RULE

Department of Health
Bureau of Health Services Financing

Expedited Licensing Process for Healthcare Facilities and Providers
(LAC 48:I.Chapter 41)

The Department of Health, Bureau of Health Services Financing has adopted LAC 48:I.Chapter 41 as authorized by R.S. 36:254 and R.S. 40:2006.2. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 48
PUBLIC HEALTH-GENERAL
Part I. General Administration
Subpart 3. Licensing and Certification

Chapter 41. Expedited Licensing Process for Healthcare Facilities and Providers Licensed by the Department of Health

§4101. Definitions

Applicant—any person, partnership, corporation, unincorporated association or other legal entity currently operating, or planning to operate, any of the health care facilities or providers licensed by the Department of Health.

Applicant Representative—the person specified by the applicant on the application form authorized to respond to inquiries from the Department of Health regarding the expedited

licensing process and to whom written notifications are sent relative to the status of the expedited licensing application.

Approval—a determination by the Department of Health that an application meets the criteria of the expedited licensing process.

Department—the Louisiana Department of Health (LDH).

Health Standards Section (HSS)-the section in the Department of Health responsible for licensing health care facilities and agencies, certifying facilities and agencies that apply for participation in the Medicaid (titles XIX and XXI) and Medicare (title XVIII) programs, and conducting surveys and inspections.

Licensing–deemed to include initial licensing of a provider or facility, licensure upon a change of ownership, licensing due to relocation or replacement facility, or licensing due to adding locations, off-sites, satellites, beds, units, fleet additions or services.

Notification—deemed to be given on the date on which an applicant representative receives notice from LDH of the expedited license determination, either electronically or by certified mail to the last known address of the applicant representative.

Readiness Date-the date that the applicant indicates to the HSS field office assigned scheduler that the facility or

provider is ready for the licensing survey to be conducted by the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2006.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 44:

§4103. General Provisions

A. Any person, partnership, corporation, unincorporated association or other legal entity currently operating, or planning to operate, any of the health care facilities or providers licensed by the department may seek an expedited licensing process as provided for in this Chapter.

B. The provisions of this Chapter shall apply to an applicant provider or facility for any of the health care facility or provider types licensed by the department.

C. The expedited licensing process provided for in this Chapter is at the discretion of the applicant provider or facility requesting such expedited process.

1. A request for the expedited licensing process is voluntary.

2. An applicant provider or facility shall not be delayed from the usual licensing and/or survey scheduling process and timeframe, if the expedited licensing process is not requested.

D. The department shall ensure that no applicant provider or facility seeking approval to apply for licensure pursuant to a pre-licensing facility need review approval process is affected by another provider of the same license type choosing the expedited licensing process instead of the regular licensing process.

E. The department shall not utilize existing employees who conduct regular licensing surveys to conduct any expedited licensing survey.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2006.2.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 44:

§4105. Expedited Licensing Applications and Fees

A. Requests for expedited licensing applications shall be submitted to the LDH Health Standards Section (HSS) on the forms indicated for that purpose, containing such information as the department may require, and shall be accompanied by the specified fee as established in Paragraph E of this Section.

B. The applicant shall designate a representative on the expedited licensing process application.

1. The designated applicant representative shall be the only person to whom HSS will send written notification in

matters relative to the status of the expedited licensing process.

2. If the applicant representative or his/her address changes at any time during the licensing process, it is the responsibility of the applicant to notify HSS in writing of such change.

C. Documentation and correspondence related to the expedited licensing process may be submitted and received via electronic transmission to shorten the timeframe of the process.

D. The expedited licensing process fee is required at the time that the application is submitted to the department. The expedited licensing process fee shall be:

1. made payable to the Louisiana Department of Health; and

2. made in the manner required by the department on the expedited licensing process application.

