underpaid, divided by the sum of underpayments for all of the hospitals described in this Section.

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, Bureau of Health Services Financing, LR 43:

Interested persons may submit written comments to Jen Steele, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Steele is responsible for responding to all inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Rebekah E. Gee MD, MPH
Secretary

1702#042

DECLARATION OF EMERGENCY

Department of Health
Bureau of Health Services Financing

Professional Services Program
Reimbursement Methodology
Supplemental Payments
(LAC 50:IX.15151 and 15153)

The Department of Health, Bureau of Health Services Financing amends LAC 50:IX.15151 and §15153 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953 (B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing amended the provisions governing the reimbursement methodology for professional services to provide a supplemental payment to physicians and other professional practitioners employed by, or under contract with, non-state owned or operated governmental entities (*Louisiana Register,* Volume 40, Number 3).

The Department of Health, Bureau of Health Services Financing has determined that it is necessary to amend the provisions governing the Professional Services Program to revise the reimbursement methodology for supplemental payments to physicians and other professional service practitioners in order to clarify the qualifying criteria for these payments and to reformat the provisions to ensure they are promulgated in a clear and concise manner in the *Louisiana Administrative Code*. This action is being taken to promote the health and welfare of Medicaid recipients by encouraging continued provider participation in the Medicaid Program to ensure recipient access to services. It is estimated that implementation of this Emergency Rule will have no fiscal impact to the state in fiscal year 2017.

Effective February 20, 2017, the Department of Health, Bureau of Health Services Financing amends the provisions governing the Professional Services Program to amend the reimbursement methodology for supplemental payments to physicians and other professional service practitioners.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part IX. Professional Services Program
Subpart 15. Reimbursement
Chapter 151. Reimbursement Methodology
Subchapter F. Supplemental Payments
§15151. State Owned or Operated Professional Services Practices

A. Qualifying Criteria. Effective for dates of service on or after February 20, 2017, in order to qualify to receive supplemental payments, physicians and other eligible professional service practitioners must be:

1. licensed by the state of Louisiana;
2. enrolled as a Louisiana Medicaid provider; and
3. employed by, or under contract to provide services in affiliation with, a state-owned or operated entity, such as a state-operated hospital or other state entity, including a state academic health system, which:
   a. has been designated by the bureau as an essential provider. Essential providers include:
      i. LSU School of Medicine – New Orleans;
      ii. LSU School of Medicine – Shreveport;
      iii. LSU School of Dentistry; and
      iv. LSU state-operated hospitals (Lallie Kemp Regional Medical Center and Villa Feliciana Geriatric Hospital); and
   b. has furnished satisfactory data to LDH regarding the commercial insurance payments made to its employed physicians and other professional service practitioners.

B. Qualifying Provider Types. For purposes of qualifying for supplemental payments under this Section, services provided by the following professional practitioners will be included:

1. physicians;
2. physician assistants;
3. certified registered nurse practitioners;
4. certified nurse anesthetists;
5. nurse midwives;
6. psychiatrists;
7. psychologists;
8. speech-language pathologists;
9. physical therapists;
10. occupational therapists;
11. podiatrists;
12. optometrists;
13. social workers;
14. dentists;
15. audiologists;
16. chemical dependency counselors;
17. mental health professionals;
18. opticians;
19. nutritionists;
20. paramedics; and
21. doctors of chiropractic.

C. Payment Methodology

1. The supplemental payment to each qualifying physician or other eligible professional services practitioner in the practice plan will equal the difference between the Medicaid payments otherwise made to these qualifying providers for professional services and the average amount that would have been paid at the equivalent community rate. The *community rate* is defined as the average amount that

would have been paid by commercial insurers for the same services.

2. The supplemental payments shall be calculated by applying a conversion factor to actual charges for claims paid during a quarter for Medicaid services provided by the state-owned or operated practice plan providers. The commercial payments and respective charges shall be obtained for the state fiscal year preceding the reimbursement year. If this data is not provided satisfactorily to LDH, the default conversion factor shall equal "1". This conversion factor shall be established annually for qualifying physicians/practitioners by:

a. determining the amount that private commercial insurance companies paid for commercial claims submitted by the state-owned or operated practice plan or entity; and

b. dividing that amount by the respective charges for these payers.

3. The actual charges for paid Medicaid services shall be multiplied by the conversion factor to determine the maximum allowable Medicaid reimbursement. For eligible non-physician practitioners, the maximum allowable Medicaid reimbursement shall be limited to 80 percent of this amount.

4. The actual base Medicaid payments to the qualifying physicians/practitioners employed by a state-owned or operated entity shall then be subtracted from the maximum Medicaid reimbursable amount to determine the supplemental payment amount.

D. Supplemental payments for services provided by the qualifying state-owned or operated physician practice plan will be implemented through a quarterly supplemental payment to providers, based on specific Medicaid paid claim data.

E. - F. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:544 (March 2014), promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:

§15153. Non-State Owned or Operated Professional Services Practices

A. Qualifying Criteria. Effective for dates of service on or after February 20, 2017, in order to qualify to receive supplemental payments, physicians and other eligible professional service practitioners must be:

1. licensed by the state of Louisiana;
2. enrolled as a Louisiana Medicaid provider; and
3. employed by, or under contract to provide services at a non-state owned or operated governmental entity and identified by the non-state owned or operated governmental entity as a physician that is employed by, or under contract to provide services at said entity.

