Medicaid Provider Manuals Public Comments

Date Submitted	Item Number	My question/comment
2/18/2022 15:05	2022-BH-2 Section 2.3 – Outpatient Services - PCS	Interested in being a provider for this population.
1/28/2022 14:24	2021 – Professional Services - 24 Section 5.1 – Sinus Procedures	As an otolaryngologist and a co-author of "Clinical Practice Guideline: Adult Sinusitis" published in 2015, I write to express my endorsement of the proposed coverage policy regarding the treatment for chronic rhinosinusitis in Louisiana. The recommendation to pursue 6 weeks of medical therapy prior to embarking on surgical procedures is supported by the published medical literature. Jay F. Piccirillo, MD, FACS Washington University School of Medicine, St. Louis, MO
1/26/2022 10:51	2021 – Professional Services - 24 Section 5.1 – Sinus Procedures	I had previously submitted a public comment on January 24th but made a minor change. Can the newly submitted one (sent Jan 25) be posted instead? Thank you.

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1/26/2022 10:49	2021 – Professional Services - 24 Section 5.1 – Sinus Procedures	We are writing in support of the proposed coverage policy regarding treatment for chronic rhinosinusitis in Louisiana. From a review of treatments for patients with chronic rhinosinusitis, we have found published evidence that conservative approaches are higher value and should be prioritized as a first-line treatment compared to invasive approaches such as balloon ostial dilation and functional endoscopic sinus surgery. This comprehensive policy to determine eligibility for nasal sinus endoscopy procedures has immense potential for increasing utilization of evidence-based treatments and reducing low-value use of risky and expensive procedures to treat Louisiana Medicaid beneficiaries with chronic rhinosinusitis. There are several available treatments intended to relieve symptoms of chronic rhinosinusitis. Evidence strongly supports the use of saline irrigation and topical corticosteroids as first-line therapy, with clinical trials revealing improvements in chronic rhinosinusitis symptoms and quality of life as well as reduced need for procedural intervention following use of these treatments.1 Clinical practice guidelines from the American Academy of Otolaryngology-Head and Neck Surgery and International Forum of Allergy and Rhinology recommend, with Grade A evidence, their use as first-line treatments for chronic rhinosinusitis.2,3 However, when chronic rhinosinusitis is refractory to medical therapy alone, patients sometimes receive functional endoscopic sinus surgery or balloon ostial dilation. Clinical trial evaluations of the efficacy of balloon ostial dilation and functional endoscopic sinus surgery have typically been uncontrolled and unblinded, with relatively small enrollment.4 In their most recent clinical guidelines, the American Academy of Otolaryngology-Head and Neck Surgery did not address the use of these sinus procedures due to the lack of rigorous evidence comparing either procedure to placebo.5 Due to this lack of robust evidence, it is critical that medical therapy, which is strongly backed by clinical studies, be employed prior to attempting any interventional procedures. Therefore, we endorse this proposed coverage policy for providing a standardized definition for chronic rhinosinusitis and reserving functional endoscopic sinus surgery or balloon ostial dilation only for cases that are refractory to at least 6 weeks of evidence-based medical therapies. We believe this prior authorization-based program can do much to improve care for Louisiana's Medicaid beneficiaries with chronic rhinosinusitis.

		Robin Ji, BA. UCSF School of Medicine, San Francisco, CA. Sanket S. Dhruva, MD, MHS. UCSF School of Medicine, San Francisco, CA. Rita F. Redberg, MD, MSc. UCSF School of Medicine, San Francisco, CA. References 1. Rudmik L, Soler ZM. Medical Therapies for Adult Chronic Sinusitis. JAMA. 2015;314(9):926. doi:10.1001/jama.2015.7544 2. Thomas WW, Harvey RJ, Rudmik L, Hwang PH, Schlosser RJ. Distribution of topical agents to the paranasal sinuses: an evidence-based review with recommendations. Int Forum Allergy Rhinol. 2013;3(9):691-703. doi:10.1002/alr.21172 3. Orlandi RR, Kingdom TT, Smith TL, et al. International consensus statement on allergy and rhinology: rhinosinusitis 2021. Int Forum Allergy Rhinol. 2021;11(3):213-739. doi:https://doi.org/10.1002/alr.22741 4. Soler ZM, Smith TL. Quality of Life Outcomes after Functional Endoscopic Sinus Surgery. Otolaryngol Clin North Am. 2010;43(3):605-612. doi:10.1016/j.otc.2010.03.001 5. Rosenfeld RM, Piccirillo JF, Chandrasekhar SS, et al. Clinical practice guideline (update): Adult sinusitis. Otolaryngol - Head Neck Surg U S. 2015;152:S1-S39. doi:10.1177/0194599815572097

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1/25/2022 17:58	2021 – Professional Services - 24 Section 5.1 – Sinus Procedures	We are writing in support of the proposed coverage policy regarding treatment for chronic rhinosinusitis in Louisiana. From a review of treatments for patients with chronic rhinosinusitis, we have found published evidence that conservative approaches are higher value and should be prioritized as a first-line treatment compared to invasive approaches such as balloon ostial dilation and functional endoscopic sinus surgery. This comprehensive policy to determine eligibility for nasal sinus endoscopy procedures has immense potential for increasing utilization of evidence-based treatments and reducing low-value use of risky and expensive procedures to treat Louisiana Medicaid beneficiaries with chronic rhinosinusitis. There are several available treatments intended to relieve symptoms of chronic rhinosinusitis. Evidence strongly supports the use of saline irrigation and topical corticosteroids as first-line therapy, with clinical trials revealing improvements in chronic rhinosinusitis symptoms and quality of life as well as reduced need for procedural intervention following use of these treatments.1 Clinical practice guidelines from the American Academy of Otolaryngology-Head and Neck Surgery and International Forum of Allergy and Rhinology recommend, with Grade A evidence, their use as first-line treatments for chronic rhinosinusitis.2,3 However, when chronic rhinosinusitis is refractory to medical therapy alone, patients sometimes receive functional endoscopic sinus surgery or balloon ostial dilation. Clinical trial evaluations of the efficacy of balloon ostial dilation and functional endoscopic sinus surgery have typically been uncontrolled and unblinded, with relatively small enrollment.4 Studies comparing continued medical therapy to continued medical therapy in combination with functional endoscopic sinus surgery have demonstrated the ability of continued medical therapy (combination of sinus irrigation and broad-spectrum antibiotic) to delay endoscopic intervention in 58% of patients for 1 year.5 In their most recent clinical guidelines, the American Academy of Otolaryngology-Head and Neck Surgery did not address the use of these sinus procedures due to the lack of rigorous evidence comparing either procedure to placebo.6 Due to this lack of robust evidence, it is critical that medical therapy, which is strongly backed by clinical studies, be employed prior to attempting any interventional procedures. Therefore, we endorse this proposed coverage policy for providing a standardized definition for chronic rhinosinusitis and reserving functional endoscopic sinus surgery or balloon ostial dilation only for cases that are refractory to at least 6 weeks of evidence-based

		medical therapies. We believe this prior authorization-based program can do much to improve care for Louisiana's Medicaid beneficiaries with chronic rhinosinusitis. Robin Ji, BA. UCSF School of Medicine, San Francisco, CA. Sanket S. Dhruva, MD, MHS. UCSF School of Medicine, San Francisco, CA. Rita F. Redberg, MD, MSc. UCSF School of Medicine, San Francisco, CA. References 1. Rudmik L, Soler ZM. Medical Therapies for Adult Chronic Sinusitis. JAMA. 2015;314(9):926. doi:10.1001/jama.2015.7544 2. Thomas WW, Harvey RJ, Rudmik L, Hwang PH, Schlosser RJ. Distribution of topical agents to the paranasal sinuses: an evidence-based review with recommendations. Int Forum Allergy Rhinol. 2013;3(9):691-703. doi:10.1002/alr.21172 3. Orlandi RR, Kingdom TT, Smith TL, et al. International consensus statement on allergy and rhinology: rhinosinusitis 2021. Int Forum Allergy Rhinol. 2021;11(3):213-739. doi:https://doi.org/10.1002/alr.22741 4. Soler ZM, Smith TL. Quality of Life Outcomes after Functional Endoscopic Sinus Surgery. Otolaryngol Clin North Am. 2010;43(3):605-612. doi:10.1016/j.otc.2010.03.001 5. Hartog B, van Benthem PP, Prins LC, Hordijk GJ. Efficacy of sinus irrigation versus sinus irrigation followed by functional endoscopic sinus surgery. Ann Otol Rhinol Laryngol. 1997;106(9):759-766. doi:10.1177/000348949710600909 6. Rosenfeld RM, Piccirillo JF, Chandrasekhar SS, et al. Clinical practice guideline (update): Adult sinusitis. Otolaryngol - Head Neck Surg U S. 2015;152:S1-S39. doi:10.1177/0194599815572097

