RULE

Department of Health and Hospitals
Bureau of Health Services Financing

Inpatient Hospital Services
Non-Rural, Non-State Hospitals
Children's Specialty Hospitals Reimbursements
(LAC 50:V.967)

The Department of Health and Hospitals, Bureau of Health Services Financing has amended LAC 50:V.967 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.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE
Part V. Hospital Services
Subpart 1. Inpatient Hospitals

Chapter 9. Non-Rural, Non-State Hospitals

Subchapter B. Reimbursement Methodology

§967. Children's Specialty Hospitals

A. Routine Pediatric Inpatient Services. For dates of service on or after October 4, 2014, payment shall be made per a prospective per diem rate that is 81.1 percent of the routine pediatric inpatient cost per day as calculated per the "as filed" fiscal year end cost report ending during SFY 2014. The "as filed" cost report will be reviewed by the department for accuracy prior to determination of the final per diem rate.

1. Repealed.

B. Inpatient Psychiatric Services. For dates of service on or after October 4, 2014, payment shall be a prospective per diem rate that is 100 percent of the distinct part psychiatric cost per day as calculated per the as filed fiscal year end cost report ending during SFY 2014. The as filed cost report will be reviewed by the department for accuracy prior to determination of the final per diem rate.

1. Costs and per discharge/per diem limitation comparisons shall be calculated and applied separately for acute, psychiatric and each specialty service.

C. Carve-Out Specialty Services. These services are rendered by neonatal intensive care units, pediatric intensive care units, burn units and include transplants.

1. Transplants. Payment shall be the lesser of costs or the per diem limitation for each type of transplant. The base period per diem limitation amounts shall be calculated using the allowable inpatient cost per day for each type of transplant per the cost reporting period which ended in SFY 2009. The target rate shall be inflated using the update factors published by the Centers for Medicare and Medicaid (CMS) beginning with the cost reporting periods starting on or after January 1, 2010.

a. For dates of service on or after September 1, 2009, payment shall be the lesser of the allowable inpatient

costs as determined by the cost report or the Medicaid days for the period for each type of transplant multiplied times the per diem limitation for the period.

2. Neonatal Intensive Care Units, Pediatric Intensive Care Units, and Burn Units. For dates of service on or after October 4, 2014, payment for neonatal intensive care units, pediatric intensive care units, and burn units shall be made per prospective per diem rates that are 84.5 percent of the cost per day for each service as calculated per the "as filed" fiscal year end cost report ending during SFY 2014. The "as filed" cost report will be reviewed by the department for accuracy prior to determination of the final per diem rate.

D. Children's specialty hospitals shall be eligible for outlier payments for dates of service on or after October 4, 2014.

1. Repealed.

E. …

1. Repealed.

F. Effective for dates of service on or after February 3, 2010, the per diem rates as calculated per §967.C.1 above shall be reduced by 5 percent. Effective for dates of service on or after January 1, 2011, final payment shall be the lesser of allowable inpatient acute care costs as determined by the cost report or the Medicaid days as specified per §967.C.1 for the

period, multiplied by 95 percent of the target rate per diem limitation as specified per §967.C.1 for the period.

G. Effective for dates of service on or after August 1, 2010, the per diem rates as calculated per §967.C.1 above shall be reduced by 4.6 percent. Effective for dates of service on or after January 1, 2011, final payment shall be the lesser of allowable inpatient acute care costs as determined by the cost report or the Medicaid days as specified per §967.C.1 for the period, multiplied by 90.63 percent of the target rate per diem limitation as specified per §967.C.1 for the period.

H. Effective for dates of service on or after January 1, 2011, the per diem rates as calculated per §967.C.1 above shall be reduced by 2 percent. Final payment shall be the lesser of allowable inpatient acute care costs as determined by the cost report or the Medicaid days as specified per §967.C.1 for the period, multiplied by 88.82 percent of the target rate per diem limitation as specified per §967.C.1 for the period.

I. – I.3. …

J. Effective for dates of service on or after August 1, 2012, the per diem rates as calculated per §967.C.1 above shall be reduced by 3.7 percent. Final payment shall be the lesser of allowable inpatient acute care costs as determined by the cost report or the Medicaid days as specified per §967.C.1 for the

period, multiplied by 85.53 percent of the target rate per diem limitation as specified per §967.C.1 for the period.