E. The expedited licensing process fee shall be determined by the complexity and acuity of the requested licensing process and shall be assessed on a tiered basis pursuant to §4107 of this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2006.2.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 44:

§4107. Expedited Licensing Survey Types and Tiers

A. The fees associated with the expedited licensing process shall be assessed according to the following tiers:

1. Tier 1. Expedited licensing fee is set at $7,000.

2. Tier 2. Expedited licensing fee is set at $6,000.

3. Tier 3. Expedited licensing fee is set at $5,000.

B. Tier 1 expedited licensing processes include, but are not limited to, the following:

1. initial licensing of a hospital or off-site location of a hospital;

2. licensing of a replacement facility or location (or relocation) of the main campus of a hospital;

3. licensing of a replacement facility or location (or relocation) of an off-site campus of a hospital that has any of the following:

a. licensed beds;

b. surgical services; or

c. an emergency department; and

4. initial licensing of the following:

a. an ambulatory surgical center (ASC);

b. an end stage renal disease (ESRD) facility;

c. a rural health clinic (RHC);

d. a nursing facility (NF); or

e. a home and community-based services (HCBS) provider or an off-site or satellite location of the provider.

C. Tier 2 expedited licensing processes include, but are not limited to, the following:

1. initial licensing of the following:

a. an adult residential care provider (ARCP) level 1, 2, 3 or 4;

b. a crisis receiving center (CRC);

c. an intermediate care facility for people with developmental disabilities (ICF/DD);

d. a pediatric day health care (PDHC) facility;

e. a home health agency (HHA) or an off-site or satellite location of a HHA;

f. a hospice agency, an off-site or satellite location of a hospice agency or an inpatient hospice facility;

g. a psychiatric residential treatment facility (PRTF);

h. a therapeutic group home (TGH);

i. a behavioral health services provider (BHSP);

j. an adult day health care (ADHC) facility.

k. a forensic supervised transitional residential and aftercare (FSTRA) facility;

l. a pain management clinic (PMC);

m. an adult brain injury (ABI) facility;

n. an emergency medical transportation services (EMTS) provider; or

o. any other provider or facility licensed by LDH;

2. licensing of a replacement facility or location (or relocation) of the following:

a. an ASC;

b. an ESRD facility;

c. an RHC;

d. a CRC;

e. a NF; or

f. an HCBS provider or an off-site or satellite location of the provider; and

3. licensing of additional units, services or beds, or other action at an existing licensed hospital, ASC, ESRD facility or NF that requires a physical environment survey.

D. Tier 3 expedited licensing processes include, but are not limited to, the following:

1. licensing of a replacement facility (or relocation) for the following:

a. an ICF/DD;

b. a PDHC;

c. an ADHC facility;

d. an ARCP level 1, 2, 3 or 4;

e. an HHA or an off-site or satellite location of a HHA;

f. a hospice agency or an off-site or satellite location of hospice agency or an inpatient hospice facility;

g. a PRTF;

h. a TGH;

i. a BHSP;

j. a FSTRA facility;

k. a PMC;

l. an ABI facility; or

m. any other provider or facility licensed by LDH; and

2. licensing additional units, services, beds, or other action an existing licensed ICF/DD, PDHC, HCBS provider, ADHC center, ARCP (levels 1, 2, 3 and 4), PRTF, TGH, BHSP, CRC, FSTRA facility, ABI facility, or other provider or facility licensed by the department that requires a physical environment survey, or a fleet addition for an EMTS provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2006.2.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 44:

§4109. Expedited Licensing Application Review Process

A. If an applicant provider or facility submits an expedited licensing process application and pays all applicable fees in the required manner, the department shall prioritize the application. After priority review of the application, the department shall:

1. notify the applicant provider or facility of any missing documentation or information; or

2. notify the applicant of the approval of the completed expedited licensing application packet.

B. The department shall notify the applicant representative, upon approval of the completed expedited licensing application packet, that the applicant shall provide a readiness date for the expedited survey to the appropriate HSS field office.

C. The applicant shall not contact the HSS field office to schedule the expedited survey until notified of approval as provided for in Paragraphs A and B of this Section.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2006.2.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 44:

§4111. Expedited Licensing Survey Process

A. Once the expedited licensing application packet has been approved, the department shall conduct the expedited licensing survey within 10 working days of the readiness date indicated by the applicant provider or facility, or such other time period to which the provider has agreed.

