FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES
RULE TITLE: Optometry

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

The proposed rule changes will not result in any material costs or savings for state or local governments other than a marginal, one-time publication expense of $600 for the LA State Board of Optometry Examiners. The proposed rule changes increase fees in the aggregate for optometry examiners in Louisiana, as well as amend various rules regarding administrative, clerical, practical, and continuing education duties.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed rule change will increase revenues for the LA State Board of Optometry Examiners by an indeterminable amount due to the increase in examination application fees by $400, from $100 to $500. For reference, the LSBOE had 16 examination applications filed in FY 17, which yields an additional $6,400 in revenue (16 * $500 – 16 * $100) under the new fee.

Furthermore, the proposed rule change consolidates a number of separate fees that will not affect revenue collections in the aggregate. The proposed rule change consolidates fees associated with the now-defunct Therapeutic Pharmaceutical Agent (TPA) Certificate, which has not been required since 2014, into the new fee schedule for optometry licenses. While the TPA Certificate has not been required since 2014, the LSBOE has continued to collect the certificate's associated fees.

The new license renewal fee of $200 is a consolidation of the current license renewal fee ($100) and the Therapeutic Pharmaceutical Agent (TPA) Certificate renewal fee ($100). The new delinquent license fee of $300 is a consolidation of the current delinquent license fee ($150) and the current TPA Certificate delinquent license fee ($150). The new license reinstatement fee of $300 is a consolidation of the current license reinstatement fee ($150) and the current TPA Certificate reinstatement fee ($150).

Lastly, the proposed rule change adds a new $100 fee for the renewal of an inactive license. Revenues derived from the inactive license renewal fee are indeterminable and dependent upon the number of licensees that go to inactive status, and then choose to reactivate their license.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The proposed rule change increases the examination application fee by $400, from $100 to $500, which increases costs for persons seeking licensure as optometry examiners in Louisiana. Because it is unknown how many people will seek licensure from the LSBOE, the aggregate impact of the fee increase is unknown.

Proposed rule changes 109(B), 111(A)-(D), and 112 may benefit optometry examiners because they outline the types of facilities they may accept employment from, provide exceptions to the prohibition on fee splitting for certain types of firms, allow optometry examiners to contract with firms organized to perform the administrative functions of operating a clinic, allow optometry examiners to participate in a government-approved shared savings or alternative payment model, and protect the professional judgment of an optometry examiner from interference by a business partner or contractor. Optometry examiners will likely benefit from the aforementioned rule changes because it provides them more flexibility in who they may choose to enter into business partnerships with when opening clinics, while also protecting their professional judgment if a partner attempts to interfere. Furthermore, the proposed rules clearly enumerate the types of firms optometry examiners may be employed by.

Proposed rule change 503(F)(1) creates a continuing education requirement of 16 hours annually for doctors maintaining a certificate to treat ocular pathology. As a result, persons holding this certificate will incur undetermined costs for annual courses to maintain it. In addition, proposed changes to 503(G) amend topics that may qualify for an optometry examiner's continuing education requirement.

Furthermore, the proposed rule changes amend clinical practice rules regarding the prescription of Schedule II drugs, allowing optometrists to write 7-day prescriptions with a subsequent 7-day refill if needed, rather than the existing 48-hour dosages previously allowed; prohibit the creation of false medical records, and prohibit the destruction of medical records except as allowed by law; establish professional standards for optometrists, as well as pre-examination requirements for persons applying for optometry licenses in Louisiana. These changes do not carry explicit costs to optometry examiners and/or examination applicants, but likely represent a marginal workload increase for the affected parties.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The proposed rule changes may affect competition and employment as a result of optometry examiners having greater flexibility with the types of business partners they may open clinics with, as well as allowing for the contracting of certain administrative clinical services with firms created for that purpose. However, the aggregate effect on competition and employment cannot be predicted because it is unknown if the proposed rule changes will lead to an increase or decrease in optometry firms statewide.

J. Graves Theus, Jr.
Attorney
1803#022

Gregory V. Albrecht
Chief Economist
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health
Bureau of Health Services Financing
and
Office of Behavioral Health

Adult Behavioral Health Services
(LAC 50:XXXIII.6103 and Chapters 63-65)

The Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health propose to amend LAC 50:XXXIII.Chapters 61-65 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, Bureau of Health Services Financing and the Office of Behavioral Health propose to amend the provisions governing adult behavioral health services in order to: 1) clarify the medical necessity criteria and target population for mental health services; 2) allow for more frequent assessments and treatment plan updates based on individual needs; 3) clarify information required to ensure treatment records are comprehensive and include all necessary documents; and 4) update language and revise service authorization requirements.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXXIII. Behavioral Health Services
Subpart 7. Adult Mental Health Services
Chapter 61. General Provisions
§6103. Recipient Qualifications

A. Individuals, 21 years of age and older, who meet Medicaid eligibility, shall qualify to receive adult mental health services referenced in §6307 if medically necessary in accordance with LAC 50:I.1101, if the recipient presents with mental health symptoms that are consistent with a diagnosable mental disorder, and the services are therapeutically appropriate and most beneficial to the recipient.

