NOTICE OF INTENT

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

Act 421 Children's Medicaid Option
(LAC 50:I.3103, III.2331, and XXII.Chapters 81-85)

The Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities propose to amend LAC 50:I.3103, adopt III.2331, and repeal XXII.Chapters 81-85 in the Medical Assistance Program as authorized by R.S. 36:254, 46:977.21-977.25 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Act 421 of the 2019 Regular Session of the Louisiana Legislature directed the Department of Health to establish the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) option within the Medical Assistance Program through which children with disabilities can access Medicaid-funded services regardless of their parents' income. In compliance with Act 421, the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities adopted provisions to establish the Act 421 Children's Medicaid Option (421-CMO) program as a Section 1115 demonstration waiver (*Louisiana Register*, Volume 46, Number 12, repromulgated

Louisiana Register, Volume 47, Number 1) subject to the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. The department has now decided to include 421-CMO as an optional eligibility group under the Medicaid State Plan instead of implementing the program as a Section 1115 demonstration waiver. The department proposes to repeal the provisions of the Act 421 Children's Medicaid Option waiver program in order to adopt provisions establishing Act 421 Children's Medicaid Option as an optional Medicaid eligibility group.

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. The following Medicaid recipients shall be mandatory participants in ~~coordinated~~ managed care ~~networks~~:

1. mandatory enrollees:

a. - i. ...

j. individuals and families who have more income than is allowed for Medicaid eligibility, but who meet the standards for the Regular Medically Needy Program; ~~or~~

k. individuals from age 19 to 65 years old at or below 133 percent of the federal poverty level with a 5

percent income disregard as provided in 42 CFR 435.119, hereafter referred to as the new adult group~~.~~; or

1. individuals eligible through the Act 421 Children's Medicaid Option (421-CMO) program.

B. ...

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

a. – a.vi. ...

b. individuals under the age of 21 who are otherwise eligible for Medicaid, and who are listed on the DHH Office for Citizens with Developmental Disabilities' request for services registry and not enrolled in the 421-CMO. These children are identified as Chisholm class members:

B.1.b.i. – I. ...

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

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

41:2363 (November 2015), LR 42:754 (May 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1522 (September 2016), LR 43:663 (April 2017), LR 43:1553 (August 2017), LR 44:1253 (July 2018), LR 47:

Part III. Eligibility
Subpart 3. Eligibility Groups and Factors

Chapter 23. Eligibility Groups and Medicaid Programs

§2331. Act 421 Children's Medicaid Option (TEFRA/Katie Beckett)

A. General Provisions

1. 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.

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

B. Eligibility Requirements. In order to qualify for the 421-CMO program, an individual must meet both programmatic and clinical eligibility requirements set forth herein.

`1. Programmatic Eligibility Requirements. In order to be eligible for the 421-CMO program, an individual must meet all of the following criteria:

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

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

c. is a Louisiana resident;

d. has or has applied for a Social Security Number;

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

i. only the applicant/421-CMO enrollee's resources shall be considered in determining eligibility for the 421-CMO program;

f. 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);

i. only the applicant/421-CMO enrollee's income shall be considered in determining eligibility for the 421-CMO program;

g. has care needs that can be safely met at home at a lower cost than the cost of services provided in an institutional setting; and

h. is not otherwise eligible for Medicaid or CHIP.