B. The expedited licensing survey shall be conducted in accordance with this Subchapter and applicable published licensing statutes, rules and regulations for the particular health care provider or facility type for which the applicant has applied.

C. The expedited licensing survey shall be scheduled and conducted in an expedited manner pursuant to the usual survey process, protocols and procedure.

D. The department shall provide written notification to the applicant representative of the results of the expedited licensing survey within 10 working days of the survey exit date. This notification may be made by electronic transmission.

1. The written notification of the expedited survey results shall include any licensing deficiencies, requirements for a plan of correction, and review and/or appeal rights as to the deficiencies, if applicable, pursuant to applicable licensing statutes, rules and regulations.

2. If deficiencies are cited at the expedited licensing survey, the department may, at its option:

a. require a plan of correction and conduct a follow-up licensing survey;

b. issue a provisional license, pursuant to applicable licensing regulations; or

c. issue a license denial, including appeal rights, pursuant to applicable licensing regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2006.2.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 44:

§4113. Expedited Licensing Survey Refunds

A. The department shall refund the expedited licensing process fee amount paid by an applicant provider or facility if the survey is not conducted within the time periods specified in §4111.A, unless such failure to conduct the survey is due to the unavailability of the facility or provider.

B. If the applicant facility or provider fails to be ready when the department begins to conduct the expedited licensing survey, the survey will be ended, no refund of the expedited licensing fee will be due, and the applicant facility or provider shall have the choice to:

1. re-submit a new expedited licensing process application and applicable fee; or

2. submit a regular licensing process application and applicable fee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2006.2.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 44:

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Federally Qualified Health Centers
Reimbursement Methodology
Mammography Separate Payments
(LAC 50:XI.10703)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XI.10703 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. This Rule is hereby adopted on the day of promulgation.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XI. Clinic Services
Subpart 13. Federally-Qualified Health Centers

Chapter 107. Reimbursement Methodology

§10703. Alternate Payment Methodology

A. – C. ...

D. Effective for dates of service on or after January 1, 2019, FQHCs shall be reimbursed a separate payment outside of the prospective payment system (PPS) rate for the following services:

1. – 1.a. ...

2. Mammogram Screening and Diagnosis

a. Reimbursement for mammogram screening and diagnostics shall be a flat fee on file based on Medicaid covered current procedural terminology (CPT) code(s), in addition to the PPS rate for the associated encounter/office visit.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1033 (June 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 44: 1894 (October 2018), LR 44:

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
and
Office of Aging and Adult Services

Home and Community-Based Services Waivers
Adult Day Health Care Waiver
(LAC 50:XXI.Chapters 21-27)

The Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services have amended LAC 50:XXI.Chapters 21-27 under the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXI. Home and Community-Based Services Waivers
Subpart 3. Adult Day Health Care Waiver

Chapter 21. General Provisions

§2101. Introduction

A. These standards for participation specify the requirements of the Adult Day Health Care (ADHC) Waiver Program. The program is funded as a waived service under the provisions of Title XIX of the Social Security Act and is administrated by the Department of Health (LDH).

B. – C. ...

D. Each individual who requests ADHC waiver services has the option to designate a responsible representative. For purposes of these provisions, a responsible representative shall be defined as the person designated by the individual to act on his/her behalf in the process of accessing and/or maintaining ADHC waiver services.

1. The appropriate form authorized by the Office of Aging and Adult Services (OAAS) shall be used to designate a responsible representative.

a. The written designation of a responsible representative does not take away the right of the individual to continue to transact business on his/her own behalf nor does it give the representative any legal authority other than as specified in the designation form.

b. The written designation is valid until revoked by the individual granting the designation.

i. To revoke the written designation, the revocation must be submitted in writing to OAAS or its designee.

2. The functions of a responsible representative are to:

a. assist and represent the individual in the assessment, care plan development and service delivery processes; and

b. aid the participant in obtaining all of the necessary documentation for these processes.

