RULE

Department of Health
Bureau of Health Services Financing

Federally Qualified Health Centers
Fluoride Varnish Applications
Delegated Appliers
(LAC 50:XI.10301)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XI.10301 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.

Title 50

PUBLIC HEALTH-MEDICAL ASSISTANCE
Part XI. Clinic Services
Subpart 13. Federally-Qualified Health Centers

Chapter 103. Services

§10301. Scope of Services

[Formerly §10501]

A. – C.1.d. ...

e. registered nurses;

f. licensed practical nurses; or

g. certified medical assistants.

2. All participating staff must review the Smiles for Life training module for fluoride varnish and successfully pass the post assessment. All staff involved in the varnish

application must be deemed as competent to perform the service by the FQHC.

a. Physicians shall maintain a copy of the successfully completed post assessment certificate in their files for review, and shall provide the certificate to the department, or its fiscal intermediary, upon request.

b. Approved delegated appliers of fluoride varnish must also complete the training module and their certificates shall be retained on file locally as evidence of training.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:2328 (October 2004), repromulgated LR 30:2487 (November 2004), amended LR 32:1902 (October 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:2629 (September 2011), LR 39:3076 (November 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 42:

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 for Citizens with Developmental Disabilities

Home and Community-Based Services Waivers
New Opportunities Waiver
Emergency Opportunities
(LAC 50:XXI.13709)

The Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities have amended LAC 50:XXI.13709 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.

Title 50

PUBLIC HEALTH-MEDICAL ASSISTANCE
Part XXI. Home and Community Based Services Waivers
Subpart 11. New Opportunities Waiver

Chapter 137. General Provisions

§13709. Emergency Opportunities

A. Requests for emergency waiver services shall be made through the local governing entities (LGEs) responsible for coordination of services for persons with developmental disabilities. When a request for emergency services is received, the LGE shall complete a standardized screening tool that incorporates standardized operational procedures to determine the priority of the individual’s urgency of need in a

fair and consistent manner.

B. To be considered for emergency waiver supports, the individual must need long-term supports, not temporary or short-term supports.

1. - 5. Repealed.

C. Effective for dates of service on or after September 20, 2016, an individual must meet the required criteria within the OCDD standardized screening tool in order to qualify for emergency waiver services.

1. Documentation that any one of the following criteria within the OCDD standardized screening tool has been met will qualify an individual for an emergency waiver opportunity:

a. the caregiver is no longer able to provide support and the individual’s health and/or safety is placed at risk;

b. the individual has no other support available after the death of a caregiver;

c. the caregiver needs immediate assistance to provide support and maintain the individual’s current living situation;

d. the individual has been placed in custody and, as a result, requires essential, community-based supports;

e. the individual requires long term care supports to address imminent risk of incarceration;

f. the individual needs immediate supports to stay in his/her own home;

g. intolerable conditions exist within the residence with an immediate need for a new residential option;

h. the individual's eligibility will expire and/or the individual "ages out" of the program or funding source providing essential supports within the next 90 days; and

i. additional supports are needed to ensure health and safety and/or to keep the individual from being placed in an institutional situation.

D. For individuals who meet the criteria for an emergency waiver opportunity, as determined by the OCDD standardized screening tool, the LGE will forward copies of all documentation used for determination of eligibility for NOW emergency services, including the standardized screening tool, to the appropriate DHH emergency review manager at OCDD.

1. OCDD will verify each qualifying applicant's request for services registry (RFSR) date and assign waiver opportunities in order, based on their protected RFSR dates.

2. In instances when there are more requests than available emergency waiver opportunities, qualifying individuals who have the earliest protected request dates on the NOW RFSR will receive their opportunities first.

3. If there are more applicants than available emergency waiver opportunities, those individuals may reapply

when additional emergency waiver opportunities become available.

E. The LGE will keep all of the supporting documentation used to determine whether an applicant has met emergency waiver criteria.

F. Individuals who do not meet the criteria and are denied an emergency waiver opportunity have the right to an administrative appeal.

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 Community Supports and Services, LR 30:1201 (November 2005), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 40:71 (January 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 42:

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

Hospice Services
(LAC 50:XV.4101)

The Department of Health, Bureau of Health Services Financing, has amended LAC 50:XV.4101 under 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.

