RULE

Department of Health
Bureau of Health Services Financing
and
Office for Citizens with Developmental Disabilities
and
Office of Aging and Adult Services

Home and Community-Based Services Waivers
Cost Reporting Requirements
(LAC 50:XXI.Chapters 7 and Chapter 29)

The Department of Health, Bureau of Health Services Financing, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services have amended LAC 50:XXI.Chapter 7 and repealed LAC 50:XXI.Chapter 29 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act.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 XXI. Home and Community-Based Services Waivers
Subpart 1. General Provisions

Chapter 7. Reimbursement Methodology

Subchapter A. Personal Care Services Providers

§701. General Provisions

A. The Department of Health (LDH) establishes reimbursement methodologies and cost reporting requirements for

providers of home and community-based services waiver programs who provide personal care services (including personal care services, personal care attendant services, community living supports services, attendant care services, personal assistance services, in-home respite, and individual and family support services).

B. – C. Repealed.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, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 39:509 (March 2013), amended LR 42:898 (June 2016),amended by the Department of Health, Bureau of Health Services Financing, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:

§703. Cost Reporting Requirements

A. Effective July 1, 2012, the department implemented mandatory cost reporting requirements for providers of home and community-based waiver services listed above in §701.A. The cost reports will be used to verify expenditures and to support rate setting for the services rendered to waiver participants.

1. – 7. Repealed.

B. Providers of services in the following waiver programs shall be required to submit cost reports:

1. Adult Day Health Care Waiver;

2. Children’s Choice Waiver;

3. Community Choices Waiver;

4. New Opportunities Waiver;

5. Residential Options Waiver; and

6. Supports Waiver.

C. Each provider shall complete the LDH approved cost report and submit the cost report(s) to the department no later than five months after the state’s fiscal year ends (June 30).

1. – 5. Repealed.

D. When a provider fails to submit a cost report by the last day of November, which is five months after the state fiscal year ends (June 30), a penalty of 5 percent of the total monthly payment for the first month and a progressive penalty of 5 percent of the total monthly payment for each succeeding month may be levied and withheld from the provider’s payment for each month that the cost report is due, not extended and not received. The penalty is non-refundable and not subject to an administrative appeal.

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 Aging and Adult Services, LR 39:509 (March 2013), amended LR 42:898 (June 2016), amended by the Department of Health, Bureau of Health Services Financing, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:

§705. Rate Methodology

EDITOR'S NOTE: This Section was previously numbered LAC 50:XXI.703 and complies with Act 299 of the 2011 Regular Session of the Louisiana Legislature.

A. Reimbursement for the following services shall be a prospective flat rate for each approved unit of service that is provided to the participant:

1. personal care services;
2. personal care attendant services;
3. community living supports services;
4. attendant care services;
5. personal assistance services;
6. in-home respite; and
7. individual and family support services,

collectively referred to as reimbursable assistance services.

B. One quarter hour (15 minutes) shall be the standard unit of service. Reimbursement shall not be paid for the provision of less than one quarter hour (15 minutes) of service.

C. Effective July 1, 2016, a rate validation process occurred to determine the sufficiency of reimbursement rates. This process will be repeated at a minimum of every two years thereafter. The rate validation process will involve the comparison of current provider reimbursement rates to reimbursement rates established using the department's reimbursement methodology.

1. The department's reimbursement methodology will establish an estimated reimbursement rate through the summation of the following two rate component totals:

a. adjusted staff cost rate component; and

b. other operational cost rate component.

2. The adjusted staff cost rate component will be determined in the following manner.

a. Direct service worker wage expense, contract labor expense, and hours worked for reimbursable assistance services will be collected from provider cost reports.

i. Collected wage and contract labor expense will be divided by collected hours worked, on an individual cost report basis, to determine a per hour labor rate for direct service workers.

ii. The individual cost report hourly labor rates will be aggregated for all applicable filed cost reports, outliers will be removed, and a simple average statewide labor rate will be determined.

b. A blended direct service worker labor rate will be calculated by comparing the simple average statewide labor rate to the most recently available, as of the calculation of the department’s rate validation process, average personal care aide wage rate from the *Louisiana Occupational Employment and Wages* report for all Louisiana parishes published by the Louisiana Workforce Commission (or its successor).

i. If the simple average statewide labor rate is less than the wage rate from the *Louisiana Occupational Employment and Wages* report, a blended wage rate will be calculated using 50 percent of both wage rates.

ii. If the simple average statewide labor rate is equal to or greater than the wage rate from the *Louisiana Occupational Employment and Wages* report, the simple average statewide labor rate will be utilized.

c. An employee benefit factor will be added to the blended direct service worker wage rate to determine the unadjusted hourly staff cost.

i. Employee benefit expense allocated to reimbursable assistance services will be collected from provider cost reports.

ii. Employee benefit expense, on an individual cost report basis, will be divided by the cost report direct service wage and contract labor expense for reimbursable assistance services to calculate employee benefits as a percentage of labor costs.

iii. The individual cost report employee benefit percentages will be aggregated for all applicable filed cost reports, outliers will be removed, and a simple average statewide employee benefit percentage will be determined.

iv. The simple average statewide employee benefit percentage will be multiplied by the blended direct service worker labor rate to calculate the employee benefit factor.

d. The department will be solely responsible for determining if adjustments to the unadjusted hourly staff cost for items that are underrepresented or not represented in provider cost reports is considered appropriate.

e. The unadjusted hourly staff cost will be multiplied by a productive hours' adjustment to calculate the hourly adjusted staff cost rate component total. The productive hours' adjustment allows the reimbursement rate to reflect the

cost associated with direct service worker time spent performing required non-billable activities. The productive hours' adjustment will be calculated as follows.

i. The department will determine estimates for the amount of time a direct service worker spends performing required non-billable activities during an eight-hour period. Examples of non-billable time include, but are not limited to: meetings, substitute staff, training, wait-time, supervising, etc.

ii. The total time associated with direct service worker non-billable activities will be subtracted from eight hours to determine direct service worker total billable time.

iii. Eight hours will be divided by the direct service worker total billable time to calculate the productive hours' adjustment.