3. No individual, unless granted an exception by OAAS, may concurrently serve as a responsible representative for more than two participants in OAAS-operated Medicaid home and community-based service programs including:

a. the Program of All-Inclusive Care for the Elderly;

b. long-term personal care services (LT-PCS);

c. the Community Choices Waiver; and

d. the Adult Day Health Care Waiver.

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 Human Resources, Office of Family Security, LR 11:623 (June 1985), repromulgated LR 13:181 (March 1987),amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 23:1149 (September 1997), repromulgated LR 30:2034 (September 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2161 (October 2008), repromulgated LR 34:2565 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2494 (September 2013), amended

by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§2105. Request for Services Registry

[Formerly §2107]

A. The Department of Health is responsible for the Request for Services Registry, hereafter referred to as “the registry”, for the ADHC Waiver. An individual who wishes to have his or her name placed on the registry shall contact a toll free telephone number, which shall be maintained by LDH.

B. Individuals who desire their name to be placed on the ADHC waiver registry shall be screened to determine whether they:

1. meet nursing facility level of care; and

2. are members of the target population as identified in the federally-approved waiver document.

C. Only individuals who pass the screening in §2105.B shall be added to the registry.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2035 (September 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office of Aging and Adult Services, LR 32:2256 (December 2006),

LR 34:2161 (October 2008), repromulgated LR 34:2566 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2495 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§2107. Programmatic Allocation of Waiver Opportunities

A. When funding is appropriated for a new ADHC waiver opportunity or an existing opportunity is vacated, the department shall send a written notice to an individual on the registry indicating that a waiver opportunity is available. That individual shall be evaluated for a possible ADHC waiver opportunity assignment.

B. Adult day health care waiver opportunities shall be offered to individuals on the registry according to priority groups. The following groups shall have priority for ADHC waiver opportunities in the order listed:

1. individuals with substantiated cases of abuse or neglect referred by protective services who, without ADHC waiver services, would require institutional placement to prevent further abuse and neglect;

2. individuals who have been discharged after a hospitalization within the past 30 calendar days that involved a stay of at least one night;

3. individuals admitted to, or residing in, a nursing facility who have Medicaid as the sole payer source for the nursing facility stay; and

B.4. – C. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2162 (October 2008), repromulgated LR 34:2566 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2624 (September 2011), LR 39:2495 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

Chapter 23. Services

§2301. Covered Services

A. The following services are available to participants in the ADHC Waiver. All services must be provided in accordance with the approved plan of care (POC). No services shall be provided until the POC has been approved.

1. Adult Day Health Care. Services furnished as specified in the POC at a licensed ADHC center, in a non-institutional, community-based setting encompassing both

health/medical and social services needed to ensure the optimal functioning of the participant. Services are furnished on a regularly scheduled basis, not to exceed 10 hours a day, 50 hours a week. ADHC services include those core service requirements identified in the ADHC licensing standards (LAC 48:I.4243) in addition to:

a. medical care management; and

b. transportation to and from medical and social activities (if the participant is accompanied by the ADHC center staff).

c. – j. Repealed.

2. Support Coordination. These services assist participants in gaining access to necessary waiver and other state plan services, as well as needed medical, social, educational, housing, and other services, regardless of the funding source for these services. Support coordination agencies shall be required to perform the following core elements of support coordination services:

a. ...

b. assessment and reassessment;

c. ...

d. follow-up/monitoring;

e. critical incident management; and

f. transition/discharge and closure.

g. – l. Repealed.

3. Transition Intensive Support Coordination. These services will assist participants currently residing in nursing facilities in gaining access to needed waiver and other state plan services, as well as needed medical, social, housing, educational and other services regardless of the funding source for these services. Support coordinators shall initiate and oversee the process for assessment and reassessment, as well as be responsible for ongoing monitoring of the provision of services included in the participants approved POC.

a. This service is paid up to six months prior to transitioning from the nursing facility when adequate pre-transition supports and activities are provided and documented.

b. The scope of transition intensive support coordination shall not overlap with the scope of support coordination.

c. Support coordinators may assist participants to transition for up to six months while the participants still resides in the facility.