K. Effective for dates of service on or after February 1, 2013, the per diem rates as calculated per §967.C.1 above shall be reduced by 1 percent. Final payment shall be the lesser of allowable inpatient acute care costs as determined by the cost report or the Medicaid days as specified per §967.-C.1 for the period, multiplied by 84.67 percent of the target rate per diem limitation as specified per §967.C.1 for the period.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2562 (November 2010), amended LR 37:2162 (July 2011), LR 38:2773 (November 2012), LR 39:3097 (November 2013), LR 40:312 (February 2014), repromulgated LR 40:1940 (October 2014), amended LR 40:1941 (October 2014), LR 42:

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health and Hospitals
Bureau of Health Services Financing

Intermediate Care Facilities for Persons with Intellectual Disabilities
Complex Care Reimbursements
(LAC 50:VII.32915)

The Department of Health and Hospitals, Bureau of Health Services Financing has adopted LAC 50:VII.32915 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.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE
Part VII. Long Term Care
Subpart 3. Intermediate Care Facilities for Persons with Intellectual Disabilities

Chapter 329. Reimbursement Methodology

Subchapter A. Non-State Facilities

§32915. Complex Care Reimbursements

A. Effective for dates of service on or after October 1, 2014, non-state intermediate care facilities for persons with intellectual disabilities (ICFs/ID) may receive an add-on payment to the per diem rate for providing complex care to Medicaid recipients who require such services. The add-on rate

adjustment shall be a flat fee amount and may consist of payment for any one of the following components:

1. equipment only;

2. direct service worker (DSW);

3. nursing only;

4. equipment and DSW;

5. DSW and nursing;

6. nursing and equipment; or

7. DSW, nursing, and equipment.

B. Non-state owned ICFs/ID may qualify for an add-on rate for recipients meeting documented major medical or behavioral complex care criteria. This must be documented on the complex support need screening tool provided by the department. All medical documentation indicated by the screening tool form and any additional documentation requested by the department must be provided to qualify for the add-on payment.

C. In order to meet the complex care criteria, the presence of a significant medical or behavioral health need must exist and be documented. This must include:

1. endorsement of at least one qualifying condition with supporting documentation; and

2. endorsement of symptom severity in the appropriate category based on qualifying condition(s) with supporting documentation.

a. Qualifying conditions for complex care must include at least one of the following as documented on the complex support need screening tool:

i. significant physical and nutritional needs requiring full assistance with nutrition, mobility, and activities of daily living;

ii. complex medical needs/medically fragile; or

iii. complex behavioral/mental health needs.

D. Enhanced Supports. Enhanced supports must be provided and verified with supporting documentation to qualify for the add-on payment. This includes:

1. endorsement and supporting documentation indicating the need for additional direct service worker resources;

2. endorsement and supporting documentation indicating the need for additional nursing resources; or

3. endorsement and supporting documentation indicating the need for enhanced equipment resources (beyond basic equipment such as wheelchairs and grab bars).

E. One of the following admission requirements must be met in order to qualify for the add-on payment:

1. the recipient has been admitted to the facility for more than 30 days with supporting documentation of necessity and provision of enhanced supports; or

2. the recipient is transitioning from another similar agency with supporting documentation of necessity and provision of enhanced supports.

F. All of the following criteria will apply for continued evaluation and payment for complex care.

1. Recipients receiving enhanced rates will be included in annual surveys to ensure continuation of supports and review of individual outcomes.

2. Fiscal analysis and reporting will be required annually.

3. The provider will be required to report on the following outcomes:

a. hospital admissions and diagnosis/reasons for admission;

b. emergency room visits and diagnosis/reasons for admission;

c. major injuries;

d. falls; and

e. behavioral incidents.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 42:

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health and Hospitals
Bureau of Health Services Financing

Managed Care for Physical and Basic Behavioral Health
Timely Filing of Claims
(LAC 50:I.3511)

The Department of Health and Hospitals, Bureau of Health Services Financing has amended LAC 50:I.3511 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.