B. Additional Recipient Eligibility Criteria for Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR)

1. Members must meet the Substance Abuse and Mental Health Services Administration (SAMHSA) definition of, serious mental illness (SMI). In addition to having a diagnosable mental disorder, the condition must substantially interfere with, or limit, one or more major life activities, such as:

a. basic daily living (for example, eating or dressing);

b. instrumental living (for example, taking prescribed medications or getting around the community); and

c. participating in a family, school, or workplace.

2. A member must have a rating of three or greater on the functional status domain on the level of care utilization system (LOCUS).

a. - c. Repealed.

3. Recipients receiving CPST and/or PSR shall have at least a composite score of three on the LOCUS.

4. An adult with longstanding deficits who does not experience any acute changes in their status and has previously met the criteria stated in §6103.B.2-B.3, but who now meets a composite LOCUS score of two or lower, and needs subsequent medically necessary services for stabilization and maintenance at a lower intensity, may continue to receive CPST services and/or PSR, if deemed medically necessary.

C. An adult with a diagnosis of a substance use disorder or intellectual and developmental disability without an additional co-occurring qualifying mental health diagnosis shall not meet the criteria for adult mental health rehabilitation services.

D. 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 38:358 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:378 (February 2015), LR 42:60 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:

Chapter 63. Services
§6301. General Provisions

A. ...

B. All services must be authorized.

C. - E. ...

F. Services may be provided at a facility, in the community, or in the individual's place of residence as outlined in the treatment plan. Services may be furnished in a nursing facility only in accordance with policies and procedures issued 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 38:359 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:378 (February 2015), LR 42:60 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:

§6303. Assessments

A. For mental health rehabilitation services, each enrollee shall be assessed and have a treatment plan developed for CPST and PSR.

B. ...

C. Assessments must be performed at least once every 365 days or any time there is a significant change to the enrollee's circumstances.

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 38:359 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:378 (February 2015), LR 42:60 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:

§6305. Treatment Plan

A. Each enrollee who receives CPST and PSR services shall have a treatment plan developed based upon the assessment.

B. The individualized treatment plan shall be developed according to the criteria established by the department and in accordance with the provisions of this Rule, the provider manual and other notices or directives issued by the department.

1. The treatment plan shall be reviewed at least once every 365 days or when there is a significant change in the individual's circumstances.

C. The treatment plan shall be developed by the LMHP or physician in collaboration with direct care staff, the recipient, family and natural supports.

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 38:359 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 42:60 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:

§6307. Covered Services

A. The following mental health services shall be reimbursed under the Medicaid Program:

1. therapeutic services, including diagnosis and treatment delivered by LMHPs and physicians; and

2. rehabilitation services, including community psychiatric support and treatment (CPST) and psychosocial rehabilitation and crisis intervention.

3. Repealed.

B. - B.3. ...

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 38:359 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 42:61 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:

Chapter 65. Provider Participation

§6501. Provider Responsibilities

A. - B. ...

C. Anyone providing adult mental health services must operate within their scope of practice license.

D. Providers shall maintain case records that include, at a minimum:

1. the name of the individual;

2. the dates and time of service;

3. assessments;

4. a copy of the treatment plans, which include at a minimum:

a. goals and objectives, which are specific, measureable, action oriented, realistic and time-limited;

b. specific interventions;

c. the service locations for each intervention;

d. the staff providing the intervention; and

e. the dates of service;

5. progress notes that include the content of each delivered service, including the reason for the contact describing the goals/objectives addressed during the service, specific intervention(s), progress made toward functional and clinical improvement;

6. units of services provided;

7. crisis plan;

8. discharge plan; and

9. advanced directive.

E. - E.6. 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 38:360 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:378 (February 2015), LR 42:61 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have no impact on family functioning, stability and autonomy as described in R.S. 49:972.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, but may result in direct or indirect cost to the provider to provide the same level of service due to the change in criteria for receipt of these services. The proposed Rule may also have a negative impact on the provider's ability to provide the same level of service as described in HCR 170 if the reduction in payments adversely impacts the provider's financial standing.

Public Comments

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 inquiries regarding this proposed Rule. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Public Hearing

A public hearing on this proposed Rule is scheduled for Thursday, April 26, 2018 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.