2. Clinical Eligibility Requirements. In order to be eligible for the 421-CMO program, an individual must meet all of the following criteria:

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

b. requires 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;

i. an individual meets ICF/IID level of care when he/she:

(a). has obtained a statement of approval from the Office for Citizens with Developmental Disabilities or its designee, 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 Form 90-L;

ii. an individual meets nursing facility level of care when he/she demonstrates one of the following two

standards, assessed in accordance with the Act 421 children's Medicaid option assessment tool:

(a). Standard I

(i). the need for skilled nursing and/or therapeutic interventions on a regular and sustained basis; and

(ii). substantial functional limitations as compared to same age peer group in two of the following areas: learning, communication, self-care, mobility, social competency, money management (for children 18 and older), work, and meal preparation;

(b). Standard II

(i). substantial functional limitations as compared to same age peer group in four of the following areas: learning, communication, self-care, mobility, social competency, money management (for children 18 and older), work, and meal preparation;

iii. an individual meets hospital level of care when he/she demonstrates the following, assessed in accordance with the Act 421 children's Medicaid 0ption assessment tool:

(a). the need for frequent and complex medical care that requires the use of equipment to prevent life-

threatening situations, with skilled medical care required multiple times during each 24-hour period;

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

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

C. Ineligibility for Services

1. 421-CMO enrollees shall be terminated from the 421-CMO program if admitted to an ICF/IID, nursing facility, or hospital without the intent to return to 421-CMO services.

a. A 421-CMO enrollee is deemed to intend to return to 421-CMO services when documentation is received from the treating physician that the admission is temporary and shall not exceed 90 days

b. The 421-CMO enrollee will be discharged from the 421-CMO program on the ninety-first day after admission if the 421-CMO enrollee is still in the ICF/IID, nursing facility, or hospital.

D. Cost Effectiveness

1. On an annual basis, each 421-CMO enrollee'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:

Part XXII. 1115 Demonstration Waivers
Subpart 9. Act 421 Children's Medicaid Option

Chapter 81. General Provisions

§8101. Purpose

~~A. The purpose of the Act 421 Children's Medicaid Option (421-CMO) program is to provide Medicaid State Plan services to children with disabilities who meet the eligibility criteria set forth in this Subpart, despite parental or household income that would otherwise exclude them from Medicaid eligibility.~~

~~B. The Department of Health (LDH) has expenditure authority under section 1115 of the Social Security Act (Act) to claim as medical assistance the costs of services provided under~~

~~a risk contract to eligible individuals. Through this section 1115 demonstration, the State is allowed to permit Medicaid managed care organizations (MCOs) to provide Medicaid State Plan services to children with disabilities regardless of their parents' and/or household income. LDH shall, subject to the approval of the Centers for Medicare and Medicaid Services (CMS), institute a program to provide health care services via the State's Medicaid program for the population contemplated under Section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248), subject to additional terms and conditions set forth in this Subpart.~~

~~C. 421-CMO enrollees are eligible for all medically necessary Medicaid State Plan services.~~

~~D. The number of enrollees in the 421-CMO program is contingent upon the amount appropriated by the Louisiana legislature annually for that purpose.~~Repealed.

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 and the Office for Citizens with Developmental Disabilities, LR 46:1676 (December 2020), repromulgated LR 47:43 (January 2021), repealed LR 47:

§8103. Effective Date and Administration

~~A. Services provided under the 421-CMO program shall begin upon approval of expenditure authority under section 1115 of the Act by CMS.~~

~~B. Upon approval by CMS, enrollment and start of services will commence at the beginning of the first calendar quarter after conclusion of the initial registration period.~~

~~C. The 421-CMO program shall be administered as a section 1115 demonstration waiver under the authority of LDH, in collaboration with the Healthy Louisiana MCOs.~~

~~D. The 421-CMO program is a demonstration waiver that will span five years. LDH may request approval for an extension of this section 1115 demonstration from CMS prior to the expiration date.~~Repealed.

