

RULE

Department of Health Bureau of Health Services Financing

Eligibility Family Opportunity Act Medicaid Program (LAC 50:VIII.2303)

The Department of Health, Bureau of Health Services Financing have amended LAC 50:VII.2303 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 III. Eligibility Subpart 3. Eligibility Group and Factors

Chapter 23. Eligibility Groups and Medicaid Programs

§2303. Family Opportunity Act Medicaid Program

A. – B.2.b. ...

3. The child may be uninsured or underinsured.

a. Parents are required to enroll in available employer-sponsored health plans when the employer contributes at least 50 percent of the annual premium costs. Participation in such employer-sponsored health plans is a condition of Medicaid coverage pursuant to the Family Opportunity Act Medicaid Program.

C. - D.2.b.iii. ...

3. The first premium is due the month following the month that eligibility is established. Prepayment of premiums is not required. A child's eligibility for medical assistance will not terminate on the basis of failure to pay a premium during the 12-month continuous eligibility period. A child's eligibility for medical assistance will terminate at the end of the 12-month continuous eligibility period if a failure to pay has continued for at least 60 days from the date on which the premium was past due.

4. - 4.b. ...

5. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1628 (August 2008), amended LR 35:69 (January 2009), amended 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

RULE

Department of Health Bureau of Health Services Financing

Refugee Medical Assistance (LAC 50:XXXI)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XXXI 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 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 XXXI. Refugee Medical Assistance

Chapter 1. Refugee Medical Assistance Program

§101. General Provisions

- A. Repealed.
- B. The Refugee Medical Assistance Program (RMA) provides medical assistance to individuals who meet the eligibility requirements and conditions set forth in 45 CFR part 400 subpart G.

C. Refugee medical assistance is available to all individuals with the immigration status of refugee or asylee.

D. All recipients who receive refugee cash assistance through the Office of Refugee Resettlement, and who are not eligible for Medicaid or SCHIP program, shall be certified for RMA.

1. Receipt or application for refugee cash assistance is not a requirement of the RMA program.

E. A refugee who has been certified in a regular Medicaid program and loses that coverage because of increased earnings from employment, and is within the eligibility time period, shall be transferred to RMA.

F. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Public Law 82-414, 8 U.S. Code 1522(e)(5).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1112 (June 2009), amended by the Department of Health, Bureau of Health Services Financing, LR 51:

§103. Eligibility Requirements

A. Individuals may qualify for the RMA program if they meet the following requirements:

1. has an immigration status recognized by the Office of Refugee Resettlement (ORR) through policy or federal notice that qualifies for resettlement assistance;

2. has income and resources that do not exceed the guidelines set forth in 42 CFR 435.831, as reflected in the State approved Title XIX Medicaid plan;

3. is not otherwise eligible for Medicaid or SCHIP;

4. provides the name of the resettlement agency that resettled them, if applicable;

- a. Repealed.

5. not enrolled as a full-time student in a higher education program, except where such enrollment is approved by the State or its designee.

B. An individual does not need to apply for or receive refugee cash assistance (RCA) in order to qualify for the RMA.

1. Repealed.

C. All recipients of RCA who are not otherwise eligible for Medicaid or SCHIP are eligible for RMA.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Public Law 82-414, 8 U.S. Code 1522(e)(5).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1112 (June 2009), amended by the Department of Health, Bureau of Health Services Financing, LR 51:

§107. Eligibility Period

A. Repealed.

B. The RMA eligibility period shall be determined in accordance with 45 CFR 400.211.

1. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Public Law 82-414, 8 U.S. Code 1522(e)(5).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1113 (June 2009), amended by the Department of Health, Bureau of Health Services Financing, LR 51:

§108. Termination of Services

A. RMA benefits shall terminate upon the earliest of the following:

1. the individual's eligibility period expires;
2. the individual enrolls in Medicaid or SCHIP;
3. termination of ORR eligible immigration status;

or

4. relocation from the state of Louisiana.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Public Law 82-414, 8 U.S. Code 1522 (e)(5).

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

RULE

Department of Health Bureau of Health Services Financing

Professional Services Reimbursement Methodology (LAC 50:IX.8305, 8505, 15113, 15133, and XIX.4334)

The Department of Health, Bureau of Health Services Financing has adopted LAC 50:IX.8305, 8505, 15113, 15133, and XIX.4334 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 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 IX. Professional Services Program

Subpart 7. Immunizations

Chapter 83. Children's Immunizations

§8305. Reimbursement Methodology

A. – B. ...

C. Effective for dates of service on or after July 1, 2025, reimbursement for the administration of childhood and adolescent vaccines shall be set at 85 percent of the 2024

Louisiana Region 99 Medicare allowable fee, or billed charges, whichever is the lesser amount.