B. Qualifying Provider Types. For purposes of qualifying for supplemental payments under this Section, services provided by the following professional practitioners will be included:

1. physicians;
2. physician assistants;
3. certified registered nurse practitioners;
4. certified nurse anesthetists;
5. nurse midwives;
6. psychiatrists;
7. psychologists;
8. speech-language pathologists;
9. physical therapists;
10. occupational therapists;
11. podiatrists;
12. optometrists;
13. social workers;
14. dentists;
15. audiologists;
16. chemical dependency counselors;
17. mental health professionals;
18. opticians;
19. nutritionists;
20. paramedics; and
21. doctors of chiropractic.

C. The supplemental payment will be determined in a manner to bring payments for these services up to the community rate level.

1. For purposes of this Section, the community rate shall be defined as the rates paid by commercial payers for the same service.

D. The non-state governmental entity shall periodically furnish satisfactory data for calculating the community rate as requested by LDH.

E. Payment Methodology

1. The supplemental payment amount shall be determined by establishing a Medicare to community rate conversion factor for the physician or physician practice plan.

2. At the end of each quarter, for each Medicaid claim paid during the quarter, a Medicare payment amount will be calculated and the Medicare to community rate conversion factor will be applied to the result.

3. Medicaid payments made for the claims paid during the quarter will then be subtracted from this amount to establish the supplemental payment amount for that quarter.

F. The supplemental payments shall be made on a quarterly basis and the Medicare to community rate conversion factor shall be recalculated periodically as determined by the department.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:544 (March 2014), promulgated by the Department of Health, Bureau of Health Services Financing, LR 43:

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.

Interested persons may submit written comments to Jen Steele, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. Ms. Steele is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Rebekah E. Gee MD, MPH
Secretary

1702#043

DECLARATION OF EMERGENCY

Department of Health
Bureau of Health Services Financing

Recovery Audit Contractor Program
(LAC 50:I.Chapter 85)

The Department of Health, Bureau of Health Services Financing adopts LAC 50:I.Chapter 85 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Patient Protection and Affordable Care Act (PPACA), U.S. Public Law 111-148, and 111-152 directed states to establish a Recovery Audit Contractor (RAC) program to audit payments to Medicaid providers. Act 568 of the 2014 Regular Session of the Louisiana Legislature directed the Department of Health and Hospitals to implement a recovery audit contractor program. In compliance with the Patient Protection and Affordable Care Act (PPACA) and Act 568, the department promulgated an Emergency Rule which adopted provisions to establish the RAC program (*Louisiana Register*, Volume 40, Number 11). This Emergency Rule is being promulgated to continue the provisions of the November 20, 2014 Emergency Rule. This action is being taken to avoid federal sanctions.

Effective March 16, 2017, the Department of Health, Bureau of Health Services Financing adopts provisions establishing the Recovery Audit Contractor program.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part I. Administration
Subpart 9. Recovery
Chapter 85. Recovery Audit Contractor

§8501. General Provisions

A. Pursuant to the provisions of the Patient Protection and Affordable Care Act (PPACA), Public Law 111-148, 111-152, and Act 562 of the Regular Session of the Louisiana Legislature, the Medicaid Program adopts provisions to establish a recovery audit contractor (RAC) program.

B. These provisions do not prohibit or restrict any other audit functions that may be performed by the department or its contractors. This Rule shall only apply to Medicaid RACs as they are defined in applicable federal law.

C. This Rule shall apply to RAC audits that begin on or after November 20, 2014, regardless of dates of claims reviewed.

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, Bureau of Health Services Financing, LR 43:

§8503. Definitions

Adverse Determination—any decision rendered by the recovery audit contractor that results in a payment to a provider for a claim or service being reduced either partially or completely.

Department—Department of Health (LDH) or any of its sections, bureaus, offices, or its contracted designee.

Provider—any healthcare entity enrolled with the department as a provider in the Medicaid program.

Recovery Audit Contractor (RAC)—a Medicaid recovery audit contractor selected by the department to perform audits for the purpose of ensuring Medicaid program integrity in accordance with the provisions of 42 CFR 455 et seq.

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, Bureau of Health Services Financing, LR 43:

§8505. Contractor Functions

A. Notwithstanding any law to the contrary, the RAC shall perform all of the following functions.

1. The RAC shall ensure it is reviewing claims within three years of the date of its initial payment. For purposes of this requirement, the three-year look-back period shall commence from the beginning date of the relevant audit.

2. The RAC shall send a determination letter concluding an audit within 60 days of receipt of all requested materials from a provider.

3. For any records which are requested from a provider, the RAC shall ensure proper identification of which records it is seeking. Information shall include, but is not limited to:

a. recipient name;
b. claim number;
c. medical record number (if known); and
d. date(s) of service.

B. Pursuant to applicable statute, the RAC program's scope of review shall exclude the following:

1. all claims processed or paid within 90 days of implementation of any Medicaid managed care program that relates to said claims. This shall not preclude review of claims not related to any Medicaid managed care program implementation;

2. claims processed or paid through a capitated Medicaid managed care program. This scope restriction shall not prohibit any audits of per member per month payments from the department to any capitated Medicaid managed care plan utilizing such claims; and

3. medical necessity reviews in which the provider has obtained prior authorization for the service.

C. The RAC shall refer claims it suspects to be fraudulent directly to the department for investigation.

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, Bureau of Health Services Financing, LR 43:

§8507. Reimbursement and Recoupment

A. The department has in place, and shall retain, a process to ensure that providers receive or retain the appropriate reimbursement amount for claims within any look-back period in which the RAC determines that services delivered have been improperly billed, but reasonable and necessary. It shall be the provider's responsibility to provide documentation to support and justify any recalculation.

B. The RAC and the department shall not recoup any overpayments identified by the RAC until all informal and formal appeals processes have been completed. For purposes of this Section, a final decision by the Division of