RULE

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

Behavioral Health Services
Substance Use Disorders Services
(LAC 50:XXXIII.14101,14301,14303, and 14501)

The Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health have amended LAC 50:XXXIII.14101, §14301, §14303, and §14501 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 XXXIII. Behavioral Health Services
Subpart 15. Substance Use Disorders Services

Chapter 141. General Provisions

§14101. Introduction

A. ...

B. The SUD services rendered shall be those services which are medically necessary to reduce the disability resulting from the illness and to restore the individual to his/her best possible level of functioning in the community.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:426 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2357 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1890 (October 2018), LR 45:

Chapter 143. Services

§14301. General Provisions

A. All SUD services must be medically necessary. The medical necessity for services shall be determined by a licensed mental health practitioner (LMHP) or physician who is acting within the scope of his/her professional license and applicable state law.

B. American Society of Addiction Medicine (ASAM) levels of care require reviews on an ongoing basis, as deemed necessary by the department to document compliance with national standards.

C. Children who are in need of SUD services should be served within the context of the family and not as an isolated unit. Services provided to children and youth shall include

communication and coordination with the family and/or legal guardian and custodial agency for children in state custody provided that written consent is obtained from minor. Coordination with other child-serving systems should occur as needed to achieve the treatment goals subject to the minor's consent and applicable privacy laws. All coordination and consent must be documented in the child's medical record.

1. Services shall be:

a. delivered in a culturally and linguistically competent manner; and

b. respectful of the individual receiving services.

2. Services shall be appropriate to individuals of diverse racial, ethnic, religious, sexual, and gender identities, and other cultural and linguistic groups.

3. Services shall also be appropriate for:

a. age;

b. development; and

c. education.

D. Evidence-based practices require prior approval and fidelity reviews on an ongoing basis as determined necessary by the department.

D.1. – 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 Hospitals, Bureau of Health Services Financing, LR 38:426 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2357 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1890 (October 2018), LR 45:

§14303. Covered Services

A. The following SUD services shall be reimbursed under the Medicaid Program:

1. assessment;

2. outpatient treatment;

3. residential treatment; and

4. inpatient treatment.

B. Service Exclusions. The following services/components shall be excluded from Medicaid reimbursement:

1. – 2. ...

3. any services or components in which the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of an individual receiving services; and

4. room and board for any rates provided in a residential setting.

5. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:426 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2357 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1891 (October 2018), LR 45:

Chapter 145. Provider Participation

§14501. Provider Responsibilities

A. – D. ...

E. Providers shall maintain case records that include, at a minimum:

1. the name of the individual;

2. the dates and time of service;

3. assessments;

4. a copy of the treatment plans, which include at a minimum:

a. goals and objectives, which are specific, measureable, action oriented, realistic and time-limited;

b. specific interventions;

c. the service locations for each intervention;

d. the staff providing the intervention; and

e. the dates of service;

5. progress notes that include the content of each delivered service, including the reason for the contact describing the goals/objectives addressed during the service, specific intervention(s), progress made toward functional and clinical improvement;

6. units of services provided;

7. crisis plan;

8. discharge plan; and

9. advanced directive.

F. Residential treatment facilities shall meet the following additional requirements:

1. Be a licensed organization, pursuant to the residential service provider qualifications described in the *Louisiana Administrative Code* and the Louisiana Medicaid provider manual.

2. Residential addiction treatment facilities shall be accredited by an approved accrediting body and maintain such accreditation. Denial, loss of or any negative change in

accreditation status must be reported to the MCO in writing within the time limit established by the department.

3. Provide full disclosure of ownership and control, including but not limited to any relative contractual agreements, partnerships, etc.

4. Follow all residential treatment provider qualifications and program standards in licensure, Medicaid provider manual, managed care contracts or credentialing.

5. Must deliver care consistent with the specifications in the ASAM Criteria or other OBH approved, nationally recognized SUD program standards, hours of clinical care, and credentials of staff for residential treatment settings.

