluded from the July 1, 2012 rate reduction.

Effective for dates of service on or after August 1, 2013, the reimbursement fees for EPSDT dental services shall be reduced by 1.5 percent of the rate on file July 31, 2013, unless otherwise stated.

1. The following services shall be excluded from the August 1, 2013 rate reduction:
   a. removable prosthodontics; and
   b. orthodontic services

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CITATION	Medical and Remedial Care and Services
42 CFR 447.304	Item 4.b.(contd.)
447.200-205 and Section 1905(r)(5) of the Act	II. The following services that are not otherwise covered under the Louisiana State Plan will be reimbursed when provided to an EPSDT recipient:

A. Hospice Services

Hospice care will be reimbursed utilizing the principles of reimbursement as detailed in the State Medicaid Manual, Chapter IV, Sections 4305 and 4307.

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

Effective February 9, 2007, an hourly wage enhancement payment in the amount of $2 will be reimbursed to providers for personal care workers who provide services to Medicaid recipients.

The rate methodology is uniform for both governmental and non-governmental providers. The fee schedule is published on the Medicaid Provider Website www.lamedicaid.com.

C. Chiropractors

1. Method of Payment

Reimbursement is only for manual manipulation of the spine (procedure codes 97260 and 97261). 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 Bureau's provider reimbursement fee schedule.

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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

Reimbursements for services are based upon a Medicaid fee schedule established by the State of Louisiana.

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.

Effective for dates of service on or after April 20, 2013, the reimbursement for behavioral health services rendered by a physician under the LBHP shall be 75 percent of the 2009 Louisiana Medicare Region 99 allowable for services rendered to Medicaid recipients.

Effective for dates of service on or after September 1, 2013, the reimbursement for procedure codes 90791, 90792, 90832, 90834, and 90837 shall be excluded from the January 2013 Medicare rate changes and shall remain at the Medicaid fee schedule on file as of December 31, 2012.

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. Room and board costs are not included in the Medicaid fee schedule.

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 are 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 .

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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:

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

- Staffing Assumptions and Staff Wages
- Employee-Related Expenses – Benefits, Employer Taxes (e.g., FICA, unemployment, and workers compensation)
- Program-Related Expenses (e.g., supplies)
- Provider Overhead Expenses
- 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.

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Date Received: 28 June, 2013
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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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State: Louisiana
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Date approved: 12/15/14
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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 (cont)

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 DHH. 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 DHH 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

Unit of Service: Reimbursement for the TGH is based on a daily rate for the skill building providing by unlicensed practitioners.

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED
LIMITATIONS ON THE AMOUNT, DURATION, AND SCOPE OF CERTAIN ITEMS OF PROVIDED MEDICAL AND REMEDIAL CARE AND SERVICES ARE DESCRIBED AS FOLLOWS:

Medical and Remedial Care and Services
Item 4.b, EPSDT services (Cont'd)

State: Louisiana
Date Approved: 1/5/16
Date Received: 10/21/15
Date Effective: 12/1/15
Transmittal Number: LA 15-0024

Behavioral Health Services Provided by Local Education Agencies

Medicaid services provided in schools are services that are medically necessary and provided in schools to Medicaid recipients in accordance with an Individualized Education Program, (IEP). Covered services include the following:

1. Other Licensed Practitioner Behavioral Health Services (described in Attachment 3.1-A, Item 4b)
2. Rehabilitation Behavioral Health Services (includes Addiction Services as described in Attachment 3.1-A, Item 13.d)

The interim payment to the local education agencies (LEAs) for services listed above are based on the behavioral health fee schedule methodology as outlined in the Louisiana Medicaid Fee Schedule.

Summary of Payment Methodology

Final payment to each LEA is the lesser of: 1) number of units billed multiplied by $100 (to be adjusted by DHH periodically per the Agency's fee schedule rate set as of March 1, 2012 and effective for services provided on or after that date. All rates are published on the Agency's website at www.lamedicaid.com) or 2) the most recent school year's actual cost as determined by desk review and/or audit for each LEA provider.

