RULE

Department of Health
Bureau of Health Services Financing

Adult Dentures Program
Reimbursement
(LAC 50:XXV.701)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XXV.701 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 XXV. Adult Dentures

Chapter 7. Reimbursement

§701. Fees

A. – D.1. ...

E. Effective for dates of service on or after July 1, 2023, the reimbursement rates for adult denture services shall be reimbursed based on the Louisiana Medicaid fee schedule. All rates in the fee schedule are published on the Medicaid provider website at www.lamedicaid.com.

1. Implementation of these rates is subject to approval by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

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 31:81 (January 2005), repromulgated LR 31:1589 (July 2005), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:316 (February 2013), LR 40:1006 (May 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 49:

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.

Stephen R. Russo, JD

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Early and Periodic Screening, Diagnosis and Treatment
Dental Services
(LAC 50:XV.6905)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XV.6905 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 III. Eligibility

Chapter69. Dental Services

§6905. Reimbursement

A. – K.1.b. ...

L. Effective for dates of service on or after July 1, 2023, the reimbursement rates for EPSDT dental services shall be reimbursed based on the Louisiana Medicaid fee schedule. All rates in the fee schedule are published on the Medicaid provider website at www.lamedicaid.com.

1. Implementation of these rates is subject to approval by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

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 31:81 (January 2005), repromulgated LR 31:1589 (July 2005), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:316 (February 2013), LR 40:1006 (May 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 49:

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.

Stephen R. Russo, JD

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Federally Qualified Health Centers
Alternative Payment Methodology
(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. – I. ...

J. Effective for dates of service on or after July 20, 2023, Medicaid will increase FQHC payments by $30 per encounter. This payment shall be reimbursed through an alternative payment methodology when these services are provided on the same date as a medical/dental/behavioral health visit that includes an evaluation and management procedure code as one of the detailed lines on the claim. The APM will pay FQHCs an add-on amount of

$30 in addition to the PPS rate on file for the date of service. The APM must be agreed to by the department and the FQHC and must result in a payment to the FQHC, which is at least the PPS rate on file for the date 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 34:1033 (June 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 44:1894 (October 2018), LR 44:2162 (December 2018), LR 45:434 (March 2019), 46:182 (February 2020), LR 47:1528 (October 2021), LR 47:1875 (December 2021), LR 49:

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.

Stephen R. Russo, JD

LDH Secretary

RULE

Department of Health
Bureau of Health Services Financing

Healthcare Facility Sanctions
(LAC 48:I.Chapter 46)

The Department of Health, Bureau of Health Services Financing has amended LAC 48:I.Chapter 46 as authorized by R.S. 36:254, 40:2009.11, 40:2009.23, 40:2199, and 40:2199.1. 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-MEDICAL ASSISTANCE
Part I. Administration
Subpart 3. Licensing and Certification

Chapter 46. Healthcare Facility Sanctions

Subchapter A. General Provisions

§4601. Introduction

A. The purpose of this Chapter is to:

1. provide for the development, establishment, and enforcement of statewide standards for the imposition of sanctions pursuant to state statutes against healthcare facilities in the state of Louisiana that have violations of federal or state law or statutes, licensure standards and requirements, certification requirements, or Medicaid requirements;

2. – 6. ...

B. This Chapter shall not apply to any individual healthcare provider who is licensed or certified by one of the boards under LDH. These boards include, but are not limited to:

1. – 6. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.11, 40:2009.23, 40:2199 and 40:2199.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3077 (November 2013), LR 49:

§4603. Definitions

Administrative Reconsideration—for purposes of this Chapter, also known as an informal reconsideration.

Class A Violation—a violation of a rule or regulation that creates a condition or occurrence relating to the maintenance and/or operation of a facility which results in death or serious harm to the resident(s), patient(s), or client(s). Examples of class A violations include, but are not limited to:

1. acts or omissions by an employee or employees of a facility that either knowingly or negligently resulted in the death of the resident(s), patient(s), or client(s); or

2. acts or omissions by an employee or employees of a facility that either knowingly or negligently resulted in serious harm to the resident(s), patient(s), or client(s).

Class B Violation—a violation of a rule or regulation in which a condition or occurrence relating to the maintenance and/or operation of a facility is created which results in the substantial probability of death or serious physical or mental harm to the resident(s), patient(s), or client(s). Examples of class B violations include, but are not limited to:

1. - 3 ...

