

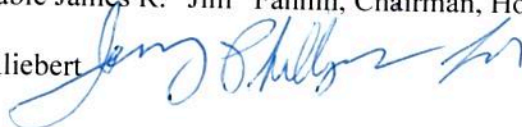


State of Louisiana
Department of Health and Hospitals
Office of the Secretary

March 7, 2014

MEMORANDUM

TO: The Honorable John A. Alario, President, Louisiana Senate
The Honorable Chuck Kleckley, Speaker of the House
The Honorable David Heitmeir, Chair, Senate Committee on Health and Welfare
The Honorable Scott Simon, Chair, House Committee on Health and Welfare
The Honorable Jack Donahue, Chair, Senate Finance Committee
The Honorable James R. "Jim" Fannin, Chairman, House Appropriations Committee

FROM: Kathy H. Kliebert
Secretary 

RE: Oversight Report on Bureau of Health Services Financing Proposed Rulemaking

In accordance with the Administrative Procedure Act (R.S. 49:950 et seq.) as amended, we are submitting the attached documents for the proposed Rule for Dental Benefits Prepaid Ambulatory Health Plan.

The Department published a Notice of Intent on this proposed Rule in the January 20, 2014 issue of the *Louisiana Register* (Volume 40, Number 1). A public hearing was held on February 26, 2014 at which only Department of Health and Hospitals staff were present. No oral testimony was given, nor written correspondence received, regarding this proposed Rule.

The Department anticipates adopting the Notice of Intent as a final Rule in the April 20, 2014 issue of the *Louisiana Register*.

The following documents are attached:

1. a copy of the Notice of Intent;
2. the public hearing certification; and
3. the public hearing attendance roster.

KHK/JP/CEC

Attachments (3)

NOTICE OF INTENT

**Department of Health and Hospitals
Bureau of Health Services Financing**

**Dental Benefits Prepaid Ambulatory Health Plan
(LAC 50:I.Chapter 21)**

The Department of Health and Hospitals, Bureau of Health Services Financing adopts LAC 50:Chapter 21 in the Medical Assistance Program as authorized by R.S. 36:254 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.

The Department of Health and Hospitals, Bureau of Health Services Financing currently provides coverage and reimbursement for dental services rendered to Medicaid recipients through its fee-for-service delivery system. In June 2010, the department implemented a coordinated system of care in the Medicaid Program designed to improve quality of care and health care outcomes through a healthcare delivery system called coordinated care networks, also known as the BAYOU HEALTH Program (*Louisiana Register*, Volume 37, Number 6).

In order to build on the successes achieved in the establishment of the BAYOU HEALTH Program, the department has now determined that it is necessary to adopt provisions to implement a coordinated dental services system under the Medicaid Program to provide dental services through a statewide dental benefits prepaid ambulatory health plan (PAHP) administrator. Dental services administered through the PAHP

are expected to enhance service quality, facilitate access to dental services, and effectively manage costs in the Dental Program.

Title 50

PUBLIC HEALTH-MEDICAL ASSISTANCE

Part I. Administration

Subpart 3. Medicaid Coordinated Care

Chapter 21. Dental Benefits Prepaid Ambulatory Health Plan

§2101. General Provisions

A. Effective May 1, 2014, the Department of Health and Hospitals, Bureau of Health Services Financing shall adopt provisions to establish a comprehensive system of delivery for dental services covered under the Medicaid Program. The dental benefits plan shall be administered under the authority of a 1915(b) Waiver by implementing a prepaid ambulatory health plan (PAHP) which shall be responsible for the necessary operational and administrative functions to ensure adequate service coordination and delivery.

B. All Medicaid recipients that are receiving dental services through the fee-for-service system will receive dental services administered by a dental benefit plan manager (DBPM).

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:

§2103. Participation Requirements

A. In order to participate in the Medicaid Program, a DBPM must be a successful bidder, be awarded a contract with the department, and complete the readiness review.

B. A DBPM must:

1. meet the federal definition of a PAHP as defined in 42 CFR §438.2;
2. have a license or certificate of authority issued by the Louisiana Department of Insurance to operate as a Medicaid risk bearing "prepaid entity" pursuant to R.S. 22:1016 and submit with the proposal response;
3. have a certificate from the Louisiana Secretary of State, to conduct business in the state;
4. meet solvency standards as specified in federal regulations and Title 22 of the Louisiana Revised Statutes;
5. have a network capacity to enroll a minimum of 1,288,625 Medicaid members into the network;
6. is without an actual or perceived conflict of interest that would interfere or give the appearance of impropriety or of interfering with the contractual duties and obligations under this Contract or any other contract with DHH, and any and all applicable DHH written policies. Conflict of interest shall include, but is not limited to, the Contractor serving, as the Medicaid fiscal intermediary contractor for DHH;

7. is awarded a contract with DHH, and successfully completed the readiness review prior to the start date of operations; and

8. have the ability to provide core dental benefits and services to all assigned members on the day the Dental Benefits Program is implemented.

C. A DBPM shall ensure the provision of core dental benefits and services to all eligible enrollees when the Dental Benefit Program is implemented.

D. Upon request by the Centers for Medicare and Medicaid Services, the Office of Inspector General, the Government Accounting Office, the department or its designee, a DBPM shall make all of its records pertaining to its contract (services provided thereunder and payment for services) with the department available for review, evaluation and audit. The records shall include, but are not limited to the following:

1. pertinent books and documents;
2. financial records;
3. dental records and documents; and
4. provider records and documents involving financial transactions related to the contract.

E. A DBPM shall maintain an automated management information system that collects, analyzes, integrates, and reports data that complies with department and federal reporting requirements.

F. A DBPM shall obtain insurance coverage(s) as specified in the terms of the contract. Subcontractors, if any, shall be covered under these policies or have insurance comparable to the DBPM's required coverage.

G. A DBPM shall provide all financial reporting as specified in the terms of the contract.

H. A DBPM shall be subject to a retainage of 10 percent from all billings under the contract as surety for performance as specified in the terms of the contract during the life of the contract.

I. In the event of noncompliance with the contract and the department's guidelines, a DBPM shall be subject to the sanctions specified in the terms of the contract including, but not limited to:

1. corrective action plans;
2. monetary penalties; or
3. suspension and/or termination of the DBPM's contract.

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:

§2105. Prepaid Ambulatory Health Plan Responsibilities

A. The DBPM shall be responsible for the administration and management of its requirements and responsibilities under the

contract with the department and any and all department issued guidance. This includes all subcontracts, employees, agents and anyone acting for or on behalf of the DBPM.

1. No subcontract or delegation of responsibility shall terminate the legal obligation of the DBPM to the department to ensure that all requirements are carried out.

B. A DBPM shall possess the expertise and resources to ensure the delivery of dental benefits and services to members and to assist in the coordination of covered dental services, as specified in the terms of the contract.

C. A DBPM shall have written policies and procedures governing its operation as specified in the contract and department issued guidance.

D. A DBPM shall not discriminate against enrollees on the basis of race, gender, color, national origin, age, health status or need for dental services, and shall not use any policy or practice that has the effect of discriminating on any such basis.

E. A DBPM shall be required to provide service authorization, referrals, coordination, and/or assistance in scheduling the covered dental services as specified in the terms of the contract.

F. The DBPM shall establish and implement a quality assessment and performance improvement program as specified in the terms of the contract and department issued guidance.

G. A DBPM shall develop and maintain a utilization management program including policies and procedures with defined structures and processes as specified in the terms of the contract and department issued guides.

H. The DBPM must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse. The DBPM shall comply with all state and federal laws and regulations relating to fraud, abuse, and waste in the Medicaid programs as well all requirements set forth in the contract and department issued guidance.

I. A DBPM shall collect data on enrollees and provider characteristics and on services furnished to members through an encounter data system as specified in the contract and all department issued guidance.

J. A DBPM shall be responsible for conducting routine provider monitoring to ensure:

1. Continued access to dental care for eligible Medicaid recipients; and

2. Compliance with departmental and contract requirements.

K. A DBPM shall not engage the services of a provider who is in non-payment status with the department or is excluded from

participation in federal health care programs (i.e., Medicare, Medicaid, CHIP, etc.).

L. Dental records shall be maintained in accordance with the terms and conditions of the contract. These records shall be safeguarded in such a manner as to protect confidentiality and avoid inappropriate disclosure according to federal and state law.

M. The DBPM shall provide both member and provider services in accordance with the terms of the contract and department issued guides.

1. The DBPM shall submit provider manuals and provider directory to the department for approval prior to distribution, annually and subsequent to any revisions.

a. The DBPM must provide a minimum of 60 days' notice to the department of any proposed material changes to the member handbooks and/or provider manuals.

b. After approval has been received from the department, the DBPM must provide a minimum of 30 days' notice to the members and/or providers of any proposed material changes to the required member education materials and/or provider manuals.

