**RULE**

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

**Adult Behavioral Health Services**
**(LAC 50:XXXIII.6103 Chapters 63-65)**

The Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health have amended LAC 50:XXXIII.Chapters 61-65 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 7. Adult Mental Health Services**

**Chapter 61. General Provisions**

**§6103. Recipient Qualifications**

A. Individuals, 21 years of age and older, who meet Medicaid eligibility, shall qualify to receive adult mental health services referenced in section §6307 if medically necessary in accordance with LAC 50:I.1101, if the recipient presents with mental health symptoms that are consistent with a diagnosable mental disorder, and the services are

therapeutically appropriate and most beneficial to the recipient.

B. Additional Recipient Eligibility Criteria for Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR)

1. Members must meet the Substance Abuse and Mental Health Services Administration (SAMHSA) definition of, serious mental illness (SMI). In addition to having a diagnosable mental disorder, the condition must substantially interfere with, or limit, one or more major life activities, such as:

a. basic daily living (for example, eating or dressing);

b. instrumental living (for example, taking prescribed medications or getting around the community); and

c. participating in a family, school, or workplace.

2. A member must have a rating of three or greater on the functional status domain on the level of care utilization system (LOCUS).

a. - c. Repealed.

3. Recipients receiving CPST and/or PSR shall have at least a composite score of three on the LOCUS.

4. An adult with longstanding deficits who does not experience any acute changes in their status and has previously

met the criteria stated in §6103.B.2.- B.3, but who now meets a composite LOCUS score of two or lower, and needs subsequent medically necessary services for stabilization and maintenance at a lower intensity, may continue to receive CPST services and/or PSR, if deemed medically necessary.

C. An adult with a diagnosis of a substance use disorder or intellectual and developmental disability without an additional co-occurring qualifying mental health diagnosis shall not meet the criteria for adult mental health rehabilitation services.

D. 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 38:358 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:378 (February 2015), LR 42:60 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:

**Chapter 63. Services**

**§6301. General Provisions**

A. ...

B. All services must be authorized.

C. - E. ...

F. Services may be provided at a facility, in the community, or in the individual's place of residence as outlined in the treatment plan. Services may be furnished in a nursing facility only in accordance with policies and procedures issued 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 Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:359 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:378 (February 2015), LR 42:60 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:

**§6303. Assessments**

A. For mental health rehabilitation services, each enrollee shall be assessed and have a treatment plan developed for CPST and PSR.

B. ...

C. Assessments must be performed at least once every 365 days or any time there is a significant change to the enrollee's circumstances.

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 38:359 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:378 (February 2015), LR 42:60 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:

**§6305. Treatment Plan**

A. Each enrollee who receives CPST and PSR services shall have a treatment plan developed based upon the assessment.

B. The individualized treatment plan shall be developed according to the criteria established by the department and in accordance with the provisions of this Rule, the provider manual and other notices or directives issued by the department.

1. The treatment plan shall be reviewed at least once every 365 days or when there is a significant change in the individual’s circumstances.

C. The treatment plan shall be developed by the LMHP or physician in collaboration with direct care staff, the recipient, family and natural supports.

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 38:359 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 42:60 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:

**§6307. Covered Services**

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

1. therapeutic services, including diagnosis and treatment delivered by LMHPs and physicians; and

2. rehabilitation services, including community psychiatric support and treatment (CPST) and psychosocial rehabilitation and crisis intervention.

3. Repealed.

B. - B.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, Bureau of Health Services Financing, LR 38:359 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 42:61 (January 2016), amended by the

Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:

**Chapter 65. Provider Participation**

**§6501. Provider Responsibilities**

A. - B. ...

C. Anyone providing adult mental health services must operate within their scope of practice license.

D. 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.

E. - E.6. 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 38:360 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:378 (February 2015), LR 42:61 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, 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**

**Healthcare Services Provider Fees**
**(LAC 48:I.Chapter 40)**

The Department of Health, Bureau of Health Services Financing has amended LAC 48:I.Chapter 40 in the Medical Assistance Program as authorized by R.S. 36:254 and R.S. 46:2625. 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 1. General**

**Chapter 40. Provider Fees**

**§4001. Specific Fees**

A. Definitions

*Emergency Ground Ambulance Service Provider*-a non-public, non-federal provider of emergency ground ambulance services.