4. failure to employ a sufficient number of adequately trained staff to care for resident(s), patient(s), or client(s); or

5. ...

Class C Violation—a violation of a rule or regulation in which a condition or occurrence relating to the maintenance and/or operation of a facility creates a potential for harm by directly threatening the health, safety, or welfare of the resident(s), patient(s) or client(s). Examples of class C violations include, but are not limited to:

1. - 5 ...

6. lack of adequately trained staff necessary to meet the resident(s), patient(s), or client(s)' needs;

7. failure of a regulated entity to display on its premises at least one sign, which is at least 18 inches tall by 18 inches wide and written in the English language with letters

that are not less than one-square-inch in size, in a conspicuous location in a publically-accessible area;

8. failure by a regulated entity to develop a workplace violence prevention plan that includes, as a minimum, all of the following resources:

a. resources for ongoing education on the issue of workplace violence;

b. resources for prevention of workplace violence; and

c. resources on responding to incidents of workplace violence and debriefing with respect to such incidents and responses thereto;

9. failure by a regulated entity to have a healthcare workplace violence prevention plan that addresses and encompasses all of the following:

a. personnel education and policies requiring all healthcare workers who provide direct care to resident(s), patient(s), or client(s) to receive, at least annually, education and training in a format that provides an opportunity for interactive questions and answers with a person knowledgeable about the workplace violence prevention plan. The education and training delivered pursuant to a workplace violence prevention plan that covers topics including but not limited to all of the following:

i. how to recognize the potential for violence to occur;

ii. when and how to seek assistance to prevent or respond to violence;

iii. how to report violent incidents to law enforcement; and

iv. resources available to employee or employees for coping with incidents of workplace violence.

b. a system for responding to and investigating violent incidents and situations involving violence; and

c. a system for regularly, and not less than annually, assessing and improving upon factors that may contribute to or help in preventing workplace violence. The system must address, without limitation, all of the following aspects of the workplace:

i. staffing, including staffing patterns that may contribute to, or be insufficient to address, the risk of violence;

ii. sufficiency of security systems including alarms, emergency response systems, and availability of security personnel;

iii. job design, equipment, and facilities; and

iv. security risks associated with particular units of the workplace, areas of the regulated entity’s facility with uncontrolled access, late night, or early morning shifts, and areas surrounding the facility such as employee or employees’ parking areas;

10. failure by a regulated entity to orient all permanent and temporary employee or employees of the entity’s workplace violence prevention plan;

11. failure by a regulated entity to maintain its workplace violence prevention plan in effect at all times; or

12. failure by a regulated entity to protect resident(s), patient(s), or client(s) from personal exploitation including, but not limited to, sexual conduct involving facility staff and the resident(s), patient(s), or client(s).

Class D Violation—a violation of a rule or regulation related to administrative and reporting requirements that do not directly threaten the health, safety, or welfare of the resident(s), patient(s), or client(s), or the safety of its employee or employees through workplace violence. Examples of *class D violations* include, but are not limited to:

1. – 2. ...

3. falsification of a record;

4. failure to maintain the resident(s), patient(s), or client(s)' financial records as required by rules and regulations;

5. failure by a regulated entity to maintain and make available to its employee or employees, a written safety and security plan; or

6. a regulated entity taking retaliatory action against a person who, in good faith:

a. reports an allegation or instance of workplace violence;

b. seeks assistance and intervention from local emergency services or law enforcement when a violent incident occurs; or

c. reports to law enforcement a crime or allegation involving workplace violence at the regulated entity's facility.

***

Department or LDH—the Louisiana Department of Health.

***

Employee—for purposes of this Chapter, a person who performs a job or task for the healthcare provider. An employed person may be permanent, temporary, or contracted.

Healthcare Facility or *Facility*—any healthcare provider or entity licensed or certified by LDH, including all regulated

entities, as defined by R.S. 40:2199.12, under the regulatory jurisdiction of LDH. In other laws, statutes and regulations, this entity may be referred to as a provider, agency, clinic, residential unit, or home. A healthcare facility shall include, but not be limited to a/an:

1. – 11. ...