N. Member education materials shall include, but not be limited to:

1. a welcome packet including, but not limited to:

a. a welcome letter highlighting major program features and contact information for the DBPM; and

- b. a Provider Directory when specifically requested by the member (also must be available in searchable format on-line);
 2. member rights and protections as specified in 42 CFR §438.100 and the DBPM's contract with the department including, but not limited to:
 - a. a member's right to change providers within the DBPM;
 - b. any restrictions on the member's freedom of choice among DBPM providers; and
 - c. a member's right to refuse to undergo any dental service, diagnoses, or treatment or to accept any service provided by the DBPM if the member objects (or in the case of a child, if the parent or guardian objects) on religious grounds;
 3. member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the DBPM or the department including, but not limited to reporting to the department's Medicaid Customer Service Unit if the member has or obtains another health insurance policy, including employer sponsored insurance; and
 4. the amount, duration, and scope of benefits available under the DBPM's contract with the department in sufficient detail to ensure that members understand the benefits to which they are entitled, including, but not limited to:

- a. information about oral health education and promotion programs;
- b. the procedures for obtaining benefits, including prior authorization requirements and benefit limits;
- c. how members may obtain benefits, including emergency services, from out-of-network providers;
- d. the policy on referrals for specialty care; and
- e. the extent to which, and how, after-hour services are provided;

5. information to call the Medicaid Customer Service Unit toll free telephone number or visit a local Medicaid eligibility office to report changes in parish of residence, mailing address or family size changes;

6. a description of the DBPM's member services and the toll-free telephone number, fax telephone number, e-mail address and mailing address to contact DBPM's member services department;

7. instructions on how to request multi-lingual interpretation and translation services when needed at no cost to the member. This information shall be included in all versions of the handbook in English, Spanish and Vietnamese; and

8. grievance, appeal and state fair hearing procedures and time frames as described in 42 CFR §438.400 through §438.424 and in the DBPM's contract with the department.

0. The provider manual shall include but not be limited to:

1. description of the DBPM;
2. core dental benefits and services the DBPM must provide;
3. emergency dental service responsibilities;
4. policies and procedures that cover the provider complaint system. This information shall include, but not be limited to:
 - a. specific instructions regarding how to contact the DBPM to file a provider complaint; and
 - b. which individual(s) has the authority to review a provider complaint;
5. information about the DBPM's Grievance System, that the provider may file a grievance or appeal on behalf of the member with the member's written consent, the time frames and requirements, the availability of assistance in filing, the toll-free telephone numbers and the member's right to request continuation of services while utilizing the grievance system;
6. medical necessity standards as defined by DHH and practice guidelines;
7. practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions;
8. primary care dentist responsibilities;
9. other provider responsibilities under the subcontract with the DBPM;

10. prior authorization and referral procedures;
11. dental records standards;
12. claims submission protocols and standards, including instructions and all information necessary for a clean and complete claim and samples of clean and complete claims;
13. DBPM prompt pay requirements;
14. notice that provider complaints regarding claims payment shall be sent to the DBPM;
15. quality performance requirements; and
16. provider rights and responsibilities.

P. The provider directory for members shall be developed in two formats:

1. a hard copy directory for members and, upon request, potential members; and
2. a web-based online directory for members and the public.

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:

§2107. Network Access Standards and Guidelines

A. The DBPM must maintain and monitor a provider network that is supported by written agreements and is sufficient to provide

adequate access to enrollees as required by federal law and the terms as set forth in the contract. The DBPM shall adhere to the federal regulations governing access standards, as well as the specific requirements of the contract and all department-issued guides.

B. The DBPM shall cover all necessary services to treat an emergency dental condition.

1. *Emergency Dental Condition*-a dental or oral condition that requires immediate services for relief of symptoms and stabilization of the condition. Such conditions include:

- a. severe pain;
- b. hemorrhage;
- c. acute infection;
- d. traumatic injury to the teeth and surrounding tissue; or
- e. unusual swelling of the face or gums.

2. Emergency dental services are those services necessary for the treatment of any condition requiring immediate attention for the relief of pain, hemorrhage, acute infection, or traumatic injury to the teeth, supporting structures (periodontal membrane, gingival, alveolar bone), jaws, and tissue of the oral cavity.

C. The DBPM must maintain a provider network and in-area referral providers in sufficient numbers, as determined by the department, to ensure that all of the required core dental benefits and services are available and accessible in a timely manner in

accordance with the terms and conditions in the contract and department issued guide.

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:

§2109. Benefits and Services

A. Core benefits and services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to enrollees under the Louisiana Medicaid State Plan.

1. Core benefits and services shall be defined as those oral health care services and benefits required to be provided to Medicaid eligible individuals as specified under the terms of the contract and department-issued guides.

B. The following is a summary listing of the core dental benefits and services that a DBPM is required to provide:

1. diagnostic services which include oral examinations, radiographs and oral/facial images, diagnostic casts and accession of tissue - gross and microscopic examinations;

2. preventive services which include:

a. prophylaxis;

b. topical fluoride treatments;

c. sealants;

- d. fixed space maintainers; and
 - e. re-cementation of space maintainers;
3. restorative services which include:
- a. amalgam restorations;
 - b. composite restorations;
 - c. stainless steel and polycarbonate crowns;
 - d. stainless steel crowns with resin window;
 - e. pins, core build-ups, pre-fabricated posts and
cores;
 - f. resin-based composite restorations;
 - g. appliance removal;
 - h. unspecified restorative procedures; and
 - i. ancillary medical services;
4. endodontic services which include:
- a. pulp capping;
 - b. pulpotomy;
 - c. endodontic therapy on primary and permanent teeth
(including treatment plan, clinical procedures, and follow-up care);
 - d. apexification/recalcification;
 - e. apicoectomy/periradicular services;
 - f. unspecified endodontic procedures; and
 - g. organ transplant-related services;
5. periodontal services which include:
- a. gingivectomy;

- b. periodontal scaling and root planning;
 - c. full mouth debridement; and
 - d. unspecified periodontal procedures;
6. removable prosthodontics services which include:
- a. complete dentures;
 - b. partial dentures;
 - c. denture repairs;
 - d. denture relines; and
 - e. unspecified prosthodontics procedures;
7. maxillofacial prosthetics services which include fluoride gel carrier;
8. fixed prosthodontics services which include:
- a. fixed partial denture pontic;
 - b. fixed partial denture retainer; and
 - c. other unspecified fixed partial denture services;
9. oral and maxillofacial surgery services which include:
- a. non-surgical extractions;
 - b. surgical extractions;
 - c. coronal remnants extractions;
 - d. other surgical procedures;
 - e. alveoloplasty;
 - f. surgical incision;
 - g. temporomandibular joint (TMJ) procedure;
 - h. other unspecified repair procedures;

- i. durable medical equipment and certain supplies;
- 10. orthodontic services which include:
 - a. interceptive and comprehensive orthodontic treatments;
 - b. minor treatment to control harmful habits; and
 - c. other orthodontic services; and
- 11. adjunctive general services which include:
 - a. palliative (emergency) treatment;
 - b. anesthesia;
 - c. professional visits;
 - d. miscellaneous services; and
 - e. unspecified adjunctive procedures.

NOTE: This overview is not all inclusive. The contract, policy transmittals, approved Medicaid State Plan, regulations, provider bulletins, provider manuals, published fee schedules, and guides issued by the department are the final authority regarding services.

C. The core benefits and services provided to the members shall include, but are not limited to, those services specified in the contract policy transmittals, approved Medicaid State Plan, regulations, provider bulletins, provider manuals, and fee schedules, issued by the department are the final authority regarding services.

D. Excluded Services. The DBPM is not obligated to provide for services that are experimental, non-FDA approved,

investigational, or cosmetic and are specifically excluded from Medicaid coverage and will be deemed "not medically necessary." The Medicaid Director, in consultation with the Medicaid Dental Director, may consider authorizing services at his/her discretion on a case-by-case basis.

E. Utilization Management

1. The DBPM shall develop and maintain policies and procedures with defined structures and processes for a utilization management (UM) program that incorporates utilization review and service authorization, which include, at minimum, procedures to evaluate medical necessity and the process used to review and approve the provision of dental services. The DBPM shall submit an electronic copy of the UM policies and procedures to DHH for written approval within thirty calendar days from the date the contract is signed by the DBPM, but no later than prior to the readiness review, annually thereafter, and prior to any revisions.

2. The UM Program policies and procedures shall meet all Utilization Review Accreditation Commission (URAC) standards or equivalent and include medical management criteria and practice guidelines that:

a. are adopted in consultation with a contracting dental care professionals;

b. are objective and based on valid and reliable clinical evidence or a consensus of dental care professionals in the particular field;

c. are considering the needs of the members; and

d. are reviewed annually and updated periodically as appropriate.

3. The policies and procedures shall include, but not be limited to:

a. the methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of dental care services;

b. the data sources and clinical review criteria used in decision making;

c. the appropriateness of clinical review shall be fully documented;

d. the process for conducting informal reconsiderations for adverse determinations;

e. mechanisms to ensure consistent application of review criteria and compatible decisions;

f. data collection processes and analytical methods used in assessing utilization of dental care services; and

g. provisions for assuring confidentiality of clinical and proprietary information.

