RULE

Department of Health
Bureau of Health Services Financing

Dental Benefits Prepaid Ambulatory Health Plan
Payment Methodology
(LAC 50:I.2111)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:I.2111 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE
Part I. Administration
Subpart 3. Managed Care for Physical and Basic Behavioral Health

Chapter 21. Dental Benefits Prepaid Ambulatory Health Plan

§2111. Payment Methodology

A. - A.2. ...

3. The department or its fiscal intermediary, may reimburse a DBPM’s monthly capitation payments in the aggregate on a lump sum basis when administratively necessary.

B. – I. ...

J. A DBPM shall have a medical loss ratio (MLR) for each MLR reporting year, which shall be a calendar year, except in

circumstances in which the reporting period must be revised to align to a CMS-approved capitation rating period.

1. Following the end of the MLR reporting year, a DBPM shall provide an annual MLR report, in accordance with the financial reporting guide issued by the department.

2. The annual MLR report shall be limited to the DBPM's MLR for services provided to Medicaid enrollees and payment received under the contract with the department, separate from any other products the DBPM may offer in the state of Louisiana.

3. An MLR shall be reported in the aggregate, including all services provided under the contract, unless the department requires separate reporting and a separate MLR calculation for specific populations.

a. The MLR shall not be less than 85 percent using definitions for health care services, quality initiatives and administrative cost as specified in 42 CFR 438.8. If the MLR is less than 85 percent, the DBPM will be subject to refund the difference, within the timeframe specified, to the department. The portion of any refund due the department that has not been paid, within the timeframe specified, will be subject to interest at the current Federal Reserve Board lending rate or in the amount of 10 percent per annum, whichever is higher.

4. The department shall provide for an audit of the DBPM's annual MLR report and make public the results within 60 calendar days of finalization of the audit.

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 40:788 (April 2014), amended by the Department of Health, Bureau of Health Services Financing LR 46:953 (July 2020), LR 47:

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.

Dr. Courtney N. Phillips

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Intermediate Care Facilities for
Persons with Intellectual Disabilities
Reimbursement Methodology
(LAC 50:VII.32903)

The Department of Health, Bureau of Health Services Financing proposes has amended LAC 50:VII.32903 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE
Part VII. Long Term Care
Subpart 3. Intermediate Care Facilities for Persons with Intellectual Disabilities

Chapter 329. Reimbursement Methodology

Subchapter A. Non-State Facilities

§32903. Rate Determination

A. – M. ...

N. Pursuant to the provisions of Act 1 of the 2020 First Extraordinary Session of the Louisiana Legislature, effective for dates of service on or after July 1, 2020, private ICF/IID facilities that downsized from over 100 beds to less than 35 beds prior to December 31, 2010 without the benefit of a cooperative endeavor agreement (CEA) or transitional rate and who incurred excessive capital costs, shall have their per diem rates (excluding provider

fees) increased by a percent equal to the percent difference of per diem rates (excluding provider fees) they were paid as of June 30, 2019. See chart below with the applicable percentages:

	Intermittent	Limited	Extensive	Pervasive
1-8 beds	6.2 percent	6.2 percent	6.2 percent	6.1 percent
9-15 beds	3.2 percent	6.2 percent	6.2 percent	6.1 percent
16-32 beds	N/A	N/A	N/A	N/A
33+ beds	N/A	N/A	N/A	N/A

1. The applicable differential shall be applied anytime there is a change to the per diem rates (for example, during rebase, rate reductions, inflationary changes, or special legislative appropriations). This differential shall not extend beyond December 31, 2024.

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 31:2253 (September 2005), amended LR 33:462 (March 2007), LR 33:2202 (October 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:1555 (July 2010), LR 37:3028 (October 2011), LR 39:1780 (July 2013), LR 39:2766 (October 2013), LR 41:539 (March 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 47:

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.

Dr. Courtney N. Phillips

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Medical Transportation Program
Non-Emergency Medical Transportation
(LAC 50:XXVII.541)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XXVII.541 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 Procedures Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 50

PUBLIC HEALTH-MEDICAL ASSISTANCE
Part XXVII. Medical Transportation Program

Chapter 5. Non-Emergency Medical Transportation
Subchapter C. Provider Responsibilities

§541. Provider Enrollment

A. - C. ...

D. As a condition of participation for out-of-state transport, providers of transportation to out-of-state medical or behavioral health services must be in compliance with all applicable federal intrastate commerce laws regarding such transportation, including but not limited to, the $1,500,000 insurance requirement.

E. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 20:1115-1117 (October 1994), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1092 (July 2016), LR 46:694 (May 2020), LR 47:

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.

Dr. Courtney N. Phillips

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Nursing Facilities
Non-Emergency Transportation for Medical Appointments
(LAC 50:II.10137)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:II.10137 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 3. Standards for Payment

Chapter 101. Standards for Payment for Nursing Facilities

Subchapter D. Resident Care Services

§10137. Ancillary Services

A. – D.5. ...

E. Non-Emergency Transportation for Medical Appointments

1. It is the responsibility of the nursing facility to arrange for or provide its residents with non-emergency transportation to all necessary medical appointments when use of an ambulance is not appropriate. This includes wheelchair bound residents and those residents going to therapies and

hemodialysis. Transportation shall be provided to the nearest available qualified provider of routine or specialty care within reasonable proximity to the facility. Residents can be encouraged to utilize medical providers of their choice in the community in which the facility is located when they are in need of transportation services. It is also acceptable if the facility or legal representative/sponsor chooses to transport the resident.

2. If non-emergency transportation is required, and it is medically necessary for the resident to be transported to a necessary medical appointment by ambulance, the nursing facility will be responsible for contacting the appropriate managed care organization (MCO) or fee-for-service (FFS) transportation representative and submitting the completed Certification of Ambulance Transportation form to the MCO or FFS representative prior to the scheduled pick-up time.

F. ...

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 22:34 (January 1996), amended by the Department of Health, Bureau of Health Services Financing, LR 47:

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 if required.

Dr. Courtney N. Phillips

Secretary