12. free-standing birth center;

13. supplier of portable x-ray services;

14. home and community-based services (HCBS) provider;

15. home health agency;

16. hospice agency;

17. hospital;

18. intermediate care facility for persons with developmental disabilities (ICF-DD);

19. mental health clinic;

20. mental health center;

21. mental health rehabilitation agency;

22. non-emergency medical transportation agency;

23. nursing facility;

24. nurse staffing agency;

25. rural health clinic;

26. pain management clinic;

27. pediatric day healthcare (PDHC) facility;

28. psychiatric residential treatment facility (PRTF);

29. substance use/addiction treatment facility;

30. therapeutic group home (TGH); and

31. any other program licensed or certified by LDH.

HSS—the LDH Health Standards Section.

***

Regulated Entity—any licensed healthcare facility as defined by R.S. 40:2199.12.

Secretary—the secretary of LDH or his/her designee.

Workplace Violence—violent acts, including battery or the intentional placing of another person in reasonable apprehension of sustaining battery, directed toward persons at work or on duty with their employment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.11, 40:2009.23, 40:2199 and 40:2199.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3077 (November 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 49:

Subchapter B. Sanctions and Standards for the Imposition of Sanctions

§4611. General Provisions

A. – B.12.c. ...

C. Considerations. When determining whether to impose a sanction, the department may consider some or all of the following factors:

1. whether the violations pose an immediate threat to the health, safety, or welfare of the resident(s), patient(s), or client(s);

C.2. - E ...

F. Any facility sanctioned under this Rule and found to have a violation that poses a threat to the health, safety, or welfare of the resident(s), patient(s), or client(s) may have additional actions, such as criminal charges, brought against it under another applicable law, statute or regulation.

G. Unless otherwise provided for in state law or statute, if the secretary determines that the violations committed by the facility pose an imminent or immediate threat to the health, safety, or welfare of any resident(s), patient(s), or client(s) receiving services, the imposition of the sanction may be immediate and may be enforced during the pendency of the administrative appeal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.11, 40:2009.23, 40:2199 and 40:2199.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3078

(November 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 49:

§4613. Civil Fines

A. – B.2. ...

C. Class C Violations

1. ...

2. A facility may elect to pay 50 percent of the civil fine imposed for a class C violation in exchange for waiving its right to an administrative reconsideration and appeal if it submits, and HSS receives, the following within 30 days of the facility's receipt of the civil fine notice:

a. ...

b. the facility's written waiver of the right to an administrative reconsideration and appeal on the form provided by LDH.

D. – E.1. ...

F. Determination of the Amount of Civil Fines

1. In establishing the amount of civil fines to be imposed against the provider, the department may consider:

a. all relevant aggravating circumstances, including, but not limited to:

i. – iii. ...

iv. the extent of actual or potential harm to resident(s), patient(s), or client(s); and

b. – F.2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.11, 40:2009.23, 40:2199 and 40:2199.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3079 (November 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 49:

§4619. Removal from the Freedom of Choice List

A. The department may impose the sanction of removal from the freedom of choice list to a facility placed on a freedom of choice list. LDH may impose this sanction for any violation including, but not limited to:

A.1. – C. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.11, 40:2009.23, 40:2199 and 40:2199.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3080 (November 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 49:

§4621. Transfer of Resident(s), Patient(s), or Client(s) Receiving Services

A. The department may impose the sanction of transfer of resident(s), patient(s), or client(s) receiving services provided by a facility. This sanction may be imposed for any

violation of statute, rule or regulation including but not limited to:

A.1. – F.3. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.11, 40:2009.23, 40:2199 and 40:2199.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3080 (November 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 49:

§4623. License Suspension

A. Unless otherwise provided by federal or state law, the department may impose a suspension of a license if the department determines that the violations committed by the facility pose an imminent or immediate threat to the health, welfare or safety of its resident(s), patient(s), or client(s).