3. The other operational cost rate component will be calculated in the following manner.

a. Capital expense, transportation expense, other direct non-labor expense, and other overhead expense allocated to reimbursable assistance services will be collected from provider cost reports.

b. Capital expense, transportation expense, supplies, and other direct non-labor expense, and other overhead

expense, on an individual cost report basis, will be divided by the cost report direct service wage and contract labor expense for reimbursable assistance services to calculate other operational costs as a percentage of labor costs.

c. The individual cost report other operational cost percentages will be aggregated for all applicable filed cost reports, outliers will be removed, and a simple average statewide other operational cost percentage will be determined.

d. The simple average other operational cost percentage will be multiplied by the blended direct service worker labor rate to calculate the other operational cost rate component.

4. The calculated department reimbursement rates will be adjusted to a one quarter hour unit of service by dividing the hourly adjusted staff cost rate component and the hourly other operational cost rate component totals by four.

5. The department will be solely responsible for determining the sufficiency of the current reimbursement rates during the rate validation process. Any reimbursement rate change deemed necessary due to rate validation process will be subject to legislative budgetary appropriation restrictions prior to implementation.

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, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:

Subchapter B. Adult Day Health Care Providers

§707. General Provisions

A. The Department of Health (LDH) establishes reimbursement methodologies and cost reporting requirements for Adult Day Health Care (ADHC) providers of home and community-based waiver programs.

B. ADHC providers in the following waiver programs shall be required to submit cost reports:

1. Adult Day Health Care (ADHC) Waiver;

2. Community Choices Waiver; and

3. Residential Options Waiver (ROW).

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, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:

§709. Rate Methodology

A. Adult day health care providers shall be reimbursed a per quarter hour rate for services provided under a prospective

payment system (PPS). The system shall be designed in a manner that recognizes and reflects the cost of direct care services provided. The reimbursement methodology is designed to improve the quality of care for all waiver participants by ensuring that direct care services are provided at an acceptable level while fairly reimbursing the providers.

B. Reimbursement shall not be made for ADHC waiver services provided under the waivers prior to the department's approval of the POC.

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, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:

§711. Cost Reporting

A. Cost Centers Components

1. Direct Care Costs. This component reimburses for in-house and contractual direct care staffing, social services, and activities (excluding the activities director) and fringe benefits and direct care supplies.

2. Care Related Costs. This component reimburses for in-house and contractual salaries and fringe benefits for

supervisory and dietary staff, raw food costs, and care related supplies.

3. Administrative and Operating Costs. This component reimburses for in-house or contractual salaries and related benefits for administrative, housekeeping, laundry, and maintenance staff. Also included are:

a. utilities;

b. accounting;

c. dietary supplies;

d. housekeeping and maintenance supplies; and

e. all other administrative and operating type expenditures.

4. Property. This component reimburses for depreciation, interest on capital assets, lease expenses, property taxes, and other expenses related to capital assets, excluding property costs related to participant transportation.

5. Transportation. This component reimburses for in-house and contractual driver salaries and related benefits, non-emergency medical transportation, vehicle maintenance, and supply expense, motor vehicle depreciation, interest expense related to vehicles, vehicle insurance, and auto leases.

B. Providers of ADHC services are required to file acceptable annual cost reports of all reasonable and allowable costs. An acceptable cost report is one that is prepared in

accordance with the requirements of this Section and for which the provider has supporting documentation necessary for completion of a desk review or audit. The annual cost reports are the basis for determining reimbursement rates. A copy of all reports and statistical data must be retained by the center for no less than five years following the date cost reports are submitted to the bureau. A chart of accounts and an accounting system on the accrual basis or converted to the accrual basis at year end are required in the cost report preparation process. The bureau or its designee will perform desk reviews of the cost reports. In addition to the desk review, a representative number of the centers shall be subject to a full-scope, annual on-site audit. All ADHC cost reports shall be filed with a fiscal year from July 1 through June 30.

1. When a provider ceases to participate as an ADHC provider the provider must file a cost report covering a period under this program up to the effective date of cessation of participation in the program. Depending on the circumstances involved in the preparation of the provider's final cost report, the provider may file the cost report for a period of not less than one month or not more than 13 months.

C. The cost reporting forms and instructions developed by the Bureau must be used by all ADHC centers participating in the Louisiana Medicaid Program. Hospital based and other provider

based ADHC which use Medicare forms for step down in completing their ADHC Medicaid cost reports must submit copies of the applicable Medicare cost report forms also. All amounts must be rounded to the nearest dollar and must foot and cross foot. Only per diem cost amounts will not be rounded. Cost reports submitted that have not been rounded in accordance with this policy will be returned and will not be considered as received until they are resubmitted.

D. Annual Reporting. Cost reports are to be filed on or before the last day of September following the close of the cost reporting period. Should the due date fall on a Saturday, Sunday, or an official state or federal holiday, the due date shall be the following business day. The cost report forms and schedules must be filed with one copy of the following documents:

1. a cost report grouping schedule. This schedule should include all trial balance accounts grouped by cost report line item. All subtotals should agree to a specific line item on the cost report. This grouping schedule should be done for the balance sheet, income statement, and expenses;

2. a depreciation schedule. The depreciation schedule which reconciles to the depreciation expense reported on the cost report must be submitted. If the center files a home office cost report, copies of the home office depreciation

schedules must also be submitted with the home office cost report. All hospital based centers must submit a copy of a depreciation schedule that clearly shows and totals assets that are hospital only, ADHC only and shared assets;

3. an amortization schedule(s), if applicable;

4. a schedule of adjustment and reclassification entries;

5. a narrative description of purchased management services and a copy of contracts for managed services, if applicable;

6. for management services provided by a related party or home office, a description of the basis used to allocate the costs to providers in the group and to non-provider activities and copies of the cost allocation worksheet, if applicable. Costs of related management/home offices must be reported on a separate cost report that includes an allocation schedule; and

7. all allocation worksheets must be submitted by hospital-based centers. The Medicare worksheets that must be attached by centers using the Medicare forms for allocation are:

a. A;

b. A-6;

c. A-7 parts I, II and III;

d. A-8;

e. A-8-1;

f. B part 1; and

g. B-1.

E. Each copy of the cost report must have the original signatures of an officer or center administrator on the certification. The cost report and related documents must be submitted to the address indicated on the cost report instruction form. In order to avoid a penalty for delinquency, cost reports must be postmarked on or before the due date.