Title 50

PUBLIC HEALTH-MEDICAL ASSISTANCE
Part XV. Services for Special Populations
Subpart 3. Hospice

Chapter 41. Prior Authorization

§4101. Prior Authorization of Hospice Services

A. ...

1. The Medicare criteria found in local coverage determination (LCD) hospice determining terminal status (L34538) will be used in analyzing information provided by the hospice to determine if the patient meets clinical requirements for this program.

A.2. – D. ...

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 by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:131 (January 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 42:

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Managed Care for Physical and Behavioral Health
Non-Emergency Medical Transportation
(LAC 50:I.3103)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:I.3103 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.

Title 50

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

Chapter 31. General Provisions

§3103. Recipient Participation

A. – B. ...

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

B.1.a. – D. ...

E. Mandatory MCO Populations - Specialized Behavioral Health Services and Non-Emergency Ambulance Services Only

1. The following populations are mandatory enrollees in Bayou Health for specialized behavioral health services and non-emergency ambulance services only:

a. – b. ...

F. Mandatory MCO Populations - Specialized Behavioral Health and NEMT Services (Ambulance and Non-Ambulance) Only

F.1. – I. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1573 (June 2011), amended LR 40:310 (February 2014), LR 40:1096 (June 2014), LR 40:2258 (November 2014), LR 41:929 (May 2015), LR 41:2363 (November 2015), LR 42:754 (May 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 42:

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Nursing Facilities
Reimbursement Methodology
(LAC 50:II.20001)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:II.20001 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.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE
Part II. Nursing Facilities
Subpart 5. Reimbursement

Chapter 200. Reimbursement Methodology

§20001. General Provisions

A. Definitions

Administrative and Operating Cost Component—the portion of the Medicaid daily rate that is attributable to the general administration and operation of a nursing facility.

Assessment Reference Date—the date on the minimum data set (MDS) used to determine the due date and delinquency of assessments. This date is used in the case-mix reimbursement system to determine the last assessment for each resident

present in the facility and is included in the quarterly case-mix report.

Base Resident—Weighted Median Costs and Prices-the resident-weighted median costs and prices calculated in accordance with §20005 of this rule during rebase years.

Calendar Quarter—a three-month period beginning January 1, April 1, July 1, or October 1.

Capital Cost Component—the portion of the Medicaid daily rate that is:

a. attributable to depreciation;

b. capital related interest;

c. rent; and/or

d. lease and amortization expenses.

Care Related Cost Component—the portion of the Medicaid daily rate that is attributable to those costs indirectly related to providing clinical resident care services to Medicaid recipients.

Case Mix-a measure of the intensity of care and services used by similar residents in a facility.

Case-Mix Index (CMI)—a numerical value that describes the resident's relative resource use within the groups under the resource utilization group (RUG-III) classification system, or its successor, prescribed by the department based on the resident's MDS assessments. Two average CMIs will be determined

for each facility on a quarterly basis, one using all residents (the facility average CMI) and one using only Medicaid residents (the Medicaid average CMI).

Case-Mix MDS Documentation Review (CMDR) —a review of original legal medical record documentation on a randomly selected MDS assessment sample. The original legal medical record documentation supplied by the nursing facility is to support certain reported values that resulted in a specific RUG classification. The review of the documentation provided by the nursing facility will result in the RUG classification being supported or unsupported.

Cost Neutralization—refers to the process of removing cost variations associated with different levels of resident case mix. Neutralized cost is determined by dividing a facility's per diem direct care costs by the facility cost report period case-mix index.

Delinquent MDS Resident Assessment—an MDS assessment that is more than 121 days old, as measured by the assessment reference date (ARD) field on the MDS.

Direct Care Cost Component—the portion of the Medicaid daily rate that is attributable to:

a. registered nurse (RN), licensed practical nurse (LPN) and nurse aide salaries and wages;

b. a proportionate allocation of allowable

employee benefits; and

c. the direct allowable cost of acquiring RN, LPN and nurse aide staff from outside staffing companies.