6. Effective April 1, 2019, must offer medication-assisted treatment (MAT) on-site or facilitate access to MAT off-site, and appropriately document MAT options, education and facilitation efforts in accordance with requirements outlined in the Medicaid provider manual.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:427 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of

Behavioral Health, LR 41:2357 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1891 (October 2018), LR 45:

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 Behavioral Health

Healthy Louisiana Opioid Use Disorder/Substance Use Disorder Waiver
(LAC 50:XXII.Chapters 61-69)

The Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health have adopted LAC 50:XXII.Chapters 61-69 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 XXII. 1115 Demonstration Waivers
Subpart 7. Healthy Louisiana Opioid Use Disorder/Substance Use Disorder Waiver

Chapter 61. General Provisions

§6101. Purpose

A. The Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health hereby implement a section 1115(a) demonstration waiver called the Healthy Louisiana Opioid Use Disorder/Substance Use Disorder (OUD/SUD) Waiver which is designed to maintain critical access to OUD/SUD services and continue delivery system improvements for these

services to provide more coordinated and comprehensive OUD/SUD treatment for Medicaid recipients. This demonstration waiver provides the state with the authority to provide high-quality, clinically appropriate OUD/SUD treatment services for residents in residential and inpatient treatment settings that qualify as an institution for mental disease (IMD).

B. The Healthy Louisiana OUD/SUD Waiver is a 59-month demonstration project which was approved by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) effective February 1, 2018 and will span five years, through December 31, 2022. Louisiana may request an extension of this demonstration project through CMS prior to the expiration date.

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

HISTORICAL NOTE: Promulgated by the Louisiana Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 45:

Chapter 63. Eligibility

§6301. General Provisions

A. The Healthy Louisiana OUD/SUD Waiver services shall be available to individuals who:

1. meet the eligibility criteria for Medicaid set forth in the State Plan;

2. meet clinical criteria, including having a SUD diagnosis; and

3. receive OUD/SUD treatment services in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise matchable expenditures under §1903 of the Social Security Act.

B. Retroactive coverage is not available in the Healthy Louisiana OUD/SUD Waiver program.

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

HISTORICAL NOTE: Promulgated by the Louisiana Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 45:

Chapter 65. Services

§6501. Covered Services

A. The coverage of OUD/SUD residential treatment and withdrawal management services during residential stays under the scope of this demonstration project are:

1. inpatient services provided to recipients in IMDs;

2. residential treatment provided to recipients in IMDs;

3. clinically managed withdrawal management provided to recipients in IMDs;

4. medically monitored/managed withdrawal management provided to recipients in IMDs; and

5. medication-assisted treatment (MAT) provided to recipients in IMDs.

B. A licensed mental health practitioner (LMHP) or physician who is acting within the scope of his/her professional license and applicable state law shall determine the medical necessity of all OUD/SUD services furnished under this waiver.

1. For the purposes of this Chapter, the term medically necessary means that the services provided under this waiver are reasonably calculated by an LMHP or a physician:

a. to reduce the disability resulting from the illness; and

b. to restore the recipient to his/her best possible functioning level in the community.

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

HISTORICAL NOTE: Promulgated by the Louisiana Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 45:

§6503. Service Delivery

A. All Healthy Louisiana OUD/SUD Waiver services are to be provided to recipient groups through a managed care delivery system, except for the following:

1. spend-down medically needy population.

B. All of the covered services under this waiver shall be delivered by an IMD provider contracted with one or more of the managed care organizations (MCOs) operating within the state's Medicaid system.

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

HISTORICAL NOTE: Promulgated by the Louisiana Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 45:

Chapter 67. Provider Participation

§6701. General Provisions

A. All providers participating in the delivery of services covered under the Healthy Louisiana OUD/SUD Waiver shall adhere to all of the applicable federal and state regulations, policies, rules, manuals and laws.

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

HISTORICAL NOTE: Promulgated by the Louisiana Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 45:

§6703. Reporting Requirements

A. MCOs and their contracted providers of OUD/SUD services under this demonstration project shall be required to provide data as outlined or requested by the Department of Health.

B. Data shall be provided in the format and frequency specified by the department including any additional data requests as identified by the department.

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

HISTORICAL NOTE: Promulgated by the Louisiana Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 45:

Chapter 69. Reimbursement

§6901. General Provisions

A. MCOs and their contracted IMD providers shall ensure that reimbursement for services covered under the Healthy Louisiana OUD/SUD Waiver is requested and paid only for those recipients who meet the eligibility criteria and for whom services were rendered:

1. providers/IMDs shall retain any and all supporting financial information and documents that are adequate to ensure that payment is made in accordance with applicable federal and state laws;

2. any such documents shall be retained for a period of at least six years from the date of service, or until the final resolution of all litigation, claims, financial management reviews or audits pertaining, whichever is the longest time period; and

3. there shall not be any restrictions on the right of the state and federal government to conduct inspections and/or audits as deemed necessary to assure quality, appropriateness or timeliness of services and reasonableness of costs.