Each LEA shall determine its own costs and certify to those costs annually by using DHH's Cost Report for Direct Service Cost template (the Direct Service Cost Report) form as approved by the Centers for Medicare and Medicaid Services (CMS) in November, 2005. Direct cost is limited to the amount of total compensation (salaries and fringe benefits) of current direct service providers as allocated to direct services for Medicaid special education recipients. The basis of allocation for direct compensation cost is DHH's Direct Services Time Study Methodology approved by CMS November 2005. This time study incorporates the CMS-approved Medicaid Administrative Claiming (MAC) methodology for direct service personnel and is used to determine the percentage of time direct service personnel spend on direct IDEA/IEP services and General and Administrative (G&A) time. There are no additional direct costs included in the rate. Indirect cost is derived by multiplying the cognizant agency indirect cost unrestricted rate assigned by the Department of Education to each LEA. There are no additional indirect costs included. The Direct Service Cost Report initially provides the total cost of all school-based services provided, regardless of payer. To determine the amount of direct services cost that may be attributed to Medicaid, the ratio of Medicaid covered students with IEPs to all students with IEPs is multiplied by total direct cost. Cost data is subject to certification by each parish. This serves as the basis for obtaining Federal Medicaid funding.

For each of the IDEA-related school based services other than specialized transportation services, the participating LEA's actual cost of providing the services will be claimed for Medicaid reimbursement. The State will gather actual expenditure information for each LEA through its payroll/benefits and accounts payable system. These costs are also reflected in the annual financial report (AFR) that all LEAs are required to certify and submit to the Department of Education. All costs included in the amount of cost to be certified and used subsequently to determine reconciliation and final settlement amounts as well as interim rates are identified on the CMS-approved Direct Services Cost Report and are allowed in the Office of Management and Budget (OMB) Circular A-87. The State also will use other LEA-specific information including the general fund budget and full-time equivalent (FTE) counts.

STATE OF LOUISIANA

PAYMENTS FOR 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:

Step 1: Develop Direct Cost-The Payroll Cost Base

Total annual salaries and benefits paid as well as contracted (vendor) payments are obtained initially from each LEA's payroll/benefits and accounts payable system. This data will be reported on DHH's Direct Services Cost Report form for all direct service personnel (i.e., all personnel providing LEA direct treatment services covered under the State Plan).

Step 2: Adjust the Payroll Cost Base

The payroll cost base is reduced for amounts reimbursed by other funding sources (e.g. Federal grants). The payroll cost base does not include any amounts for staff whose compensation is 100 percent reimbursed by a funding source other than state/local funds. The application of Step 2 results in total adjusted salary cost.

Step 3: Determine the Percentage of Time to Provide All Direct Services

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

To reallocate G&A time to direct IDEA/IEP services, the percentage of time spent on direct IDEA/IEP services is divided by 100 percent, minus the percentage of time spent on G&A. This will result in a percentage that represents the IDEA/IEP services with appropriate allocation of G&A. This percentage is multiplied by total adjusted salary cost as determined in Step 2 to allocate cost to school-based services. The product represents total direct cost. A sufficient number of direct service personnel will be sampled to ensure results that will have a confidence level of at least 95 percent with a precision of plus or minus five percent overall.

Step 4: Determine Indirect Cost

Indirect cost is determined by multiplying each LEA's indirect unrestricted rate assigned by the cognizant agency (the Department of Education) by total adjusted direct cost as determined under Step 3. No additional indirect cost is recognized outside of the cognizant agency indirect rate. The sum of direct cost and indirect cost is total direct service costs for all students with an IEP.

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STATE OF LOUISIANA

PAYMENTS FOR 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:

Step 5: Allocate Direct Service Cost to Medicaid

To determine the amount of cost that may be attributed to Medicaid, total cost as determined under Step 4 is multiplied by the ratio of Medicaid recipients with an IEP to all students with an IEP. This results in total cost that may be certified as Medicaid's portion of school-based services cost.