4. The DBPM shall disseminate the practice guidelines to all affected providers and, upon request, to members. The DBPM shall take steps to encourage adoption of the guidelines.

5. The DBPM must identify the source of the dental management criteria used for the review of service authorization requests, including but not limited to:

a. the vendor must be identified if the criteria were purchased;

b. the association or society must be identified if the criteria are developed/recommended or endorsed by a national or state dental care provider association or society;

c. the guideline source must be identified if the criteria are based on national best practice guidelines; and

d. the individuals who will make medical necessity determinations must be identified if the criteria are based on the dental/medical training, qualifications, and experience of the DBPM Dental Director or other qualified and trained professionals.

6. UM Program dental management criteria and practice guidelines shall be disseminated to all affected providers and members upon request. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines.

7. The DBPM shall have written procedures listing the information required from a member or dental care provider in order to make medical necessity determinations. Such procedures shall be given verbally to the covered person or healthcare provider when requested. The procedures shall outline the process to be followed in the event the DBPM determines the need for additional information not initially requested.

8. The DBPM shall have written procedures to address the failure or inability of a provider or member to provide all the necessary information for review. In cases where the provider or member will not release necessary information, the DBPM may deny authorization of the requested service(s).

9. The DBPM shall have sufficient staff with clinical expertise and training to apply service authorization medical management criteria and practice guidelines

10. The DBPM shall use the department's definition of medical necessity for medical necessity determinations. The DBPM shall make medical necessity determinations that are consistent with the department's definition.

11. The DBPM shall submit written policies and processes for DHH approval, within thirty calendar days, but no later than prior to the readiness review, of the contract signed by the DBPM, on how the core dental benefits and services the DBPM provides ensure:

- a. the prevention, diagnosis, and treatment of health impairments;
- b. the ability to achieve age-appropriate growth and development; and
- c. the ability to attain, maintain, or regain functional capacity.

12. The DBPM must identify the qualification of staff who will determine medical necessity. Determinations of medical necessity must be made by qualified and trained practitioners in accordance with state and federal regulations.

13. The DBPM shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease shall determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested.

14. The individual(s) making these determinations shall have no history of disciplinary action or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional or moral character.

15. The individual making these determinations is required to attest that no adverse determination will be made regarding any

dental procedure or service outside of the scope of such individual's expertise.

16. The DBPM shall provide a mechanism to reduce inappropriate and duplicative use of healthcare services. Services shall be sufficient in an amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished and that are no less than the amount, duration or scope for the same services furnished to eligibles under the Medicaid State Plan. The DBPM shall not arbitrarily deny or reduce the amount, duration or scope of required services solely because of diagnosis, type of illness or condition of the member. The DBPM may place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization control (with the exception of EPSDT services), provided the services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR 438.210.

17. The DBPM shall ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member.

18. The DBPM shall report fraud and abuse information identified through the UM program to DHH's Program Integrity Unit.

19. In accordance with 42 CFR §456.111 and 456.211, the DBPM Utilization Review plan must provide that each enrollee's record includes information needed for the UR committee to perform UR

required under this Section. This information must include, at least, the following:

- a. identification of the enrollee;
- b. the name of the enrollee's dentist;
- c. date of admission and dates of application for, and authorization of, Medicaid benefits if application is made after admission;
- d. the plan of care required under 42 CFR 456.80 and 456.180;
- e. initial and subsequent continued stay review dates described under 42 CFR 456.128, 456.133; 456.233 and 456.234;
- f. date of operating room reservation, if applicable; and
- g. justification of emergency admission, if applicable.

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:

§2111. Payment Methodology

A. Payments to the Dental Benefit Plan. The department, or its fiscal intermediary, shall make monthly capitation payments to the dental benefit plan based on a per member, per month (PMPM) rate.

1. The department reserves the right to re-negotiate the PMPM rates:

- a. if the rate floor is removed;
- b. as a result of federal or state budget reductions or increases;
- c. due to the inclusion or removal of a Medicaid covered dental service(s) not incorporated into the monthly capitation rates; or
- d. in order to comply with federal requirements.

2. The rates may also be adjusted based on legislative appropriations and budgetary constraints. Any adjusted rates must continue to be actuarially sound as determined by the department's actuarial contractor and will require an amendment to the contract that is mutually agreed upon by both parties.

B. The DBPM must agree to accept the PMPM rate as payment-in-full from the department and agree not to seek additional payment from a member for any unpaid cost.

C. A DBPM shall assume 100 percent liability for any expenditure above the prepaid premium.

D. A DBPM shall meet all financial reporting requirements specified in the terms of the contract.

E. Any cost sharing imposed on Medicaid members must be in accordance with the federal regulations governing cost sharing and cannot exceed the amounts reflected in the Medicaid State Plan, but

the amounts can be less than the cost sharing levels in the State Plan.

F. The DBPM shall not assign its rights to receive the PMPM payment, or its obligation to pay, to any other entity.

G. In the event that an incorrect payment is made to the DBPM, all parties agree that reconciliation will occur. If an error or overcharge is discovered by the department, it will be handled in accordance with the terms and conditions of the DBPM's contract.

H. Network Provider Reimbursement

1. The DBPM shall provide reimbursement for defined core dental benefits and services provided by an in-network provider. The DBPM rate of reimbursement shall be no less than the published Medicaid fee-for-service rate in effect on July 1, 2013, unless the department has granted an exception for a provider-initiated alternative payment arrangement.

2. The network provider may enter into alternative reimbursement arrangements with the DBPM if the network provider initiates the request and it is approved in advance by the department.

I. Emergency or Out-of-Network Provider Reimbursement. The DBPM shall make prompt payment for covered emergency dental services that are furnished by providers that have no arrangements with the DBPM for the provision of such services. Reimbursement by the DBPM to

out-of-network providers for the provision of emergency dental services shall be no more than what would be paid under Medicaid FFS.

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:

§2113. Prompt Payment of Claims

A. Network Providers. All subcontracts executed by the DBPM shall comply with the terms in the contract. Requirements shall include at a minimum:

1. the name and address of the official payee to whom payment shall be made;
2. the full disclosure of the method and amount of compensation or other consideration to be received from the DBPM; and
3. the standards for the receipt and processing of claims as specified by the department in the DBPM's contract with the department and department-issued guides.

B. Network and Out-of-Network Providers

1. The DBPM shall make payments to its network providers, and out-of-network providers, subject to conditions outlined in the contract and department-issued guides.

a. The DBPM shall pay 90 percent of all clean claims, as defined by the department, received from each provider type within 15 business days of the date of receipt.

b. The DBPM shall pay 99 percent of all clean claims within 30 calendar days of the date of receipt.

2. The provider must submit all claims for payment no later than 12 months from the date of service.

3. The DBPM and all providers shall retain any and all supporting financial information and documents that are adequate to ensure that payment is made in accordance with applicable federal and state laws.

a. Any such documents shall be retained for a period of at least six years or until the final resolution of all litigation, claims, financial management reviews, or audits pertaining to the contract.

4. There shall not be any restrictions on the right of the state and federal government to conduct inspections and/or audits as deemed necessary to assure quality, appropriateness or timeliness of services and reasonableness of costs.

C. Claims Management

1. The DBPM shall process a provider's claims for covered services provided to members in compliance with all applicable state and federal laws, rules, and regulations as well as all applicable DBPM policies and procedures including, but not limited to:

- a. claims format requirements;
- b. claims processing methodology requirements;

c. explanation of benefits and related function requirements;

d. processing of payment errors;

e. notification to providers requirements; and

f. timely filing.

D. Provider Claims Dispute

1. The DBPM shall:

a. have an internal claims dispute procedure that is in compliance with the contract and must be approved by the department;

b. contract with independent reviewers to review disputed claims;

c. systematically capture the status and resolution of all claim disputes as well as all associate documentation; and

d. report the status of all disputes and their resolution to the department on a monthly basis as specified in the contract.

E. Claims Payment Accuracy Report

1. The DBPM shall submit an audited claims payment accuracy percentage report to the department on a monthly basis as specified in the contract and department-issued DBPM guides.

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:

§2115. Grievance and Appeals Processes

A. The DBPM shall adhere to the provisions governing the grievance and appeals processes for coordinated care network prepaid models outlined in LAC 50:I.Chapter 37, Subparts B and C.

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 39:

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.

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 or autonomy as described in R.S. 49:972 by improving access to dental services, care coordination, and enhancing the quality of care Medicaid recipients will receive.

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 a 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 is expected to provide better coordination of services which will reduce the family's costs associated with the treatment of dental conditions and ease the financial burden on families.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. She is responsible for responding to inquiries regarding this proposed Rule. A public hearing on this proposed Rule is scheduled for Wednesday, February 26, 2014 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Kathy H. Kliebert

Secretary

Bobby Jindal
GOVERNOR



Kathy H. Kliebert
SECRETARY

State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing

PUBLIC HEARING CERTIFICATION
February 26, 2014
9:30 a.m.

