NOTICE OF INTENT

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 proposes to amend 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 proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health, Bureau of Health Services Financing proposes to amend the provisions governing Medicaid managed care organizations (MCOs) to allow practitioner and practitioner groups to participate in directed payments, in accordance with the preprint approved by Centers for Medicare and Medicaid Services (CMS). This allows practitioners under managed care plan contracts to receive directed payments and be included in the calculations for those payments.

The rule text below has been drafted utilizing plain language principles to ensure clarity and accessibility for all users. It has also been reviewed and tested for compliance with web accessibility standards.

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.

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on

the family has been considered. It is anticipated that this proposed Rule will have no impact on family functioning, stability and autonomy as described in R.S. 49:972.

Poverty Impact Statement

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

Small Business Impact

In compliance with the Small Business Protection Act, the economic impact of this proposed Rule on small businesses has been considered. It is anticipated that this proposed Rule will have a positive impact on small businesses, since it includes practitioners in directed payments.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct or indirect cost to the provider to provide the same level of service, but may

improve the provider's ability to provide the same level of service as described in HCR 170 since practitioners will now be included in directed payments.

Public Comments

Interested persons may submit written comments to Kimberly Sullivan, JD, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. Ms. Sullivan is responsible for responding to inquiries regarding this proposed Rule. The deadline for submitting written comments is October 20, 2025.

Public Hearing

Interested persons may submit a written request to conduct a public hearing by U.S. mail to the Office of the Secretary ATTN: LDH Rulemaking Coordinator, Post Office Box 629, Baton Rouge, LA 70821-0629; however, such request must be received no later than 4:30 p.m. on October 10, 2025. If the criteria set forth in R.S. 49:961(B)(1) are satisfied, LDH will conduct a public hearing at 9:30 a.m. on October 30, 2025 in Room 118 of the Bienville Building, which is located at 628 North Fourth Street, Baton Rouge, LA. To confirm whether or not a public hearing will be held, interested persons should first call Allen Enger at (225) 342-1342 after October 10, 2025. If a public hearing is to be held, all interested persons are invited to attend and present data, views, comments, or arguments, orally or in writing.

Bruce D. Greenstein

Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Managed Care Healthy Louisiana

Hospital and Practitioner Directed Payments

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

It is anticipated that implementation of this proposed rule will have no programmatic fiscal impact to the state other than the cost of promulgation for FY 25-26. It is anticipated that $864 ($432 SGF and $432 FED) will be expended in FY 25-26 for the state’s administrative expense for promulgation of this proposed rule and the final rule.

This proposed rule amends the provisions governing Medicaid Managed Care Organizations (MCOs) to allow practitioner and practitioner groups to participate in directed payments, in accordance with the preprint approved by Centers for Medicare and Medicaid Services (CMS). This allows practitioners under managed care plan contracts to receive directed payments and be included in the calculations for those payments.

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

It is anticipated that implementation of this proposed rule will have no impact on state or local governmental revenue collections for FY 25-26. It is anticipated that $432 will be collected in FY 25-26 for the federal share of the expense for promulgation of this proposed rule and the final rule.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS, SMALL BUSINESSES, OR NON-GOVERNMENTAL GROUPS (Summary)

This proposed rule amends the provisions governing Medicaid MCOs to allow practitioner and practitioner groups to participate in directed payments, in accordance with the preprint approved by CMS. Implementation of this rule is anticipated to have no cost or economic benefit to providers or small businesses in FY 25-26, FY 26-27, or FY 27-28.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This proposed rule has no known effect on competition and employment.