*Net Operating Revenue*—Repealed.

*Quarter*—for purposes of this Chapter, quarters shall be constituted as follows:

| | |
|---|---|
| First Quarter | December, January, February |

| | |
|---|---|
| Second Quarter | March, April, May |
| Third Quarter | June, July, August |
| Fourth Quarter | September, October, November |

a. Exception. For purposes of hospital and emergency ground ambulance services, quarters shall be constituted as follows:

| | |
|---|---|
| First Quarter | July, August, September |
| Second Quarter | October, November, December |
| Third Quarter | January, February, March |
| Fourth Quarter | April, May, June |

B. Nursing Facility Services

1. A fee shall be paid by each facility licensed as a nursing home in accordance with R.S. 40:2009.3 et seq., for each occupied bed on a per day basis. A bed shall be considered occupied, regardless of physical occupancy, based upon payment for nursing facility services available or provided to any individual or payer through formal or informal agreement. For example, a bed reserved and paid for during a temporary absence from a nursing facility shall be subject to the fee. Likewise, any bed or beds under contract to a hospice shall be subject to the fee for each day payment is made by the hospice. Contracts,

agreements, or reservations, whether formal or informal, shall be subject to the fee only where payment is made for nursing services available or provided. Nursing facilities subject to the fee shall provide documentation quarterly, on a form provided by the department, of occupied beds in conjunction with payment of the fee.

2. The fee imposed for nursing facility services shall not exceed 6 percent of the net patient revenues received by providers of that class of services and shall not exceed $12.08 per occupied bed per day. The fee amount shall be calculated annually in conjunction with updating provider reimbursement rates under the Medical Assistance Program. Notice to providers subject to fees shall be given in conjunction with the annual rate setting notification by the Bureau of Health Services Financing.

C. Intermediate Care Facility for Individuals with Developmental Disabilities (ICF/DD) Services

1. A fee shall be paid by each facility licensed as an intermediate care facility for individuals with developmental disabilities in accordance with R.S. 46:2625 et seq., for each occupied bed per day. A bed shall be considered occupied, regardless of physical occupancy, based on payment for ICF/DD facility services available or provided to any individual or payer through formal or informal agreement. For example, a bed

reserved and paid for during a temporary absence from a facility shall be subject to the fee. Likewise, any bed or beds under contract to a hospice shall be subject to the fee for each day payment is made by the hospice. Contracts, agreements, or reservations, whether formal or informal, shall be subject to the fee only where payment is made for ICF/DD facility services available or provided. ICF/DD facilities subject to fees shall provide documentation quarterly, on a form provided by the department, of occupied beds in conjunction with payment of the fee.

2. The fees imposed for ICF/DD facility services shall not exceed 6 percent of the net patient revenues received by providers of that class of service and shall not exceed $30 per occupied bed per day. The fee amount shall be calculated annually in conjunction with updating provider reimbursement rates under the Medical Assistance Program. Notice to providers subject to fees shall be given in conjunction with the annual rate setting notification by the Bureau of Health Services Financing.

D. Pharmacy Services. A fee shall be paid by each pharmacy and dispensing physician for each out-patient prescription dispensed. The fee shall be $0.10 per prescription dispensed by a pharmacist or dispensing physician. Where a prescription is filled outside of Louisiana and not shipped or

delivered in any form or manner to a patient in the state, no fee shall be imposed. However, out-of-state pharmacies or dispensing physicians dispensing prescriptions which are shipped, mailed or delivered in any manner inside the state of Louisiana shall be subject to the $0.10 fee per prescription. The fee only applies to prescriptions which are dispensed for human use. Pharmacies and dispensing physicians subject to the fees shall provide documentation quarterly, on a form provided by the department, in conjunction with payment of fees.