RE: Dental Benefits Prepaid Ambulatory Health Plan
Docket # 022614-01
Department of Health and Hospitals
State of Louisiana

CERTIFICATION

In accordance with LA R.S. 49:950 et seq., the attached public hearing agenda, together with one digital recording of the public hearing conducted on February 26, 2014 in Baton Rouge, Louisiana constitute the official record of the above-referenced public hearing.

A handwritten signature in black ink, appearing to read "Cedric Clark", written over a horizontal line.

Cedric Clark
Policy Development Section

02/26/2014
Date

DHH/BHSF PUBLIC HEARING

Topic – Dental Benefits Prepaid Ambulatory Health Plan

February 26, 2014

Name	Address	Telephone Number	AGENCY or GROUP you represent
1. Cornette Scott	State of Louisiana Dept. of Health & Hospitals 628 N. 4th Street Baton Rouge, LA 70802	225-342-3881	DHH
2.			
3.			
4.			
5.			
6.			



State of Louisiana
Department of Health and Hospitals
Office of the Secretary

March 7, 2014

MEMORANDUM

TO: The Honorable John A. Alario, President, Louisiana Senate
The Honorable Chuck Kleckley, Speaker of the House
The Honorable David Heitmeir, Chair, Senate Committee on Health and Welfare
The Honorable Scott Simon, Chair, House Committee on Health and Welfare
The Honorable Jack Donahue, Chair, Senate Finance Committee
The Honorable James R. "Jim" Fannin, Chairman, House Appropriations Committee

FROM: Kathy H. Kliebert
Secretary

RE: Oversight Report on Bureau of Health Services Financing Proposed Rulemaking

In accordance with the Administrative Procedure Act (R.S. 49:950 et seq.) as amended, we are submitting the attached documents for the proposed Rule for Disproportionate Share Hospital Payments.

The Department published a Notice of Intent on this proposed Rule in the January 20, 2014 issue of the *Louisiana Register* (Volume 40, Number 1). A public hearing was held on February 26, 2014 at which only Department of Health and Hospitals staff were present. No oral testimony was given, nor written correspondence received, regarding this proposed Rule.

The Department anticipates adopting the Notice of Intent as a final Rule in the April 20, 2014 issue of the *Louisiana Register*.

The following documents are attached:

1. a copy of the Notice of Intent;
2. the public hearing certification; and
3. the public hearing attendance roster.

KHK/JP/CEC

Attachments (3)

NOTICE OF INTENT

**Department of Health and Hospitals
Bureau of Health Services Financing**

**Disproportionate Share Hospital Payments
(LAC 50.V.2501 and Chapter 27)**

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to amend LAC 50:V.2501 and Chapter 27 in the Medical Assistance Program as authorized by R.S. 36:254 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.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amended the provisions governing disproportionate share hospital (DSH) payments to revise the provisions governing non-rural community hospitals and federally mandated statutory hospitals to clarify that hospitals qualifying as a non-rural community hospital in state fiscal year 2007-08 may also qualify in the federally mandated statutory hospital category, and to revise the definition of a non-rural community hospital (*Louisiana Register*, Volume 34, Number 11). In compliance with Act 228 of the 2009 Regular Session of the Louisiana Legislature, the department promulgated an Emergency Rule which amended the provisions governing disproportionate share hospital payments to reallocate any remaining funds from the fiscal year 2009 DSH appropriation to

non-rural community hospitals and issue a supplemental payment to these hospitals for their uncompensated care costs (*Louisiana Register*, Volume 35, Number 7).

Act 10 of the 2009 Regular Session of the Louisiana Legislature directed the department to amend the DSH qualifying criteria and payment methodologies for non-rural community hospitals. In compliance with Act 10, the Department of Health and Hospitals, Bureau of Health Services Financing promulgated an Emergency Rule which amended the provisions of the June 26, 2009 Emergency Rule governing supplemental DSH payments to non-rural community hospitals (*Louisiana Register*, Volume 36, Number 1). The department promulgated an Emergency Rule which amended the January 20, 2010 Emergency Rule to amend the provisions governing supplemental DSH payments to non-rural community hospitals in order to redistribute the funds allocated for the state fiscal year 2010 DSH appropriation (*Louisiana Register*, Volume 36, Number 7).

The department promulgated an Emergency Rule which amended the June 29, 2010 Emergency Rule to revise the provisions governing DSH payments to allow for additional payments after completion of the Centers for Medicare and Medicaid Services' mandated independent audit for the state fiscal year (*Louisiana Register*, Volume 37, Number 6). Due to a budgetary shortfall in state fiscal year 2013, the department promulgated an Emergency

Rule which amended the provisions governing DSH payments to non-rural community hospitals to eliminate the community hospital psychiatric DSH pool (*Louisiana Register*, Volume 39, Number 1).

The department subsequently promulgated an Emergency Rule to amend the provisions of the June 20, 2011 Emergency Rule in order to revise the formatting as a result of the promulgation of the February 1, 2013 Emergency Rule governing non-rural community hospitals (*Louisiana Register*, Volume 39, Number 11). This proposed Rule is being promulgated to continue the provisions of the November 20, 2013 Emergency Rule.

TITLE 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part V. Medical Assistance Program—Hospital Services

Subpart 3. Disproportionate Share Hospital Payments

Chapter 25. Disproportionate Share Hospital Payment

Methodologies

§2501. General Provisions

A. - B.3. ...

4. Qualification is based on the hospital's latest filed cost report and related uncompensated cost data as required by the Department. Qualification for small rural hospitals is based on the latest filed cost report. Hospitals must file cost reports in accordance with Medicare deadlines, including extensions. Hospitals that fail to timely file Medicare cost reports and related uncompensated cost data will be assumed to be

ineligible for disproportionate share payments. Only hospitals that return timely disproportionate share qualification documentation will be considered for disproportionate share payments. After the final payment during the state fiscal year has been issued, no adjustment will be given on DSH payments with the exception of public state-operated hospitals, even if subsequently submitted documentation demonstrates an increase in uncompensated care costs for the qualifying hospital. After completion of a Center for Medicare and Medicaid Services' (CMS) mandated independent audit for the state fiscal year, additional payments may occur subject to the conditions specified in §2705.D.2 and §2707.B. For hospitals with distinct part psychiatric units, qualification is based on the entire hospital's utilization.

B.5. - 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 34:654 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:65 (January 2010), amended LR 36:512 (March 2010), LR 40:

Chapter 27. Qualifying Hospitals

§2701. Non-Rural Community Hospitals

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, Office of the Secretary, Bureau of Health Services Financing, LR 34:655 (April 2008), amended LR 34:2402 (November 2008), repealed by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§2705. Small Rural Hospitals

A. - D.1.b. ...

2. Additional payments shall only be made after finalization of the CMS mandated DSH audit for the state fiscal year. Payments shall be limited to the aggregate amount recouped from small rural hospitals based on these reported audit results. If the small rural hospitals' aggregate amount of underpayments reported per the audit results exceeds the aggregate amount overpaid, the payment redistribution to underpaid shall be paid on a pro rata basis calculated using each hospital's amount underpaid divided by the sum of underpayments for all small rural hospitals.

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 34:657 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§2707. Public State-Operated Hospitals

A. ...

B. DSH payments to individual public state-owned or operated hospitals shall be up to 100 percent of the hospital's net uncompensated costs. Final payment shall be made in accordance with final uncompensated care costs as calculated per the CMS mandated audit for the state fiscal year.

C. - D.2.d. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:658 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

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 no impact on family functioning, stability or autonomy as described in R.S. 49:972.

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 no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. She is responsible for responding to inquiries regarding this proposed Rule. A public hearing on this proposed Rule is scheduled for Wednesday, February 26, 2014 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Kathy H. Kliebert

Secretary



State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing

PUBLIC HEARING CERTIFICATION
February 26, 2014
9:30 a.m.

RE: Disproportionate Share Hospital Payments
Docket # 022614-02
Department of Health and Hospitals
State of Louisiana

CERTIFICATION

In accordance with LA R.S. 49:950 et seq., the attached public hearing agenda, together with one digital recording of the public hearing conducted on February 26, 2014 in Baton Rouge, Louisiana constitute the official record of the above-referenced public hearing.



Cedric Clark
Policy Development Section

02/26/2014
Date

DHH/BHSF PUBLIC HEARING

Topic — Disproportionate Share Hospital Payments

February 26, 2014

Name	Address	Telephone Number	AGENCY or GROUP you represent
1. Cornelia Scott	State of Louisiana Department of Health & Hospitals 628 N. 4 th St. Baton Rouge, LA 70802	225-342-3881	DHH
2.			
3.			
4.			
5.			
6.			