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12/6/2021 11:04	2021-Medical Transportation-7 Section 10.13 – Ambulance – Claims and Encounters	Section 10.13 – Ambulance – Claims and Encounters 1. Ambulance Transportation Modifiers Provision: “Emergency ambulance claims, that are not treatment-in-place, are only payable with a destination modifier of H, I, or X. Valid treatment-in-place ambulance claim modifiers are identified in the Treatment-in-Place section.” (Ambulance Transportation Modifiers section, pg. 5) Comment/Recommendation: The concern on this would be that as the ambulance industry evolves and newer alternative destinations are considered covered for payment, this provision would preclude any sort of payment for transports to alternative destinations. For instance, there are multiple examples of this type of change currently occurring in the ambulance industry. On the Medicare level, a pilot program known as the ET3 model allows Medicare to pay participants for transports to alternative destinations, such as primary care offices, urgent care clinics, community mental health centers, etc. In addition, alternative destination transports have been allowed by CMS during the current COVID-19 public health emergency. Our recommendation would be to delete the provision which states “emergency ambulance claims, that are not treatment-in-place, are only payable with a destination modifier of H, I, or X. Valid treatment-in-place ambulance claim modifiers are identified in the Treatment-in-Place section.” This provision does not allow for flexibility and innovation in the realm of ambulance transports. Providers are currently collaborating with multiple payers (Medicare, commercial insurance, etc.) on the practice of reimbursement for transportation to alternative destinations, and the Medicaid program should not have such a rigid restriction contained in the Medicaid manual. In addition, this language could discourage the Medicaid program and MCOs from discussing the idea of alternative destinations with providers or implementing an alternative destination program for Medicaid beneficiaries. 2. Medicaid Non-Covered Ambulance Modifiers Provision: “Edits shall be in place to deny ambulance claims as non-covered services when any of the following modifiers are billed on the claim, in the any modifier field.” (Medicaid Non-Covered Ambulance Modifiers section, pg. 5)

		The modifiers listed are as follows: GY - An item or service is that statutorily excluded; QL - The patient is pronounced dead after the ambulance is called but before transport; TQ - Basic life support by a volunteer ambulance provider. Comment/Recommendation: The comment on this provision is regarding the QL modifier being included on this list of edits which must be denied by the Medicaid program. Medicare will pay for a "QL" response, and Medicaid is responsible for the Medicare co-pay/deductible amount up to the Medicaid allowed amount. Medicare will pay for the base rate, but not mileage when this modifier is used. If there is an automatic edit on secondary claims to deny this modifier, then Medicaid will not pay their cost sharing portion. Thus, an automatic denial edit when the QL modifier is used would lead to Medicaid not paying amounts which are owed to ambulance providers. It is our recommendation that the QL modifier be removed from this list of non-covered modifiers so that providers can be paid amounts owed when a Medicare claim crosses over to the Medicaid program.

11/5/2021 18:46	2021-Professional Services-23 Section 5.1 - Covered Services – Cardiovascular	We are writing in support of the proposed coverage policy regarding endovascular revascularization in Louisiana. From a review of treatments for patients with lower extremity peripheral artery disease who have intermittent claudication, we have found widespread published evidence that conservative approaches that focus on tobacco cessation, medication therapy, and supervised exercise therapy are higher value, although underutilized, compared to invasive approaches such as endovascular revascularization. Studies comparing endovascular revascularization with optimal medical therapy and supervised exercise therapy in patients with lower extremity peripheral artery disease and intermittent claudication have shown similar clinical outcomes, greater patient safety, and better cost-effectiveness with medical therapy. The Claudication: Exercise Versus Endoluminal Revascularization (CLEVER)1, Endovascular Revascularization And Supervised Exercise (ERASE)2, and Invasive Revascularization or Not in Intermittent Claudication (IRONIC)3 clinical trials are just a few examples of the robust data that has shown conservative therapy not only resulted in similar quality of life, functional, and long-term outcomes as endovascular revascularization, but also prevented severe procedure-related complications such as renal failure, stroke, bleeding, and death. Beyond clinical outcomes, cost-effectiveness analyses have shown that supervised exercise therapy is more cost-effective than endovascular revascularization, with total mean cumulative costs per patient significantly higher in endovascular revascularization groups and surpassing the generally accepted threshold willingness-to-pay value, which favors exercise.4 Despite this evidence, numerous studies show that clinical practice has not yet adopted optimal medical therapy and supervised exercise therapy as the primary treatment option. A national assessment of availability and utilization of supervised exercise therapy in the treatment of lower extremity peripheral artery disease with intermittent claudication found that while 98% of the 135 surveyed physicians indicated that they would refer patients to a SET program if there was one available, 49% had never referred a patient for SET, and 26% were not aware that SET sessions were covered by the Centers for Medicare & Medicaid Services.5 In an analysis of 1,982 outpatient visits from 2005-2012 for patients with peripheral artery disease, any antiplatelet therapy was used in only 35.7% of visits, statin in 33.1%, angiotensin-converting enzyme inhibitors or angiotensin receptor blockers in 28.4%, cilostazol in 4.7%, exercise or diet counseling was used in 22% of visits, and smoking cessation treatment was used in 35.8% of visits for patients that were smokers.6 These data

		demonstrate that access to optimal medical therapy and participation in supervised exercise is underutilized despite their being safer, more affordable, and recommended as Class 1A recommendation in clinical practice guidelines by Society for Vascular Surgery.7 Given the preponderance of evidence, we endorse this proposed coverage policy requiring up to 36 sessions of supervised exercise therapy as well as documented lack of improvement from conservative measures prior to coverage of endovascular intervention. This comprehensive policy to determine eligibility for endovascular revascularization has immense potential for increasing utilization of evidence-based treatments and reducing the harms caused by widespread, low-value use of a risky and expensive procedure. We believe this prior authorization-based program can do much to improve care for Louisiana's Medicaid beneficiaries with lower extremity peripheral artery disease with intermittent claudication. Robin Ji, BA. UCSF School of Medicine, San Francisco, CA. Sanket S. Dhruva, MD, MHS. UCSF School of Medicine, San Francisco, CA. Rita F. Redberg, MD, MSc. UCSF School of Medicine, San Francisco, CA. Ashwin Shetty, MS. Louisiana State University Health Science Center School of Medicine, New Orleans. 1. Reynolds MR, Apruzzese P, Galper BZ, et al. Cost?Effectiveness of Supervised Exercise, Stenting, and Optimal Medical Care for Claudication: Results From the Claudication: Exercise Versus Endoluminal Revascularization (CLEVER) Trial. J Am Heart Assoc. 3(6):e001233. doi:10.1161/JAHA.114.001233 2. Fakhry F, Spronk S, van der Laan L, et al. Endovascular Revascularization and Supervised Exercise for Peripheral Artery Disease and Intermittent Claudication: A Randomized Clinical Trial. JAMA. 2015;314(18):1936-1944. doi:10.1001/jama.2015.14851 3. Djerf H, Millinger J, Falkenberg M, Jivegård L, Svensson M,