F. When it is determined, upon initial review for completeness, that an incomplete or improperly completed cost report has been submitted, the provider will be notified. The provider will be allowed a specified amount of time to submit the requested information without incurring the penalty for a delinquent cost report. For cost reports that are submitted by the due date, 10 working days from the date of the provider’s receipt of the request for additional information will be allowed for the submission of the additional information. For cost reports that are submitted after the due date, five working days from the date of the provider’s receipt of the request for additional information will be allowed for the submission of the additional information. An exception exists in the event that the due date comes after the specified number of days for submission of the requested information. In these cases, the

provider will be allowed to submit the additional requested information on or before the due date of the cost report. If requested additional information has not been submitted by the specified date, a second request for the information will be made. Requested information not received after the second request may not be subsequently submitted and shall not be considered for reimbursement purposes. An appeal of the disallowance of the costs associated with the requested information may not be made. Allowable costs will be adjusted to disallow any expenses for which requested information is not submitted.

G. Accounting Basis. The cost report must be prepared on the accrual basis of accounting. If a center is on a cash basis, it will be necessary to convert from a cash basis to an accrual basis for cost reporting purposes. Particular attention must be given to an accurate accrual of all costs at the year-end for appropriate recordation of costs in the applicable cost reporting period. Care must be given to the proper allocation of costs for contracts to the period covered by such contracts. Amounts earned although not actually received and amounts owed to creditors but not paid must be included in the appropriate cost reporting period.

H. Supporting Information. Providers are required to maintain adequate financial records and statistical data for

proper determination of reimbursable costs. Financial and statistical records must be maintained by the center for five years from the date the cost report is submitted to the Bureau. Cost information must be current, accurate and in sufficient detail to support amounts reported in the cost report. This includes all ledgers, journals, records, and original evidences of cost (canceled checks, purchase orders, invoices, vouchers, inventories, time cards, payrolls, bases for apportioning costs, etc.) that pertain to the reported costs. Census data reported on the cost report must be supportable by daily census records. Such information must be adequate and available for auditing.

I. Attendance Records

1. Attendance data reported on the cost report must be supportable by daily attendance records. Such information must be adequate and available for auditing.

2. Daily attendance records should include the time of each participant’s arrival and departure from the center. The attendance records should document the presence or absence of each participant on each day the center is open. The center’s attendance records should document all admissions and discharges on the attendance records. Attendance records should be kept for all participants that attend the adult day center. This includes Medicaid, Veteran’s Administration, insurance, private, waiver, and other participants. The attendance of all participants

should be documented regardless of whether a payment is received on behalf of the participant. Supporting documentation such as admission documents, discharge summaries, nurse’s progress notes, sign-in/out logs, etc. should be maintained to support services provided to each participant.

J. Employee Record

1. the provider shall retain written verification of hours worked by individual employees:

a. records may be sign-in sheets or time cards, but shall indicate the date and hours worked;

b. records shall include all employees even on a contractual or consultant basis;

2. verification of employee orientation and in-service training; and

3. verification of the employee’s communicable disease screening.

K. Billing Records

1. The provider shall maintain billing records in accordance with recognized fiscal and accounting procedures. Individual records shall be maintained for each participant. These records shall meet the following criteria.

a. Records shall clearly detail each charge and each payment made on behalf of the participant.

b. Records shall be current and shall clearly reveal to whom charges were made and for whom payments were received.

c. Records shall itemize each billing entry.

d. Records shall show the amount of each payment received and the date received.

2. The provider shall maintain supporting fiscal documents and other records necessary to ensure that claims are made in accordance with federal and state requirements.

L. Non-Acceptable Descriptions. Miscellaneous, other, and various, without further detailed explanation, are not acceptable descriptions for cost reporting purposes. If any of these are used as descriptions in the cost report, a request for information will not be made and the related line item expense will be automatically disallowed. The provider will not be allowed to submit the proper detail of the expense at a later date, and an appeal of the disallowance of the costs may not be made.

M. Exceptions. Limited exceptions to the cost report filing requirements will be considered on an individual provider basis upon written request from the provider to the Bureau of Health Services Financing, Rate and Audit Review Section. If an exception is allowed, the provider must attach a statement describing fully the nature of the exception for which prior

written permission was requested and granted. Exceptions which may be allowed with written approval are as follows.

1. If the center has been purchased or established during the reporting period, a partial year cost report may be filed in lieu of the required 12-month report.

2. If the center experiences unavoidable difficulties in preparing the cost report by the prescribed due date, an extension may be requested prior to the due date. Requests for exception must contain a full statement of the cause of the difficulties that rendered timely preparation of the cost report impossible.

N. Delinquent Cost Report. When an ADHC provider fails to submit a cost report by the last day of September following the close of the cost reporting period, a penalty of 5 percent of the monthly payment for the first month and a progressive penalty of 5 percent of the monthly payment for each succeeding month may be levied and withheld from the ADHC provider’s payment for each month that the cost report is due, not extended and not received. The penalty is non-refundable and not subject to an administrative appeal.

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, the Office for

Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:

§713. Cost Categories Included in the Cost Report

A. Direct Care (DC) Costs

1. Salaries, Aides-gross salaries of certified nurse aides and nurse aides in training.

2. Salaries, LPNs-gross salaries of nonsupervisory licensed practical nurses and graduate practical nurses.

3. Salaries, RNs-gross salaries of nonsupervisory registered nurses and graduate nurses (excluding director of nursing and participant assessment instrument coordinator).

4. Salaries, Social Services-gross salaries of nonsupervisory licensed social services personnel providing medically needed social services to attain or maintain the highest practicable physical, mental, or psychosocial well-being of the participants.

5. Salaries, Activities—gross salaries of nonsupervisory activities/recreational personnel providing an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interest and the physical, mental, and psychosocial well-being of the participants.

6. Payroll Taxes—cost of employer's portion of Federal Insurance Contribution Act (FICA), Federal Unemployment

Tax Act (FUTA), State Unemployment Tax Act (SUTA), and Medicare tax for direct care employees.

7. Group Insurance, DC—cost of employer's contribution to employee health, life, accident and disability insurance for direct care employees.