C.1. – D. ...

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 35:71 (January 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Public Health, LR 39:96 (January 2013), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:1289 (July 2015), amended by the Department of Health, Bureau of Health Services Financing LR 47:49 (January 2021), LR 47:887 (July 2021), LR 51:

Chapter 85. Adult Immunizations

§8505. Reimbursement Methodology

A. – D. ...

E. Effective for dates of service on or after July 1, 2025, the reimbursement for adult vaccine administration (beneficiaries age 19 and older) shall be set at 85 percent of the 2024 Louisiana Region 99 Medicare allowable fee or billed charges, whichever is the lesser amount.

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 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 41:1290 (July 2015), amended by the Department of Health, Bureau of Health Services Financing LR 47:50 (January 2021), LR 47:887 (July 2021), LR 51:

Subpart 15. Reimbursement

Chapter 151. Reimbursement Methodology

Subchapter B. Physician Services

§15113. Reimbursement Methodology

A. – N.1.b.ii. ...

0. Effective for dates of service on or after July 1, 2025, the Medicaid fee shall be set at 85 percent of the 2024 Louisiana Region 99 Medicare allowable fee for both current and newly added procedure codes.

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 36:1252 (June 2010), amended LR 36:2282 (October 2010), LR 37:904 (March 2011), LR 39:3300, 3301 (December 2013), LR 41:541 (March 2015), LR 41:1119 (June 2015), LR 41:1291 (July 2015), amended by the Department of Health, Bureau of Health Services Financing, LR

44:62 (January 2018), amended by the Department of Health, Bureau of Health Services Financing, LR 44:62 (January 2018), LR 47:477 (April 2021), LR 47:887 (July 2021), LR 48:1100 (April 2022), LR 51:71 (January 2025), LR 51:

Subchapter D. Anesthesia Services

§15133. Formula-Based Reimbursement

A. – F. ...

G. Effective for dates of service on or after July 1, 2025, the Medicaid fee for formula-based anesthesia services rendered by a physician shall be 85 percent of the 2024 Louisiana Medicare Region 99 allowable for services rendered to Medicaid recipients.

H. Effective for dates of service on or after July 1, 2025, the reimbursement for formula-based anesthesia services rendered by a certified registered nurse anesthetist (CRNA) shall be 85 percent of the 2024 Louisiana Medicare Region 99 allowable for services rendered to Medicaid recipients.

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 36:1251 (June 2010), amended LR 36:2282 (October 2010), LR 39:1781 (July 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 51:

§15135. Flat Fee Reimbursement

A. - G. ...

H. Effective for dates of service on or after July 1, 2025, the flat fee for reimbursement of maternity related anesthesia services shall be 85 percent of the 2024 Louisiana Medicare Region 99 allowable for services rendered to Medicaid recipients. If there is no equivalent Medicare fee, an alternate methodology may be used.

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 36:1251 (June 2010), amended LR 36:1251 (June 2010), LR 39:1781 (July 2013), LR 51:

Part XIX. Other Services

Subpart 3. Laboratory and Radiology Services

Chapter 43. Reimbursement

§4334. Radiology Services Reimbursement Methodology

A. - B. ...

C. Effective for dates of service on or after July 1, 2025, the Medicaid fee for radiology services shall be set at 85 percent of the 2024 Louisiana Region 99 Medicare allowable fee. This applies to both current and newly added procedure codes.

1. Repealed.

D. - I. ...

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 35:1897 (September 2009), amended LR 36:1248 (June 2010), LR 36:2563 (November 2010), LR 37:3029 (October 2011), LR 39:1284 (May 2013), LR 41:539 (March 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 44:283 (February 2018), amended by the Department of Health, Bureau of Health Services Financing, LR 47:252 (February 2021), LR 47:1638 (November 2021), 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

Medical Transportation Program Non-Emergency Medical Transportation (50:XXVII.Chapter 5)

The Department of Health, Bureau of Health Services Financing have amended LAC 50:XXVII.Chapter 5 and have adopted LAC 50:XXVII.519 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 XXVII. Medical Transportation Program

Chapter 5. Non-Emergency Medical Transportation

Subchapter A. General Provisions

§501. Overview

A. ...

1. *Traditional Providers*—non-profit and for-profit providers who are not Transportation Network Companies.

2. *Non-profit Providers*—those providers who are operated by or affiliated with a public organization such as state, federal, parish or city entities, community action agencies, or parish Councils on Aging. If a provider qualifies

as a non-profit entity according to Internal Revenue Service regulations, they may only enroll as non-profit providers.