		Nordanstig J. Absence of Long-Term Benefit of Revascularization in Patients With Intermittent Claudication: Five-Year Results From the IRONIC Randomized Controlled Trial. Circ Cardiovasc Interv. 2020;13(1):e008450. doi:10.1161/CIRCINTERVENTIONS.119.008450 4. Spronk S, Bosch JL, Hoed PT den, Veen HF, Pattynama PMT, Hunink MGM. Cost-effectiveness of endovascular revascularization compared to supervised hospital-based exercise training in patients with intermittent claudication: A randomized controlled trial. J Vasc Surg. 2008;48(6):1472-1480. doi:10.1016/j.jvs.2008.06.016 5. Dua A, Gologorsky R, Savage D, et al. National assessment of availability, awareness, and utilization of supervised exercise therapy for peripheral artery disease patients with intermittent claudication. J Vasc Surg. 2020;71(5):1702-1707. doi:10.1016/j.jvs.2019.08.238 6. Berger JS, Ladapo JA. Underuse of Prevention and Lifestyle Counseling in Patients With Peripheral Artery Disease. J Am Coll Cardiol. 2017;69(18):2293-2300. doi:10.1016/j.jacc.2017.02.064 7. Saxon JT, Safley DM, Mena-Hurtado C, Heyligers J, Fitridge R, Shishehbor M. Adherence to Guideline-Recommended Therapy Including Supervised Exercise Therapy Referral Across Peripheral Artery Disease Specialty Clinics: Insights From the International PORTRAIT Registry. J Vasc Surg. 2020;71(5):1813-1814. doi:10.1016/j.jvs.2020.02.007

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11/4/2021 17:02	2021-Medical Transportation-4 Section 10.4 – Provider Responsibilities	Section 10.4 NEMT - Provider Responsibilities Provision: A revision to the Medicaid manual states, "the transportation broker shall ensure that transportation providers comply with the following provider responsibilities for all NEMT and NEAT services within this section." (Section 10.4: NEMT - Provider Responsibilities, pg. 1 of the proposed Medicaid Manual Section) Comments/Recommendations: This seems to add ambulance providers into sections of the manual which are historically and currently NEMT provider sections. Ambulance providers have never had these requirements placed on them by statute, rule, or policy. It seems as though some of the new requirements placed on ambulance providers by this section would mandate providers be in line with requirements set out in RS 46:450.2 which applies to vehicles engaged in providing nonemergency, nonambulance transportation. Another example of these provider responsibilities only needing to be placed on NEMT providers is the emergency action procedure section. The vast majority, if not all, of the NEAT providers respond to 911 emergency situations and are well equipped to handle a medical emergency if one should arise during a non-emergency ambulance transport. There should not be specific provisions in a Medicaid manual to dictate how to handle this type of situation. This type of thing would be covered in their ambulance service's medical protocols. As stated above, these provider responsibility provisions have always pertained to NEMT providers in previous versions of the manual, and it seems to be unnecessary to include ambulance providers into this section of the manual. These provisions seem to be trying to place ambulance providers who provide non-emergency medical ambulance transportation services into the same space as traditional non-emergency, nonambulance medical transportation providers when the duties, responsibilities, and requirements of the two different service providers are exceedingly dissimilar. Ambulance providers who already must meet all federal, state, and local requirements should not have

		additional responsibilities placed on them. The provider manual currently expresses the necessary standards and responsibilities for ambulance providers by stating: "To participate in the Medicaid program, ambulance providers must meet the requirements of La. R.S. 40:1135.3. Licensing by the Louisiana Department of Health (LDH) Bureau of Emergency Medical Services is also required. Services must be provided in accordance with state law and regulations governing the administration of these services. Additionally, licensure is required for the medical technicians and other ambulance personnel by the LDH Bureau of Emergency Medical Services." This or a substantially similar standard has historically been mandated on ambulance providers. The recommendation is that the quoted above provisions be the only necessary requirements/standards/responsibilities placed on ambulance providers in the Medicaid manual, and that the provider responsibilities listed in the NEMT sections of the Medicaid manual only apply to non-emergency, nonambulance medical transportation providers as has historically been done. The manual provision relating to provider responsibilities should state that "the transportation broker shall ensure that non-emergency, nonambulance medical transportation providers comply with the following provider responsibilities for all NEMT services within this section." This also goes back to previous comments that ambulance (NEAT) and NEMT provisions should be contained in separate sections of the manual for clarity and to avoid confusion and unintended consequences. It cannot be stressed enough that ambulance providers should have their own distinct and separate sections/provisions in the manual and ambulance policies/guidelines should not be added into NEMT sections.

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11/4/2021 16:56	2021-Medical Transportation-3 Section 10.3 – Provider Requirements	The Louisiana Ambulance Alliance ("the Alliance") appreciates the opportunity to comment on the recent proposed changes to the Medicaid manual affecting non-emergency ambulance transportation ("NEAT") in Louisiana. The Alliance is the membership organization for EMS providers in Louisiana. From Acadian Ambulance, the state's largest EMS provider, to Caddo Fire District #6, one of the state's smallest providers, we speak with one voice. For the reasons detailed below, we urge the Louisiana Department of Health adopt the following suggestions and revise the proposed Medicaid manual provisions posted on September 24, 2021. 3. Section 10.3 NEMT - Provider Requirements Provision: "The transportation broker shall ensure that the transportation provider agrees to cover the entire parish for which he or she provides NEMT or NEAT services." (Section 10.3: NEMT - Provider Requirements, General Requirements, pg. 1 of the proposed Medicaid Manual Section) Comments/Recommendations: This is another provision which has pertained only to NEMT providers throughout previous versions of the Medicaid Medical Transportation Manual. This provision will lead to problems in the general structure of ambulance providers. Ambulance providers are strictly governed by local governing bodies (municipalities and parishes). Providers must receive permits and permission to provide services in an area. An issue will materialize due to the fact some providers may have a permit/permission to provide services to/in a municipality within a parish, but not to/in the entire parish itself. With exclusivity agreements, it is not uncommon for a provider to have part of parish where it can provide services while another provider can provide services in the rest of the parish. This provision could possibly disqualify all providers who can currently provide non-emergency services due to the fact they can provide services within a municipality or section of the parish, but not the entire parish. This provision could leave places throughout the state without ambulance providers to provide non-emergency transports to Medicaid enrollees in the area.

		Historically, this provision has been contained in the NEMT section of the Medicaid manual. For the reasons expressed above, the recommendation would be to delete “or NEAT” services from this provision of the Medicaid manual. In addition, it is unclear on whether the other parts of section 10.3: NEMT Provider Requirements apply to ambulance providers. There are parts which apply to drivers, transportation providers, and NEMT providers. Read with the language in the revised Covered Services section, it could easily be interpreted that all these provisions apply to ambulance providers which should not be the case. This goes back to previous comments that ambulance (NEAT) and NEMT provisions should be contained in separate sections of the manual for clarity and to avoid confusion and unintended consequences.

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11/4/2021 16:54	202-Medical Transportation-2 Section 10.2 – Scheduling and Authorization	The Louisiana Ambulance Alliance ("the Alliance") appreciates the opportunity to comment on the recent proposed changes to the Medicaid manual affecting non-emergency ambulance transportation ("NEAT") in Louisiana. The Alliance is the membership organization for EMS providers in Louisiana. From Acadian Ambulance, the state's largest EMS provider, to Caddo Fire District #6, one of the state's smallest providers, we speak with one voice. For the reasons detailed below, we urge the Louisiana Department of Health adopt the following suggestions and revise the proposed Medicaid Manual provisions posted on September 24, 2021. 2. Section 10.2 NEMT - Scheduling and Authorizing Provision: Beneficiaries shall be allowed a choice of providers when the costs of two or more providers are equal, according to LAC 50: XXVII 505(B). When multiple providers meet the least costly standard, the beneficiary may choose a preferred transportation provider, as outline by the Louisiana Medicaid Plan, Attachment 3.1A, Item 24.a, Page 4, Section II.C.1.4. The transportation broker is prohibited from dispatching trips to out-of-region providers, unless the transportation broker retains documentation to support that there is no willing and available provider in the administrative region1 where the beneficiary is domiciled able to comply with time requirements or that the out-of-region provider is the least costly option. (Section 10.2: NEMT Scheduling and Authorization – General Requirements, pg. 1 of the proposed Medicaid Manual Section) Comments: This paragraph has no specific reference to NEMT or NEAT. However, the Louisiana Medicaid State Plan citation refers to a section only pertaining to non-emergency non-ambulance transportation. This leads to the question on whether this provision applies to ambulance providers. As stated in previous comments to this manual, each program should have distinct sections and provisions which are clearly identified and separated from one another to avoid confusion and ambiguity in provisions. The recommendation would be that all of the provisions which pertain to NEMT be placed in the NEMT sections of the manual,