B. – D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.11, 40:2009.23, 40:2199 and 40:2199.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3081 (November 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 49:

§4627. Special Staffing Requirements

A. – B.5. ...

C. The department may impose the sanction of special staffing for any violation of statute, rule or regulation including, but not limited to:

1. a violation of a rule or regulation that creates a condition or occurrence relating to the maintenance and/or operation of a facility which results in death or serious harm to the resident(s), patient(s), or client(s);

2. a violation of a rule or regulation in which a condition or occurrence relating to the maintenance and/or operation of a facility is created and results in the substantial probability of death or serious physical or mental harm to the resident(s), patient(s) or client(s) will result from the violation;

3. a repeat violation of a rule or regulation in which a condition or occurrence relating to the maintenance and/or operation of a facility creates a potential for harm by directly threatening the health, safety, or welfare of the resident(s), patient(s), or client(s);

4. ...

5. when there is an imminent threat to the health, safety, or welfare of the facility's resident(s), patient(s), or client(s).

D. – E.2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.11, 40:2009.23, 40:2199 and 40:2199.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3081 (November 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 49:

§4629. Temporary Management

A. The department may require the immediate appointment of a temporary manager, at the facility's expense, to:

1. ...

2. ensure the health, safety, and welfare of the facility's resident(s), patient(s), or client(s).

B. Temporary management may be imposed for any violation of statute, rule or regulation including, but not limited to:

1. a violation of a rule or regulation that creates a condition or occurrence relating to the maintenance and/or operation of a facility which results in death or serious harm to the resident(s), patient(s) or client(s);

2. a violation of a rule or regulation in which a condition or occurrence relating to the maintenance and/or operation of a facility is created and results in the substantial probability of death, serious physical harm or mental harm to the resident(s), patient(s) or client(s);

3. a repeat violation of a rule or regulation in which a condition or occurrence relating to the maintenance and/or operation of a facility creates a potential for harm by directly threatening the health, safety, or welfare of the resident(s), patient(s), or client(s);

B.4. – G. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.11, 40:2009.23, 40:2199 and 40:2199.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3082 (November 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 49:

Subchapter C. Notice and Appeals

§4643. Administrative Appeal Process

A. – C.5. ...

D. Hearings

1. – 2.b.v. ...

c. The administrative law judge (ALJ) may question any party or witness and may admit any relevant and material evidence.

2.d. – 7. ...

8. The ALJ does not have the authority to:

a. rescind or amend any violation of federal law, statute, or regulation found by LDH on behalf of CMS; or

D.8.b. – F. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.11, 40:2009.23, 40:2199 and 40:2199.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3083 (November 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 49:

Subchapter D. Enforcement of Sanctions

§4651. Enforcement of Sanctions/Collection of Fines

A. – D.2. ...

E. The facility is prohibited from:

1. ...

2. increasing charges to resident(s), patient(s), or client(s) as a result of civil fines and/or interest imposed by LDH.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.11, 40:2009.23, 40:2199 and 40:2199.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3085 (November 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 49:

Stephen R. Russo, JD

Secretary

RULE

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

Healthy Louisiana and Coordinated System of Care Waiver
Behavioral Health Directed Payments
(LAC 50:XXXIII.503 and 703)

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

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXXIII. Behavioral Health Services
Subpart 1. Healthy Louisiana and Coordinated System of Care Waiver

Chapter 5. Reimbursement

§503. Directed Payments

A. Provider Directed Payments

1. Subject to written approval by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), the Department of Health (hereafter referred to as “the department” and/or “LDH”) shall provide directed payments to qualifying providers that participate in

the Healthy Louisiana Medicaid managed care program or Coordinated System of Care (CSoC) waiver, in accordance with the applicable section 438.6(c) preprint(s) approved by CMS, federal regulations, and departmental requirements. Each CMS approved directed payment arrangement is effective for one Healthy Louisiana Medicaid managed care or CSoC contract rating period, unless otherwise approved by CMS.

2. Qualifying Provider

a. High fidelity wraparound agencies (WAA) and wraparound facilitators (WF), WF supervisors, WAA coaches, and WAA administrators that meet the criteria specified in the applicable section 438.6(c) preprint approved by CMS and departmental requirements; or

b. Peer support specialists, supervisors, trainers, and administrators employed by the family support organization (FSO) that meet the criteria specified in the applicable section 438.6(c) preprint approved by CMS and departmental requirements; or

c. Licensed mental health practitioners (LMHPs) and psychiatrists that provide behavioral health outpatient services and that meet the criteria specified in the applicable section 438.6(c) preprint approved by CMS and departmental requirements.