4. Transition Services. These services are time limited, non-recurring set-up expenses available for individuals who have been offered and approved for an ADHC waiver opportunity and are transitioning from a nursing facility to a

living arrangement in a private residence where the individual is directly responsible for his/her own expenses.

a. Allowable expense are those necessary to enable the individual to establish a basic household (excluding expenses for room and board) including, but not limited to:

i. security deposits that are required to obtain a lease on an apartment or house;

ii. specific set up fees or deposits

iii. activities to assess need, arrange for and procure needed resources;

iv. essential furnishings to establish basic living arrangements; and

v. health, safety, and welfare assurances.

b. These services must be prior approved in the participant’s plan of care.

c. These services do not include monthly rental, mortgage expenses, food, recurring monthly utilities charges and household appliances and/or items intended for purely diversional/recreational purposes.

d. These services may not be used to pay for furnishings or set-up living arrangements that are owned or leased by a waiver provider.

e. Support coordinators shall exhaust all other resources to obtain these items prior to utilizing the waiver.

f. Funds are available up to the lifetime maximum amount identified in the federally-approved waiver document.

B. – E. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 11:623 (June 1985), amended LR 13:181 (March 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 23:1149 (September 1997), amended LR 25:1100 (June 1999), repromulgated LR 30:2036 (September 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2162 (October 2008), repromulgated LR 34:2566 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2625 (September 2011), LR 39:2495 (September 2013), LR 40:791 (April 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§2303. Individualized Service Plan

A. All participants shall have an ADHC individualized service plan (ISP) written in accordance with ADHC licensing standards (LAC 48:I.4281).

1. – 15. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 11:623 (June 1985), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 13:181 (March 1987), LR 23:1150, 1156 and 1163 (September 1997), LR 28:2356 (November 2002), repromulgated LR 30:2036 (September 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2162 (October 2008), repromulgated LR 34:2567 (December 2008), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§2305. Plan of Care

A. The applicant and support coordinator have the flexibility to construct a plan of care (POC) that serves the participant’s health, safety and welfare needs. The service package provided under the POC shall include services covered under the Adult Day Health Care Waiver, Medicaid State Plan

services, and any other services, regardless of the funding source.

A.1. – B. ...

C. The POC shall contain the:

1. types and number of services (including waiver and all other services) necessary to reasonably assure health and welfare and to maintain the individual in the community;

2. individual cost of each waiver service; and

3. total cost of waiver services covered by the POC.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:2496 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

Chapter 25. Admission and Discharge Criteria

§2501. Admission Criteria

A. Admission to the ADHC Waiver Program shall be determined in accordance with the following criteria:

1. ...

2. initial and continued Medicaid eligibility;

3. initial and continued eligibility for nursing facility level of care;

4. ...

5. reasonable assurance that the health, safety and welfare of the individual can be maintained in the community with the provision of ADHC waiver services.

B. ...

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 Human Resources, Office of Family Security, LR 11:626 (June 1985), amended LR 13:181 (March 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 23:1153 (September 1997), repromulgated LR 30:2040 (September 2004), amended by the Department Of Hospitals, Office of Aging and Adult Services, LR 34:2163 (October 2008), repromulgated LR 34:2568 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2625 (September 2011), LR 39:2496 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§2503. Admission Denial or Discharge Criteria

A. Admission shall be denied or the participant shall be discharged from the ADHC Waiver Program if any of the following conditions are determined:

1. The individual does not meet the target population criteria as specified in the federally approved waiver document.

2. The individual does not meet the criteria for Medicaid eligibility.

3. The individual does not meet the criteria for nursing facility level of care.

4. The individual resides in another state or the participant has a change of residence to another state.

5. Continuity of services is interrupted as a result of the participant not receiving and/or refusing ADHC waiver services (exclusive of support coordination services) for a period of 30 consecutive days.

a. Exceptions may be granted by OAAS to delay discharge if interruption is due to an acute care hospital, rehabilitation hospital, or nursing facility admission.

6. The health, safety and welfare of the individual cannot be assured through the provision of ADHC waiver services.

7. The individual/participant fails to cooperate in the eligibility determination process, POC development, or in the performance of the POC.