		and all NEAT provisions should be included in the ambulance sections of the manual. This is necessary to provide clarity on which provisions are applicable to each provider type. Provisions: New provisions under the Scheduling and Dispatching/Authorization Section (Section 10.2: NEMT Scheduling and Authorization – General Requirements, pg. 2 of the proposed Medicaid Manual Section) state: "Transportation providers shall pick up enrollees no later than three hours after notification by a medical facility of a scheduled discharge or two hours after the scheduled discharge time, whichever is later. Examples are as follows: • If a medical facility notifies the transportation broker at 12:00 pm for a 12:30 pm discharge, the enrollee shall be picked up no later than 3 pm. • If a medical facility notifies the transportation broker at 12:00 pm for a 2 pm discharge, the enrollee shall be picked up no later than 4 pm. • If a medical facility notifies the transportation broker at 8 pm for a 7 am discharge the next day, the enrollee shall be picked up no later than 9 am." Comments/Recommendations: Would this requirement apply for all NEMT and NEAT providers? It is not clear considering the wording of the manual. We completely agree that discharges from hospitals should be made timely. However, there are many scenarios in which an ambulance provider may need more than two- or three-hours advance notice to transport a patient for a hospital discharge, such as during emergency circumstances. There should be a provision where extenuating circumstances or force majeure permit a provider to transport a hospital discharge outside of these rigid parameters without consequence to the provider. If there is an emergency or unavoidable situation, such as multiple trauma calls, a medical surge event such as a public health emergency, or a

		weather event, an exception should be made to these strict timelines. Adhering to these timelines for 100% of discharges will be exceedingly difficult considering the dire workforce shortage and extended hospital wait times providers are currently facing. An important note to remember is that ambulance providers are responding to unscheduled emergency calls throughout the state while also providing non-emergency ambulance services. The recommendation would be for there to be an exemption to these timelines in the manual for extenuating circumstances/good cause or force majeure.

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11/4/2021 16:47	2021-Medical Transportation-1 Section 10.1 – Covered Services	The Louisiana Ambulance Alliance ("the Alliance") appreciates the opportunity to comment on the recent proposed changes to the Medicaid manual affecting non-emergency ambulance transportation ("NEAT") in Louisiana. The Alliance is the membership organization for EMS providers in Louisiana. From Acadian Ambulance, the state's largest EMS provider, to Caddo Fire District #6, one of the state's smallest providers, we speak with one voice. For the reasons detailed below, we urge the Louisiana Department of Health adopt the following suggestions and revise the proposed MCO manual provisions posted on September 24, 2021. 1. Section 10.1 NEMT Covered Services Provision: "The transportation broker shall authorize cover Non-Emergency Medical Transportation (NEMT), including Non-Emergency Ambulance Transportation (NEAT), for the least costly means of transportation available that accommodates the level of service required by the beneficiary to and/or from a qualified provider of routine or specialty care providers of routine Medicaid covered services for Medicaid beneficiaries." (Section 10.1: NEMT - Covered Services Section, pg. 1 of the proposed Medicaid Manual Section) Comment/Recommendations: This provision has historically only been included in the NEMT section of the Medicaid manual, not the ambulance portion of the manual, and did not have an impact on ambulance providers. It seems as though the language is taken from a non-emergency nonambulance transportation services section of the Louisiana Medicaid State Plan and language from a proposed rule which only affect non-emergency nonambulance providers. Thus, the recommendation would be for the provision "including Non-Emergency Ambulance Transportation (NEAT)" be deleted from this provision as it should not apply to ambulance providers. Provision: "Transportation requirements in this section apply to

		both NEMT and NEAT services unless otherwise specified (i.e. NEMT specific guidance applies only to non-ambulance transportation)." (Section 10.1: NEMT - Covered Services Section, pg. 1 of the proposed Medicaid Manual Section) Comments/Recommendations: These statements are ambiguous and leave a lot open to interpretation. Does this mean that there must be a specific reference to NEAT for a provision to apply to non-emergency ambulance transportation? For example, in the Medicaid manual, there are several sections which are general and there is no specific NEMT or NEAT reference, would these provisions pertain to NEAT? Specific examples of this include but are not limited to sections relating to Exclusions, Gas Reimbursement, Attendants, Children, Signage, Vehicle Inspections, Record Keeping etc. In addition, there are several sections which pertain to NEMT providers in the manual itself. Since NEAT is a form of NEMT under the proposed manual, would these provisions pertain to NEAT? An argument can be made that any reference to NEMT providers could include ambulance providers under the proposed revisions. There are fundamental differences between the NEMT program and its providers and the NEAT program and its providers. They are completely different provider types who must adhere to entirely different standards, rules, and laws. In Louisiana law, the two different types of providers are not included in any single section of law. To place them in the same grouping would be an injustice to each unique program. There should be an unambiguous delineation between NEMT and NEAT. As in the past, each different type of provider should have their own specific set of provisions in different sections of the manual. They should not be comingled and lumped into the same sections. If NEAT and NEMT provisions are included in the same sections, this will likely lead to confusion and unintended consequences for the providers and the Medicaid program including its enrollees. There should not be an instance in which provisions apply to both providers in one section of the manual when providers have specific sections that apply to them. All

		policies pertaining to NEMT should be placed in the NEMT sections of the manual and all of the policies pertaining to NEAT should be placed in the ambulance sections of the manual. They should not be comingled. The recommendation would be that any reference to NEAT being a form of NEMT be deleted. In addition, the provision that states "transportation requirements in this section apply to both NEMT and NEAT services" should be deleted. Furthermore, it is recommended that all of the provisions which pertain to NEMT be placed in the NEMT sections of the manual, and all NEAT provisions should be included in the ambulance sections of the manual. This change would ensure that there is not confusion about which rules apply to which program. Provision: The third paragraph states "See the Ambulance section of this Manual for additional guidelines specific to NEAT. Services shall be provided in accordance with the Louisiana Administrative Code, Title 50, Part XXVII, Chapter 5." (Section 10.1: NEMT - Covered Services Section, pg. 1 of the proposed Medicaid Manual Section) Comments/Recommendations: The word additional is added to this section which means that there are provisions in the NEMT section which apply to NEAT. Historically, the NEMT and ambulance provisions have been clearly separated from one another. This goes back to the points made in previous comments that the provisions pertaining to NEMT and ambulance should be separated and not comingled to avoid confusion and unintended consequences since they are distinct and separate provider types. The recommendation is to delete the revision which adds "additional" to this provision. To go further into the separation of the provider types, the statement should be revised to state "See the Ambulance Section for NEAT guidelines." As stated previously, each program should have distinct sections and provisions which are separated from one another. This change would ensure that there is not confusion about which policies apply to which program.