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 and the Office for Citizens with Developmental Disabilities, LR 46:1677 (December 2020), repromulgated LR 47:43 (January 2021), repealed LR 47:

§8105. Enrollee Qualifications and Admissions Criteria

~~A. In order to qualify for the 421-CMO program, an individual must meet both programmatic eligibility and clinical eligibility criteria as set forth in this Subpart.~~

~~B. Programmatic eligibility. In order to be programmatically eligible for the 421-CMO program, an individual must meet all of the following criteria:~~

~~1. Is 18 years of age or younger (under 19 years of age).~~

~~2. Is a U.S. Citizen or qualified alien.~~

~~3. Is a Louisiana resident.~~

~~4. Has or has applied for a Social Security Number.~~

~~5. Has countable resources of $2,000 or less (parental/household resources not considered).~~

~~6. Has care needs that can be safely met at home at a lower cost than the cost of services provided in an institutional setting.~~

~~7. Maintains pre-existing private health insurance for major medical coverage, either through employer sponsored insurance, the federal marketplace, or other independently purchased commercial health insurance, unless a hardship exception is applied for and granted by LDH.~~

~~a. LDH will employ a look-back period of one 180 days to determine pre-existing private health insurance.~~

~~b. Lock-out period. If LDH determines that a family or responsible adult has discontinued pre-existing private health insurance, either during the look-back period or~~

~~at any time during the enrollee's enrollment in the 421-CMO program, LDH will impose a lock-out.~~

~~c. During the lock-out period, the enrollee will be unable to receive services, but will retain his or her enrollment in the 421-CMO program.~~

~~d. The lock-out period will end when the enrollee demonstrates new or former pre-existing private health insurance has been re-instated.~~

~~e. The lock-out period will extend up to 180 days from discontinuation of pre-existing private health insurance or 421-CMO program offer, whichever date is later.~~

~~f. At the conclusion of the 180-day lock-out period, if the enrollee has not re-instated the pre-existing private health insurance, the enrollee will be terminated from the 421-CMO program.~~

~~g. If terminated, the individual can re-register for the 421-CMO program and be placed on the 421-CMO registry as a new applicant.~~

~~h. Hardship Exception. The enrollee can apply for a hardship exception at any time, including during a lock-out period.~~

~~i. A hardship exists when:~~

~~(a). private health insurance premiums and any additional deductibles and co-payments or out of pocket~~

~~healthcare costs for the individual obtaining coverage equal or exceed 5 percent of the household income;~~

~~(b). unemployment resulting in loss of employer-sponsored private insurance for the child; or~~

~~(c). an exemption period of 90 days for transition to new employment, after which the enrollee must resume private health insurance.~~

~~ii. LDH's grant of a hardship exception will end the lock-out period.~~

~~8. Is not otherwise eligible for Medicaid or CHIP.~~

~~C. Clinical eligibility. In order to be clinically eligible for the 421-CMO program, an individual must meet all of the following criteria:~~

~~1. Has a disability, defined as a medically determinable physical or mental impairment (or combination of impairments) that:~~

~~a. results in marked and severe functional limitations; and~~

~~b. has lasted or is expected to last for at least one year or to result in death.~~

~~2. Meets the medical necessity requirement, assessed on an annual basis, for institutional placement in an intermediate care facility for individuals with intellectual disabilities (ICF/IID), a nursing facility, or a hospital.~~

~~a. An individual meets ICF/IID level of care when he/she:~~

~~i. has obtained a statement of approval from the Office for Citizens with Developmental Disabilities, confirming that he has a developmental disability as defined in R.S. 28:451.2; and~~

~~ii. meets the requirements for active treatment of a developmental disability under the supervision of a qualified developmental disability professional, as prescribed on Form 90-L.~~

~~b. An individual meets nursing facility level of care when he demonstrates the following, assessed in accordance with the Act 421 Children's Medicaid Option Assessment Tool:~~

~~i. the need for skilled nursing and/or therapeutic interventions on a regular and sustained basis; and~~

~~ii. substantial functional limitations as compared to same age peer group in two of the following areas: learning, communication, self-care, mobility, social competency, money management (for children 18 and older), work, and meal preparation.~~

~~c. An individual meets hospital level of care when he demonstrates the following, assessed in accordance with the Act 421 Children's Medicaid Option Assessment Tool:~~

~~i. frequent and complex medical care that requires the use of equipment to prevent life-threatening situations, with skilled medical care required multiple times during each 24-hour period;~~

~~ii. complex skilled medical interventions that are expected to persist for at least six months; and~~

~~iii. overall health condition that is highly unstable and presents constant potential for complications or rapid deterioration, with the result that the child requires continuous assessment by professional nurses, parents, or other properly instructed individuals, in order to detect unstable and life-threatening condition and respond promptly with appropriate care.~~Repealed.

