RULE

Department of Health
Bureau of Health Services Financing

Applied Behavior Analysis-Based Therapy Services
Reimbursement Rate Realignment
(LAC 50:XV.703)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XV.703 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50

PUBLIC HEALTH-MEDICAL ASSISTANCE
Part XV. Services for Special Populations
Subpart 1. Applied Behavior Analysis-Based Therapy Services

Chapter 7. Reimbursements

§703. Reimbursement Methodology

A. Reimbursement for ABA-based therapy services shall be based upon a percentage of the commercial rates for ABA-based therapy services in the state of Louisiana.

B. Effective for dates of service on or after January 1, 2017, ABA rates and codes in effect on December 31, 2016 will be realigned to be consistent with the commercial rates in the state related to these codes which go into effect statewide on January 1, 2017.

1. Prior authorizations already in effect on the

promulgation date of these provisions will be honored. Those services shall be paid at the rate in effect on December 31, 2016.

2. New prior authorizations with a begin date after the promulgation date of these provisions must use the codes in effect prior to January 1, 2017 for those services provided and to be delivered prior to January 1, 2017, and for any services provided after January 1, 2017, the codes in effect on January 1, 2017 must be used.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:928 (May 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Intermediate Care Facilities for Persons with Intellectual Disabilities
Supplemental Payments
(LAC 50:VII.32917)

The Department of Health, Bureau of Health Services Financing has adopted LAC 50:VII.32917 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50

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

Chapter 329. Reimbursement Methodology

Subchapter A. Non-State Facilities

§32917. Supplemental Payments

A. Effective for dates of service on or after August 1, 2015, monthly supplemental payments shall be made to qualifying privately-owned intermediate care facilities for persons with intellectual disabilities.

1. In order to qualify for the supplemental payment, the private entity must enter into a cooperative endeavor agreement with the department.

B. Effective for dates of service on or after August 1, 2016, monthly supplemental payments shall be made to qualifying privately-owned intermediate care facilities for persons with intellectual disabilities (ICFs/ID) to provide a privately operated living setting to residents discharging from Pinecrest Supports and Services Center.

1. In order to qualify for the supplemental payment, the private entity must enter into a cooperative endeavor agreement with the department to provide a privately operated living setting, with an end goal of increased community placement opportunities, to residents of Pinecrest who desire to discharge and have been deemed ready for discharge by their interdisciplinary teams, and meet the admission protocol/criteria of the contracted party but have not been successful in securing a placement with a private provider.

C. Supplemental payments for services rendered to Medicaid recipients shall not exceed the facility's upper payment limit (UPL) pursuant to 42 CFR 447.272. The UPL will be based on the Centers for Medicare and Medicaid Services' approved ICF transitional rate of $329.26 including provider fee.

D. The supplemental payment will be the difference between the actual Medicaid payment and what would have been paid if the ICF/ID was paid up to the UPL amount.

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

HISTORICAL NOTE: Promulgated by the Department of Health,

Bureau of Health Services Financing, LR 43:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Managed Care for Physical and Behavioral Health
Louisiana Health Insurance Premium Payment Program
(LAC 50:I.3103)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:I.3103 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part I. Administration
Subpart 3. Managed Care for Physical and Behavioral Health

Chapter 31. General Provisions

§3103. Recipient Participation

A. – G. ...

H. Participation Exclusion

1. The following Medicaid and/or CHIP recipients are excluded from participation in an MCO and cannot voluntarily enroll in an MCO. Individuals who:

a. – c. ...

d. have a limited period of eligibility and participate in either the Spend-Down Medically Needy Program or the Emergency Services Only program;

e. receive services through the Take Charge Plus program; or

f. are enrolled in the Louisiana Health Insurance Premium Payment (LaHIPP) program.

I. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1573 (June 2011), amended LR 40:310 (February 2014), LR 40:1096 (June 2014), LR 40:2258 (November 2014), LR 41:929 (May 2015), LR 41:2363 (November 2015), LR 42:754 (May 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1522 (September 2016), LR 43:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Medicaid Eligibility
Louisiana Health Insurance Premium Payment Program
(LAC 50:III.2311)

The Department of Health, Bureau of Health Services Financing has adopted LAC 50:III.2311 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE
Part III. Eligibility
Subpart 3. Eligibility Groups and Factors

Chapter 23. Eligibility Groups and Medicaid Programs

§2311. Louisiana Health Insurance Premium Payment Program

A. Section 1906 of Title XIX of the Social Security Act mandates that Medicaid recipients enroll, and maintain their enrollment, in cost-effective group health insurance plans as a condition of Medicaid eligibility if such a plan is available. In compliance with section 1906, the department hereby establishes the Louisiana Health Insurance Premium Payment (LaHIPP) Program to provide Medicaid payment of the costs associated with the

enrollment of recipients in cost-effective group health insurance plans.

B. Medicaid recipients shall be enrolled in LaHIPP when cost-effective health plans are available through the recipient's employer or a responsible party's employer-based health plan if the recipient is enrolled or eligible for such a health plan.

1. The enrollment period for the LaHIPP Program shall be no less than six months.

C. When coverage for eligible family members is not possible unless ineligible family members are enrolled, the Medicaid Program will pay the premiums for the enrollment of other family members when it is cost-effective.

D. The recipient, or the individual acting on behalf of the recipient, shall cooperate to establish the availability and cost effectiveness of group health insurance.

1. Medicaid benefits of the parent may be terminated for failure to cooperate unless good cause for non-cooperation is established. Medicaid benefits for a child shall not be terminated due to the parent’s or authorized representative’s failure to cooperate.

E. Continued eligibility for this program is dependent upon the individual's ongoing eligibility for Medicaid.

F. LaHIPP recipients shall be entitled to coverage of the patient responsibility amounts for services covered under the

group health insurance to the extent allowed under the Medicaid State Plan and for all services that are not covered by the group health insurance but are provided for under the Medicaid State Plan and rendered by Medicaid providers.

G. The department shall be entitled to any rate refund made when the health insurance carrier determines a return of premiums to the policy holder is due because of lower than anticipated claims for any period of time in which the department paid the premiums.

H. The Medicaid Program will make the determination whether the group health insurance plan(s) available to the recipient is cost effective.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Rebekah E. Gee MD, MPH

Secretary