State of Louisiana
Department of Health and Hospitals
Office of the Secretary

March 7, 2014

MEMORANDUM

TO: The Honorable John A. Alario, President, Louisiana Senate
The Honorable Chuck Kleckley, Speaker of the House
The Honorable David Heitmeier, Chair, Senate Committee on Health and Welfare
The Honorable Scott Simon, Chair, House Committee on Health and Welfare
The Honorable Jack Donahue, Chair, Senate Finance Committee
The Honorable James R. "Jim" Fannin, Chairman, House Appropriations Committee

FROM: Kathy H. Kliebert
Secretary

Jerry Phillips for

RE: Oversight Report on Bureau of Health Services Financing Proposed Rulemaking

In accordance with the Administrative Procedure Act (R.S. 49:950 et seq.) as amended, we are submitting the attached documents for the proposed Rule for Home and Community-Based Services Waivers - Adult Day Health Care - Covered Services.

The Department published a Notice of Intent on this proposed Rule in the January 20, 2014 issue of the *Louisiana Register* (Volume 40, Number 1). A public hearing was subsequently held on February 26, 2014 at which only Department of Health and Hospitals staff were present. No oral testimony was given, nor written correspondence received, regarding this proposed Rule.

The Department anticipates adopting the Notice of Intent as a final Rule in the April 20, 2014 issue of the *Louisiana Register*.

The following documents are attached:

1. a copy of the Notice of Intent;
2. the public hearing certification; and
3. the public hearing attendance roster.

KHK/JP/RKA

Attachments (3)

NOTICE OF INTENT

**Department of Health and Hospitals
Bureau of Health Services Financing and
Office of Aging and Adult Services**

**Home and Community-Based Services Waivers
Adult Day Health Care
Covered Services
(LAC 50:XXI.2301)**

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services propose to amend LAC 50:XXI.2301 in the Medical Assistance Program as authorized by R.S. 36:254 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.

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services amended the provisions governing the Adult Day Health Care (ADHC) Waiver in order to clarify the service definitions, the provider responsibilities, and the admissions and discharge criteria (*Louisiana Register*, Volume 39, Number 9).

The department now proposes to amend the provisions governing the ADHC Waiver in order to incorporate the revisions that were inadvertently omitted from the September 20, 2013 final Rule.

Title 50

**PUBLIC HEALTH-MEDICAL ASSISTANCE
Part XXI. Home and Community-Based Services Waivers
Subpart 3. Adult Day Health Care**

Chapter 23. Services

§2301. Covered Services

A. ...

1. Adult Day Health Care. ADHC services furnished as specified in the plan of care at the ADHC center, in a non-institutional, community-based setting encompassing both health/medical and social services needed to ensure the optimal functioning of the participant. Services are furnished on a regularly scheduled basis, not to exceed 10 hours a day, 50 hours a week. An adult day health care center shall, at a minimum, furnish the following services:

a. - g. ...

i. monitoring vital signs appropriate to the diagnosis and medication regimen of each recipient no less frequently than monthly;

ii. administering medications and treatments in accordance with physicians' orders;

iii. monitoring self-administration of medications while the recipient is at the ADHC center;

NOTE: All nursing services shall be provided in accordance with acceptable professional practice standards.

A.1.h. - 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 30:2036 (September 2004), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2162 (October 2008), repromulgated LR 34:2566 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2625 (September 2011), LR 39:2495 (September 2013), LR 40:

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.

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 no impact on family functioning, stability or autonomy as described in R.S. 49:972.

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 no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. She is responsible for responding to inquiries regarding this proposed Rule. A public hearing on this proposed Rule is scheduled for Wednesday, February 26, 2014 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Kathy H. Kliebert

Secretary



State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing

PUBLIC HEARING CERTIFICATION
February 26, 2014
9:30 a.m.

RE: Home and Community-Based Service Waivers
Adult Day Health Care
Covered Services
Docket # 022614-03
Department of Health and Hospitals
State of Louisiana

CERTIFICATION

In accordance with LA R.S. 49:950 et seq., the attached public hearing agenda, together with one digital recording of the public hearing conducted on February 26, 2014 in Baton Rouge, Louisiana constitute the official record of the above-referenced public hearing.

A handwritten signature in black ink, appearing to read "Cedric Clark", written over a horizontal line.

Cedric Clark
Policy Development Section

02/26/2014
Date

DHH/BHSF PUBLIC HEARING

Topic - Home & Community-Based Services Waivers-Adult Day Health Care- Covered Services

February 26, 2014

Name	Address	Telephone Number	AGENCY or GROUP you represent
1. <i>Connally Scott</i>	<i>State of Louisiana Department of Health & Hospitals 628 N. 4th St. Baton Rouge, LA 70802</i>	<i>225-342-3881</i>	<i>DHH</i>
2.			
3.			
4.			
5.			
6.			



State of Louisiana
Department of Health and Hospitals
Office of the Secretary

March 7, 2014

MEMORANDUM

TO: The Honorable John A. Alario, President, Louisiana Senate
The Honorable Chuck Kleckley, Speaker of the House
The Honorable David Heitmeier, Chair, Senate Committee on Health and Welfare
The Honorable Scott Simon, Chair, House Committee on Health and Welfare
The Honorable Jack Donahue, Chair, Senate Finance Committee
The Honorable James R. "Jim" Fannin, Chairman, House Appropriations Committee

FROM: Kathy H. Kliebert
Secretary

Handwritten signature: Kathy H. Kliebert

RE: Oversight Report on Bureau of Health Services Financing Proposed Rulemaking

In accordance with the Administrative Procedure Act (R.S. 49:950 et seq.) as amended, we are submitting the attached documents for the proposed Rule for Nursing Facilities - Reimbursement Methodology - Low Income and Needy Care Collaboration.

The Department published a Notice of Intent on this proposed Rule in the January 20, 2014 issue of the *Louisiana Register* (Volume 40, Number 1). A public hearing was subsequently held on February 26, 2014 at which only Department of Health and Hospitals staff were present. No oral testimony was given, nor written correspondence received, regarding this proposed Rule.

The Department anticipates adopting the Notice of Intent as a final Rule in the April 20, 2014 issue of the *Louisiana Register*.

The following documents are attached:

1. a copy of the Notice of Intent;
2. the public hearing certification; and
3. the public hearing attendance roster.

KHK/JP/RKA

Attachments (3)

NOTICE OF INTENT

Department of Health and Hospitals
Bureau of Health Services Financing

Nursing Facilities
Reimbursement Methodology
Low Income and Needy Care Collaboration
(LAC 50:II.20025)

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to adopt LAC 50:II.20025 in the Medical Assistance Program as authorized by R.S. 36:254 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.

The Department of Health and Hospitals, Bureau of Health Services Financing promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for nursing facilities to adopt provisions to establish a supplemental Medicaid payment for nursing facilities who enter into an agreement with a state or local governmental entity for the purpose of providing health care services to low income and needy patients (*Louisiana Register*, Volume 37, Number 11). This proposed Rule is being promulgated to continue the provisions of the November 1, 2011 Emergency Rule.

Title 50

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

Chapter 200. Reimbursement Methodology

§20025. Low Income and Needy Care Collaboration

A. Effective for dates of service on or after November 1, 2011, quarterly supplemental payments shall be issued to qualifying nursing facilities for services rendered during the quarter. Maximum aggregate payments to all qualifying nursing facilities shall not exceed the available upper payment limit per state fiscal year.

B. Qualifying Criteria. In order to qualify for the supplemental payment, the nursing facility must be affiliated with a state or local governmental entity through a Low Income and Needy Care Nursing Facility Collaboration Agreement.

1. A nursing facility is defined as a currently licensed and certified nursing facility which is owned or operated by a private entity or non-state governmental entity.

2. A Low Income and Needy Care Nursing Facility Collaboration Agreement is defined as an agreement between a nursing facility and a state or local governmental entity to collaborate for purposes of providing healthcare services to low income and needy patients.

C. Each qualifying nursing facility shall receive quarterly supplemental payments for nursing facility services. Quarterly payment distribution shall be limited to one-fourth of the aggregated difference between each qualifying nursing

facility's Medicare rate and Medicaid payments the nursing facility receives for covered services provided to Medicaid recipients during a 12 consecutive month period. Medicare rates in effect for the dates of service included in the supplemental payment period will be used to establish the upper payment limit. Medicaid payments will be used for the same time period.

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:

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.

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 may have a positive impact on family functioning, stability or autonomy as described in R.S. 49:972 as it will ensure sufficient provider participation in the Nursing Facilities program.

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 may have a 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 will secure new federal funding to ensure sufficient provider participation which will increase access to Medicaid covered nursing services and may reduce the costs to families for health care services.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. She is responsible for responding to inquiries regarding this proposed Rule. A public hearing on this proposed Rule is scheduled for Wednesday, February 26, 2014 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Kathy H. Kliebert

Secretary



State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

PUBLIC HEARING CERTIFICATION

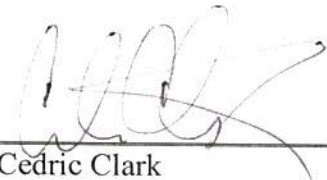
February 26, 2014

9:30 a.m.

RE: Nursing Facilities
Reimbursement Methodology
Low Income and Needy Care Collaboration
Docket # 022614-05
Department of Health and Hospitals
State of Louisiana

CERTIFICATION

In accordance with LA R.S. 49:950 et seq., the attached public hearing agenda, together with one digital recording of the public hearing conducted on February 26, 2014 in Baton Rouge, Louisiana constitute the official record of the above-referenced public hearing.