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 and the Office for Citizens with Developmental Disabilities, LR 46:1677 (December 2020), repromulgated LR 47:43 (January 2021), repealed LR 47:

§8107. Admission Denial or Discharge Criteria

~~A. Individuals shall be denied admission to or discharged from 421-CMO program if any of the following criteria is met:~~

~~1. the individual does not meet the programmatic eligibility requirements for the 421-CMO program;~~

~~2. the individual does not meet the clinical eligibility requirements for the 421-CMO program;~~

~~3. the individual is incarcerated or placed under the jurisdiction of penal authorities, courts or state juvenile justice authorities;~~

~~4. the individual resides in another state or has a change of residence to another state;~~

~~5. the individual or responsible adult fails to cooperate in the eligibility determination/re-determination process; or~~

~~6. the 421-CMO enrollee is admitted to an ICF/IID, nursing facility, or hospital with the intent to not return to 421-CMO services;~~

~~a. the enrollee is deemed to intend to return to 421-CMO services when documentation is received from the treating physician that the admission is temporary and shall not exceed ninety (90) days;~~

~~b. the enrollee will be discharged from 421-CMO on the ninety-first (91st) day after admission if the enrollee is still in the ICF/IID, nursing facility, or hospital.~~Repealed.

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 and the Office for Citizens with Developmental Disabilities, LR 46:1678 (December 2020), repromulgated LR 47:44 (January 2021), repealed LR 47:

§8109. Allocation of Act 421 Children's Medicaid Option Opportunities

~~A. The Act 421 Children's Medicaid Option request for services registry, hereafter referred to as the 421-CMO registry, shall be used to identify persons who meet ICF/IID, nursing facility, or hospital level of care who are waiting for a 421-CMO program slot. Individuals who are found eligible and who request 421-CMO program services will be added to the 421-CMO registry. Funded 421-CMO program slots will be offered in accordance with this Subpart.~~

~~B. Initial Registration~~

~~1. There will be an initial registration period lasting one month, during which time registration will occur in two pathways:~~

~~a. Online registration forms will be taken from individuals who are not currently on the~~

~~intellectual/developmental disabilities (I/DD) request for services registry or otherwise enrolled in Medicaid.~~

~~b. Children 18 years of age and under (under 19) who are on the I/DD request for services registry and are not currently enrolled in Medicaid or CHIP will be automatically registered for participation.~~

~~i. Individuals receiving automatic placement on the 421-CMO registry will receive a preprinted mailed form explaining the 421-CMO program and that they are automatically registered. The form will provide them with the opportunity to opt out of participation, and if they do not opt out, attest to prioritization needs per the process set forth in this Subpart.~~

~~2. LDH will create a numerically ordered 421-CMO registry based on individuals that registered during the initial registration period, placing them in random order.~~

~~3. Individuals registered during the initial registration period will receive 421-CMO program offers according to the prioritization process established in this Subpart first. Once priority offers are complete, 421-CMO program offers will then be made in numeric order of the 421-CMO registry.~~

~~4. Individuals who do not receive 421-CMO program offers will remain on the 421-CMO registry in the numeric order~~

~~assigned, with a protected registry date corresponding to the close of the initial registration period.~~

~~C. Ongoing Registration. After the initial registration period and slot allocation, subsequent registrants for the 421-CMO program will be assigned a 421-CMO registry date based on the date on which they register and will receive an offer on a first-come, first-served basis unless otherwise prioritized as provided for in this Subpart. 421-CMO program offers will be made upon availability.~~