E. Emergency Ground Ambulance Services. Effective August 1, 2016, a fee shall be imposed on emergency ground ambulance service providers in accordance with R.S. 46:2626.

1. The total assessment for the initial state fiscal year in which the assessment is charged shall not exceed the lesser of the following:

a. the state portion of the cost, excluding any federal financial participation, of the reimbursement enhancements provided for in R.S. 46:2626 that are directly attributable to payments to emergency ground ambulance services providers; or

b. 1 1/2 percent of the net operating revenue of all emergency ground ambulance service providers assessed relating to the provision of emergency ground ambulance transportation.

c. - d. Repealed.

2. Except for the first year maximum fee of 1 1/2 percent of the net operating revenue, the department shall not impose any new fee or increase any fee on any emergency ground ambulance service provider on or after July 1, 2016, without first obtaining either of the following:

a. prior approval of the specific fee amount by record vote of two-thirds of the elected members of each house of the legislature while in regular session.

b. written agreement of those providers subject to the fee which provide a minimum of 65 percent of the emergency ground ambulance transports.

3. After the initial year of assessment, the assessment shall be a percentage fee, determined at the discretion of the secretary and subject to the provisions below in collaboration with the express and written mutual agreement of the emergency ground ambulance service providers subject to the assessment and which make up a minimum of 65 percent of all emergency ground ambulance transports in the state of Louisiana.

a. the maximum fee allowable in any year shall not exceed 3 1/2 percent of the annual net operating revenue of the emergency ground ambulance service provider and subject to audit for the previous fiscal year of the provider.

4. Prior to levying or collecting the assessment for the applicable assessment period, the department shall publish in the official state journal the total amount of the assessment and the corresponding applicable percentage of net operating revenue that will be applied to the assessed providers.

F. Hospital Services

1. Effective January 1, 2017, a hospital stabilization assessment fee shall be levied and collected in accordance with article VII, section 10.13 of the Constitution of Louisiana and any legislation setting forth the hospital stabilization formula.

a. The total assessment for each state fiscal year shall be equal to, but shall not exceed, the lesser of the following:

i. the state portion of the cost, excluding any federal financial participation and any costs associated with full Medicaid pricing, of payments for healthcare services through the implementation of a health coverage expansion of the Louisiana Medical Assistance Program that meets all the necessary requirements necessary for the state to maximize federal matching funds as set forth in 42 U.S.C. 1396(d)y of title XIX of the Social Security Act, which are directly attributable to payments to hospitals; or

1.a.ii. – 4. ...

AUTHORITY NOTE: Promulgated in accordance with Chapter 45 of Title 46 as enacted in 1992, 46:2601-2605, designated as Chapter 47 of Title 46, containing R.S. 46:2621 to 46:2625 and P.L. 102-234.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Management and Finance, LR 19:347 (March 1993), amended LR 20:51 (January 1994), LR 26:1478 (July 2000), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 33:100 (January 2007), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1887, 1888 (November 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 43:73 (January 2017), repromulgated LR 43:323 (February 2017), amended LR 44:

**§4003. Due Date for Submission of Reports and Payment**

A. Quarterly Reports and fees shall be submitted to the department and shall be due on the twentieth calendar day of the month following the close of the quarter and shall be deemed delinquent on the thirtieth calendar day of that month. Even if no fee is due, submission of the report is still mandatory.

B. For hospital and emergency ground ambulance services, payment is due 30 days from the notification of the amount owed.

1. - 2. Repealed.