Cedric Clark
Policy Development Section

02/26/2014

Date

DHH/BHSF PUBLIC HEARING

Topic -- Nursing Facilities – Reimbursement Methodology – Low Income & Needy Collaboration February 4, 2014

Name	Address	Telephone Number	AGENCY or GROUP you represent
1. <i>Cornelia Scott</i>	<i>State of Louisiana Department of Health & Hospitals 628 N. 4th Street Baton Rouge, LA 70802</i>	<i>225-342-3881</i>	<i>Staff</i>
2.			
3.			
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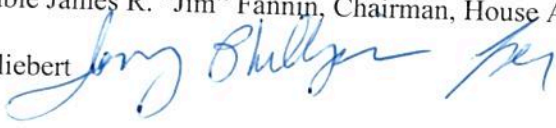


State of Louisiana
Department of Health and Hospitals
Office of the Secretary

March 7, 2014

MEMORANDUM

TO: The Honorable John A. Alario, President, Louisiana Senate
The Honorable Chuck Kleckley, Speaker of the House
The Honorable David Heitmeier, Chair, Senate Committee on Health and Welfare
The Honorable Scott Simon, Chair, House Committee on Health and Welfare
The Honorable Jack Donahue, Chair, Senate Finance Committee
The Honorable James R. "Jim" Fannin, Chairman, House Appropriations Committee

FROM: Kathy H. Kliebert 
Secretary

RE: Oversight Report on Bureau of Health Services Financing Proposed Rulemaking

In accordance with the Administrative Procedure Act (R.S. 49:950 et seq.) as amended, we are submitting the attached documents for the proposed Rule for Home and Community-Based Services Waivers - Community Choices Waiver.

The Department published a Notice of Intent on this proposed Rule in the January 20, 2014 issue of the *Louisiana Register* (Volume 40, Number 1). A public hearing was subsequently held on February 26, 2014 at which representatives from Seniorlink/Caregiver Homes and Department of Health and Hospitals staff were present. Oral testimony and written comments were given by Mr. Garrett Blanton of Seniorlink/Caregiver Homes regarding this proposed Rule.

The Department anticipates adopting the Notice of Intent as a final Rule in the April 20, 2014 issue of the *Louisiana Register*.

The following documents are attached:

1. a copy of the Notice of Intent;
2. the public hearing certification;
3. the public hearing attendance roster;
4. comments from Mr. Garrett Blanton; and
5. agency response to Mr. Garrett Blanton.

KHK/JP/RKA

Attachments (5)

NOTICE OF INTENT

**Department of Health and Hospitals
Bureau of Health Services Financing and
Office of Aging and Adult Services**

**Home and Community-Based Services Waivers
Community Choices Waiver**

(LAC 50:XXI.8101, 8307, 8313, 8329, Chapter 86, and 9501)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services propose to amend LAC 50:XXI.8101, §8307, §8313 and §9501 and to adopt §8329 and Chapter 86 in the Medical Assistance Program as authorized by R.S. 36:254 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.

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services amended the provisions governing the Community Choices Waiver to add two new waiver services, to incorporate a new service delivery method, and to clarify the provisions governing personal assistance services (*Louisiana Register*, Volume 39, Number 7). The department now proposes to amend the provisions governing the Community Choices Waiver to further clarify these provisions, and to adopt a new waiver service and a new service delivery option.

**Title 50
PUBLIC HEALTH-MEDICAL ASSISTANCE
Part XXI. Home and Community Based Services Waivers**

Subpart 7. Community Choices Waiver

Chapter 81. General Provisions

§8101. Introduction

A. - D.2.b. ...

3. No individual may concurrently serve as a responsible representative for more than two participants in OAAS-operated Medicaid home and community-based service programs. This includes but is not limited to:

- a. the Program of All-Inclusive Care for the Elderly;
- b. Long-Term Personal Care Services;
- c. the Community Choices Waiver; and
- d. the Adult Day Health Care Waiver.

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 37:3517 (December 2011), amended LR 40:

Chapter 83. Covered Services

§8307. Personal Assistance Services

A. - I.6. ...

J. Participants are not permitted to receive PAS while living in a home or property owned, operated, or controlled by an owner, operator, agent, or employee of a licensed provider of

long-term care services and providers are prohibited from providing and billing for services under these circumstances. Participants may not live in the home of a direct support worker unless the direct support is related by blood or marriage to the participant.

1. The provisions of §8307.J may be waived with prior written approval by OAAS or its designee.

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, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3519 (December 2011), amended LR 39:320 (February 2013), LR 39:1778 (July 2013), LR 40:

§8313. Caregiver Temporary Support Services

A. - H. ...

I. Caregiver temporary support may be provided for the relief of the principal caregiver for participants who receive monitored in-home caregiving services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3521 (December 2011), amended LR 39:321 (February 2013), LR 40:

§8329. Monitored In-Home Caregiving Services

A. Monitored in-home caregiving services are services provided to a participant living in a private home with a principal caregiver. The goal of this service is to provide a community-based option that provides continuous care, supports, and professional oversight. This goal is achieved by promoting a cooperative relationship between a participant, a principal caregiver, the professional staff of a monitored in-home caregiving agency provider, and the participant's support coordinator.

B. The principal caregiver is responsible for supporting the participant to maximize the highest level of independence possible by providing necessary care and supports that may include:

1. supervision or assistance in performing activities of daily living;
2. supervision or assistance in performing instrumental activities of daily living;
3. protective supervision provided solely to assure the health and welfare of a participant;
4. supervision or assistance with health related tasks (any health related procedures governed under the Nurse Practice Act) in accordance with applicable laws governing the delegation of medical tasks/medication administration;
5. supervision or assistance while

escorting/accompanying the individual outside of the home to perform tasks, including instrumental activities of daily living, health maintenance or other needs as identified in the plan of care and to provide the same supervision or assistance as would be rendered in the home; and

6. extension of therapy services to maximize independence when the caregiver has been instructed in the performance of the activities by a licensed therapist or registered nurse.

C. The following individuals are prohibited from being paid as a monitored in-home caregiving principal caregiver:

1. the participant's curator;
2. the participant's tutor;
3. the participant's legal guardian;
4. the participant's responsible representative; or
5. the person to whom the participant has given representative and mandate authority (also known as power of attorney).

D. Participants electing monitored in-home caregiving services are not eligible to receive the following Community Choices Waiver services during the period of time that the participant is receiving monitored in-home caregiving services:

1. personal assistance services;
2. adult day health care services; or
3. home delivered meal services.

E. Monitored in-home caregiving providers must be agency providers who employ professional nursing staff and other professionals to train and support caregivers to perform the direct care activities performed in the home. The agency provider must assess and approve the home in which services will be provided, and shall enter into contractual agreements with caregivers who the agency has approved and trained. The agency provider will pay per diem foster care stipends to caregivers.

F. The agency provider must:

1. capture daily notes electronically;
2. use the information collected to monitor participant health and caregiver performance; and
3. make daily notes available to support coordinators and the state, upon request.

G. The Department of Health and Hospitals (DHH) shall reimburse for monitored in-home caregiving services based upon a two-tiered model which is designed to address the participant's acuity.

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 40:

Chapter 86. Organized Health Care Delivery System

§8601. General Provisions

A. An Organized Health Care Delivery System (OHCDS) is an entity with an identifiable component within its mission to provide services to individuals receiving Community Choices Waiver services. The entity must be a qualified and enrolled Medicaid provider and must directly render at least one service offered in the Community Choices Waiver. As long as the entity furnishes at least one waiver service itself, it may contract with other qualified providers to furnish the other required waiver services.

B. Entities that function as an OHCDS must ensure that subcontracted entities meet all of the applicable provider qualification standards for the services they are rendering.

C. The OHCDS must attest that all provider qualifications are met in accordance with all of the applicable waiver provider qualifications as set forth in the waiver document.

D. Prior to enrollment, an OHCDS must show the ability to provide all of the services available in the Community Choices Waiver on December 1, 2012, with the exceptions of support coordination, transition intensive support coordination, transition services, and adult day health care if there is no

licensed adult day health care provider in the service area.

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 40:

Chapter 95. Reimbursement

§9501. Reimbursement Methodology

A. - A.6. ...

B. The following services shall be reimbursed at the authorized rate or approved amount of the assessment, inspection, installation/fitting, maintenance, repairs, adaptation, device, equipment, or supply item and when the service has been prior authorized by the plan of care:

1. - 2. ...

3. home delivered meals (not to exceed the maximum limit set by OAAS);

4. transition expenses up to a lifetime maximum of \$1500; and

5. the assessment performed by the monitored in-home caregiving provider.

C. The following services shall be reimbursed at a per diem rate:

1. caregiver temporary support services when rendered by the following providers:

- a. ...
 - b. nursing facility; or
 - c. respite center; and
2. monitored in-home caregiving services
- a. The per diem rate for monitored in-home caregiving services does not include payment for room and board, and Federal financial participation is not claimed for room and board.

