RULE

Department of Health
Bureau of Health Services Financing

Managed Care Healthy Louisiana
Hospital and Practitioner Directed Payments
(LAC 50:I.3113)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:I.3113 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part I. Administration

Subpart 3. Managed Care for Physical and Behavioral Health

Chapter 31. General Provisions

§3113. Directed Payments

A. Hospital and Practitioner Directed Payments

1. Subject to written approval by the Centers for Medicare and Medicaid Services (CMS), the Louisiana Department of Health (LDH) shall provide directed payments to qualifying hospitals and practitioner/groups. Practitioners include physicians, physician assistants, certified registered nurse

practitioners, and certified nurse anesthetists, as well practitioner groups. These entities must participate in Healthy Louisiana Medicaid managed care program. All directed payments shall be made in accordance with the applicable 42 CFR §438.6(c) preprint(s) approved by CMS, as well as relevant federal and departmental regulations.

2. *Qualifying Hospital or Practitioner*—one of the following:

a. an in-state provider of inpatient and outpatient hospital services (excluding freestanding psychiatric hospitals, freestanding rehabilitation hospitals, and long-term acute care hospitals) that meets the criteria specified in the applicable 42 CFR §438.6(c) preprint approved by CMS and departmental regulations;

b. an in-state hospital provider of long-term acute care, psychiatric services, and rehabilitation services for both inpatient and outpatient hospital services that meet the criteria specified in the applicable 42 CFR §438.6(c) preprint approved by CMS and departmental regulations; or

c. an in-state practitioner for professional services, primary care services and specialty physician services that meet the criteria specified in the applicable 42 CFR §438.6(c) preprint approved by CMS and the departmental regulations.

3. The department shall assign qualifying hospitals or practitioners to provider classes based upon criteria specified in the applicable 42 CFR §438.6(c) preprint(s) approved by CMS, in accordance with departmental regulations.

a. Qualifying hospitals or practitioners shall have no right to an administrative appeal regarding any issue related to provider classification, including, but not limited to, provider class assignment, the effective date of provider class assignment, or qualifying determinations.

4. The department shall utilize an interim payment process, whereby interim directed payments will be calculated based on provider class assignment utilizing the data and methodology specified in the applicable 42 CFR §438.6(c) preprint(s) approved by CMS, in accordance with departmental regulations.

a. Qualifying hospitals or practitioners shall have no right to an administrative appeal regarding calculation of interim directed payments.

b. The department reserves the right to discontinue the interim directed payments to any hospital or practitioner whose projected recoupment due to shifts in utilization is greater than 50 percent of their estimated interim directed payments or any hospital or practitioner who

discontinues operations during or prior to the directed payment contract period.

5. ...

a. The MCOs shall pay interim directed payments to qualified hospitals or practitioners within 10 business days of receipt of quarterly interim directed payment information from LDH. If a barrier exists that will not allow the MCO to pay the interim directed payments within 10 business days of receipt, the MCO shall immediately notify LDH. LDH at its sole discretion will determine if penalties for late payment may be waived.

b. The qualifying hospital or practitioner may request that the MCOs deposit their interim directed payments into a separate bank account owned/held by the qualifying hospital or practitioner. Interim directed payments shall not be deposited into a bank account that is owned/held by more than one qualifying hospital or practitioner.

6. In accordance with the applicable 42 CFR §438.6(c) preprint(s) approved by CMS, federal regulations, and departmental requirements, directed payments must be based on actual utilization and delivery of services during the applicable contract period.

a. Within 12 months of the end of each state fiscal year (SFY), LDH shall perform a reconciliation of

hospital interim payments as specified in the applicable 42 CFR §438.6(c) preprint approved by CMS and departmental regulations.

b. LDH shall reconcile the interim payment for practitioners as specified in the applicable 42 CFR §438.6(c) preprint approval by CMS and departmental regulations.

i. Qualifying hospitals or practitioners shall have no right to an administrative appeal regarding any issue related to reconciliation, including, but not limited to, the timing and process.

c. Qualified hospitals or practitioners are strongly encouraged to submit claims as quickly as possible.