AUTHORITY NOTE: Promulgated in accordance with Chapter 45 of Title 46 as enacted in 1992, 46:2601-2605, redesignated as Chapter 47 of Title 46, containing R.S. 46:2621 to 46:2625 and PL 102-234.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Management and Finance, LR 19:347 (March 1993), amended LR 26:1479 (July 2000), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1887 (November 2016), LR 44:

**§4005. Delinquent and/or Unfiled Reports**

A. Penalty Assessment. In the case a report has been determined delinquent, the specific penalty shall be 5 percent of the total fee due on the report for every 30 days that the report is not filed, not to exceed 180 days. When a report is not received within 180 days from the due date, the report shall be deemed not filed and there shall be cause for an audit, investigation or examination to be made by the department.

B. Estimation of Provider Fee Due. In those cases in which a health care provider fails to file the quarterly report, the department will estimate the provider fee due. The department will, by certified mail, notify the provider of the estimated fee due, the method used to calculate the estimated fee and the department's intent to collect the delinquent fee. The provider shall have 15 days from the date of the notice to

file a provider fee report with the department. Any provider who fails to file the quarterly report within 15 days of the date of the department's estimated provider fee notice shall waive any and all rights to appeal the department's action and to contest payment of the estimated fee.

C. Incorrect Reporting. If a provider submits a quarterly report required by the provisions of this Chapter and the report made and filed does not correctly compute the amount of the fee owed, there shall be cause for an audit, investigation or examination to be made by the department.

D. False or Fraudulent Reporting. When a provider files a quarterly report that is false or fraudulent or grossly incorrect, there shall be imposed, in addition to any other sanctions allowed under rule or law, a specific penalty of 50 percent of the fee due.

E. ...

AUTHORITY NOTE: Promulgated in accordance with Chapter 45 of Title 46 as enacted in 1992, 46:2601-2605, redesignated as Chapter 47 of Title 46, containing R.S. 46:2621 to 46:2625 and PL 102-234.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Management and Finance, LR 19:347 (March 1993), amended LR 26:1479 (July 2000), amended by the

Department of Health, Bureau of Health Services Financing, LR 44:

**§4007. Delinquent and/or Unpaid Fees**

A. When the provider fails to pay the fee due, or any portion thereof, on or before the date it becomes delinquent, interest at the rate of 1 1/2 percent per month compounded daily shall be assessed on the unpaid balance until paid.

B. Collection of Delinquent Fees

1. For those health care providers enrolled in the Louisiana Medical Assistance Program (Medicaid), collection of delinquent provider fees will be as follows.

a. The department will withhold from the provider's Medicaid reimbursement, an amount equal to 50 percent of the reimbursement or the actual amount of the delinquent provider fee, including interest and penalty, whichever is less.

B.1.b. – C. ...

D. – E.1.b. Repealed.

AUTHORITY NOTE: Promulgated in accordance with Chapter 45 of Title 46 as enacted in 1992, 46:2601-2605, redesignated as Chapter 47 of Title 46, containing R.S. 46:2621 to 46:2625 and PL 102-234.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Management and Finance, LR 19:347 (March 1993), amended LR 20:1114 (October 1994), LR 26:1479

(July 2000), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1887 (November 2016), 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**
**Admissions and Continued Stay Criteria**
**(LAC 50:II.Chapter 5)**

The Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services have amended LAC 50:II.Chapter 5 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**

**§501. Preadmission Screening**

A. Preadmission screening shall be performed for all individuals seeking admission to a Medicaid-certified nursing facility, regardless of the source of payment for the nursing facility services or the individual’s known diagnoses. The purpose of the preadmission screening and resident review (PASRR) process is to identify applicants or residents who have

a diagnosis of serious mental illness or mental retardation (hereafter referred to as intellectual/developmental disability) and to determine whether these individuals require nursing facility services and/or specialized services for their mental condition.

1. - 1.c.ii. ...

2. An individual is considered to have intellectual/developmental disability if the individual meets the criteria as described in the *American Association on Intellectual and Developmental Disabilities' Manual on Intellectual Disability: Definition, Classification, and Systems of Supports*, 11th edition, or its successor.

a. *Intellectual/Developmental Disability* (*I/DD*)—a disability that originates before the age of 18 and is characterized by significant limitations in both intellectual functioning (reasoning, learning, problem solving) and adaptive behavior, which covers a range of everyday social and practical skills.

b. ...