D. - L.1. ...

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 37:3525 (December 2011), amended LR 39:322 (February 2013), LR 39:508, (March 2013), repromulgated LR 39:1048 (April 2013), amended LR 39:1779 (July 2013), LR 40:

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.

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 or autonomy as described in R.S. 49:972 by providing additional support services to waiver participants.

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 a positive impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973 by providing access to additional Medicaid covered support services for waiver participants which may reduce the health care costs to families.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. She is responsible for responding to inquiries regarding this proposed Rule. A public hearing on this proposed Rule is scheduled for Wednesday, February 26, 2014 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Kathy H. Kliebert

Secretary



State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

PUBLIC HEARING CERTIFICATION February 26, 2014 9:30 a.m.

RE: Home and Community-Based Service Waivers
Community Choices Waiver
Docket # 022614-04
Department of Health and Hospitals
State of Louisiana

CERTIFICATION

In accordance with LA R.S. 49:950 et seq., the attached public hearing agenda, together with one digital recording of the public hearing conducted on February 26, 2014 in Baton Rouge, Louisiana constitute the official record of the above-referenced public hearing.



Cedric Clark
Policy Development Section

02/26/2014

Date

DHH/BHSF PUBLIC HEARING

Topic – Home & Community–Based Service Waivers – Community Choice Waiver

February 4, 2014

Name	Address	Telephone Number	AGENCY or GROUP you represent
1. Cornelia Pratt	State of LA Dept. of Health & Hospitals 628 N. 4th Street Baton Rouge, LA 70802	225/342-3881	DHH
2. Garrett Blanton	2840 Killeferane Tallahassee FL 32309	850-499-7537	SeniorLink
3. Rick Henley	DHH/OAAS	225-219-6223	rick.henley@la.gov OAAS
4.			
5.			
6.			

500 Boylston Street
Suite 640
Boston, MA 02116
t 617-456-3700
www.caregiverhomes.com

RECEIVED

FEB 26 2014

Policy Development and Implementation

February 26, 2014

J. Ruth Kennedy
Bureau of Health Services Financing
P.O. Box 91030
Baton Rouge, LA 70821-9030

Re: Notice of Intent to amend Louisiana Administrative Code 50:XXI, Chapter 83

Dear Ms. Kennedy,

On behalf of Caregiver Homes, a division of Seniorlink, I am pleased to submit these comments in support of regulatory changes proposed by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office on Aging and Adult Services, as published in the Louisiana Register on January 20, 2014, to amend the Community Choices Waiver (CCW). Caregiver Homes' comments here are focused on the addition of Monitored In-Home Caregiving (MIHC) services to the list of CCW covered services, and the conforming revision to the definition of Caregiver Temporary Support services.

We appreciate the leadership and thoughtful work of the Office of Aging and Adult Services (OAAS) in developing innovative and comprehensive models of care to support elders and individuals with disabilities to live independently in their homes and communities. Caregiver Homes delivers an MIHC-like model of care, a model that we call Structured Family Caregiving, to more than 2000 consumers across four states. We support consumers of all ages who have significant need for assistance with personal care, such as bathing, ambulating, and toileting, and complex behavioral and medical conditions, typically requiring daily symptom management. We are supporting individuals - who would otherwise need services in more restrictive and expensive settings - to receive needed supports at home.

Through this experience, we have come to identify program features that enable services like MIHC to successfully support consumers with complex needs in the community. We are pleased that OAAS has incorporated many of these features in the MIHC service:

- Family caregivers - a passionate, committed, and high quality workforce;
- 1:1 matches between consumers and caregivers that are responsive to the high level of personal care and care coordination needs of consumers who choose MIHC;
- Consumer or caregiver's home as an approvable setting - this is critical for adoption;
- Provider agency oversight and support of caregivers – this is key to long-lasting, high quality services and promotes access by avoiding administratively burdensome processes for credentialing caregivers and qualifying home settings;
- Daily payment rates that allow for modest caregiver financial stipends and sufficient provider agency staff support (e.g. home visits);
- Access to additional services, such as Caregiver Temporary Support, to enable appropriate respite for committed, full-time caregivers.

Caregiver Homes looks forward to working in Louisiana to deliver MIHC as a comprehensive and cost-effective option for consumers who need extensive supports to live in the community. We will continue the development of collaborative relationships with Support Coordination Agencies, community-based organizations, advocates, and other professionals to ensure that we can deliver timely and high-quality services and supports to consumers, caregivers, and family members. Further, as Louisiana moves toward managed long-term services and supports (MLTSS), we will partner with health plans to make MIHC accessible and available to families across Louisiana.

Thank you again for the opportunity to comment on the proposed amendments to the Louisiana Administrative Code. The addition of Monitored In-Home Caregiving to the Community Choices Waiver is an exciting development for elders and individuals with disabilities in Louisiana, and we are pleased to support this development in any way that we can.

Please feel free to contact me if you have any questions about Caregiver Homes' testimony. I can be reached at gblanton@seniorlink.com or 850-499-7597.

Sincerely,

Garrett Blanton
Regional Director, Government and Community Relations

cc: Rick Henley, J.D., Division Director Policy & Program Management

Bobby Jindal
GOVERNOR



Kathy H. Kliebert
SECRETARY

State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing

March 4, 2014

Garrett Blanton
Senior Link / Caregiver Homes
500 Boylston Street
Suite 640
Boston, MA 02116

RE: Home and Community-Based Services Waivers – Community Choices Waiver Notice of Intent

Dear Mr. Blanton:

This letter is in response to your correspondence received in our office on February 26, 2014 regarding the above referenced Notice of Intent that was published in the January 20, 2014 edition of the *Louisiana Register*.

The Notice of Intent proposes to amend the provisions governing the Community Choices Waiver to further clarify these provisions, and to adopt a new waiver service and a new service delivery option. Your comments in support of these provisions have been reviewed and are greatly appreciated.

I would like to thank you for taking the time to comment on this Notice of Intent and hope that you will continue to work with us as we strive to improve health care outcomes for Louisiana citizens who utilize waiver services.

Should you have any questions or comments regarding Medicaid administrative rulemaking activity, you may contact LaLauni Williams, Rulemaking Unit Manager, at (225) 342-3238 or by email to LaLauni.Williams@la.gov.

Sincerely,

A handwritten signature in cursive script, appearing to read "J. Ruth Kennedy".

J. Ruth Kennedy
Medicaid Director

JRK/DA/llw

c: Rick Henley, OAAS Policy Director

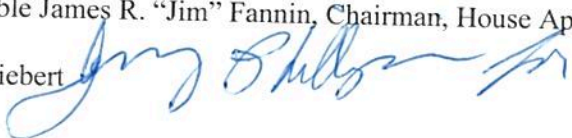


State of Louisiana
Department of Health and Hospitals
Office of the Secretary

March 7, 2014

MEMORANDUM

TO: The Honorable John A. Alario, President, Louisiana Senate
The Honorable Chuck Kleckley, Speaker of the House
The Honorable David Heitmeier, Chair, Senate Committee on Health and Welfare
The Honorable Scott Simon, Chair, House Committee on Health and Welfare
The Honorable Jack Donahue, Chair, Senate Finance Committee
The Honorable James R. "Jim" Fannin, Chairman, House Appropriations Committee

FROM: Kathy H. Kliebert 
Secretary

RE: Oversight Report on Bureau of Health Services Financing Proposed Rulemaking

In accordance with the Administrative Procedure Act (R.S. 49:950 et seq.) as amended, we are submitting the attached documents for the proposed Rule for Nursing Facilities - Reimbursement Methodology - Private Room Conversions.

The Department published a Notice of Intent on this proposed Rule in the January 20, 2014 issue of the *Louisiana Register* (Volume 40, Number 1). A public hearing was subsequently held on February 26, 2014 at which only Department of Health and Hospitals staff were present. No oral testimony was given, nor written correspondence received, regarding this proposed Rule.

The Department anticipates adopting the Notice of Intent as a final Rule in the April 20, 2014 issue of the *Louisiana Register*.

The following documents are attached:

1. a copy of the Notice of Intent;
2. the public hearing certification; and
3. the public hearing attendance roster.

KHK/JP/RKA

Attachments (3)

NOTICE OF INTENT

**Department of Health and Hospitals
Bureau of Health Services Financing**

**Nursing Facilities
Reimbursement Methodology
Private Room Conversions
(LAC 50:II.20010)**

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to amend LAC 50:II.20010 in the Medical Assistance Program as authorized by R.S. 36:254 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.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amended the provisions governing the reimbursement methodology for nursing facilities to allow for additional payments for private room conversions when a Medicaid participating nursing facility converts one or more semi-private rooms to private rooms for occupancy by Medicaid recipients (*Louisiana Register*, Volume 33, Number 8). Act 150 of the 2010 Regular Session of the Louisiana Legislature directed the department to increase the fair rental value minimum occupancy percentage from 70 percent to 85 percent. The department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for nursing facilities to ensure that the provisions governing private room conversions are consistent with the increase in the fair rental value minimum

occupancy percentage which was adopted on July 1, 2011 (*Louisiana Register*, Volume 37, Number 10). This proposed Rule is being promulgated to continue the provisions of the November 1, 2011 Emergency Rule.