7. If a qualifying hospital or practitioner that is subject to a reconciliation or adjustment will not be participating in a directed payment arrangement in the future, the qualified hospital or practitioner shall pay all amounts owed to LDH or the MCO, if any, within 30 calendar days' notice of the amount owed, in accordance with departmental regulations.

a. In addition to all other available remedies, LDH or the MCOs has the authority to offset all amounts owed by a qualifying hospital or practitioner due to a reconciliation or adjustment against any payment owed to the qualifying hospital or practitioner, including, but not limited to, any payment owed by the MCO or LDH.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:245 and Title XIX of the Social Security Act

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 49:264 (February 2023), amended LR 49:1566 (September 2023), LR 50:1649 (November 2024), LR 51:

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.

Bruce D. Greenstein

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Targeted Case Management
Ventilator Care Coordination
(LAC 50:XV.10101, 10107, 11101, 11103)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XV.10101 and 10107 and adopted LAC 50:XV.11101 and 11103 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XV. Services for Special Populations
Subpart 7. Targeted Case Management

Chapter 101. General Provisions

§10101. Program Description

A. – D.2. …

E. Repealed.

F. …

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 Human Resources, Office of Family Security, LR 12:834 (December 1986), amended by the Department of Health and

Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 19:648 (May 1993), LR 23:732 (June 1997), repealed and promulgated LR 25:1251 (July 1999), repromulgated for inclusion in LAC, LR 30:1036 (May 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 32:1607 (September 2006), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:1124 (August 2021), LR 49:2107 (December 2023), amended by the Department of Health, Bureau of Health Services Financing, LR 51:

Chapter 107. Reimbursement

§10701. Reimbursement

A. – E. …

F. All targeted case management services shall be reimbursed at a flat rate for each approved unit of service. The standard of service is equivalent to one month.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:1040 (May 2004), amended LR 31:2032 (August 2005), LR 35:73 (January 2009), amended by the Department of Health and Hospitals, Bureau of Health Services

Financing, LR 35:1903 (September 2009), LR 36:1783 (August 2010), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Public Health, LR 39:97 (January 2013), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3302 (December 2013), LR 40:1700, 1701 (September 2014), LR 41:1490 (August 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:63 (January 2018), LR 47:1128 (August 2021), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 48:2976 (December 2022), amended by the Department of Health, Bureau of Health Services Financing, LR 51:

Chapter 111. Ventilator Care Coordination

§11101. Recipient Qualifications

A. The targeted population for ventilator care coordination shall consist of Medicaid beneficiaries, birth through age 25, who require the use of mechanical ventilation and are participants of the Children’s Choice Waiver (CC), New Opportunities Waiver (NOW), Residential Options Waiver (ROW), Early Steps Program, or meet requirements to receive Early Periodic Screening Diagnostic and Treatment (EPSDT) Targeted Case Management services as specified in LAC 50:XV.11303. Those eligible for and electing to receive ventilator care

coordination may not receive other Medicaid-funded case management services.

B. Ventilator care coordination provides technical medical expertise relative to mechanical ventilation, including:

1. intensive case management that focuses on medical needs and addressing socioeconomic and environmental factors;

2. discussing with beneficiary/family when medical concerns arise and acting accordingly;

3. updating physicians on medical concerns/issues between hospitalizations to maximize patient care;

4. collaborating with skilled professionals to assess equipment needs for each beneficiary to ensure appropriateness;

5. advocating between the beneficiary/family, the supply/equipment vendor, and other providers when needed;

6. assessing beneficiary needs to have updated prescriptions for ventilator supplies and durable medical equipment;

7. working with the home health agency, family, and pharmacy to avoid the risk of medication reaction or error;

8. reviewing the home health agency’s plan of care to determine the accuracy and appropriateness of the services provided; and

9. providing training and technical assistance to care providers and agencies that administer the provision of care to promote the health and safety of ventilator care coordination beneficiaries in their homes, at school, and in the community.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 51:

§11103. Ventilator Care Coordination Provider Qualifications

A. Each Medicaid-enrolled provider must employ the following staff:

1. licensed registered nurse; and

2. registered respiratory therapist.

B. The staff listed in Paragraphs A.1 and A.2 of this Section must possess at least two years of experience working with individuals who require mechanical ventilation.

C. Ventilator care coordinators may not exceed a caseload of 25 beneficiaries.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 51:

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.

Bruce D. Greenstein

Secretary