Step 6: Compare the amount of behavioral health services authorized and billed through the interim process to the cost of the services

Final payment to each LEA is the lesser of: 1) number of units billed multiplied by $100 (to be adjusted by DHH periodically per the Agency's fee schedule rate set as of March 1, 2012, and effective for services provided on or after that date. All rates are published on the Agency's website at www.lamedicaid.com) or 2) the most recent school year's actual cost as determined by desk review and/or audit for each LEA provider.

Each LEA will complete the Direct Services and Transportation Cost Reports as applicable and submit the cost report(s) no later than five months after the June 30 fiscal year period ends and reconciliation will be completed within 12 months from the fiscal year end. If a provider's interim payments exceed the actual, certified costs for behavioral health Medicaid services provided in schools to Medicaid clients, the provider will remit the federal share of the overpayment at the time the cost report is submitted.

The Bureau of Health Services Financing (BHSF) will submit the federal share of the overpayment to CMS within 60 days of identification. If the actual, certified costs of a LEA provider exceed the interim payments, BHSF will pay the federal share of the difference of the lesser of 1) number of units billed multiplied by $100 (to be adjusted by DHH periodically per the Agency's fee schedule rate set as of March 1, 2012, and effective for services provided on or after that date. All rates are published on the Agency's website at www.lamedicaid.com) or 2) the most recent school year's actual cost as determined by desk review and/or audit for each LEA provider, to the provider in accordance with the final actual certification agreement and submit claims to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

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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:

CITATION
42 CFR
447.201

Medical and Remedial
Care and Services
Item 4.b. (Cont'd)

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 3 settings:

1) Natural Environment-which may include a child's home or settings in the community that are natural or normal for the child's age and peers who have no disabilities.
2) Special Purpose Facility-which includes children with no disabilities including child care center, nursery schools, preschools with at least 50% of the children with no disabilities or developmental delays.
3) Center-Based Special Purpose Facility-which is a 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. Fee schedules can be found on the Louisiana Medicaid provider website at www.lamedicaid.com.

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 a natural environment shall be reduced by 2 percent of the rate in effect on December 31, 2010. The following services shall be reimbursed at the reduced rate:

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

STATE Louisiana
DATE RECD 12-20-10
DATE APPVD 2-28-11
DATE EFF 1-1-11
HCFA 179 10-58
A

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:

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

Governmental and private providers are paid using the same fee schedule.

STATE Louisiana
DATE REC'D 12-20-10
DATE APPV'D 2-28-11
DATE EFF 1-1-11
HCFA 179 10-58
A

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

LIMITATIONS OF THE AMOUNT, DURATION, AND SCOPE OF CERTAIN ITEMS OF PROVIDED MEDICAL AND REMEDIAL CARE AND SERVICES ARE DESCRIBED AS FOLLOWS:

Substance Abuse Services

The Medicaid Program shall provide reimbursement to the Office of Behavioral Health (OBH) for substance abuse services rendered to EPSDT recipients. Payments to OBH shall sunset as of February 29, 2012.

Reimbursement Methodology

A. Reimbursement for these services shall be based on the most recent actual cost to OBH. Cost data shall be derived from the Department's ISIS reporting of costs for the period. The cost period shall be consistent with the state fiscal year. Costs are determined by selecting the expenditures paid from state and local funds for the state fiscal year.

B. OBH encounter data from their database shall be used to identify allowable services. Encounter data for recipients under the age of 21 shall be extracted and used in calculations to determine actual cost to OBH.

C. Costs shall be calculated by using the cost-weighted amount and include the Medicaid eligible under 21 database costs divided by total database costs times OBH's expenditures for the program which were derived from the state's ISIS data.

STATE Louisiana
DATE REC'D 6-29-11
DATE APPV'D 5-22-12
DATE EFF 4-22-11
HCFA 179 11-14
A

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

Effective July 21, 2010, reimbursement for PDHC services shall be a statewide fixed per diem rate which is based on the number of hours that a qualified recipient attends the PDHC facility.

