RULE

Department of Health
Bureau of Health Services Financing

Adult Residential Care Providers
Licensing Standards
Involuntary Termination of Residency Agreement
(LAC 48:I.6837)

The Department of Health, Bureau of Health Services Financing has amended LAC 48:I.6837 governing the licensing standards for adult residential care providers as authorized by R.S. 36:254 and R.S. 40:2166.1-2166.8 et seq. 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 68. Adult Residential Care Providers

Subchapter C. Residency Criteria, Person-Centered Service Plans, and Residency Agreements

§6837. Termination of Residency Agreements

A. – B.2.d.iii. ...

3. The resident and/or the resident’s representative, if applicable, shall have the right to dispute

any involuntary termination of the residency agreement in accordance with §6833.G.6-7.

B.4. – C.3. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1097 (June 2015), amended 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
Cost Reporting
(LAC 50:XI.10503 and 10701)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XI.10503 and 10701 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 105. Provider Participation

§10503. Standards for Participation

[Formerly §10303]

A. – D. ...

1. Each member of the instructional team must:

a. be a certified diabetes educator certified by the National Certification Board for Diabetes Educators; or

b. ...

2. At a minimum, the instructional team must consist of one of the following professionals who is a certified diabetes educator:

2.a. – 3. ...

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 30:2328 (October 2004), repromulgated LR 30:2488 (November 2004), amended LR 32:1901 (October 2006), amended LR 37:2630 (September 2011), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

Chapter 107. Reimbursement Methodology

§10701. Prospective Payment System

A. – F. ...

G. Cost Reports. FQHCs shall submit cost reports when there is an increase or decrease in their scope of services.

1. *Change in Scope of Services*—an addition, removal or relocation of services sites, and the addition or deletion of specialty and non-primary care services that were not included in the base line rate calculation.

2. The final PPS rate shall be calculated using the first two years of audited Medicaid cost reports, which shall include documentation of the change in scope.

3. Cost reports shall not be accepted for rate changes without a change in the scope of service.

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 32:1902 (October 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:2630 (September 2011), LR 39:3076 (November 2013), amended by the Department of Health, Bureau of Health Services Financing, 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

Managed Care for Physical and Behavioral Health
Applied Behavior Analysis-Based Therapy Services
(LAC 50:I.3103 and 3507)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:I.3103 and §3507 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 I. Administration
Subpart 3. Managed Care for Physical and Behavioral Health

Chapter 31. General Provisions

§3103. Recipient Participation

A. – A.1.k. ...

B. Mandatory, Voluntary Opt-In Participants

1. Participation in an MCO for the following participants is mandatory for specialized behavioral health, applied behavior analysis (ABA)-based therapy and non-emergency medical transportation (NEMT) services (ambulance and non-ambulance) only, and is voluntary for physical health services:

B.1.a. – 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 43:663 (April 2017), LR 43:1553 (August 2017), LR 44:

Chapter 35. Managed Care Organization Participation Criteria

§3507. Benefits and Services

A. – C.4. ...

D. The following is a summary listing of the core benefits and services that an MCO is required to provide:

1. – 5. ...

6. EPSDT/well child visits, excluding dental services;

D.7. – H.5. ...

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 37:1585 (June 2011), amended LR 39:92 (January 2013), repromulgated LR

39:318 (February 2013), LR 41:936 (May 2015), LR 41:2367 (November 2015), LR 42:755 (May 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 44:61 (January 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.

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