B. A Medicaid-certified nursing facility shall not admit a person with a diagnosis of a serious mental illness or intellectual/developmental disability without a preadmission screening.

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 36:1010 (May 2010), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

**§503. Medical Certification**

A. Evaluative data for medical certification (level of care determination) must be submitted to the Office of Aging and Adult Services (OAAS) or its designee for all initial admissions to and requests for continued stays in Medicare or Medicaid-certified nursing facilities, regardless of payer source.

1. Initial Admissions

a. Required Documents. The following documents are required for initial admission to a nursing facility. The initial admission process does not begin until all of the following documents are complete and submitted to OAAS. These documents must not be dated more than 30 calendar days prior to the date of admission and must reflect the individual’s current functioning:

i. a level of care eligibility tool (LOCET) assessment;

ii. a preadmission screening and resident review (level I PASRR) form completed by a qualified health care professional. The level 1 PASRR form must be signed and dated on the date that it is completed. The level I PASRR form addresses the specific identifiers of MI or I/DD that indicate that a more in-depth evaluation is needed to determine the need for specialized services. The need for this in-depth assessment does not necessarily mean that the individual cannot be admitted to a nursing facility, only that the need for other services must be determined prior to admission;

(a). if the information on the level I PASRR indicates that the individual may have a diagnosis of MI and/or I/DD, and the individual meets the criteria for nursing facility level of care, the individual shall be referred to the Office of Behavioral Health or the Office for Citizens with Developmental Disabilities (the state’s mental health and intellectual disability level II authorities) for a level II screening to determine if the individual requires the level of services provided by a nursing facility and whether specialized services are needed. Medical certification is not guaranteed for an individual who has been referred for a level II screening. A Medicaid-certified nursing facility shall not admit an individual identified for a level II screening until the

screening has been completed and a decision is made by the level II authority;

(b). if there is no indication on the level I PASRR or in other records that the individual may have a diagnosis of MI and/or I/DD and he/she meets the criteria for nursing facility level of care, OAAS may approve the individual for admission to the nursing facility;

iii. for nursing facility admission under a specialized level of care, additional documentation that supports the need for specialized care; and

iv. OAAS or its designee may require the submittal of additional documentation to support the need for a nursing facility stay.

b. Vendor Payment. Once approval has been obtained, the individual must be admitted to the facility within 30 calendar days of the date of the approval notice. The nursing facility shall submit a completed BHSF Form 148, immediately upon admission, to the local Medicaid eligibility office and OAAS indicating the anticipated payment source for the nursing facility services. Medicaid vendor payment shall not begin prior to the date that medical and financial eligibility is established, and shall only begin once the individual is actually admitted to the facility.

NOTE: Repealed.

2. Continued Stay Requests

a. Required documents. The following documents are required in order for OAAS or its designee to determine the need for continued services in a nursing facility. The continued stay process does not begin until all of the following documents are complete and submitted to OAAS.

i. a continued stay request form as issued by OAAS or its designee;

ii. documentation to support the request for continued stay including an MDS 3.0 conducted no more than 14 calendar days prior to the request shall be required. 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). there is additional supporting documentation demonstrating a significant change in status; or

(b). the individual is seeking admission to a facility different than the facility from which they were discharged; and

iii. additional documentation as required by the level II authorities.

b. Vendor payment. Medicaid payment shall be made in accordance with the Notice of Medical Certification (BHSF Form 142) issued by OAAS or the level II authority.

A.3. - D. 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 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), LR 44:

**§507. Exempted Hospital Discharges**

A. - A.3. ...

B. If prior to admission, the individual does not meet the criteria for an exempted hospital discharge, then the individual will be referred to the appropriate level II authority for an assessment.