Title 50

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

Chapter 200. Reimbursement Methodology

§20010. Additional Payments and Square Footage Adjustments for Private Room Conversion [Formerly LAC 50:VII.1310]

A. - D.2.c. ...

3. Resident days used in the fair rental value per diem calculation will be the greater of the annualized actual resident days from the base year cost report or 85 percent of the revised annual bed days available after the change in licensed beds.

D.4 - E.2. ...

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 33:1646 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

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 no impact on family functioning, stability or autonomy as described in R.S. 49:972.

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 no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. She is responsible for responding to inquiries regarding this proposed Rule. A public hearing on this proposed Rule is scheduled for Wednesday, February 26, 2014 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Kathy H. Kliebert

Secretary



State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

PUBLIC HEARING CERTIFICATION
February 26, 2014
9:30 a.m.

RE: Nursing Facilities
Reimbursement Methodology
Private Room Conversions
Docket # 022614-06
Department of Health and Hospitals
State of Louisiana

CERTIFICATION

In accordance with LA R.S. 49:950 et seq., the attached public hearing agenda, together with one digital recording of the public hearing conducted on February 26, 2014 in Baton Rouge, Louisiana constitute the official record of the above-referenced public hearing.

A handwritten signature in black ink, appearing to read "Cedric Clark", written over a horizontal line.

Cedric Clark
Policy Development Section

02/26/2014
Date

DHH/BHSF PUBLIC HEARING

Topic – Nursing Facilities – Reimbursement Methodology – Private Room Conversions

February 26, 2014

Name	Address	Telephone Number	AGENCY or GROUP you represent
1. Cornette Scott	State of Louisiana Department of Health & Hospitals 628 North 4th Street Baton Rouge LA 70130	225-342-3881	DHH
2.			
3.			
4.			
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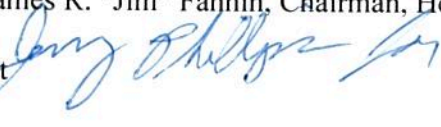


State of Louisiana
Department of Health and Hospitals
Office of the Secretary

March 7, 2014

MEMORANDUM

TO: The Honorable John A. Alario, President, Louisiana Senate
The Honorable Chuck Kleckley, Speaker of the House
The Honorable David Heitmeir, Chair, Senate Committee on Health and Welfare
The Honorable Scott Simon, Chair, House Committee on Health and Welfare
The Honorable Jack Donahue, Chair, Senate Finance Committee
The Honorable James R. "Jim" Fannin, Chairman, House Appropriations Committee

FROM: Kathy H. Kliebert 
Secretary

RE: Oversight Report on Bureau of Health Services Financing Proposed Rulemaking

In accordance with the Administrative Procedure Act (R.S. 49:950 et seq.) as amended, we are submitting the attached documents for the proposed Rule for Pregnant Women Extended Services – Substance Abuse Screening and Intervention Services.

The Department published a Notice of Intent on this proposed Rule in the January 20, 2014 issue of the *Louisiana Register* (Volume 40, Number 1). A public hearing was held on February 26, 2014 at which only Department of Health and Hospitals staff were present. No oral testimony was given, nor written correspondence received, regarding this proposed Rule.

The Department anticipates adopting the Notice of Intent as a final Rule in the April 20, 2014 issue of the *Louisiana Register*.

The following documents are attached:

1. a copy of the Notice of Intent;
2. the public hearing certification; and
3. the public hearing attendance roster.

KHK/JP/CEC

Attachments (3)

NOTICE OF INTENT

**Department of Health and Hospitals
Bureau of Health Services Financing**

**Pregnant Women Extended Services
Substance Abuse Screening and Intervention Services
(LAC 50:XV.Chapter 163)**

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to adopt LAC 50:XV.Chapter 163 in the Medical Assistance Program as authorized by R.S. 36:254 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.

The Department of Health and Hospital, Bureau of Health Services Financing, in collaboration with the Office of Behavioral Health, promulgated an Emergency Rule which adopted provisions to establish Medicaid coverage for substance abuse screening and brief intervention services rendered to Medicaid eligible pregnant women as part of the department's ongoing initiative to improve birth outcomes in the state (*Louisiana Register*, Volume 37, Number 4). Research has shown that tobacco dependence and substance abuse intervention programs targeted to pregnant women improves the overall health of the mother and reduces the occurrences of low birth-weight babies and perinatal deaths. It is anticipated that these new services will improve birth outcomes and subsequently reduce Medicaid costs associated with the care of pregnant women and their babies.

The department promulgated an Emergency Rule which amended the April 1, 2011 Emergency Rule in order to require providers to use the Louisiana Health Assessment Referral and Treatment System (LaHART) to receive payment for substance abuse screening and brief intervention services rendered to Medicaid eligible pregnant women (*Louisiana Register*, Volume 38, Number 11). LaHART is a web-based, prenatal behavioral health screening system that screens for tobacco, drug and alcohol abuse as well as domestic violence.

The department subsequently promulgated an Emergency Rule which amended the November 20, 2012 Emergency Rule in order to allow additional LaHART screening and brief intervention services during the service limit time period under certain circumstances (*Louisiana Register*, Volume 39, Number 1). This proposed Rule is being promulgated to continue the provisions of the January 20, 2013 Emergency Rule.

Title 50

PUBLIC HEALTH-MEDICAL ASSISTANCE

Part XV. Services for Special Populations

Subpart 13. Pregnant Women Extended Services

Chapter 163. Substance Abuse Screening and Intervention Services

§16301. General Provisions

A. Effective for dates of service on or after April 1, 2011, the department shall provide coverage of substance abuse screening and brief intervention services rendered to Medicaid eligible pregnant women with the Louisiana Health Assessment Referral and Treatment system.

B. Substance abuse screening and intervention services may be performed with the Louisiana Health Assessment Referral and Treatment system at the discretion of the medical professional providing care to the pregnant woman.

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:

§16303. Scope of Services

A. Screening services shall include the screening of pregnant women with the Louisiana Health Assessment Referral and Treatment system for the use of:

1. alcohol;
2. tobacco;
3. drugs; and/or
4. domestic violence.

B. Intervention services shall include a brief 15-30 minute counseling session with a health care professional intended to help motivate the recipient to develop a plan to moderate or cease their use of alcohol, tobacco, or drugs.

C. Service Limits. Substance abuse screening and intervention services shall be limited to one occurrence each per pregnancy, or once every 270 days.

1. If the patient experiences a miscarriage or fetal death and becomes pregnant within the 270 day period, all LaHART

screening and brief intervention services will be reimbursed for the subsequent pregnancy.

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:

§16305. Reimbursement Methodology

A. Effective for dates of service on or after April 1, 2011, the Medicaid Program shall provide reimbursement for substance abuse screening and intervention services rendered to Medicaid eligible pregnant women.

B. Reimbursement for these services shall be a flat fee based on the appropriate Healthcare Common Procedure Coding (HCPC) code.

C. Effective for dates of service on or after January 1, 2013, Medicaid reimbursement for substance abuse screening and intervention services shall only be made to providers with documented use of the LaHART system.

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:

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 or autonomy

as described in R.S. 49:972 by reducing the pregnancy complications and childhood health/behavioral problems associated with substance abuse, which would place stressors on the family unit.

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 a 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 is expected to reduce the costs of pregnancy complications associated with substance abuse, which will ease the financial burden on families.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. She is responsible for responding to inquiries regarding this proposed Rule. A public hearing on this proposed Rule is scheduled for Wednesday, February 26, 2014 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Kathy H. Kliebert

Secretary

Bobby Jindal
GOVERNOR



Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Bureau of Health Services Financing

PUBLIC HEARING CERTIFICATION

February 26, 2014

9:30 a.m.

RE: Pregnant Women
Extended Services
Substance Abuse Screening and Intervention Services
Docket # 022614-07
Department of Health and Hospitals
State of Louisiana

CERTIFICATION

In accordance with LA R.S. 49:950 et seq., the attached public hearing agenda, together with one digital recording of the public hearing conducted on February 26, 2014 in Baton Rouge, Louisiana constitute the official record of the above-referenced public hearing.

A handwritten signature in black ink, appearing to read "Cedric Clark", written over a horizontal line.

Cedric Clark
Policy Development Section

02/26/2014

Date

DHH/BHSF PUBLIC HEARING

Topic – Pregnant Women – Extended Services – Substance Abuse Screening and Intervention Services February 26, 2014

Name	Address	Telephone Number	AGENCY or GROUP you represent
1. <i>Cornette Deane</i>	<i>State of Louisiana Dept. of Health & Hospitals 628 North Street Baton Rouge, LA 70802</i>	<i>225-342-3881</i>	<i>RTH</i>
2.			
3.			
4.			
5.			
6.			