8. Pensions, DC—cost of employer's contribution to employee pensions for direct care employees.

9. Uniform Allowance, DC—employer's cost of uniform allowance and/or uniforms for direct care employees.

10. Worker's Comp, DC—cost of worker's compensation insurance for direct care employees.

11. Contract, Aides—cost of aides through contract that are not center employees.

12. Contract, LPNs—cost of LPNs and graduate practical nurses hired through contract that are not center employees.

13. Contract, RNs—cost of RNs and graduate nurses hired through contract that are not center employees.

14. Drugs, Over-the-Counter and Non-Legend—cost of over-the-counter and non-legend drugs provided by the center to its participants. This is for drugs not covered by Medicaid.

15. Medical Supplies—cost of participant-specific items of medical supplies such as catheters, syringes and sterile dressings.

16. Medical Waste Disposal—cost of medical waste disposal including storage containers and disposal costs.

17. Recreational Supplies, DC—cost of items used in the recreational activities of the center.

18. Other Supplies, DC—cost of items used in the direct care of participants which are not participant-specific such as prep supplies, alcohol pads, betadine solution in bulk, tongue depressors, cotton balls, thermometers, blood pressure cuffs and under-pads and diapers (reusable and disposable).

19. Allocated Costs, Hospital Based—the amount of costs that have been allocated through the step-down process from a hospital or state institution as direct care costs when those costs include allocated overhead.

20. Miscellaneous, DC—costs incurred in providing direct care services that cannot be assigned to any other direct care line item on the cost report.

21. Total Direct Care Costs—sum of the above line items.

B. Care Related (CR) Costs

1. Salaries—gross salaries for care related supervisory staff including supervisors or directors over nursing, social service, and activities/recreation.

2. Salaries, Dietary—gross salaries of kitchen personnel including dietary supervisors, cooks, helpers, and dishwashers.

3. Payroll Taxes—cost of employer's portion of Federal Insurance Contribution Act (FICA), Federal Unemployment Tax Act (FUTA), State Unemployment Tax Act (SUTA), and Medicare tax for care related employees.

4. Group Insurance, CR—cost of employer's contribution to employee health, life, accident, and disability insurance for care related employees.

5. Pensions, CR—cost of employer's contribution to employee pensions for care related employees.

6. Uniform Allowance, CR—employer's cost of uniform allowance and/or uniforms for care related employees.

7. Worker's Comp, CR—cost of worker's compensation insurance for care related employees.

8. Contract, Dietary—cost of dietary services, and personnel hired through contract that are not employees of the center.

9. Consultant Fees, Activities—fees paid to activities personnel, not on the center’s payroll, for providing advisory, and educational services to the center.

10. Consultant Fees, Nursing—fees paid to nursing personnel, not on the center’s payroll, for providing advisory, and educational services to the center.

11. Consultant Fees, Pharmacy—fees paid to a registered pharmacist, not on the center’s payroll, for providing advisory, and educational services to the center.

12. Consultant Fees, Social Worker—fees paid to a social worker, not on the center’s payroll, for providing advisory, and educational services to the center.

13. Consultant Fees, Therapists—fees paid to a licensed therapist, not on the center’s payroll, for providing advisory, and educational services to the center.

14. Food, Raw—cost of food products used to provide meals and snacks to participants. Hospital based facilities must allocate food based on the number of meals served.

15. Food, Supplements—cost of food products given in addition to normal meals and snacks under a doctor's orders. Hospital based facilities must allocate food-supplements based on the number of meals served.

16. Supplies, CR—the costs of supplies used for rendering care related services to the participants of the center. All personal care related items such as shampoo and soap administered by all staff must be included on this line.

17. Allocated Costs, Hospital Based—the amount of costs that have been allocated through the step-down process from a hospital or state institution as care related costs when those costs include allocated overhead.

18. Miscellaneous, CR—costs incurred in providing care related care services that cannot be assigned to any other care related line item on the cost report.

19. Total Care Related Costs—the sum of the care related cost line items.

C. Administrative and Operating Costs (AOC)

1. Salaries, Administrator-gross salary of administrators excluding owners. Hospital based centers must attach a schedule of the administrator's salary before allocation, the allocation method, and the amount allocated to the nursing center.

2. Salaries, Assistant Administrator—gross salary of assistant administrators excluding owners.

3. Salaries, Housekeeping—gross salaries of housekeeping personnel including housekeeping supervisors, maids, and janitors.

4. Salaries, Laundry—gross salaries of laundry personnel.

5. Salaries, Maintenance—gross salaries of personnel involved in operating and maintaining the physical plant, including maintenance personnel or plant engineers.

6. Salaries, Other Administrative—gross salaries of other administrative personnel including bookkeepers, receptionists, administrative assistants, and other office and clerical personnel.

7. Salaries, Owner or Owner/Administrator—gross salaries of all owners of the center that are paid through the center.

8. Payroll Taxes—cost of employer's portion of Federal Insurance Contribution Act (FICA), Federal Unemployment Tax Act (FUTA), State Unemployment Tax Act (SUTA), and Medicare tax for administrative and operating employees.

9. Group Insurance, AOC—cost of employer's contribution to employee health, life, accident, and disability insurance for administrative, and operating employees.

10. Pensions, AOC—cost of employer's contribution to employee pensions for administration, and operating employees.

11. Uniform Allowance, AOC—employer's cost of uniform allowance and/or uniforms for administration and operating employees.

12. Worker's Compensation, AOC—cost of worker's compensation insurance for administration and operating employees.

13. Contract, Housekeeping—cost of housekeeping services and personnel hired through contract that are not employees of the center.

14. Contract, Laundry—cost of laundry services and personnel hired through contract that are not employees of the center.

15. Contract, Maintenance—cost of maintenance services and persons hired through contract that are not employees of the center.

16. Consultant Fees, Dietician—fees paid to consulting registered dieticians.

17. Accounting Fees—fees incurred for the preparation of the cost report, audits of financial records, bookkeeping, tax return preparation of the adult day health care center and other related services excluding personal tax planning and personal tax return preparation.

18. Amortization Expense, Non-Capital—costs incurred for legal and other expenses when organizing a corporation must be amortized over a period of 60 months. Amortization of costs attributable to the negotiation or settlement of the sale or purchase of any capital asset on or after July 18, 1984, whether

by acquisition or merger, for which any payment has previously been made are non-allowable costs. If allowable cost is reported on this line, an amortization schedule must be submitted with the cost report.

19. Bank Service Charges—fees paid to banks for service charges, excluding penalties and insufficient funds charges.

20. Dietary Supplies—costs of consumable items such as soap, detergent, napkins, paper cups, straws, etc., used in the dietary department.