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

HISTORICAL NOTE: Promulgated by the Louisiana Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 45:

§6903. Reimbursement Methodology

A. For recipients enrolled in one of the MCOs, the department or its fiscal intermediary shall make monthly capitation payments to the MCOs inclusive of coverage for the provision of residential and inpatient substance use services for recipients. 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.

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

HISTORICAL NOTE: Promulgated by the Louisiana Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 45:

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 Individuals with Intellectual Disabilities—Public Facilities Transitional Rate Extension
(LAC 50:VII.32915 and 32969)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:VII.32915 and §32969 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 VII. Long Term Care
Subpart 3. Intermediate Care Facilities for Individuals with Intellectual Disabilities

Chapter 329. Reimbursement Methodology

Subchapter A. Non-State Facilities

§32915. Complex Care Reimbursements

A. Private (non-state) intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) may receive an add-on payment to the per diem rate for providing complex care to Medicaid recipients who require such services.

The add-on rate adjustment shall be a flat fee amount and may consist of payment for any one of the following components:

1. – 7. ...

B. Private (non-state) owned ICFs/IID may qualify for an add-on rate for recipients meeting documented major medical or behavioral complex care criteria. This must be documented on the complex support need screening tool provided by the department. All medical documentation indicated by the screening tool form and any additional documentation requested by the department must be provided to qualify for the add-on payment.

C. – I.3.e. ...

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 42:276 (February 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 44:1447 (August 2018), LR 45:

Subchapter C. Public Facilities

§32969. Transitional Rates for Public Facilities

A. – B. ...

1. The department may extend the period of transition up to September 30, 2020, if deemed necessary, for an active CEA facility that is:

B.1.a. – G. ...

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 39:326 (February 2013), amended LR 40:2588 (December 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 44:60 (January 2018), LR 44:772 (April 2018), LR 45:

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Managed Care Organization Payment Accountability and Provider Credentialing
(LAC 50.I.1501)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:I.1501 in the Medical Assistance Program as authorized by R.S. 36:254 and R.S. 46:460.73.A 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 I. Administration
Subpart 1. General Provisions

Chapter 15. Provider Screening and Enrollment

§1505. Managed Care Organization Payment Accountability and Provider Credentialing

A. In compliance with the requirements of Act 489 of the 2018 Regular Session of the Louisiana Legislature, the Department of Health adopts the following payment accountability and provider credentialing requirements for managed care organizations (MCOs) participating in the Medical Assistance Program:

1. Managed care organizations shall ensure that contracted or enrolled providers have met and continue to meet Medicaid provider enrollment, credentialing and accreditation requirements and other applicable state or federal requirements in order to receive reimbursement for services provided to Medicaid recipients.

2. Managed care organizations that fail to ensure proper compliance with Medicaid provider enrollment, credentialing or accreditation requirements shall be liable for reimbursement to providers for services rendered to Medicaid recipients, until such time as the deficiency is identified by the MCO and notice is issued to the provider pursuant to R.S. 46:460.72.

3. Managed care organizations shall withhold reimbursement for services provided during the 15 day remedy period after notice of the deficiency is identified by the MCO, or during a longer period if allowed by LDH, if the provider elects to continue rendering services while the deficiency is under review.

a. If the deficiency is remedied, the MCO shall remit payment to the provider.

b. If the deficiency is not remedied, nothing in this Section shall be construed to preclude the MCO from

recouping funds from the provider for any period in which the provider was not properly enrolled, credentialed or accredited.

c. If the deficiency cannot be remedied within 15 days, the provider may seek review by the department if he/she believes the deficiency was caused by good faith reliance on misinformation by the MCO and asserts that he/she acted without fault or fraudulent intent, there is no deficiency, or because of reliance on misinformation from the MCO, an exception should be made to allow reasonable time to come into compliance so as to not disrupt patient care.

i. After the initial notification of deficiency, the provider shall notify the department of his/her intent to appeal the decision within 10 calendar days of receipt of the MCO's notification, and provide a detailed request for departmental review with supporting documents within 15 calendar days of receipt of the MCO's notification.