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10/7/2021 12:27	2021 – Professional Services - 22 Section 5.1 – Covered Services - Cardiology	We strongly endorse this evidence-based cardiology coverage proposed for invasive coronary angiography (ICA) and percutaneous coronary intervention (PCI) for Louisiana. Our recommendation is based on review of published, high-quality evidence that PCI in patients with stable coronary artery disease (CAD), when compared to optimal medical therapy, has no clinical outcome benefit compared to optimal medical therapy (i.e., does not reduce myocardial infarction or death), minimal ability to alleviate anginal symptoms, significant possible risks, and high financial costs. Specifically, a robust 2020 meta-analysis of fifteen randomized control trials (RCTs) totaling 14,669 patients found that PCI led to no significant benefits in reducing the risk of death, myocardial infarction, or other major cardiovascular events in patients with CAD; results were consistent across multiple sensitivity analyses adjusting for bias, outliers, and outcome effects.1 Patients may also suffer many peri-procedural complications and longer-term risks including stent thrombosis and bleeding from post-PCI dual anti-platelet therapy.2,3 Patients are also subject to out-of-pocket costs for additional medications as a result of PCI. Beyond clinical outcomes, cost analyses showed that the incremental cost-effectiveness ratio of PCI reaches over $3,000,000 per quality-adjusted life-year for patients with minimal symptoms.4 Meanwhile, medical therapy and lifestyle changes are highly under-utilized despite their being safer, more affordable, more easily accessible, and recommended as first-line therapy by the American College of Cardiology Foundation/American Heart Association.5 Additionally, patients should not undergo ICA unless they are felt to be candidates for PCI; ICA also has associated risks and costs. We commend the proposed policy for containing clear and uniform definitions to ensure that Louisiana Medicaid managed care organizations have comprehensive guidelines in determining eligibility for elective ICA and PCI. We believe that utilizing prior authorizations and reducing or eliminating ICA and PCI among patients with CAD for which this procedure is not recommended can do a great deal to promote high value care in the state. This policy also will provide the baseline for coverage criteria amongst the five major Managed Care Organizations in Louisiana. We support this authorization-based program proposal to improve care for Louisiana's Medicaid beneficiaries by ensuring that patients with CAD patients are taking optimal medical therapy and receiving all guideline-recommended care to reduce downstream risk of adverse cardiovascular outcomes.

		Sanket S. Dhruva, MD, MHS Rita F. Redberg, MD, MSc Vinay Guduguntla, MD Robin Ji, BA UCSF School of Medicine San Francisco, California References 1. Chacko L, P Howard J, Rajkumar C, et al. Effects of Percutaneous Coronary Intervention on Death and Myocardial Infarction Stratified by Stable and Unstable Coronary Artery Disease: A Meta-Analysis of Randomized Controlled Trials. Circ Cardiovasc Qual Outcomes. 2020;13(2):e006363. doi:10.1161/CIRCOUTCOMES.119.006363 2. Madhavan MV, Kirtane AJ, Redfors B, et al. Stent-Related Adverse Events >1 Year After Percutaneous Coronary Intervention. J Am Coll Cardiol. 2020;75(6):590-604. doi:10.1016/j.jacc.2019.11.058 3. Ndrepepa G, Berger PB, Mehilli J, et al. Periprocedural bleeding and 1-year outcome after percutaneous coronary interventions: appropriateness of including bleeding as a component of a quadruple end point. J Am Coll Cardiol. 2008;51(7):690-697. doi:10.1016/j.jacc.2007.10.040 4. The Cost-Effectiveness of Percutaneous Coronary Intervention as a Function of Angina Severity in Patients With Stable Angina |

		Circulation: Cardiovascular Quality and Outcomes. Accessed October 4, 2021. https://www.ahajournals.org/doi/10.1161/CIRCOUTCOMES.110.940502 5. Fihn SD, Gardin JM, Abrams J, et al. 2012 ACCF/AHA/ACP/AATS/PCNA/SCAI/STS guideline for the diagnosis and management of patients with stable ischemic heart disease: executive summary: a report of the American College of Cardiology Foundation/American Heart Association task force on practice guidelines, and the American College of Physicians, American Association for Thoracic Surgery, Preventive Cardiovascular Nurses Association, Society for Cardiovascular Angiography and Interventions, and Society of Thoracic Surgeons. Circulation. 2012;126(25):3097-3137. doi:10.1161/CIR.0b013e3182776f83
9/1/2021 19:15	2021-Professional Services-18 Section 5.1 – Covered Services – Skin Substitutes	Initiating coverage for the diabetic foot initially is reasonable except the criteria "prior 4 weeks to application can show no measurable signs of healing". One cannot let a wound be so deteriorated it is not clean and ready for successful application. The statement below would be a better reflection of wording and what it takes to have the graft be successful on a healthier wound bed. Prior 4 weeks to application the record must show a recalcitrant wound defined as less than 50% decrease in size of wound, exudate, and necrotic tissue in past 4 weeks.

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		The sheehan study was a good representation of prediction of healing of diabetic wounds based on a 4 week initial period and success of healing in a 12 week period.
8/18/2021 11:02	2021-Professional Services-18 Section 5.1 – Covered Services – Skin Substitutes	Thank you for the consideration to add coverage of skin substitutes for those suffering with chronic wounds. On a daily basis I see Medicaid patients that are facing amputation and hospitalization due to chronic non-healing wounds and they have limited options to receive advanced healing modalities that could otherwise prevent unnecessary amputations. Too often these patients end up in a hospital with wound infections, osteomyelitis, and sepsis because their wounds have delayed healing. It should be everyone's goal to heal these wounds as fast as possible and the added coverage for skin substitutes will further allow for that to happen. Thank you Louisiana Department of Health for promoting Limb Salvage for the residents of Louisiana.
2/4/2021 19:31	2020-Behavioral Health-10 Behavioral Health Services - Section 20.0 – Outpatient Services – Peer Support Services	Where does the behavioral health peers support “cured” or “corrected” compliance law of the land story go from here? Imagine a picturesque evidence based practice that focuses on perfectionism. See how those sentiments encourages creating safe treatment programs, medical services and mediations and fact-checking between the Louisiana department of Health and Office of Behavioral Health remains swept under the hypothetical rug.
2/4/2021 11:00	2020-Behavioral Health-10 Behavioral Health Services - Section 20.0 – Outpatient Services – Peer Support Services	Please implement this policy so that more people with Substance Use Disorders and/or Mental Illness(es) will receive quality Peer Support Services. The mission of us Certified Peer Support Specialists is to engage, empower, and encourage the people we serve so they may live with purpose and meaning .

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1/13/2021 10:47	2020-Behavioral Health-10 Behavioral Health Services - Section 20.0 – Outpatient Services – Peer Support Services	Staff to client ratio is currently listed as 1 CPSS to 20 active members. I am currently a full-time Certified Peer Support Specialist with an active caseload of 29 with 11 pending referrals. If I am restricted to a max caseload of 20, consumer services would have a direct impact once implemented. Those of us operating within th eclinic setting primarily can benefit from a max case load of 20-40.
1/13/2021 10:30	2020-Behavioral Health-10 Behavioral Health Services - Section 20.0 – Outpatient Services – Peer Support Services	As a direct result of the COVID-19 pandemic, the amount of remote telephonic / Televisit services I complete as a certified peer support specialist has increased exponentially. Telephonic sessions have helped to remove transportation barriers and reduce the amount of missed appointments / Rescheduled appointments resulting in better care for clients. Are there any plans in place to cover these types of services where the current documents only allowed modes of delivery are in person Individual On Site and Off Site without including telephonic or televisit.
12/28/2020 9:55	2020-Behavioral Health-10 Behavioral Health Services - Section 20.0 – Outpatient Services – Peer Support Services	Discussions during treatment planning and treatment teams meetings between the LMHP supervisor and PSS do not count as supervision
##########	2020-TRANS-9 Transportation - 10.8 – Non Emergency Ambulance	Ambulance reimbursement for NEAT scheduled through the ambulance provider - Is it the responsibility of the ambulance provider or the healthcare provider to report the trip request to the broker?
##########	2020-TRANS-6 Transportation - 10.5 – Record Keeping	Gas Reimbursement - would a digital record of this information be allowed with appropriate signatures?