21. Dues—dues to one organization are allowable.

22. Educational Seminars and Training—the registration cost for attending educational seminars and training by employees of the center and costs incurred in the provision of in-house training for center staff, excluding owners or administrative personnel.

23. Housekeeping Supplies—cost of consumable housekeeping items including waxes, cleaners, soap, brooms and lavatory supplies.

24. Insurance, Professional Liability and Other—includes the costs of insuring the center against injury and malpractice claims.

25. Interest expense, non-capital interest paid on short term borrowing for center operations.

26. Laundry Supplies—cost of consumable goods used in the laundry including soap, detergent, starch and bleach.

27. Legal Fees—only actual and reasonable attorney fees incurred for non-litigation legal services related to participant care are allowed.

28. Linen Supplies—cost of sheets, blankets, pillows, and gowns.

29. Management Fees and Home Office Costs—the cost of purchased management services or home office costs incurred that are allocable to the provider. Costs for related management/home office must also be reported on a separate cost report that includes an allocation schedule.

30. Office Supplies and Subscriptions—cost of consumable goods used in the business office such as:

a. pencils, paper and computer supplies;

b. cost of printing forms and stationery including, but not limited to, nursing and medical forms, accounting and census forms, charge tickets, center letterhead and billing forms;

c. cost of subscribing to newspapers, magazines and periodicals.

31. Postage-cost of postage, including stamps, metered postage, freight charges, and courier services.

32. Repairs and Maintenance—supplies and services, including electricians, plumbers, extended service agreements, etc., used to repair and maintain the center building, furniture and equipment except vehicles. This includes computer software maintenance.

33. Taxes and Licenses—the cost of taxes and licenses paid that are not included on any other line of the cost report. This includes tags for vehicles, licenses for center staff (including nurse aide re-certifications) and buildings.

34. Telephone and Communications—cost of telephone services, internet and fax services.

35. Travel—cost of travel (airfare, lodging, meals, etc.) by the administrator and other authorized personnel to attend professional and continuing educational seminars and meetings or to conduct center business. Commuting expenses and travel allowances are not allowable.

36. Utilities—cost of water, sewer, gas, electric, cable TV and garbage collection services.

37. Allocated Costs, Hospital Based—costs that have been allocated through the step-down process from a hospital as administrative and operating costs.

38. Advertising–costs of employment advertising and soliciting bids. Costs related to promotional advertising are not allowable.

39. Maintenance Supplies-supplies used to repair and maintain the center building, furniture and equipment except vehicles.

40. Miscellaneous—costs incurred in providing center services that cannot be assigned to any other line item on the cost report. Examples of miscellaneous expenses are small equipment purchases, all employees' physicals and shots, nominal gifts to all employees, such as a turkey or ham at Christmas, and flowers purchased for the enjoyment of the participants. Items reported on this line must be specifically identified.

41. Total administrative and operating costs.

D. Property and Equipment

1. Amortization Expense, Capital—legal and other costs incurred when financing the center must be amortized over the life of the mortgage. Amortization of goodwill is not an allowable cost. Amortization of costs attributable to the negotiation or settlement of the sale or purchase of any capital asset on or after July 18, 1984, whether by acquisition or merger, for which any payment has previously been made are non-allowable costs. If allowable cost is reported on this line, an amortization schedule must be submitted with the cost report.

2. Depreciation—depreciation on the center's buildings, furniture, equipment, leasehold improvements, and land improvements.

3. Interest Expense, Capital—interest paid or accrued on notes, mortgages, and other loans, the proceeds of which were used to purchase the center's land, buildings and/or furniture, and equipment, excluding vehicles.

4. Property Insurance—cost of fire and casualty insurance on center buildings, and equipment, excluding vehicles. HCBS providers that share owned or leased space with other programs, Medicaid or private, should allocate building costs such as property insurance, property taxes, depreciation, etc. based on documented square footage used by each program.

5. Property Taxes—taxes levied on the center's buildings and equipment. HCBS providers that share owned or leased space with other programs, Medicaid or private, should allocate building costs such as property insurance, property taxes, depreciation, etc. based on documented square footage used by each program.

6. Rent, Building—cost of leasing the center's real property.

7. Rent, Furniture and Equipment—cost of leasing the center's furniture and equipment, excluding vehicles.

8. Allocated Costs, Hospital Based—costs that have been allocated through the step-down process from a hospital or state institution as property costs when those costs include allocated overhead.

9. Miscellaneous, Property—any capital costs related to the center that cannot be assigned to any other property and equipment line item on the cost report.

10. Total property and equipment.

E. Transportation Costs

1. Salaries, Drivers—gross salaries of personnel involved in transporting participants to and from the center.

2. Payroll Taxes, Transportation—the cost of the employer's portion of Federal Insurance Contribution Act (FICA), Federal Unemployment Tax Act (FUTA), State Unemployment Tax Act (SUTA), and Medicare tax for drivers.

3. Employee Benefits, Transportation—the cost of group insurance, pensions, uniform allowances, and other employee benefits related to drivers.

4. Workers' Compensation, Transportation—the cost of workers' compensation insurance for drivers.

5. Non-Emergency Medical Transportation—the cost of purchased non-emergency medical transportation services including, but not limited to:

a. payments to employees for use of their personal vehicle(s);

b. ambulance companies; and

c. other transportation companies for transporting participants of the center.

6. Interest Expenses, Vehicles—interest paid or accrued on loans used to purchase vehicles.

7. Property Insurance, Vehicles—the cost of vehicle insurance.

8. Vehicle Expenses—vehicle maintenance and supplies, including gas and oil.

9. Lease, Automotive—the cost of leasing vehicles used for participant care. A mileage log must be maintained. If a leased vehicle is used for both participant care and personal purposes, cost must be allocated based on the mileage log.

10. Total Transportation Costs.

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, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:

§715. Allowable Costs

EDITOR'S NOTE: The provisions of this Section were previously located in LAC 50:XXI.2907.

A. Allowable costs include those costs incurred by providers to conform to state licensure and federal certification standards. General cost principles are applied

during the desk review and audit process to determine allowable costs.