(a). The provider shall prove absence of fault or fraudulent intent by producing guidance, applications or other written communication from the MCO that bears incorrect information, including whether the misinformation or guidance was contradictory to applicable Medicaid manuals, rules, or policies.

ii. The department shall review all materials and information submitted by the provider and shall

review any information necessary that is in the custody of the MCO to render a written decision within 30 days of the date of receipt for review submitted by the provider.

(a). If the department's decision is in favor of the provider, a written decision shall be sent to the provider and the MCO via certified mail and the provider shall be afforded reasonable time to remedy the deficiency caused by the misinformation of the MCO. During this time, the provider shall be allowed to provide services and submit claims for reimbursement.

(i). The MCO shall be responsible for payment to the provider and may be subject to penalties by the department in accordance with contract provisions, or rules and regulations promulgated pursuant to the Administrative Procedure Act.

(b). If the department's decision is in favor of the MCO, the provider's contract shall be terminated immediately, pursuant to the notice provided for in R.S. 46:460.72(C).

(c). If the department's decision is that the provider acted with fault or fraudulent intent, the provisions of R.S. 46:460.73(B) shall apply.

(d). The written decision by the department is the final administrative decision and no appeal or

judicial review shall lie from this final administrative decision.

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 45:

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 the submission to CMS for review and approval is required.

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Nursing Facilities
Reimbursement Methodology
Case-Mix Documentation Reviews and Index Reports
(LAC 50:II.20013)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:II.20013 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed 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 5. Reimbursement

Chapter 200. Reimbursement Methodology

§20013. Case-Mix Documentation Reviews and Case-Mix Index Reports [Formerly LAC 50:VII.1313]

A. – B.4. ...

5. The following corrective action will apply to those nursing facility providers with unsupported MDS resident assessments identified during an on-site CMDR.

a. If the percentage of unsupported assessments in the initial on-site CMDR sample is greater than 20 percent,

the sample shall be expanded, and shall include the greater of 20 percent of the remaining resident assessments or 10 assessments.

b.- e. ...

Effective Date(A)	Threshold percent(B)
January 1, 2003	Educational
January 1, 2004	40%
January 1, 2005	35%
January 1, 2006	25%
February 20, 2019 and beyond	20%

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 28:2537 (December 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:826 (March 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:528 (March 2017), LR 45:

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

Nursing Facilities
Reimbursement Methodology
Transition of Private Facilities to State-Owned or Operated Facilities Through Change of Ownership
(LAC 50:II.20023 and 20024)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:II.20023 and adopt LAC 50:II.20024 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 5. Reimbursement

Chapter 200. Reimbursement Methodology

§20023. Transition of State-Owned or Operated Nursing Facility to a Private Facility

A. – D.7. ...

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 Hospitals, Bureau of Health Services Financing, LR 37:903

(March 2011), amended by the Department of Health, Bureau of Health Services Financing, LR 45:

§20024. Transition of Private Nursing Facility to a State-Owned or Operated Nursing Facility through a Change of Ownership

A. Any private nursing facility that undergoes a change of ownership (CHOW) to a state-owned or operated nursing facility will be exempt from the prospective reimbursement system for public nursing facilities during the transitional period.

1. The transitional period will be effective from the date of the CHOW until the July 1 rate setting period following when the state-owned or operated nursing facility has an audited or reviewed 12 month or greater cost reporting period available for use in rate setting.

2. After the transitional period, the nursing facility will be reimbursed pursuant to the requirements of the prospective reimbursement system for public nursing facilities.

B. Effective for dates of service on or after July 5, 2018, the reimbursement amount paid to a public nursing facility during the transitional period shall be as follows:

1. Public nursing facilities transitioning from private ownership shall receive a monthly interim payment based on occupancy, which shall be a per diem rate of $365.68.

2. For each cost reporting period ending during the transitional period a cost settlement process shall be

performed. The cost settlement process shall ensure that Medicaid reimbursement for each public nursing facility transitioning from private ownership is equal to 100 percent of the nursing facility’s Medicaid allowable cost for the applicable cost reporting period.

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 45:

Rebekah E. Gee MD, MPH

Secretary