Facility Cost Report Period Case—Mix Index-the average of quarterly facility-wide average case-mix indices, carried to four decimal places. The quarters used in this average will be the quarters that most closely coincide with the facility's cost reporting period that is used to determine the medians. This average includes any revisions made due to an on-site CMDR.

Example: A January 1, 2011-December 31, 2011 cost report period would use the facility-wide average case-mix indices calculated for March 31, 2011, June 30, 2011, September 30, 2011 and December 31, 2011.

Facility-Wide Average Case—Mix Index-the simple average, carried to four decimal places, of all resident case-mix indices based on the last day of each calendar quarter. If a facility does not have any residents as of the last day of a calendar quarter or the average resident case-mix indices appear invalid due to temporary closure or other circumstances, as determined by the department, a statewide average case-mix index using occupied and valid statewide facility case-mix indices may be used.

Final Case-Mix Index Report (FCIR) —the final report that reflects the acuity of the residents in the nursing

facility on the last day of the calendar quarter, referred to as the point-in-time.

Index Factor—will be based on the *Skilled Nursing Home without Capital Market Basket Index* published by Data Resources Incorporated (DRI-WEFA), or a comparable index if this index ceases to be published.

MDS Supportive Documentation Guidelines—the department's publication of the minimum medical record documentation guidelines for the MDS items associated with the RUG-III or its successor classification system. These guidelines shall be maintained by the department and updated and published as necessary.

Minimum Data Set (MDS)—a core set of screening and assessment data, including common definitions and coding categories that form the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in the Medicaid Program. The items in the MDS standardize communication about resident problems, strengths, and conditions within facilities, between facilities, and between facilities and outside agencies. The Louisiana system will employ the current MDS assessment required and approved by the Centers for Medicare and Medicaid Services (CMS).

Pass-Through Cost Component-includes the cost of

property taxes and property insurance. It also includes the provider fee as established by the Department of Health.

Preliminary Case Mix Index Report (PCIR)—the preliminary report that reflects the acuity of the residents in the nursing facility on the last day of the calendar quarter.

Rate Year-a one-year period from July 1 through June 30 of the next calendar year during which a particular set of rates are in effect. It corresponds to a state fiscal year.

Resident-Day-Weighted Median Cost—a numerical value determined by arraying the per diem costs and total actual resident days of each nursing facility from low to high and identifying the point in the array at which the cumulative total of all resident days first equals or exceeds half the number of the total resident days for all nursing facilities. The per diem cost at this point is the resident-day-weighted median cost.

RUG-III Resident Classification System—the resource utilization group used to classify residents. When a resident classifies into more than one RUG-III, or its successor's group, the RUG-III or its successor's group with the greatest CMI will be utilized to calculate the facility average CMI and Medicaid average CMI.

Summary Review Results Letter—a letter sent to the nursing facility that reports the final results of the case-mix MDS documentation review and concludes the review.

a. The summary review results letter will be sent to the nursing facility within 10 business days after the final exit conference date.

Supervised Automatic Sprinkler System—a system that operates in accordance with the latest adopted edition of the National Fire Protection Association's *Life Safety Code*. It is referred to hereafter as a *fire sprinkler system*.

Two-Hour Rated Wall—a wall that meets American Society for Testing and Materials International (ASTM) E119 standards for installation and uses two-hour rated sheetrock.

Unsupported MDS Resident Assessment—an assessment where one or more data items that are used to classify a resident pursuant to the RUG-III, 34-group, or its successor's resident classification system is not supported according to the MDS supporting documentation guidelines and a different RUG-III, or its successor, classification would result; therefore, the MDS assessment would be considered "unsupported."

B. Effective for the rate period of July 1, 2015 through June 30, 2016, the department shall suspend the provisions of LAC 50:II.Chapter 200 governing the reimbursement methodology for nursing facilities and imposes the following provisions

governing reimbursements for nursing facility services.

1. During this time period, no inflation factor will be applied to the base resident day weighted medians and prices calculated as of July 1, 2014.

2. All costs and cost components that are required by rule to be trended forward will only be trended forward to the midpoint of the 2015 state fiscal year (December 31, 2014).