Rebekah E. Gee MD, MPH
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES
RULE TITLE: Adult Behavioral Health Services

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

It is anticipated that implementation of this proposed rule will have no programmatic fiscal impact to the state other than the cost of promulgation for FY 17-18. However, it is anticipated that the implementation of this proposed rule will result in estimated state general fund programmatic savings of $1,560,524 for FY 18-19 and $1,607,340 for FY 19-20. It is anticipated that $1,080 ($540 SGF and $540 FED) will be

expended in FY 17-18 for the state's administrative expense for promulgation of this proposed rule and the final rule. The numbers reflected above are based on a blended Federal Medical Assistance Percentage (FMAP) rate of 64.23 percent in FY 18-19 and FY 19-20.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the implementation of this proposed rule will reduce federal revenue collections by $2,802,138 for FY 18-19, $2,886,202 for FY 19-20. It is anticipated that $540 will be expended in FY 17-18 for the federal administrative expenses for promulgation of this proposed rule and the final rule. The numbers reflected above are based on a blended Federal Medical Assistance Percentage (FMAP) rate of 64.23 percent in FY 18-19 and FY 19-20.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This proposed Rule amends the provisions governing adult behavioral health services in order to: 1) clarify the medical necessity criteria and target population for mental health services; 2) allow for more frequent assessments and treatment plan updates based on individual needs; 3) clarify information required to ensure treatment records are comprehensive and include all necessary documents; and 4) update language and revise service authorization requirements. Recipients may be impacted by implementation of this proposed Rule since fewer may be eligible to receive mental health services based on the revised criteria. Providers may also be impacted if the change in recipient eligibility results in reduction in payments. It is anticipated that implementation of this proposed rule will reduce programmatic expenditures for adult behavioral health services by approximately $4,362,662 for FY 18-19 and $4,493,542 for FY 19-20.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

It is anticipated that the implementation of this proposed rule will not have an effect on competition.

Jen Steele
Medicaid Director
1803#040

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health
Bureau of Health Services Financing

Healthcare Services Provider Fees (LAC 48:I.Chapter 40)

The Department of Health, Bureau of Health Services Financing proposes to amend LAC 48:I.Chapter 40 in the Medical Assistance Program as authorized by R.S. 36:254 and R.S. 46:2625. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

In compliance with the requirements of House Concurrent Resolution 8 of the 2017 Regular Session of the Louisiana Legislature and R.S. 46:2626, the Department of Health, Bureau of Health Services Financing proposes to amend the provisions governing healthcare services provider fees in order to revise the assessment methodology for hospital and emergency ground ambulance services providers. This proposed Rule also amends the provisions governing the provider fees for nursing facility services, intermediate care facilities for individuals with developmental disabilities, and pharmacy services to more closely align these provisions with current governing authorities and to ensure that they are promulgated in a clear and concise manner in the *Louisiana Administrative Code*.

Title 48
PUBLIC HEALTH—GENERAL
PART I. GENERAL Administration
Subpart 1. General
Chapter 40. Provider Fees
§4001. Specific Fees

A. Definitions

Emergency Ground Ambulance Service Provider-a non-public, non-federal provider of emergency ground ambulance services.

Net Operating Revenue—Repealed.

Quarter—for purposes of this Chapter, quarters shall be constituted as follows.

First Quarter	December, January, February
Second Quarter	March, April, May
Third Quarter	June, July, August
Fourth Quarter	September, October, November

a. Exception. For purposes of hospital and emergency ground ambulance services, quarters shall be constituted as follows.

First Quarter	July, August, September
Second Quarter	October, November, December
Third Quarter	January, February, March
Fourth Quarter	April, May, June

B. Nursing Facility Services

1. A fee shall be paid by each facility licensed as a nursing home in accordance with R.S. 40:2009.3 et seq., for each occupied bed on a per day basis. A bed shall be considered occupied, regardless of physical occupancy, based upon payment for nursing facility services available or provided to any individual or payer through formal or informal agreement. For example, a bed reserved and paid for during a temporary absence from a nursing facility shall be subject to the fee. Likewise, any bed or beds under contract to a Hospice shall be subject to the fee for each day payment is made by the Hospice. Contracts, agreements, or reservations, whether formal or informal, shall be subject to the fee only where payment is made for nursing services available or provided. Nursing facilities subject to the fee shall provide documentation quarterly, on a form provided by the department, of occupied beds in conjunction with payment of the fee.

2. The fee imposed for nursing facility services shall not exceed 6 percent of the net patient revenues received by providers of that class of services and shall not exceed $12.08 per occupied bed per day. The fee amount shall be calculated annually in conjunction with updating provider reimbursement rates under the Medical Assistance Program. Notice to providers subject to fees shall be given in conjunction with the annual rate setting notification by the Bureau of Health Services Financing.

C. Intermediate Care Facility for Individuals with Developmental Disabilities (ICF/DD) Services

1. A fee shall be paid by each facility licensed as an intermediate care facility for individuals with developmental disabilities in accordance with R.S. 46:2625 et seq., for each