Title 50

PUBLIC HEALTH-MEDICAL ASSISTANCE
Part I. Administration
Subpart 3. Managed Care for Physical and Basic Behavioral Health

Chapter 35. Managed Care Organization Participation Criteria

§3511. Prompt Pay of Claims

A. – B.1.c. ...

2. Medicaid claims must be filed within 365 days of the date of service.

a. The provider may not submit an original claim for payment more than 365 days from the date of service, unless the claim meets one of the following exceptions:

i. the claim is for a member with retroactive Medicaid eligibility and must be filed within 180 days from linkage into an MCO;

ii. the claim is a Medicare claim and shall be submitted within 180 days of Medicare adjudication; and

iii. the claim is in compliance with a court order to carry out hearing decisions or agency corrective actions taken to resolve a dispute, or to extend the benefits of a hearing decision or corrective action.

B.3. – E.1. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1589 (June 2011), amended LR 41:938 (May 2015), LR 42:

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.

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health and Hospitals
Bureau of Health Services Financing

Medical Transportation Program
Emergency Aircraft Transportation
Rotor Winged Ambulance Services Rate Increase
(LAC 50:XXVII.353)

The Department of Health and Hospitals, Bureau of Health Services Financing has amended LAC 50:XXVII.353 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.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXVII. Medical Transportation Program

Chapter 3. Emergency Medical Transportation

Subchapter C. Aircraft Transportation

§353. Reimbursement

A. – H. ...

I. Effective for dates of service on or after September 1, 2014, the reimbursement rates for rotor winged emergency air ambulance services, which originate in areas designated as rural and/or super rural by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, shall be increased to the following rates:

1. base rate, $4,862.72 per unit; and

2. mileage rate, $33.65 per unit.

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 35:70 (January 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2564 (November 2010), LR 37:3029 (October 2011), LR 39:1285 (May 2013), LR 40:1379 (July 2014), LR 42:

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health and Hospitals
Bureau of Health Services Financing

Psychiatric Residential Treatment Facilities
Licensing Standards
(LAC 48:I.Chapter 90)

The Department of Health and Hospitals, Bureau of Health Services Financing has amended LAC 48:I.Chapter 90 as authorized by R.S. 36:254 and R.S. 40:2009. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 48

PUBLIC HEALTH-GENERAL
Part I. General Administration
Subpart 3. Licensing

Chapter 90. Psychiatric Residential Treatment Facilities (under 21)

Subchapter A. General Provisions

§9003. Definitions

A. …

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Cessation of Business—Repealed.

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AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health

and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:54 (January 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:371 (February 2012), LR 39:2510 (September 2013), LR 42:

Subchapter B. Licensing

§9015. Licensing Surveys

A. – D. …

E. If deficiencies have been cited during a licensing survey, regardless of whether an acceptable plan of correction is required, the department may issue appropriate sanctions, including, but not limited to:

1. civil fines;

2. directed plans of correction;

3. provisional licensure;

4. denial of renewal; and/or

5. license revocations.

F. – F.2 …

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:375 (February 2012), amended LR 42:

§9017. Changes in Licensee Information or Personnel

A. – D.2. …

3. A PRTF that is under provisional licensure, license revocation or denial of license renewal may not undergo a CHOW.

E. – F.2. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:375 (February 2012), amended LR 42:

§9019. Cessation of Business

A. Except as provided in §9089 of these licensing regulations, a license shall be immediately null and void if a PRTF ceases to operate.

1. – 3. Repealed.

B. A cessation of business is deemed to be effective the date on which the PRTF stopped offering or providing services to the community.

C. Upon the cessation of business, the provider shall immediately return the original license to the Department.

D. Cessation of business is deemed to be a voluntary action on the part of the provider. The provider does not have a right to appeal a cessation of business.

E. Prior to the effective date of the closure or

cessation of business, the PRTF shall:

1. give 30 days' advance written notice to:

a. HSS;

b. the prescribing physician; and

c. the parent(s) or legal guardian or legal representative of each client; and

2. provide for an orderly discharge and transition of all of the clients in the facility.

F. In addition to the advance notice of voluntary closure, the PRTF shall submit a written plan for the disposition of clients' medical records for approval by the department. The plan shall include the following:

1. the effective date of the voluntary closure;

2. provisions that comply with federal and state laws on storage, maintenance, access, and confidentiality of the closed provider's clients' medical records;

3. an appointed custodian(s) who shall provide the following:

a. access to records and copies of records to the client or authorized representative, upon presentation of proper authorization(s); and

b. physical and environmental security that protects the records against fire, water, intrusion, unauthorized access, loss and destruction; and

4. public notice regarding access to records, in the newspaper with the largest circulation in close proximity to the closing provider, at least 15 days prior to the effective date of closure.