8. It is not cost effective or appropriate to serve the individual in the ADHC Waiver.

9. The participant fails to attend the ADHC center for a minimum of 36 days per calendar quarter.

10. The participant fails to maintain a safe and legal home environment.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2163 (October 2008), repromulgated LR 34:2568 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2625 (September 2011), LR 39:2496 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

Chapter 27. Provider Responsibilities

§2701. General Provisions

A. Each ADHC center shall:

1. be licensed by the Department of Health, Health Standards Section, in accordance with LAC 48:I.Chapter 42;

2. enroll as an ADHC Medicaid provider;

3. enter into a provider agreement with the department to provide services; and

4. agree to comply with the provisions of this Rule.

B. The provider shall not request payment unless the participant for whom payment is requested is receiving services in accordance with the ADHC Waiver program provisions and the services have been prior authorized and delivered.

C. Adult day health care waiver providers shall not refuse to serve any participant who chooses their agency unless there is documentation to support an inability to meet the participant’s health, safety and welfare needs, or all previous efforts to provide service and supports have failed and there is no option but to refuse services.

1. – 2. ...

D. Providers must maintain adequate documentation to support service delivery and compliance with the approved POC and will provide said documentation at the request of the department, or its designee.

E. Adult day health care providers shall not interfere with the eligibility, assessment, care plan development or care plan monitoring processes with use of methods including, but not limited to:

1. harassment;

2. intimidation; or

3. threats against program participants, members of the participant’s informal support network, LDH staff, or support coordination staff.

F. Adult day health care providers shall have the capacity and resources to provide all aspects of the services they are enrolled to provide in the specified licensed service area.

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 Human Resources, Office of Family Security, LR 11:627 (June 1985), amended LR 13:181 (March 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 23:1155 (September 1997), LR 24:457 (March 1998), repromulgated LR 30:2041 (September 2004), amended by the Department of Health and Hospitals, Office for Aging and Adult Services, LR 34:2164 (October 2008), repromulgated LR 34:2568 (December 2008),), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2625 (September 2011), LR 39:2497 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§2703. Reporting Requirements

A. Support coordinators and direct service providers, including ADHC providers, are obligated to immediately report any changes to the department that could affect the waiver participant’s eligibility including, but not limited to, those changes cited in the denial or discharge criteria listed in §2503.

B. Support coordinators and direct service providers, including ADHC providers, are responsible for documenting the occurrence of incidents or accidents that affect the health, safety and welfare of the participant and completing an incident report. The incident report shall be submitted to the department or its designee with the specified requirements within specified time lines.

C. ...

D. Adult day health care providers shall provide the participant’s approved individualized service plan to the support coordinator in a timely manner.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Office of Aging and Adult Services, LR 34:2164 (October 2008), repromulgated LR 34:2568 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of

Aging and Adult Services, LR 39:2497 (September 2013), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

§2705. Electronic Visit Verification

Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 43:74 (January 2017), repealed by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

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
and
Office of Aging and Adult Services

Nursing Facilities
Continued Stay Requests
(LAC 50:II.503)

The Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services have amended LAC 50:II.503 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. This Rule is hereby adopted on the day of promulgation.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE
Part II. Nursing Facilities
Subpart 1. General Provisions

Chapter 5. Admissions

§503. Medical Certification

A. – A.1.b. ...

2. Continued Stay Requests

a. – a.i. ...

ii. documentation to support the request for continued stay, including the most recent MDS 3.0. A LOCET will not be accepted as sufficient evidence of medical need for

an individual who has been discharged for a period of less than 14 calendar days unless:

a.ii.(a). - b. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 36:1011 (May 2010), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 43:1179 (June 2017), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 43:1179 (June 2017), LR 44:1018 (June 2018), LR 44:

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

Outpatient Hospital Services
Non-Rural, Non-State Hospitals and Children's Specialty Hospitals
Reimbursement Rate Increase
(LAC 50:V.5313,5317,5513,5517,5713,5719,5913,5917,6115, and 6119)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:V.5313, §5317, §5513, §5517, §5713, §5719, §5913, §5917, §6115 and §6119 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. This Rule is hereby adopted on the day of promulgation.