3. The base capital per square foot value, land value per square foot, and per licensed bed equipment value utilized in the calculation of the fair rental value (FRV) component will be set equal to the value of these items as of July 1, 2014.

4. Base capital values for the Bed Buy-Back program (§20012) purposes will be set equal to the value of these items as of July 1, 2014.

5. Nursing facility providers will not have their weighted age totals for the FRV component calculation purposes increased by one year as of July 1, 2015.

6. As of the July 1, 2016 rate setting, nursing facility provider weighted age totals for the FRV component calculation purposes will be increased by two years to account for the suspended year of aging occurring as of the July 1, 2015 rating period.

7. No other provisions of LAC 50:II.Chapter 200

shall be suspended for this time period.

Base Resident-Repealed.

Calendar Quarter—Repealed.

Capital Cost Component-Repealed.

1. – 4. Repealed.

Care Related Cost Component-Repealed.

Case Mix-Repealed.

Case-Mix Index-Repealed.

Case-Mix MDS Documentation Review (CMDR)-Repealed.

Cost Neutralization-Repealed.

Delinquent MDS Resident Assessment-Repealed.

Direct Care Cost Component-Repealed.

1. – 3. Repealed.

Facility Cost Report Period Case-Mix Index-Repealed.

Example: Repealed.

Facility-Wide Average Case-Mix Index-Repealed.

Final Case-Mix Index Report (FCIR)-Repealed.

Index Factor-Repealed.

Minimum Data Set (MDS)-Repealed.

MDS Supportive Documentation Guidelines-Repealed.

Pass-Through Cost Component-Repealed.

Preliminary Case Mix Index Report (PCIR)-Repealed.

Rate Year-Repealed.

Resident-Day-Weighted Median Cost-Repealed.

RUG-III Resident Classification System—Repealed.

Summary Review Results Letter-Repealed.

1. Repealed.

Supervised Automatic Sprinkler System—Repealed.

Two-Hour Rated Wall—Repealed.

Unsupported MDS Resident Assessment-Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 46:2742, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1790 (August 2002), amended LR 28:2537 (December 2002), LR 32:2262 (December 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:825 (March 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 42:

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Professional Services Program
Fluoride Varnish Applications
Delegated Appliers
(LAC 50:IX.905)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:IX.905 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.

Title 50

PUBLIC HEALTH-MEDICAL ASSISTANCE
Part IX. Professional Services Program
Subpart 1. General Provisions

Chapter 9. Fluoride Varnish Application Services

§905. Provider Participation

A. – B.4. ...

5. registered nurses;

6. licensed practical nurses; or

7. certified medical assistants.

C. Professional service providers must review the Smiles for Life training module for fluoride varnish and successfully pass the post assessment.

1. Physicians shall maintain a copy of the successfully completed post assessment certificate in their files for review, and

shall provide the certificate to the department, or its fiscal intermediary, upon request.

2. Approved delegated appliers of fluoride varnish must also complete the training module and their certificates shall be retained on file locally as evidence of training.

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 40:315 (February 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 42:

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

Rural Health Clinics
Fluoride Varnish Applications
Delegated Appliers
(LAC 50:XI.16301)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XI.16301 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.

Title 50
PUBLIC HEALTH-MEDICAL ASSISTANCE
Part XI. Clinic Services
Subpart 15. Rural Health Clinics

Chapter 163. Services

§16301. Scope of Services

[Formerly §16501]

A. – C.1.d

e. registered nurses;

f. licensed practical nurses; or

g. certified medical assistants.

2. All participating staff must review the Smiles for Life training module for fluoride varnish and successfully

pass the post assessment. All staff involved in the varnish application must be deemed as competent to perform the service by the RHC.

a. Physicians shall maintain a copy of the successfully completed post assessment certificate in their files for review, and shall provide the certificate to the department, or its fiscal intermediary, upon request.

b. Approved delegated appliers of fluoride varnish must also complete the training module and their certificates shall be retained on file locally as evidence of training.

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 32:1905 (October 2006), repromulgated LR 32:2267 (December 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:2631 (September 2011), amended by the Department of Health, Bureau of Health Services Financing. LR 40:83 (January 2014), LR 42:

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