1. These general cost principles include determining whether the cost is:

a. ordinary, necessary, and related to the delivery of care;

b. what a prudent and cost conscious business person would pay for the specific goods or services in the open market or in an arm’s length transaction; and

c. for goods or services actually provided to the center.

B. Through the desk review and/or audit process, adjustments and/or disallowances may be made to a provider’s reported costs. The Medicare Provider Reimbursement Manual is the final authority for allowable costs unless the Department has set a more restrictive policy.

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, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:

§717. Non-allowable Costs

EDITOR'S NOTE: The provisions of this Section were previously located in LAC 50:XXI.2909.

A. Costs that are not based on the reasonable cost of services covered under Medicare and are not related to the care of participants are considered non-allowable costs.

B. Reasonable cost does not include the following:

1. costs not related to participant care;

2. costs specifically not reimbursed under the program;

3. costs that flow from the provision of luxury items or services (items or services substantially in excess or more expensive than those generally considered necessary for the provision of the care);

4. costs that are found to be substantially out of line with other centers that are similar in size, scope of services, and other relevant factors;

5. costs exceeding what a prudent and cost-conscious buyer would incur to purchase the goods or services.

C. General non-allowable costs:

1. services for which Medicaid participants are charged a fee;

2. depreciation of non-participant care assets;

3. services that are reimbursable by other state or federally funded programs;

4. goods or services unrelated to participant care;

5. unreasonable costs.

D. Specific non-allowable costs (this is not an all-inclusive listing):

1. advertising—costs of advertising to the general public that seeks to increase participant utilization of the ADHC center;

2. bad debts—accounts receivable that are written off as not collectible;

3. contributions—amounts donated to charitable or other organizations;

4. courtesy allowances;

5. director’s fees;

6. educational costs for participants;

7. gifts;

8. goodwill or interest (debt service) on goodwill;

9. costs of income producing items such as fund raising costs, promotional advertising, or public relations costs, and other income producing items;

10. income taxes, state, and federal taxes on net income levied or expected to be levied by the federal or state government;

11. insurance, officers—cost of insurance on officers, and key employees of the center when the insurance is not provided to all employees;

12. judgments or settlements of any kind;

13. lobbying costs or political contributions, either directly or through a trade organization;

14. non-participant entertainment;

15. non-Medicaid related care costs—costs allocated to portions of a center that are not licensed as the reporting ADHC or are not certified to participate in Title XIX;

16. officers' life insurance with the center or owner as beneficiary;

17. payments to the parent organization or other related party;

18. penalties and sanctions—penalties and sanctions assessed by the Centers for Medicare and Medicaid Services, LDH, the Internal Revenue Service or the state Tax Commission;

19. insufficient funds charges;

20. personal comfort items; and

21. personal use of vehicles.

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, the Office for

Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:

§719. Audits

EDITOR'S NOTE: The provisions of this Section were previously located in LAC 50:XXI.2911.

A. Each provider shall file an annual center cost report and, if applicable, a central office cost report.

B. The provider shall be subject to financial and compliance audits.

C. All providers who elect to participate in the Medicaid program shall be subject to audit by state or federal regulators or their designees. Audit selection shall be at the discretion of the department.

1. The department conducts desk reviews of all of the cost reports received and also conducts on-site audits of provider cost reports.

2. The records necessary to verify information submitted to the department on Medicaid cost reports, including related-party transactions, and other business activities engaged in by the provider, must be accessible to the department's audit staff.

D. In addition to the adjustments made during desk reviews and on-site audits, the department may exclude or adjust certain expenses in the cost report data base in order to base

rates on the reasonable and necessary costs that an economical and efficient provider must incur.

E. The center shall retain such records or files as required by the department and shall have them available for inspection for five years from the date of service or until all audit exceptions are resolved, whichever period is longer.

F. If a center’s audit results in repeat findings and adjustments, the department may:

1. withhold provider’s payments until the center submits documentation that the non-compliance has been resolved;

2. exclude the provider’s cost from the database used for rate setting purposes; and

3. impose civil monetary penalties until the center submits documentation that the non-compliance has been resolved.

G. If the department’s auditors determine that a center’s financial and/or census records are unauditable, the provider’s payments may be withheld until the center submits auditable records. The provider shall be responsible for costs incurred by the department’s auditors when additional services or procedures are performed to complete the audit.

H. Provider payments may also be withheld under the following conditions:

1. a center fails to submit corrective action plans in response to financial and compliance audit findings within 15

days after receiving the notification letter from the department; or

2. a center fails to respond satisfactorily to the department’s request for information within 15 days after receiving the department’s notification letter.

I. The provider shall cooperate with the audit process by:

1. promptly providing all documents needed for review;

2. providing adequate space for uninterrupted review of records;

3. making persons responsible for center records and cost report preparation available during the audit;

4. arranging for all pertinent personnel to attend the closing conference;

5. insuring that complete information is maintained in participant’s records;

6. developing a plan of correction for areas of noncompliance with state and federal regulations immediately after the exit conference time limit of 30 calendar days.

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, the Office for

Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:

§721. Exclusions from the Database

EDITOR'S NOTE: The provisions of this Section were previously located in LAC 50:XXI.2913.

A. The following providers shall be excluded from the database used to calculate the rates:

1. providers with disclaimed audits; and

2. providers with cost reports for periods other than a 12-month 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, Bureau of Health Services Financing, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:

§723. Provider Reimbursement

A. Cost Determination Definitions

Base Rate—calculated in accordance with §723.B.5, plus any base rate adjustments granted in accordance with §723.B.7 which are in effect at the time of calculation of new rates or adjustments.

Index Factor—computed by dividing the value of the index for December of the year preceding the rate year by the

value of the index one year earlier (December of the second preceding year).

Indices—

a. *CPI, All Items*—the Consumer Price Index for All Urban Consumers-South Region (all items line) as published by the United States Department of Labor.

b. *CPI, Medical Services*—the Consumer Price Index for All Urban Consumers-South Region (medical services line) as published by the United States Department of Labor.

Rate Component—the rate is the summation of the following:

a. direct care;

b. care related costs;

c. administrative and operating costs;

d. property costs; and

e. transportation costs.

B. Rate Determination

1. The base rate is calculated based on the most recent audited or desk reviewed cost for all ADHC providers filing acceptable full year cost reports. The rates are based on cost components appropriate for an economic and efficient ADHC providing quality service. The participant per quarter hour rates represent the best judgment of the state to provide

reasonable and adequate reimbursement required to cover the costs of economic and efficient ADHC.