Title 50
PUBLIC HEALTH-MEDICAL ASSISTANCE
Part V. Hospitals
Subpart 5. Outpatient Hospitals

Chapter 53. Outpatient Surgery

Subchapter B. Reimbursement Methodology

§5313. Non-Rural, Non-State Hospitals

A. – J.1. ...

K. Effective for dates of service on or after January 1, 2019, the reimbursement rates paid to non-rural, non-state hospitals for outpatient surgery shall be increased by 11.56 percent of the rates on file as of December 31, 2018.

1. Hospitals participating in public-private partnerships as defined in §6701 shall be exempted from this rate increase.

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 Service Financing, LR 35:1900 (September 2009), amended LR 36:1250 (June 2010), LR 36:2041 (September 2010), LR 37:3266 (November 2011), LR 40:313 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:964 (May 2017), LR 43:2534 (December 2017), LR 44:

§5317. Children's Specialty Hospitals

A. – H.1. ...

I. Effective for dates of service on or after January 1, 2019, the reimbursement rates paid to children's specialty hospitals for outpatient surgery shall be increased by 5.26 percent of the rates on file as of December 31, 2018.

1. Final reimbursement shall be 97 percent of allowable cost as calculated through the cost report settlement process.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2042 (September 2010), amended LR 37:3266 (November 2011), LR 40:313 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:965 (May 2017), LR 43:2534 (December 2017), LR 44:

Chapter 55. Clinic Services

Subchapter B. Reimbursement Methodology

§5513. Non-Rural, Non-State Hospitals

A. – J.1. ...

K. Effective for dates of service on or after January 1, 2019, the reimbursement rates paid to non-rural, non-state hospitals for outpatient clinic services shall be increased by 11.56 percent of the rates on file as of December 31, 2018.

1. Hospitals participating in public-private partnerships as defined in §6701 shall be exempted from this rate increase.

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 Service Financing, LR 35:1900 (September 2009), amended LR 36:1250 (June 2010), LR 36:2042 (September 2010), LR 37:3266 (November 2011), LR 40:313 (February 2014), amended by the Department of Health, Bureau of Health

Services Financing, LR 43:965 (May 2017), LR 43:2535 (December 2017), LR 44:

§5517. Children's Specialty Hospitals

A. – H. ...

I. Effective for dates of service on or after January 1, 2019, the reimbursement rates paid to children's specialty hospitals for outpatient hospital clinic services shall be increased by 5.26 percent of the rates on file as of December 31, 2018.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2042 (September 2010), amended LR 37:3266 (November 2011), LR 40:313 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:965 (May 2017), LR 43:2535 (December 2017), LR 44:

Chapter 57. Laboratory Services

Subchapter B. Reimbursement Methodology

§5713. Non-Rural, Non-State Hospitals

A. – J.1. ...

K. Effective for dates of service on or after January 1, 2019, the reimbursement rates paid to non-rural, non-state

hospitals for outpatient laboratory services shall be increased by 11.56 percent of the rates on file as of December 31, 2018.

1. In accordance with Section 1903(i)(7) of the Social Security Act, payments for Medicaid clinical diagnostic laboratory services shall be limited to the amount that Medicare pays on a per test basis. If this or any other rate adjustment causes the Medicaid calculated rate to exceed the Medicare payment rate for a clinical laboratory test, the rate shall be adjusted to the lower Medicare payment rate.

2. Hospitals participating in public-private partnerships as defined in §6701 shall be exempted from this rate increase.

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 Service Financing, LR 35:1900 (September 2009), amended LR 36:1250 (June 2010), LR 36:2042 (September 2010), LR 37:3266 (November 2011), LR 40:313 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:965 (May 2017), LR 43:2535 (December 2017), LR 44:

§5719. Children's Specialty Hospitals

A. – H. ...

I. Effective for dates of service on or after January 1, 2019, the reimbursement rates paid to children's specialty hospitals for outpatient clinical diagnostic laboratory services shall be increased by 5.26 percent of the rates on file as of December 31, 2018.