3. The Healthy Louisiana Medicaid managed care organization (MCO) and CSoC contractor shall assign qualifying providers to provider classes based upon criteria specified in the applicable section 438.6(c) preprint(s) approved by CMS, in accordance with departmental requirements.

a. Qualifying providers shall have no right to an administrative appeal regarding the qualifying provider criteria or determination of which providers meet the qualifying provider criteria.

4. The MCO and CSoC contractor shall utilize a payment process, whereby directed payments will be calculated and paid out based on the data and methodology specified in the applicable section 438.6(c) preprint(s) approved by CMS, in accordance with departmental requirements.

a. Qualifying providers shall have no right to an administrative appeal regarding calculation of directed payments or measurement rates.

5. Based upon the methodology specified in the applicable section 438.6(c) preprint(s) approved by CMS, in accordance with departmental requirements, the department shall cause directed payments to be paid in a single upfront lump sum payment to the MCOs; and payments shall be paid to the CSoC contractor within 30 days of receipt of invoice(s), on a retrospective basis.

a. Funding for the directed payments is only available during the time period in the applicable section 438.6(c) preprint(s) approved by CMS or until payments are exhausted, whichever comes first.

6. In accordance with the applicable section 438.6(c) preprint(s) approved by CMS and departmental requirements, directed payments must be based on actual utilization and delivery of services during the applicable contract period.

a. Within six months of the end of the rating period, the MCOs and CSoC contractor shall perform a reconciliation as specified in the applicable section 438.6(c) preprint approved by CMS or as otherwise dictated in accordance with departmental requirements.

i. Qualifying providers shall have no right to an administrative appeal regarding any issue related to reconciliation, including, but not limited to, the timing, amount of the reconciliation, and process.

7. If a qualifying provider is subject to a reconciliation, the qualified provider shall pay all amounts owed to the MCO or CSoC contractor, in accordance with departmental requirements.

a. In addition to all other available remedies, the MCO and the CSoC contractor has the authority to offset all

amounts owed by a qualifying provider due to a reconciliation against any payment owed to the qualifying provider, including, but not limited to, any payment owed by the MCOs or CSoC contractor.

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 Behavioral Health, LR 49:

Chapter 7. Grievance and Appeals Process

§703. Provider Grievance and Appeal Process

A. If the provider is filing a grievance or appeal on behalf of the member, the provider shall adhere to the provisions outlined in §701 of this Chapter.

B. The MCO and CSoC contractor must have a grievance and appeals process for claims, medical necessity, and contract disputes for providers in accordance with the contract and department issued guidance.

1. The MCO and CSoC contractor shall establish and maintain a procedure for the receipt and prompt internal resolution of all provider initiated grievances and appeals as specified in the contract and department issued guidance.

2. The grievance and appeals procedures, and any changes thereto, must be approved in writing by the department prior to their implementation.

3. Notwithstanding any MCO, CSoC contractor, or department grievance and appeal process, nothing contained in any document, including, but not limited to Rule or contract, shall preclude a provider's right to pursue relief through a court of appropriate jurisdiction.

4. The MCO and CSoC contractor shall report on a monthly basis all grievance and appeals filed and resolutions in accordance with the terms of the contract and department issued guidance.

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, LR 49:

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.

Stephen R. Russo, JD

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Hospice Services
Payment Methodology
(LAC 50:XV.4305 and 4309)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XV.4305 and §4309 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 XV. Services for Special Populations
Subpart 3. Hospice

Chapter 43. Reimbursement

§4305. Payment Methodology

A. Reimbursement for hospice services is made to a designated hospice provider based on the Medicaid rates published annually in a memorandum issued by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), Center for Medicaid and CHIP Services. These rates are effective from October 1 of each year through September 30 of the following year.

1. Payment for hospice care will be made at predetermined rates for each day in which a beneficiary is under

the care of the hospice provider. The daily rate is applicable to the type and intensity of services furnished to the beneficiary for that day.

a. – b. Repealed.

2. For routine home care, continuous home care, and inpatient respite care, only one rate is applicable for each day. For continuous home care, the amount of payment is determined based on the number of hours of continuous care furnished to the recipient on that day.

a. – d.ii. Repealed.

B. A service intensity add-on (SIA) payment will be reimbursable for a visit by a registered nurse or a social worker, when provided during routine home care in the last seven days of a patient’s life. The SIA payment is made in addition to the routine home care rate.