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##########	2020-TRANS-6 Transportation - 10.5 – Record Keeping	Daily Trip Log - Please explain Physician's name requirement in more detail. Is it the assumption that the broker will capture this information at the time of trip scheduling?
##########	2020-TRANS-4 Transportation - 10.3 – Provider Requirements	Signage - For companies who utilize credentialed drivers who operate personal vehicles which meet all requirements, would signage that includes company name and phone would suffice? These vehicles will not have a designated vehicle number.
##########	2020-TRANS-4 Transportation - 10.3 – Provider Requirements	Driver requirements Age - traditional minimum age is 21 in most states. Would LDH consider a change to this requirement? Training - if brokers can document similar training curriculum to PASS, would that suffice for that requirement?
12/13/2020 9:52	2020-TRANS-4 Transportation - 10.3 – Provider Requirements	Exclusion list - please explain the prohibition for Medicaid reimbursement when a non-excluded provider is used. The assumption is to prevent payment when a non-excluded provider subcontracts to an excluded provider. If that is the case, can this language be clarified?
12/13/2020 9:42	2020-TRANS-4 Transportation - 10.3 – Provider Requirements	Scheduling order - is the MCO able to modify priorities in this list based on individual beneficiary needs? Ex, for dialysis patients, is it often inappropriate to utilize public transit, especially for the B leg.
12/13/2020 9:38	2020-TRANS-3 Transportation - 10.2 – Scheduling and Authorization	Attendant for under 17 beneficiaries - who is responsible to document attendant credentialing information? Broker or MCO?
12/12/2020 0:35	2020-TRANS-9 Transportation - 10.8 – Non Emergency Ambulance	Does not list requirements for NEAT credentialing Blue text should remain as and/or in opening paragraph Replace "the beneficiary is unable to ride in any other type of vehicle due to medical reasons" with “the beneficiary is unable to ride in any other type of vehicle as contraindicated in letter of medical necessity”

12/12/2020 0:32	2020-TRANS-7 Transportation - 10.6 – Ambulance Overview	Replace “Use of any other method of transportation would make the beneficiary susceptible to injury.” to “use of any other method of transportation that is contraindicated on a letter of medical necessity” SET is not able to make this determination, we are not medical providers
12/12/2020 0:29	2020-TRANS-5 Transportation - 10. 4 – Provider Responsibilities	Replace all “Ensure” to “Require, Verify, Confirm” “Drivers must exercise the utmost safety” remove this wording all together. This puts an unachievable goal in place as there is always some more to be done to achieve the "utmost" safety. The wording of the usage of the wheelchair securement system is clunky. “Lap positioning belts and chest straps” can be confused with the “lap and shoulder belt” which is common among most mobility device securement systems. The belts that help a person using a mobility device is called a postural support belt and is not sufficient to replace lap and shoulder belts in any securement system. Page one, last bullet. Replace "Not be under the influence of an amphetamine or any formulation thereof, a narcotic drug or any derivative thereof, or other substance to a degree which renders the driver incapable of safely operating a vehicle." with “Not be under the influence of any substance which renders the driver incapable of safely operating the vehicle. “ Page 2, above Emergency Action Procedure. Replace "Drivers shall ensure the proper installation and usage of the child passenger

		restraint systems in compliance with La. R.S. 32:295." with “Driver shall confirm the proper installation and utilization of the child passenger restraint system in compliance with LA R.S. 32:295” Accident procedures - Drivers should not make calls to LDH, Family, etc, this is a responsibility of both the provider and the broker. Drivers should not proceed to medical facility as they are not medical professionals nor do they provide emergency ambulance service, drivers may end up doing more harm than good if they move the member to the nearest medical facility.

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##########	2020-TRANS-4 Transportation - 10.3 – Provider Requirements	Replace all usage of the word "ensure" to "require, verify, or confirm." What are the exact insurance requirements for the LA Gas Reimbursement program? Do Gas Reimbursement payees require commercial insurance or personal insurance? SET's general counsel has issues with the whole GMR program at its foundations. Issuing 1099s to GMR payees would label them as subcontractors and could open the brokers to liability. If the GMR payees are only required to have a personal insurance policy versus a commercial policy it wouldn't protect the member in the event of an accident. SET's general counsel is available to discuss the GMR program. SET Compliance would like to address the credentialing of non-profit (COAs) in Louisiana. In other operations COAs, or equivalent, are under the purview of state and federal regulations outlined in their 5310/5311 grant programs. These 5310/5311s hold a different contract in other SET operations and allows them to be credentialed different. State DOTs and the Federal Transit Administration has oversight of these programs and controls their credentialing of both vehicles and drivers to obtain grant funding. Would this be a possibility in Louisiana? What does “continually thereafter” mean in reference to credentials? Is there a specific cadence or timeframe to conform to? Annually? Having the background checks and drug screens transmitted directly to the broker would mean the provider and each driver would need to sign to release that information from the testing agency to the broker. There is HIPAA concerns when transmitting drug screens, this may limit the number of labs willing to do this.

		SET would like to reconfirm that expunged records will exclude drivers and owners from the NEMT Program. SET would like to address the prohibition of salvage titles, these vehicles undergo state inspections to be allowed back on to the road. This may unnecessarily exclude vehicles from the network.

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##########	2020-TRANS-14 Transportation - 10.13 – Record Retention	The Louisiana Ambulance Alliance ("Alliance") appreciates the opportunity to comment on the recent proposed changes to the Medicaid Medical Transportation Manual. The Alliance is the membership organization for EMS providers in Louisiana. The Alliance greatly respects the work the Louisiana Department of Health ("LDH") has done in formulating these manual sections and thinks that the updated manual will help EMS agencies throughout the state. However, we ask for clarity on certain provisions and urge LDH to adopt the following recommendations. Section 10.13 Record Retention Page 1, Paragraph 1 The Alliance recommends that the last sentence of this paragraph be deleted. The ten-year retention period is reasonable due to the fact that it is mandated by law for certain entities. However, to force providers to receive express permission from LDH to delete 10-year-old files/records seems excessive. Providers should be free to dispose of or destroy the files as they see fit after the 10-year-period. In addition, does this provision only apply to providers who contract with a transportation broker and/or managed care organization? It appears as though the 10-year record retention mandate should be placed only on the managed care organizations and their subcontractors. Thus, a provider who does not contract with a managed care organization or a transportation broker should not be subject to this record retention requirement. Once again, we appreciate the opportunity to comment on the proposed manual sections. If the Alliance staff or any of our members can be a resource to you as you consider our comments, please do not hesitate to contact me.

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##########	2020-TRANS-12 Transportation - 10.11 – Return Trips and Transfers	The Louisiana Ambulance Alliance ("Alliance") appreciates the opportunity to comment on the recent proposed changes to the Medicaid Medical Transportation Manual. The Alliance is the membership organization for EMS providers in Louisiana. The Alliance greatly respects the work the Louisiana Department of Health ("LDH") has done in formulating these manual sections and thinks that the updated manual will help EMS agencies throughout the state. However, for reasons discussed below, we ask for clarification on certain provisions and urge LDH to adopt the below recommendations . Section 10.11 Return Trips and Transfers Page 1, Paragraph 1 – Return Trips The Alliance would like to seek clarification on this language. Would this prohibit a hospital, managed care organization, or transportation broker from paying for this trip outside of the Medicaid program? In the past, if an ambulance service was the only entity who could make the transport, the facility or managed care organization/broker could pay for the trip. Would this prohibit this practice, or would this prohibit just the Medicaid program itself from being responsible for the trip? Page 1, Paragraph 3 – Transfers The Alliance recommends that the sentence be changed to state: "If the physician makes the decision that the level of care required by the beneficiary cannot be provided by the hospital, and the beneficiary has to be transported to another hospital, the

		transportation provider shall be paid for both transfers once clean claims are submitted for the transfers." If the transfers are to seek a higher level of care and deemed necessary by a physician, then the ambulance provider should be paid for the transfers.

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##########	2020-TRANS-9 Transportation - 10.8 – Non Emergency Ambulance	The Louisiana Ambulance Alliance (“Alliance”) appreciates the opportunity to comment on the recent proposed changes to the Medicaid Medical Transportation Manual. The Alliance is the membership organization for EMS providers in Louisiana. The Alliance greatly respects the work the Louisiana Department of Health (“LDH”) has done in formulating these manual sections and thinks that the updated manual will help EMS agencies throughout the state. However, we are seeking clarity on certain provisions and are urging LDH to adopt the recommendations provided below. Section 10.8 Non-Emergency Ambulance Transportation Page 1, Paragraph 1 The Alliance would like to seek clarification on the language which states “transportation is provided to a Medicaid beneficiary to and/or from a provider of medical services for a covered medical service when no other means of transportation is available and the beneficiary is unable to ride in any other type of vehicle.” Would this prohibit the managed care organizations or their transportation brokers from paying for this trip outside of the Medicaid program? In the past, if an ambulance service was the only entity who could make the transport, the managed care organization/broker could pay for the trip. Would this prohibit this practice, or would this prohibit just the Medicaid program itself from being responsible for the trip?