2. For rate periods between rebasing, the rates will be trended forward using the index factor contingent upon appropriation by the legislature.

3. The median costs for each component are multiplied in accordance with §723.B.4 then by the appropriate index factors for each successive year to determine base rate components. For subsequent years, the components thus computed become the base rate components to be multiplied by the appropriate index factors, unless they are adjusted as provided in §723.B.6 below. Application of an inflationary adjustment to reimbursement rates in non-rebasing years shall apply only when the state legislature allocates funds for this purpose. The inflationary adjustment shall be made prorating allocated funds based on the weight of the rate components.

4. The inflated median shall be increased to establish the base rate median component as follows.

a. The inflated direct care median shall be multiplied times 115 percent to establish the direct care base rate component.

b. The inflated care related median shall be multiplied times 105 percent to establish the care related base rate component.

c. The administrative and operating median shall be multiplied times 105 percent to establish the administrative and operating base rate component.

5. At least every three years, audited and desk reviewed cost report items will be compared to the rate components calculated for the cost report year to insure that the rates remain reasonably related to costs.

6. Formulae. Each median cost component shall be calculated as follows.

a. Direct Care Cost Component. Direct care allowable quarter hour costs from all acceptable full year cost reports, except those for which an audit disclaimer has been issued, shall be arrayed from lowest to highest. The cost at the midpoint of the array shall be the median cost. Should there be an even number of arrayed cost, an average of the two midpoint centers shall be the median cost. The median cost shall be trended forward by dividing the value of the consumer price index-medical services (south region) index for December of the year preceding the rate year by the value of the index for the December of the year preceding the cost report year. The direct care rate component shall be set at 115 percent of the inflated median.

b. Care Related Cost Component. Care related allowable quarter hour costs from all acceptable full year cost

reports, except those for which an audit disclaimer has been issued, shall be arrayed from lowest to highest. The cost of the center at the midpoint of the array shall be the median cost. Should there be an even number of arrayed cost, an average of the two midpoint centers shall be the median cost. The median cost shall be trended forward by the value of the consumer price index-all items (south region) index for December of the year preceding the rate year by the value of the index for the December of the year preceding the cost report year. The care related rate component shall be set at 105 percent of the inflated median.

c. Administrative and Operating Cost Component. Administrative and operating allowable quarter hour cost from all acceptable full year cost reports, except those for which an audit disclaimer has been issued, shall be arrayed from lowest to highest. The cost of the midpoint of the array shall be the median cost. Should there be an even number of arrayed cost, an average of the two midpoint centers shall be the median cost. The median cost shall be trended forward by dividing the value of the CPI-all items (south region) index for December of the year preceding the base rate year by the value of the index for the December of the year preceding the cost report year. The administrative and operating rate component shall be set at 105 percent of the inflated median.

d. Property Cost Component. The property allowable quarter hour costs from all acceptable full year cost reports, except those for which an audit disclaimer has been issued, shall be arrayed from lowest to highest. The cost at the midpoint of the array shall be the median cost. Should there be an even number of arrayed cost, an average of the two midpoint centers shall be the median cost. This will be the rate component. Inflation will not be added to property costs.

e. Transportation Cost Component. The transportation allowable quarter hour costs from all acceptable full year cost reports, except those for which an audit disclaimer has been issued, will be calculated on a provider by provider basis. Should a provider not have filed an acceptable full year cost report, the provider's transportation cost will be reimbursed as follows.

i. New provider, as described in §723.E.1, will be reimbursed in an amount equal to the statewide allowable quarter hour median transportation costs.

(a). In order to calculate the statewide allowable quarter hour median transportation costs, all acceptable full year cost reports, except those for which an audit disclaimer has been issued, shall be arrayed from lowest to highest. The cost at the midpoint of the array shall be the median cost. Should there be an even number of arrayed cost, an

average of the two midpoint centers shall be the median cost. This will be the rate component. Inflation will not be added to transportation costs.

ii. Providers that have gone through a change of ownership (CHOW), as described in §723.E.2, will be reimbursed for transportation costs based upon the previous owner's specific allowable quarter hour transportation costs for the period of time between the effective date of the CHOW and the first succeeding base year in which the new owner could possibly file an allowable 12-month cost report. Thereafter, the new owner's data will be used to determine the provider's rate following the procedures specified in this Rule.

iii. Providers that have been issued an audit disclaimer, or have a non-filer status, as described in §723.E.3, will be reimbursed for transportation costs at a rate equal to the lowest allowable quarter hour transportation cost (excluding providers with no transportation costs) in the state as of the most recent audited and/or desk reviewed rate database.

iv. For rate periods between rebasing years, if a provider discontinues transportation services and reported no transportation costs on the most recently audited or desk reviewed cost report, no center specific transportation rate will be added to the center's total rate for the rate year.

7. Budgetary Constraint Rate Adjustment. Effective for the rate period July 1, 2011 to July 1, 2012, the allowable quarter hour rate components for direct care, care related, administrative and operating, property, and transportation shall be reduced by 10.8563 percent.

8. Interim Adjustments to Rates. If an unanticipated change in conditions occurs that affects the cost of at least 50 percent of the enrolled ADHC providers by an average of 5 percent or more, the rate may be changed. The department will determine whether or not the rates should be changed when requested to do so by 25 percent or more of the enrolled providers, or an organization representing at least 25 percent of the enrolled providers. The burden of proof as to the extent and cost effect of the unanticipated change will rest with the entities requesting the change. The department may initiate a rate change without a request to do so. Changes to the rates may be temporary adjustments or base rate adjustments as described below.

a. Temporary Adjustments. Temporary adjustments do not affect the base rate used to calculate new rates.

i. Changes Reflected in the Economic Indices. Temporary adjustments may be made when changes which will eventually be reflected in the economic indices, such as a change in the minimum wage, a change in FICA or a utility rate

change, occur after the end of the period covered by the indices(i.e., after the December preceding the rate calculation). Temporary adjustments are effective only until the next annual base rate calculation.

ii. Lump Sum Adjustments. Lump sum adjustments may be made when the event causing the adjustment requires a substantial financial outlay, such as a change in certification standards mandating additional equipment or furnishings. Such adjustments shall be subject to the bureau’s review and approval of costs prior to reimbursement.

b. Base Rate Adjustment. A base rate adjustment will result in a new base rate component value that will be used to calculate the new rate for the next fiscal year. A base rate adjustment may be made when the event causing the adjustment is not one that would be reflected in the indices.