~~D. Prioritization~~

~~1. In order to ensure individuals with the most urgent needs receive services, LDH will prioritize 421-CMO program offers to individuals who meet either of the following criteria:~~

~~a. The individual has been institutionalized in an ICF/IID, nursing facility, or hospital for 30 of the preceding 90 days. Institutional days do not have to be consecutive.~~

~~b. On three or more separate occasions in the preceding 90 days, the individual has been admitted to an ICF/IID, nursing facility, or hospital and remained institutionalized for at least 24 hours.~~

~~2. An individual newly registering for 421-CMO program during ongoing registration may request and, if the~~

~~individual qualifies, receive prioritization in order to receive the next available 421-CMO program offer. In addition, at any time an individual currently on the 421-CMO registry may request and, if the individual qualifies, receive prioritization.~~

~~3. Prioritization will be considered valid for a period of 180 days from the date that prioritization is approved while waiting for a 421-CMO program offer. At the expiration of the 180 days, if no 421-CMO program offer has been made, the individual loses prioritization but retains his or her original protected registry date for purposes of receiving a 421-CMO program offer.~~

~~a. If an individual's priority period has expired with no 421-CMO program offer available during that time period, he or she may request to requalify for prioritization.~~

~~i. If the individual qualifies without a break in the two priority periods (they are consecutive), he/she shall retain the original prioritization date.~~

~~ii. If the individual qualifies with a break in the priority periods, he/she shall receive a new prioritization date.~~

~~b. There is no limit on the number of times an individual may qualify for prioritization prior to receiving a 421-CMO program offer.~~

~~c. If more than one individual has received prioritization at one time, the next available 421-CMO program offer will be made to the individual with the earliest prioritization date.~~

~~4. Once enrolled in the 421-CMO program, enrollees will not be required to demonstrate ongoing need for prioritization. Prioritization is only a method of fast-tracking initial entry into the 421-CMO program for families with the highest urgency of need.~~Repealed.

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 and the Office for Citizens with Developmental Disabilities, LR 46:1678 (December 2020), repromulgated LR 47:44 (January 2021), repealed LR 47:

§8111. Eligibility and Enrollment

~~A. Upon extension of a 421-CMO program offer to an individual, the individual will need to establish programmatic and clinical eligibility by showing he or she meets all eligibility criteria. When eligibility is determined, the individual will be enrolled in the 421-CMO program and with a health and dental plan of their choice.~~

~~B. Louisiana Health Insurance Premium Payment Program (LaHIPP)~~

~~1. Enrollees in the 421-CMO program shall be enrolled in LaHIPP when cost-effective health plans are available through the individual's employer or a responsible party's employer-based health plan or other health insurance if the individual is enrolled or eligible for such a health plan.~~

~~2. All requirements and coverage through the LaHIPP program shall follow the provisions set forth in LAC 50:III.2311 except that 421-CMO program enrollees enrolled in LaHIPP shall receive their Medicaid benefits through managed care.~~Repealed.

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 and the Office for Citizens with Developmental Disabilities, LR 46:1679 (December 2020), repromulgated LR 47:45 (January 2021), repealed LR 47:

Chapter 83. Services

§8301. Covered Services

~~A. The coverage of 421-CMO services under the scope of this demonstration are all services offered under the Louisiana Medicaid State Plan.~~

~~B. All 421-CMO services must be medically necessary. The medical necessity for services shall be determined by a licensed professional or physician who is acting within the scope of his/her professional license and applicable state law.~~Repealed.