1. The hospice provider shall submit claims for payment for hospice care only on the basis of the geographic location at which the services are furnished.

a. The nursing facility shall be considered an individual’s home if the individual usually lives in the nursing facility.

2. Payment for Physician Services. The four basic payment rates for hospice care are designed to reimburse the hospice for the costs of all covered services related to the treatment of the recipient’s terminal illness. This includes the

administrative and general supervisory activities performed by physicians who are employees of or working under arrangements made with the hospice. These activities are generally performed by the physician serving as the medical director and the physician member of the hospice interdisciplinary group. Group activities include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies. The costs for these services are included in the reimbursement rates for routine home care, continuous home care, and inpatient respite care.

a. The hospice is paid for other physicians' services, such as direct patient care services, furnished to individual patients by hospice employees and for physician services furnished under arrangements made by the hospice unless the patient care services were furnished on a volunteer basis. The physician visit for the face-to-face encounter will not be reimbursed by the Medicaid Program.

b. The hospice is reimbursed in accordance with the usual Medicaid reimbursement policy for physicians' services. This reimbursement is in addition to the daily rates.

c. Physicians who are designated by recipients as the attending physician and who also volunteer services to the hospice are, as a result of their volunteer status, considered employees of the hospice in accordance with the 42

CFR 418.3. All direct patient care services rendered by these physicians to hospice patients are hospice physician services, and are reimbursed in accordance with the procedures outlined in §4305.B.1. Physician services furnished on a volunteer basis are excluded from Medicaid reimbursement. The hospice may be reimbursed on behalf of a volunteer physician for specific services rendered which are not furnished on a volunteer basis (a physician may seek reimbursement for some services while furnishing other services on a volunteer basis). The hospice must have a liability to reimburse the physician for those physician services rendered. In determining which services are furnished on a volunteer basis and which services are not, a physician must treat Medicaid patients on the same basis as other patients in the hospice.

d. An independent attending physician is reimbursed in accordance with the usual Medicaid reimbursement methodology for physician services.

i. The only services billed by the attending physician are the physician’s personal professional services. Costs for services such as lab or x-rays are not included on the attending physician’s bill.

ii. Services provided by an independent attending physician must be coordinated with any direct care services provided by hospice physicians.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1470 (June 2002), amended LR 34:441 (March 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:132 (January 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 49:

§4309. Limitation on Payments for Inpatient Care

A. Payments to a hospice for inpatient care are limited according to the number of days of inpatient care furnished to Medicaid patients.

1. A hospice cap period is a 12-month period beginning November 1 of each year and ending October 31 of the following year.

2. – 2.b. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1472 (June 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:132 (January 2015), amended by the Department

of Health, Bureau of Health Services Financing, LR 48:2294 (September 2022), LR 49:

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.

Stephen R. Russo, JD

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Hospital Licensing Standards
Rural Emergency Hospitals
(LAC 48:I.Chapter 93)

The Department of Health, Bureau of Health Services Financing has amended LAC 48:I.Chapter 93 as authorized by R.S. 36:254 and 40:2100-2115. 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 93. Hospitals

Subchapter A. General Provisions

§9301. Purpose

A. – B. ...

C. Primarily Engaged

1. – 1.b. ...

2. Exemptions. The following licensed hospitals are not subject to the primarily engaged provisions/requirements of this Chapter:

a. ...

b. a licensed hospital designated as a rural hospital as defined by R.S. 40:1189.3;

c. a licensed hospital currently certified and enrolled as a Medicare/Medicaid certified hospital which has not been determined out of compliance with the federal definition of primarily engaged; if a hospital is currently Medicare/Medicaid certified, and has been determined to be currently meeting the federal definition of primarily engaged, it shall be exempt from compliance with the following provisions in this section regarding primarily engaged; and

d. a licensed hospital designated as a rural emergency hospital, as established in Section 125 of the Consolidated Appropriations Act of 2021 and defined by the Code of Federal Regulations at 42 CFR 485.500 et seq., or its successor provisions, provided that such facility is in compliance with the provisions of Section 9310 of this Chapter.