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

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

The initial per diem rate for the Pediatric Day Health Care providers was set based on projections of the daily cost. The Department will require the PDHC providers to submit annual cost reports reflecting their actual costs and statistics related to providing care for this program. The costs would include all costs of the operation and segregate the cost into cost categories. The direct care cost category would include a breakdown of the nursing services and the different therapies. The statistics would include the daily census information as well as the encounters for each of the therapies.

These cost reports will be used by the Department to evaluate the cost effectiveness and the reasonableness of the daily rate paid to the providers. Rate adjustments may be made from time to time based on the data obtained through the cost reports or other sources.

State: Louisiana
Date Received: 6 Aug, 2012
Date Approved: 22 Aug, 2013
Effective Date: 1 July, 2012
Transmittal Number: LA 12-27

Effective for dates of service on or after July 1, 2012, the reimbursement for pediatric day health care services shall be reduced by 3.7 percent of the rates in effect on June 30, 2012.

The fee schedule will be available through the Louisiana Medicaid provider website, www.lamedicaid.com.

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:

School-Based Services

A. Effective on or after January 1, 2012, payment for EPSDT school-based nursing services shall be based on the most recent school year's actual cost as determined by desk review and/or audit for each local education agency (LEA) provider.

1. Each LEA shall determine cost annually by using DHH's Cost Report for Nursing Service Cost form based on the Direct Services Cost Report.

2. Direct cost shall be limited to the amount of total compensation (salaries, vendor payments and fringe benefits) of current nursing service providers as allocated to nursing services for Medicaid special education recipients.

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

4. In order to calculate the ratio of total Medicaid students in the LEA, the numerator should be the total number of students that are Medicaid eligible in the LEA and the denominator should be the total number of students that are enrolled in the LEA.

B. For the nursing services, the participating LEA's actual cost of providing the services shall be claimed for Medicaid Federal Financial Participation (FFP) based on the following methodology.

1. The state shall gather actual expenditure information for each LEA through its Payroll/Benefits and Accounts Payable System.

2. Develop Direct Cost - The Payroll Cost Base. Total annual salaries and benefits paid, as well as contracted (vendor) payments, shall be obtained initially from each LEA's Payroll/Benefits and Accounts Payable system. This data shall be reported on DHH's Nursing Services Cost Report form for all nursing service personnel (i.e. all personnel providing LEA nursing treatment services covered under the state plan).

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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:

State: Louisiana
Date Received: 2/17/12
Date Approved: 9/6/13
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Transmittal Number: LA 12-02

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

4. Determine the Percentage of Time to Provide All Nursing Services
A time study which incorporates the CMS-approved Medicaid Administrative Claiming (MAC) methodology for nursing service personnel shall be used to determine the percentage of time nursing service personnel spend on nursing services and General and Administrative (G&A) time. This time study will assure that there is no duplicate claiming. The G&A percentage shall be reallocated in a manner consistent with the CMS approved Medicaid Administrative Claiming methodology. Total G&A time shall be allocated to all other activity codes based on the percentage of time spent on each respective activity. To reallocate G&A time to nursing services, the percentage of time spent on nursing services shall be divided by 100 percent minus the percentage of G&A time. This shall result in a percentage that represents the nursing services with appropriate allocation of G&A. This percentage shall be multiplied by total adjusted salary cost as determined B.4 above to allocate cost to school based services. The product represents total direct cost. A sufficient number of nursing service personnel shall be sampled to ensure results that will have a confidence level of at least 95 percent with a precision of plus or minus five percent overall. The CMS approval letter for the time study will be maintained by the State of Louisiana and CMS.

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

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Transmittal Number: LA 12-02

6. Allocate Direct Service Cost to Medicaid

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

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

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

D. Cost Settlement Process.

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

1. The financial oversight of all LEAs shall include reviewing the costs reported on the Nursing Services Cost Reports against the allowable costs, performing desk reviews and conducting limited reviews.

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

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

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

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

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

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

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

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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 licensed 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

The rates are based upon 15 minute units of service, with the exception of mental health services plan which shall be reimbursed at an hourly fee rate. 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.

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Date Approved: February 11, 2015
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