G. If a PRTF fails to follow these procedures, the owners, managers, officers, directors, and administrators may be prohibited from opening, managing, directing, operating, or owning a PRTF for a period of two years.

H. Once the PRTF has ceased doing business, the PRTF shall not provide services until the provider has obtained a new initial license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:375 (February 2012), amended LR 42:

§9023. Denial of License, Revocation of License, Denial of License Renewal

A. – C.3. …

D. Revocation of License or Denial of License Renewal. A PRTF license may be revoked or may be denied renewal for any of the following reasons, including but not limited to:

1. – 13. …

14. bribery, harassment, or intimidation of any

resident or family member designed to cause that resident or family member to use or retain the services of any particular PRTF; or

15. failure to maintain accreditation or failure to obtain accreditation.

16. Repealed.

E. If a PRTF license is revoked or renewal is denied, or the license is surrendered in lieu of an adverse action, any owner, officer, member, director, manager, or administrator of such PRTF may be prohibited from opening, managing, directing, operating, or owning another PRTF for a period of two years from the date of the final disposition of the revocation, denial action, or surrender.

F. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:376 (February 2012), amended LR 42:

§9025. Notice and Appeal of License Denial, License Revocation, License Non-Renewal, and Appeal of Provisional License

A. – B. …

1. The PRTF shall request the informal

reconsideration within 15 calendar days of the receipt of the notice of the license denial, license revocation, or license non-renewal. The request for informal reconsideration must be in writing and shall be forwarded to the Health Standards Section.

B.2. – D. …

E. If a timely administrative appeal has been filed by the facility on a license denial, license non-renewal, or license revocation, the Division of Administrative Law shall conduct the hearing pursuant to the Louisiana Administrative Procedure Act.

E.1. – G.2. …

3. The provider shall request the informal reconsideration in writing, which shall be received by the Health Standards Section within five days of receipt of the notice of the results of the follow-up survey from the department.

a. Repealed.

4. The provider shall request the administrative appeal within 15 days of receipt of the notice of the results of the follow-up survey from the department. The request for administrative appeal shall be in writing and shall be submitted to the Division of Administrative Law, or its successor.

a. Repealed.

H. – H.1. …

I. If a timely administrative appeal has been filed by a facility with a provisional initial license that has expired or by an existing provider whose provisional license has expired under the provisions of this Chapter, the Division of Administrative Law shall conduct the hearing pursuant to the Louisiana Administrative Procedure Act.

1. – 2. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:377 (February 2012), amended LR 42:

§9027. Complaint Surveys

A. – J.1. …

a. The offer of the administrative appeal, if appropriate, as determined by the Health Standards Section, shall be included in the notification letter of the results of the informal reconsideration. The right to administrative appeal shall only be deemed appropriate and thereby afforded upon completion of the informal reconsideration.

2. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health

and Hospitals, Bureau of Health Services Financing, LR 38:378 (February 2012), amended LR 42:

§9029. Statement of Deficiencies

A. – C.1. …

2. The written request for informal reconsideration of the deficiencies shall be submitted to the Health Standards Section and will be considered timely if received by HSS within 10 calendar days of the provider's receipt of the statement of deficiencies.

3. – 5. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:379 (February 2012), amended LR 42:

Subchapter H. Additional Requirements for Mental Health PRTFs

§9093. Personnel Qualifications, Responsibilities, and Requirements

A. – 2.a.iv. …

b. The clinical director is responsible for the following:

i. providing clinical direction for each resident at a minimum of one hour per month, either in person on-site, or via telemedicine pursuant to R.S. 37:1261-1292, et

seq. and LAC 46:XLV.408 and Chapter 75, et seq.;

2.b.i.(a). - 3.a.iv. …

b. A LMHP or MHP shall provide for each resident a minimum weekly total of 120 minutes of individual therapy.

A.3.c. – B. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:397 (February 2012), amended LR 39:2511 (September 2013), LR 42:

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Secretary