1. Repealed.

C. If after admission it becomes apparent that a longer stay is required, the nursing facility must refer the individual to the appropriate level II authority for assessment within 30 calendar days of the admission date.

1. Approval for the admission will continue to the fortieth calendar day from the date of admission pending the level II determination.

D. Exempted hospital discharges are only applicable for persons with MI and/or I/DD. This exempted discharge does not apply to any other program or for transfers between nursing facilities.

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 36:1012 (May 2010), amended 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**
**Standards for Payment**
**(LAC 50:II.10101 and 10156)**

The Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services have amended LAC 50:II. 10101 and §10156 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 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 3. Standards for Payment**

**Chapter 101. Standards for Payment for Nursing Facilities**

**Subchapter A. Abbreviations and Definitions**

**§10101. Definitions**

A. This glossary contains a comprehensive list of abbreviations and definitions used in the requirements for payment for nursing facilities.

***

*Admission*—the date a person enters the facility and is admitted as a resident.

***

*Continued Stay*—a request for medical certification beyond the date of the currently authorized period.

***

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996), amended LR 23:970 (August 1997), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 44:

**Subchapter G. Levels of Care**

**§10156. Level of Care Pathways**

A. ...

B. When specific eligibility criteria are met within a pathway, that pathway is said to have triggered. The Medicaid program defines nursing facility level of care for Medicaid eligible individuals as the care required by individuals who meet or trigger any one of the established level of care pathways described in this Subchapter. The pathways of eligibility focus on information used to determine if an

individual has met or triggered a level of care pathway. When a pathway is triggered, that individual may be approved for a limited stay/length of service as deemed appropriate by OAAS.

C. – F.4.c. ...

5. Repealed.

G. – G.3.b.iii. ...

4. Repealed.

H. – H.3.e. ...

4. Repealed.

I. Behavior Pathway

1. Effective upon promulgation of this Rule, the behavior pathway will be eliminated as a pathway for meeting nursing facility level of care.

2. Individuals receiving services who met the nursing facility level of care only by triggering the behavior pathway prior to promulgation of this Rule shall continue to remain eligible for services requiring nursing facility level of care until:

a. the individual is discharged from long term care services; or

b. the individual has been found eligible for services in another program or setting more appropriate to their needs.

2.c. – 3.c. Repealed.

J. – J.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, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:342 (January 2011), amended LR 39:1471 (June 2013), LR 41:1289 (July 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 43:2187 (November 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**

**Pharmacy Benefits Management Program**
**Physician-Administered Drugs Reimbursement Methodology**
**(LAC 50:XXIX.949)**

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XXIX.949 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 XXIX. Pharmacy**

**Chapter 9. Methods of Payment**

**Subchapter D. Maximum Allowable Costs**

**§949. Fee for Service Cost Limits**

A. – H. ...

I. Physician-Administered Drugs. Medicaid-covered physician-administered drugs shall be reimbursed according to the Louisiana professional services fee schedule. Reimbursement shall be determined utilizing the following methodology, and periodic updates to the rates shall be made in accordance with

the approved Louisiana Medicaid State Plan provisions governing physician-administered drugs in a physician office setting.

1. Reimbursement for Medicaid-covered physician-administered drugs in a physician office setting shall be established at the current Louisiana Medicare rate, which is average sales price (ASP) plus 6 percent, for drugs appearing on the Medicare file.

2. Reimbursement rates for physician-administered drugs in a physician office setting that do not appear on the Medicare file shall be determined utilizing the following alternative methods:

a. the wholesale acquisition cost (WAC) of the drug, if available;

b. If the drug has no WAC available, one of the following methods shall be used:

i. the provider’s actual cost of the drug as documented by invoice or other acceptable documentation as deemed appropriate by the department;

ii. Medicaid rate of other states;

iii. commercial payer rate; or

iv. medical consultant recommendation.

J. – K. ...

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 32:1065 (June 2006), amended LR 34:88 (January 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:1561 (July 2010), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1185 (June 2017), LR 43:1554 (August 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