3. *For-profit Providers*—corporations, limited liability companies, partnerships, or sole proprietors. For-profit providers must comply with all state laws and the regulations of any governing state agency, commission, or local entity to which they are subject as a condition of enrollment and continued participation in the Medicaid program.

B. Medicaid covered transportation is available to Medicaid beneficiaries when:

1. – 2. ...

3. the beneficiary may utilize the elevated level of care (ELOC) transportation services, often referred to as door through door transportation, which provides assistance beyond the capacity of the beneficiary. ELOC is a higher level of care for beneficiaries with mobility limitations requiring assistance when using a wheelchair.

C. – C.2. ...

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 47:1638 (November 2021), amended LR 50:1471 (October 2024), amended LR 51:

§503. Prior Approval and Scheduling

A. – A.2. ...

B. Elevated level of care wheelchair services require verification of medical necessity through an additional prior approval.

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 47:1639 (November 2021), amended LR 50:1471 (October 2024), amended LR 51:

§505. Requirements for Coverage

A. Payment shall only be authorized for the least costly means of transportation available. The least costly means of transportation shall be determined by the department or its designee and considered the beneficiary's choice of transportation, the level of service required to safely transport the beneficiary (e.g., ambulatory, wheelchair, transfer), and the following hierarchy:

1. public transit;
2. ...
3. traditional providers (for-profit and non-profit)

who are enrolled in the Medicaid Program; and

4. Transportation Network Companies (TNCs) who are enrolled in the Medicaid Program.

B. Beneficiaries shall be allowed a choice of transportation services, with the exception of TNCs, as long as it remains the least costly means of transportation.

C. - E. ...

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 47:1639 (November 2021), amended LR 49:877 (May 2023), LR 50:1471 (October 2024), amended LR 51:

Subchapter B. Beneficiary Participation

§517. Traditional Provider Requirements

A. All traditional providers must comply with all applicable federal, state, and local laws and regulations, including, but not limited to, those pertaining to enrollment and participation in the Medicaid Program.

B. NEMT traditional providers shall have a minimum automobile split limit liability insurance coverage of \$25,000 per person, \$50,000 per accident and \$25,000 property damage policy or a combined single limit automobile coverage at a minimum of \$300,000.

1. The liability policy shall cover:

- a. any autos - owned, non-owned (rented, leased, borrowed, and hired.
- b. any autos - owned, hired autos, and non-owned autos; or
- c. scheduled autos, hired autos, and non-owned autos.

2. - 3. ...

C. As a condition of reimbursement for transporting Medicaid beneficiaries to and/or from healthcare services, gas reimbursement providers must maintain a current valid vehicle registration, the state minimum automobile liability insurance coverage, and a current valid driver's license. Proof of compliance with these requirements must be submitted to the department or its designee during the enrollment process. Gas reimbursement providers are allowed to transport up to five specified Medicaid beneficiaries or all members of one household across all contracted managed care organizations. The provider may not reside at the same physical address as the beneficiary being transported. Individuals transporting more than five Medicaid beneficiaries or all members of one household shall be considered traditional providers and shall be enrolled as such and comply with all for-profit provider requirements.

D. ...

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 47:1639 (November 2021), amended LR 49:877 (May 2023), LR 50:1472 (October 2024), amended LR 51:

§519. Transportation Network Company Requirements

A. All TNCs must comply with applicable federal requirements.

B. No driver shall provide NEMT services to a beneficiary through a TNC prior to the completion of a criminal background check that comports with the requirement for such background checks provided R.S.40:1203.1 et seq. or 48:2199.

C. Prior to facilitating NEMT services for Medicaid beneficiaries, a TNC shall be under contract with either:

1. an MCO as defined in 42 C.F.R. 438.2, or its subcontracted transportation broker.

2. the department, or its subcontracted transportation broker.

D. TNCs, drivers, and vehicles are subject to the provisions of R.S. 45:201.1 - 45.201.13.

E. Aside from city and parish non-emergency medical transportation program rules, the provisions of R.S. 48:2205 shall apply to the regulation of companies, drivers, and

vehicles facilitating or providing NEMT services as authorized in R.S. 40:1257.5.

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:

Subchapter D. Reimbursement

§523. General Provisions

A. – C. ...

D. Reimbursement for NEMT services provided by traditional providers, gas reimbursement providers, public transit, or TNCs shall only be reimbursed if scheduled by a contracted transportation broker.

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 47:1639 (November 2021), amended LR 50:1472 (October 2024), amended 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