		Page 1, Paragraph 3, Bullet 1 The Alliance would recommend that the last sentence be changed to state: "Once the trip has been dispatched to an ambulance provider and completed by the ambulance provider, the ambulance provider shall be reimbursed upon the submission of the clean claim for the transport." It should be clarified that if an ambulance provider submits a clean claim for transport, then payment shall be made to the ambulance provider for the service. The term "shall be eligible for reimbursement" leaves a gray area in which an ambulance provider would not have to be reimbursed for a service rendered to a Medicaid beneficiary. The language should be clear that if a transportation broker dispatches a trip to an ambulance provider, once a clean claim is submitted by the ambulance provider, the transportation broker shall reimburse the ambulance provider. The administrative burden of verifying eligibility, that the originating or destination address belongs to a medical facility, and that a completed Ambulance Certification Form is received should be done by the transportation broker prior to dispatching an ambulance for the trip. Thus, the only steps the ambulance provider should have to take are completing the trip and submitting a clean claim. Once those two items are completed, payment should be mandated under the circumstances.

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##########	2020-TRANS-8 Transportation - 10.7 – Emergency Ambulance	The Louisiana Ambulance Alliance ("Alliance") appreciates the opportunity to comment on the recent proposed changes to the Medicaid Medical Transportation Manual. The Alliance is the membership organization for EMS providers in Louisiana. Section 10.7 Emergency Ambulance Transportation Page 1, Paragraph 1 The Alliance recommends that this language be changed to reflect the prudent layperson's definition of an emergency medical condition. The prudent layperson definition of an emergency medical condition commonly in practice is any medical or behavioral condition of recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in placing the patient's health in serious jeopardy, cause serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy. Our recommendation would be to adopt the following language which includes the appropriate definition of the term emergency medical condition: "Emergency ambulance transportation is provided for emergency medical conditions. Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following at the time of dispatch:

		(i) Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. (ii) Serious impairment to bodily functions. (iii) Serious dysfunction of any bodily organ or part." The Balanced Budget Act of 1997 established the "prudent layperson" standard for managed care Medicaid effective October 1997, and the same standard became effective for Medicare in May 1998. The Department of Veterans Affairs adopted the standard in November 1999. With the passage of the Affordable Care Act in 2010, the standard was extended to additional insurance plans including those regulated under the Employee Retirement Income Security Act (ERISA) and qualified health plans in the state exchanges. It seems that when these changes were made at the federal level in the mid-1990's, a corresponding update was not made in Louisiana's Medicaid State Plan. The current language regarding emergency medical conditions dates back to 1994 and should have been changed after the prudent layperson definition was adopted by Congress in the Balance Budget Act of 1997. It is imperative that the state plan and this manual be amended to adhere to the prudent layperson definition of an emergency medical condition. The prudent layperson definition of an emergency medical condition is stated and utilized through both federal (42 CFR § 438.114 (a); 42 CFR § 422.113) and state (La. R.S. 40:2115.32; La. RS 22:1821) law. Another important point on why the definition needs to be updated is that the current managed care contracts include the prudent layperson's definition of an emergency medical condition. The state plan and the Medicaid manual need to be adjusted in order to be in line with federal regulations and the current managed care contracts. Inconsistent definitions for terms could lead to unintended consequences, such as erroneous denials of payments, under the Medicaid program.

		Page 1, Paragraph 2 It is the Alliance's recommendation that the following examples of emergency transportation criteria, which are currently in the Medicaid State Plan and the current version of the Medicaid manual, remain in the Medicaid manual: "The following are examples of this criteria: A recipient who has a medical condition such as a possible heart attack; stroke or altered mental status, A recipient who presents with a hemorrhage, altered mental status, or a possible spinal injury, A recipient requiring the administration of IV fluids and/or medications when the recipient would be susceptible to injury if other methods of transportation were utilized, A recipient who is unmanageable or needs restraint, A recipient who appears to be in a psychiatric crisis as indicated by unmanageable or threatening behavior." These are clear examples of conditions which would warrant an emergency transport by ambulance. The examples would serve as an illustrative list for both providers and Medicaid when assessing medical necessity of an emergency ambulance transport. Being that some level of predictability is necessary in the healthcare field, providers and payers need to know what claims will be considered an emergency, and this list helps provide a certain level of predictability and would be an easy reference for billing disputes. If these examples are clearly laid out in the Medicaid manual, then this should mean fewer denials due to the fact ambulance providers, the Medicaid program, and the managed care organizations would have some sort of reference sheet to gage whether a transport was emergent or not. Ambulance providers spend a lot of time appealing and making their case for claims for services which are denied but are clearly emergency in

		nature. If the providers can easily cite these provisions in the manual, the hope would be that there would be fewer denials and less back in forth over erroneously denied emergency claims. Pages 2 and 3 – Ambulance Telehealth Claims/Ambulance Treatment-in-Place Claims This is more of a suggestion than a change that the Alliance is specifically recommending. In the manual, LDH may want to provide flexibility for changes in the list of the qualified health care practitioners and CPT codes under the telehealth and treatment-in-place sections. The administrative burden and time to change the manual could lead to a delay in policy changes. It may be necessary for LDH to list out all of the qualified healthcare practitioners and CPT codes. However, specifically listing out these items provides for less flexibility in the future. The manual will have to be adjusted, and this takes time and administrative burden. For example, if a new practitioner type or a new code were added, this change would likely take months to adopt. Healthcare providers would be capable of providing services or using different CPT codes, but would be prevented from doing so due to the manual not being updated. Page 3, Paragraph 1 – Emergency Transportation to Hospital During Treatment in Place The Alliance recommends the language be changed to state: "If the beneficiary being treated in place has a real time deterioration in his or her clinical condition which necessitates immediate transport to an emergency department, the ambulance provider may transport the beneficiary."

		The Medicaid manual should not mandate when a provider should or should not transport a patient. There are several instances in which a provider may not transfer a patient to a hospital in this type of situation. The patient may refuse a transport or the patient may need an air transport by another entity/provider. The manual should provide flexibility in these types of situations and not mandate a specific action be taken.

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##########	2020-TRANS-7 Transportation - 10.6 – Ambulance Overview	The Louisiana Ambulance Alliance ("Alliance") appreciates the opportunity to comment on the recent proposed changes to the Medicaid Medical Transportation Manual. The Alliance is the membership organization for EMS providers in Louisiana. Section 10.6 Ambulance Overview Page 1, Paragraph 1 Our recommendation would be that the first paragraph remains unchanged from its current text which states: "Ambulance transportation is emergency or non-emergency medical transportation provided to Medicaid beneficiaries to and/or from a Medicaid provider for a medically necessary Medicaid covered service when the beneficiary's condition is such that use of any other method of transportation is contraindicated." The Centers for Medicare and Medicaid Services ("CMS") utilizes the term contraindicated in their manuals and rules for medical assistance programs. This term is commonly used and is contained in the current Medicaid manual. There is simply no need to modify the language as it is currently written. For those reasons, the Alliance recommends that the term contraindicated remain in the Louisiana Medicaid manual. Page 2, Paragraph 2, Bullet 2 The Louisiana Ambulance Alliance is currently engaging in communication with the Louisiana Department of Health to revise this outdated definition of Advanced Life Support to something more in line with the Medicare definition of the term.