1. In accordance with Section 1903(i)(7) of the Social Security Act, payments for Medicaid clinical diagnostic laboratory services shall be limited to the amount that Medicare pays on a per test basis. If this or any other rate adjustment causes the Medicaid calculated rate to exceed the Medicare payment rate for a clinical laboratory test, the rate shall be adjusted to the lower Medicare payment rate.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2043 (September 2010), amended LR 37:3267 (November 2011), LR 40:314 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:965 (May 2017), LR 43:2535 (December 2017), LR 44:

Chapter 59. Rehabilitation Services

Subchapter B. Reimbursement Methodology

§5913. Non-Rural, Non-State Hospitals

A. – D. ...

E. Effective for dates of service on or after January 1, 2019, the reimbursement rates paid to non-rural, non-state hospitals for outpatient rehabilitation services provided to recipients over the age of three years shall be increased by 11.56 percent of the rates on file as of December 31, 2018.

1. Hospitals participating in public-private partnerships as defined in §6701 shall be exempted from this rate increase.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Service Financing, LR 35:1900 (September 2009), amended LR 36:1250 (June 2010), LR 36:2043 (September 2010), LR 44:

§5917. Children's Specialty Hospitals

A. - B.1. ...

C. Effective for dates of service on or after January 1, 2019, the reimbursement rates paid to children's specialty hospitals for outpatient rehabilitation services provided to recipients over the age of three years shall be increased by 5.26 percent of the rates on file as of December 31, 2018.

1. Final reimbursement shall be 97 percent of allowable cost as calculated through the cost report settlement process.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2043 (September 2010), LR 44:

Chapter 61. Other Outpatient Hospital Services

Subchapter B. Reimbursement Methodology

§6115. Non-Rural, Non-State Hospitals

A. – J.1. ...

K. Effective for dates of service on or after January 1, 2019, the reimbursement rates paid to non-rural, non-state hospitals for outpatient hospital services, other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services and outpatient hospital facility fees, shall be increased by 11.56 percent of the rates in effect as of December 31, 2018.

1. Final reimbursement shall be 83.18 percent of allowable cost as calculated through the cost report settlement process.

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 Service Financing, LR 35:1900 (September 2009), amended LR 36:1250 (June 2010), LR 36:2043

(September 2010), LR 37:3267 (November 2011), LR 40:314 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:965 (May 2017), LR 43:2535 (December 2017), LR 44:

§6119. Children's Specialty Hospitals

A. – H.1. ...

I. Effective for dates of service on or after January 1, 2019, the reimbursement fees paid to children's specialty hospitals for outpatient hospital services, other than rehabilitation services and outpatient hospital facility fees, shall be increased by 5.26 percent of the rates in effect as of December 31, 2018.

1. Final reimbursement shall be 97 percent of allowable cost as calculated through the cost report settlement process.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2044 (September 2010), amended LR 37:3267 (November 2011), LR 40:314 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:965 (May 2017), LR 43:2535 (December 2017), LR 44:

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

Rural Health Clinics
Reimbursement Methodology
Mammography Separate Payments
(LAC 50:XI.16703)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XI.16703 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. This Rule is hereby adopted on the day of promulgation.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XI. Clinic Services
Subpart 15. Rural Health Clinics

Chapter 167. Reimbursement Methodology

§16703. Alternate Payment Methodology

A. – C. ...

D. Effective for dates of service on or after January 1, 2019, RHCs shall be reimbursed a separate payment outside of the prospective payment system (PPS) rate for the following services:

1. – 1.a. ...

2. Mammogram Screening and Diagnosis

a. Reimbursement for mammogram screening and diagnostics shall be a flat fee on file based on Medicaid covered current procedural terminology (CPT) code(s), in addition to the PPS rate for the associated encounter/office visit.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:1905 (October 2006), repromulgated LR 32:2267 (December 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:2632 (September 2011), LR 40:83 (January 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 44:1903 (October 2018), LR 44:

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