C.3. – E.9. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2399 (November 2003), amended by the

Department of Health, Bureau of Health Services Financing, LR 45:1474 (October 2019), LR 46:1682 (December 2020), LR 49:

§9303. Definitions

A. The following definitions of selected terminology are used in connection with Chapter 93 through Chapter 96.

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AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), LR 29:2400 (November 2003), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:513 (March 2010), LR 37:3028 (October 2011), LR 38:1413 (June 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 45:1475 (October 2019), LR 49:

§9310. Rural Emergency Hospitals

A. A rural emergency hospital (REH) is a hospital facility that converts from either a critical access hospital (CAH) or a rural hospital with less than 50 beds, as established in Section 125 of the Consolidated Appropriations Act of 2021. Only a CAH or rural hospital with less than 50 beds that was licensed by the department as of December 27, 2020 may convert to a REH.

B. A REH shall be in compliance with the federal regulations for REHs, namely 42 CFR 485.500 et seq., or successor regulations.

C. Pursuant to the federal requirements, the REH shall provide emergency department services and observation care, but shall not provide acute inpatient services except for the optional service of post-hospital extended care services furnished in a unit of the facility that is a distinct part skilled nursing unit.

1. The CAH or rural hospital that is converting to a REH shall contact the licensing section of the department to temporarily inactivate its licensed acute care hospital beds while it is designated and certified as a REH by the Medicare program.

2. If the facility loses its designation or certification as a REH or begins operating again as a CAH or rural hospital, the facility shall contact the licensing section of the department to immediately re-activate its licensed acute care hospital beds.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 49:

§9311. Enforcement

A. The department shall have the authority to interpret and enforce Chapter 93 through Chapter 96 as authorized by and in accordance with the Health Care Facilities and Services Enforcement Act, R.S. 40:2199.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:177 (February 1995), amended by the Department of Health, Bureau of Health Services Financing, LR 29:2404 (November 2003), LR 49:

Stephen R. Russo, JD

LDH Secretary

RULE

Department of Health
Bureau of Health Services Financing

Inpatient Hospital Services
Medicare Part A Claims for Medicaid Eligible Beneficiaries
(LAC 50:V.Chapter 23)

The Department of Health, Bureau of Health Services Financing has repealed the following uncodified Rules and adopted LAC 50:V.Chapter 23 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act:

Register Date	Title	Register Volume, Number	Page Number
November 20, 2000	Inpatient Hospital Services – Medicare Part A Claims	Vol 26 No 11	2621
November 20, 2000	Inpatient Psychiatric Services – Medicare Part A Claims	Vol 26 No 11	2621
February 20, 2002	Inpatient Hospital Services Medicare Part A	Vol 28 No 2	308

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. Hospital Services
Subpart 1. Inpatient Hospital Services

Chapter 23. Medicare Part A Claims for Medicaid Eligible Beneficiaries

§2301. Reimbursement Methodology

A. To determine the amount that Medicaid will reimburse on a claim for a Medicaid beneficiary who is also eligible for Medicare Part A, the Medicare claim payment is compared to the Medicaid payment rate on file for the inpatient service multiplied by the inpatient covered days. If the Medicare payment exceeds the Medicaid rate that would have been paid, the claim is adjudicated as a paid claim with a zero payment. If the Medicaid rate that would have been paid exceeds the Medicare payment, the claim is reimbursed at the lesser of the co-insurance and deductible or up to the Medicaid maximum payment. If the Medicaid payment is reduced or eliminated as a result of the Medicare/Medicaid payment comparison, the amount of the Medicare payment plus the amount of the Medicaid payment, if any, shall be considered to be payment in full for the service.

B. Medicare Part A claims for small rural hospitals, as defined in R.S. 40:1300, are exempt from the Medicaid maximum payment limitation.

C. The beneficiary does not have any legal liability to make payment for the 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, Bureau of Health Services Financing, LR 49:

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.

Stephen R. Russo, JD

Secretary

RULE

Department of Health
Bureau of Health Services Financing
and
Office for Citizens with Developmental Disabilities

Medicaid Eligibility
Act 421 Children's Medicaid Option
(LAC 50:III.2331)

The Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities has amended LAC 50:III.2331 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 III. Eligibility
Subpart 3. Eligibility Groups and Factors

Chapter 23. Eligibility Groups and Medicaid Programs

§2331. Act 421 Children's Medicaid Option (Act 421-CMO/TEFRA)

A. Pursuant to section 1902(e)(3) of the Social Security Act the state may extend Medicaid eligibility to certain children living in the community, who require the level of care provided in an institution, and who would be eligible for Medicaid if living in an institution.