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 and the Office for Citizens with Developmental Disabilities, LR 46:1679 (December 2020), repromulgated LR 47:46 (January 2021), repealed LR 47:

§8303. Service Delivery

~~A. Louisiana's Act 421 Children's Medicaid Option delivery system is based on an integrated managed care model for physical and behavioral health services. Under this demonstration, Healthy Louisiana will continue to operate as approved in Section 1932(a) state plan authority for managed care and concurrent 1915(b) demonstration.~~

~~B. Enrollees in the 421-CMO program shall be mandatorily enrolled in Healthy Louisiana and in a dental benefits prepaid ambulatory health plan. They shall have the opportunity to choose a health and dental plan upon application. If they do not choose a plan, one will be automatically assigned to them upon~~

~~enrollment per the current methodology outlined in the Medicaid State Plan.~~

~~C. Enrollees shall be designated as a special health care needs group, entitling recipients to receive case management and enhanced care coordination through their managed care plan.~~

~~D. All of the covered services under the 421-CMO program shall be delivered in accordance with the Medicaid State Plan.~~Repealed.

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 and the Office for Citizens with Developmental Disabilities, LR 46:1679 (December 2020), repromulgated LR 47:46 (January 2021), repealed LR 47:

Chapter 85. Reimbursement

§8501. Reimbursement Methodology

~~A. For 421-CMO program enrollees, LDH or its fiscal intermediary shall make monthly capitation payments to the managed care organizations (MCOs) and dental benefits prepaid ambulatory health plans for the provision of all covered services. The capitation rates paid to the MCOs and dental benefits prepaid ambulatory health plans shall be actuarially sound rates, and the MCOs and dental benefits prepaid ambulatory~~

~~health plans will determine the rates paid to its contracted providers. No payment shall be less than the minimum Medicaid fee-for-service fee schedule on file.~~Repealed.

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 and the Office for Citizens with Developmental Disabilities, LR 46:1680 (December 2020), repromulgated LR 47:46 (January 2021), repealed 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.

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have a positive impact on family functioning, stability and autonomy as described in R.S. 49:972 as it will provide access to Medicaid services for qualified children with disabilities.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have positive impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973 as it provides access to Medicaid services for qualified children with disabilities.

Small Business Analysis

In compliance with Act 820 of the 2008 Regular Session of the Louisiana Legislature, the economic impact of this proposed Rule on small businesses has been considered. It is anticipated that this proposed Rule may have a positive impact on small businesses, as described in R.S. 49:965.2 et seq., since it permits Medicaid reimbursement for the provision of services to qualified children with disabilities.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, but may reduce the total direct and indirect cost to the provider to provide the same level of service, and may enhance the provider's ability to

provide the same level of service as described in HCR 170 since this proposed Rule permits Medicaid reimbursement for the provision of services to qualified children with disabilities.

Public Comments

Interested persons may submit written comments to Patrick Gillies, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821—9030. Mr. Gillies is responsible for responding to inquiries regarding this proposed Rule. The deadline for submitting written comments is at 4:30 p.m. on October 30, 2021.

Public Hearing

Interested persons may submit a written request to conduct a public hearing by U.S. mail to the Office of the Secretary ATTN: LDH Rulemaking Coordinator, Post Office Box 629, Baton Rouge, LA 70821-0629; however, such request must be received no later than 4:30 p.m. on October 12, 2021. If the criteria set forth in R.S. 49:953(A)(2)(a) are satisfied, LDH will conduct a public hearing at 9:30 a.m. on October 28, 2021 in Room 118 of the Bienville Building, which is located at 628 North Fourth Street, Baton Rouge, LA. To confirm whether or not a public hearing will be held, interested persons should first call Allen Enger at (225) 342-1342 after October 12, 2021. If a public hearing is to be held, all interested persons are invited to attend and present data, views, comments, or arguments, orally

or in writing. In the event of a hearing, parking is available to the public in the Galvez Parking Garage, which is located between North Sixth and North Fifth/North and Main Streets (cater-corner from the Bienville Building). Validated parking for the Galvez Garage may be available to public hearing attendees when the parking ticket is presented to LDH staff at the hearing.

Dr. Courtney N. Phillips

Secretary