		For example, the below definitions based off of the Medicare definitions are more in line with the services provided today. Advanced life support (ALS) assessment is an assessment performed by ALS personnel as part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only ALS personnel were qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service. Advanced life support (ALS) intervention means a procedure that is required to be furnished by ALS personnel. Advanced life support means transportation by ground ambulance vehicle, medically necessary supplies and services and either an ALS assessment by ALS personnel or the provision of at least one ALS intervention. Advanced life support (ALS) personnel means an individual trained to the level of an advanced emergency medical technician or paramedic. We believe Louisiana should follow Medicare's lead and take after other states, specifically Texas, on defining the term Advanced Life Support. In the current Louisiana Scope of Practice Matrix, there are very few procedures which go above the level of an advanced emergency medical technician ("AEMT"). This is one reason AEMTs should not be excluded from being considered ALS personnel. Louisiana follows the National Registry of EMT's in the realm of education standards. NREMT provides the following information regarding advanced emergency medical technicians:

		"The primary focus of the Advanced Emergency Medical Technician is to provide basic and limited advanced emergency medical care and transportation for critical and emergent patients who access the emergency medical system. This individual possesses the basic knowledge and skills necessary to provide patient care and transportation. Advanced Emergency Medical Technicians function as part of a comprehensive EMS response, under medical oversight. Advanced Emergency Medical Technicians perform interventions with the basic and advanced equipment typically found on an ambulance." If an AEMT can provide any advanced level services, then anytime they render an advanced assessment or intervention, the service should qualify as an advanced life support service performed by the ambulance provider. The distinction between BLS and ALS would ultimately come down to the treatments and assessments provided by EMS personnel. With that being said, we ask the Medicaid program to either not cite this definition in the Medicaid manual until further discussion can be had about updating the definition or formulate a Medicaid specific definition which follows the language provided above.
12/8/2020 7:28	2020-Professional Services-9 Professional Services - 5.1 – Covered Services – Bariatric Surgery	When is/was the effective date of this policy? When will the Commercial plans update their criteria to reflect these changes?
12/7/2020 10:56	2020-TRANS-3 Transportation - 10.2 – Scheduling and Authorization	As a transportation provider, my company provides services in multiple regions, and it has come to my attention that trips will be assigned based on regions. My company is based in Region 1, but has been providing services in Regions 1 and 3 for years. In both regions, we are the preferred provider of many of those Members, and have standing orders with Members in both regions. How will these changes affect my company and those in similar situations? Also, how does it affect the Member's choice of providers, will

		their preferred provider request still be honored? I think that the Member should be allowed to have their preferred provider request honored.
12/1/2020 17:29	2020-Professional Services-9 Professional Services - 5.1 – Covered Services – Bariatric Surgery	These changes will allow the sorely needed bariatric services to become attainable by Medicaid beneficiaries. By covering bariatric interventions, the health and longevity of patients can be improved and significant monetary costs can be reduced for the health plans and the many other key stakeholders.
12/1/2020 17:26	2020-Professional Services-9 Professional Services - 5.1 – Covered Services – Bariatric Surgery	I am excited about this policy change. It brings the guidelines much closer to the accepted standards of care, and is very similar to ASMBS and ADA guidelines. My only concern is that all but one of the commercial plans require a 6 month workup process that is not in this guideline, but is not explicitly excluded. I expect a lot of confusion and denials until this is straightened out. (There is NO data to support requiring any length of workup, I fully agree with the requirements as stated. It would just make things easier for patients undergoing workup to know that would not be a potential problem.)
12/1/2020 17:17	2020-Professional Services-9 Professional Services - 5.1 – Covered Services – Bariatric Surgery	I believe that this policy change will allow for better coverage for populations who otherwise do not meet the criteria for gastric surgery. I believe this is a step in the right direction and will improve patient care and satisfaction.
11/9/2020 8:29	2020-TRANS-2 Transportation - 10.1 – Covered Services	Exclusion list includes Pharmacies. Are pharmacy trips permittable if they are tied to a medical appointment? Is the exclusion only for stand alone pharmacy trips?

Medicaid Provider Manuals Public Comments

7/1/2020 14:54	2020-Professional Services-2 Professional Services - Section 5.1 – Telemedicine	On behalf of Ochsner Health, thank you for the opportunity to comment on the proposed changes to the definition of telemedicine and telehealth in the Medicaid provider manual. We appreciate and support your efforts to make these important revisions. Since the start of the pandemic and the resulting Medicaid and Medicare telehealth waivers, Ochsner has seen an increase in utilization of telehealth services. At the height of the COVID-19 outbreak in the Spring, Ochsner delivered more than 60% of visits to patients via telehealth, making us the leading health care system in the South in the delivery of telehealth during the public health crisis. Given the increased importance of maintaining a robust and accessible telehealth network at this time, and given the recent passage of HB 589 which seeks to better align Medicaid coverage of telehealth with Medicare coverage of telehealth, we'd like to offer the following suggestions/requests for your consideration: - We respectfully request removing the words "interactive" and "video and audio" from the definition of "telecommunications system". As mentioned above, Ochsner has seen a dramatic increase in utilization of telehealth services over the past several months. A significant percentage of our Medicaid patients utilize "audio-only" telehealth due to lack of access to internet or a smart phone. While we advocate that simultaneous use of audio and video is preferable, we believe that, when necessary, audio-only is better than no care at all. By excluding audio-only, we could potentially decrease access to care for some of the Medicaid population and increase unnecessary ED visits. The allowance for audio-only would be in line with current Medicare reimbursement policy under the Medicare waiver, as well as state statute under R.S. 40:1223.3. - We are also concerned that by requiring telehealth to be "interactive" using a "physician" and "licensed practitioner" at two different sites, we could hamper other useful tools under the state "telehealth" umbrella including asynchronous store-and-forward technology and remote patient monitoring. Ochsner has a significant digital medicine program, where we utilize a team of both licensed and non-licensed members to manage care of patients with hypertension, diabetes, and other conditions such as pregnancy. Our digital medicine program uses tools such as

		Bluetooth-enabled blood pressure cuffs, digital scales, and digital glucometers. These device readings are for tracking, trending, and intervention, but are not always real-time or interactive. Therefore, we are requesting to eliminate the terms “real-time” and “interactive” from the proposed definition. - Additionally, we urge you to consider removing the new proposed requirement that the telecommunications system be HIPAA compliant. CMS has acknowledged that some telehealth technologies may not be HIPAA compliant and has communicated that they would exercise discretion in their enforcement during the public health emergency. Therefore, we believe that the addition of this language could unnecessarily discourage provision of telehealth services at this time. Thank you for your consideration.
10/30/2019 9:24	2019-FQHC-1	I fully support LPC's being listed as providers within an FQHC. The rural areas have limited access to services and need as many licensed professionals as possible to meet the growing need. LPC's are certainly more than qualified to provide mental health services and should be included for billable providers.
10/8/2019 15:25	2019-FQHC-2	I just wanted to thank LDH for hearing us and including this change in the rules. Literally thousands of Louisiana citizens would have experienced a lapse in mental healthcare as a result of restricting LPC's from billing under FQHC's, many from the most rural and impoverished Parishes. LPC's are required to have Master's Degrees, 3,000 hours of supervised practice under an approved supervisor, and pass state board exams in order to be licensed to practice independently and are able to be credentialed (and reimbursed!) by all Managed Care Organizations except Medicare. The federal government also recognizes LPC's as qualified providers for FQHC's. LPC's have been granted increasingly greater privileges in the law and by MCO's in order to increase the public's

		access to qualified mental health professionals. Precluding LPC's from billing at FQHC's would undermine this trend of forward progress. Please proceed with this change in the rules to maintain these needed services for vulnerable citizens of Louisiana.
10/8/2019 15:24	2019-FQHC-1	I just wanted to thank LDH for hearing us and including this change in the rules. Literally thousands of Louisiana citizens would have experienced a lapse in mental healthcare as a result of restricting LPC's from billing under FQHC's, many from the most rural and impoverished Parishes. LPC's are required to have Master's Degrees, 3,000 hours of supervised practice under an approved supervisor, and pass state board exams in order to be licensed to practice independently and are able to be credentialed (and reimbursed!) by all Managed Care Organizations except Medicare. The federal government also recognizes LPC's as qualified providers for FQHC's. LPC's have been granted increasingly greater privileges in the law and by MCO's in order to increase the public's access to qualified mental health professionals. Precluding LPC's from billing at FQHC's would undermine this trend of forward progress. Please proceed with this change in the rules to maintain these needed services for vulnerable citizens of Louisiana.