1. – 2. Repealed.

B. Effective January 1, 2022, the department implemented the Act 421 Children's Medicaid Option (Act 421-CMO) program to provide Medicaid State Plan services to children with disabilities who, despite parental or household income and resources, meet the eligibility criteria set forth in this Section.

1. – 2.b.iii(c). Repealed.

C. Eligibility Criteria. In order to qualify for the 421-CMO program, an applicant/Act 421-CMO beneficiary must meet all of the following criteria:

1. is 18 years of age or younger (under 19 years of age);

a. – b. Repealed.

2. is a U.S. citizen or qualified non-citizen;

3. is a Louisiana resident;

4. has countable resources that are equal to or less than the resource limits for the Supplemental Security Income (SSI) program;

5. has countable income equal to or less than the special income level for long-term care services (nursing facility, ICF/IID, and home and community-based services);

6. qualifies as a disabled individual under section 1614(a) of the Social Security Act;

7. must meet a level of care, assessed on an annual basis, provided in an intermediate care facility for individuals with intellectual disabilities (ICF/IID), a nursing facility, or a hospital; and

8. care needs are being safely met at home at a lower cost than the cost of services provided in an institutional setting.

D. Act 421 Children's Medicaid Option (Act 421-CMO/TEFRA) Levels of Care

1. The individual meets Act 421-CMO ICF/IID level of care when demonstrating both of the following:

a. has obtained a statement of approval from the Office for Citizens with Developmental Disabilities, or its designee, or EarlySteps eligibility (depending on age) confirming that he/she has a developmental disability as defined in R.S. 28:451.2; and

b. meets the requirements for active treatment of a developmental disability under the supervision of a qualified developmental disability professional, as prescribed on the Request for Medical Eligibility Determination, Form 90-L.

2. The individual meets Act 421-CMO nursing facility level of care when demonstrating both of the following, assessed in accordance with the Act 421 Children's Medicaid Option assessment tool:

a. has a diagnosis of a medical/physical condition resulting in needs requiring long term care services of at least six months; and

b. requires skilled nursing interventions and/or has substantial functional limitations (SFLs) requiring hands-on assistance from others throughout the day.

3. The individual meets hospital level of care when demonstrating all of the following, assessed in accordance with the Act 421 Children’s Medicaid 0ption assessment tool:

a. the need for frequent medical care that requires the use of equipment to prevent life-threatening situations, with skilled medical care required more than once during each 24-hour period;

b. the need for skilled medical interventions that are expected to persist for at least six months; and

c. an overall health condition that is unstable, presenting the constant potential for complications or rapid deterioration, such that he/she requires monitoring by professional nurses, parents, or other properly instructed individuals, in order to detect unstable and life-threatening conditions and respond promptly with appropriate care.

E. Cost Effectiveness

1. On an annual basis, each 421-CMO beneficiary’s expenditures will be measured against the average cost of care

in an institution that corresponds to his/her level of care (i.e. hospital, ICF/IID, nursing facility) to ensure that home and community-based care is more cost effective than institutional care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:977.21-977.25, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 47:1872 (December 2021), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 49:

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.

Stephen R. Russo, JD

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Medicaid Eligibility
Disregard of Accumulated Resources
(LAC 50:III.10705)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:III.10705 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-GENERAL
Part III. Eligibility
Subpart 5. Financial Eligibility

Chapter 107. Resources

§10705. Resource Disregards

A. – E. ...

F. Resources accumulated from March 18, 2020 through March 31, 2023, that, but for the continuous enrollment provision at section 6008(b)(3) of the Families First Coronavirus Response Act, would have been paid toward the cost of a beneficiary’s home and community-based services waiver or institutional services based on the application of post-eligibility treatment of income, will be disregarded through the

twelfth month following the first full redetermination of the beneficiary's eligibility conducted after March 31, 2023.

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 35:1899 (September 2009), amended LR 36:2867 (December 2010), LR 41:949 (May 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 45:1772 (December 2019), LR 46:1393 (October 2020), LR 49:

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.

Stephen R. Russo, JD

Secretary