9. Provider Specific Adjustment. When services required by these provisions are not made available to the participant by the provider, the department may adjust the prospective payment rate of that specific provider by an amount that is proportional to the cost of providing the service. This adjustment to the rate will be retroactive to the date that is determined by the department that the provider last provided the service and shall remain in effect until the department validates, and accepts in writing, an affidavit that the

provider is then providing the service and will continue to provide that service.

C. Cost Settlement. The direct care cost component shall be subject to cost settlement. The direct care floor shall be equal to 70 percent of the median direct care rate component trended forward for direct care services (plus 70 percent of any direct care incentive added to the rate). The Medicaid Program will recover the difference between the direct care floor and the actual direct care amount expended. If a provider receives an audit disclaimer, the cost settlement for that year will be based on the difference between the direct care floor and the lowest direct care per diem of all centers in the most recent audited and/or desk reviewed database. If the lowest direct care per diem of all centers in the most recent audited and/or desk reviewed database is lower than 50 percent of the direct care rate paid for that year, 50 percent of the direct care rate paid will be used as the provider’s direct care per diem for settlement purposes.

D. Support Coordination Services Reimbursement. Support coordination services previously provided by ADHC providers and included in the rate, including the interRAI Home Care assessment, the social assessment, the nursing assessment, the plan of care (POC) and home visits are no longer the responsibility of the ADHC provider. Support coordination

services shall be provided as a separate service covered in the waiver programs. As a result of the change in responsibilities, the rate paid to ADHC providers was adjusted accordingly.

E. New Centers, Changes of Ownership of Existing Centers, and Existing Centers with Disclaimer or Non-Filer Status.

1. New centers are those entities whose beds have not previously been certified to participate, or otherwise have participated, in the Medicaid program. New centers will be reimbursed in accordance with this Rule and receiving the direct care, care related, administrative and operating, property rate components as determined in §723.B.1-6. These new centers will also receive the state-wide average transportation rate component, as calculated in §723.B.6.e.i.(a), effective the preceding July 1.

2. A change of ownership exists if the beds of the new owner have previously been certified to participate, or otherwise have participated, in the Medicaid program under the previous owner’s provider agreement. Rates paid to centers that have undergone a change in ownership will be based upon the rate paid to the previous owner for all rate components. Thereafter, the new owner’s data will be used to determine the center’s rate following the procedures in this Rule.

3. Existing providers that have been issued an audit disclaimer, or are a provider who has failed to file a complete

cost report in accordance with §711, will be reimbursed based upon the statewide allowable quarter hour median costs for the direct care, care related, administrative and operating, and property rate components as determined in §723.B.1-7. No inflation or median adjustment factor will be included in these components. The transportation component will be reimbursed as described in §723.B.6.e.iii.

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, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXI. Home and Community Based Services Waivers
Subpart 3. Adult Day Health Care

Chapter 29. Reimbursement

§2901. General Provisions

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 Human Resources, Office of Family Security, LR 11:626 (June 1985), amended LR 13:181 (March 1987), amended by the Department

of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 23:1154 (September 1997), repromulgated LR 30:2041 (September 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office of Aging and Adult Services, LR 32:2257 (December 2006), LR 34:2164 (October 2008), repromulgated LR 34:2569 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2625 (September 2011), LR 39:2497 (September 2013), repealed by the Department of Health, Bureau of Health Services Financing, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:

§2903. Cost Reporting

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 Aging and Adult Services, LR 34:2164 (October 2008), repromulgated LR 34:2569 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2626 (September 2011), LR 41:379 (February 2015), repealed by the Department of Health, Bureau of Health

Services Financing, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:

§2905. Cost Categories Included in the Cost Report

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 Aging and Adult Services, LR 34:2166 (October 2008), repromulgated LR 34:2571 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2626 (September 2011), amended LR 41:381 (February 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 43:324 (February 2017), repealed by the Department of Health, Bureau of Health Services Financing, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:

§2907. Allowable Costs

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, the Office of Aging and Adult Services, LR

34:2168 (October 2008), repromulgated LR 34:2573 (December 2008), repealed by the Department of Health, Bureau of Health Services Financing, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:

§2909. Non-allowable Costs

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, the Office of Aging and Adult Services, LR 34:2169 (October 2008), repromulgated LR 34:2573 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 41:382 (February 2015), repealed by the Department of Health, Bureau of Health Services Financing, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:

§2911. Audits

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, the Office of Aging and Adult Services, LR 34:2169 (October 2008), repromulgated LR 34:2574 (December

2008), repealed by the Department of Health, Bureau of Health Services Financing, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:

§2913. Exclusions from the Database

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, the Office of Aging and Adult Services, LR 34:2170 (October 2008), repromulgated LR 34:2574 (December 2008), repealed by the Department of Health, Bureau of Health Services Financing, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:

§2915. Provider Reimbursement

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, the Office of Aging and Adult Services, LR 34:2170 (October 2008), repromulgated LR 34:2575 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2157 (July 2011), LR 37:2627 (September 2011), repromulgated LR 38:1594 (July 2012), amended LR 39:507 (March

2013), LR 41:382 (February 2015), repealed by the Department of Health, Bureau of Health Services Financing, the Office for Citizens with Developmental Disabilities and the Office of Aging and Adult Services, LR 47:

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.

Dr. Courtney N. Phillips

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Home Health Program
Durable Medical Equipment

The Department of Health, Bureau of Health Services Financing has repealed the following uncodified Rules in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act:

Register Date	Title	Register Volume, Number	Page Number
October 20, 1984	Kangaroo Pump	Vol. 10, No. 10	802
June 20, 2004	Durable Medical Equipment Program – HIPAA Implementation	Vol. 30, No. 6	1210

This Rule is promulgated in accordance with the provisions of the Administrative Procedures Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

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.

Dr. Courtney N. Phillips

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Intermediate Care Facilities for
Persons with Intellectual Disabilities
Reimbursement Methodology
Direct Care Floor Recoupment
(LAC 50:VII.32901)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:VII.32901 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 VII. Long Term Care
Subpart 3. Intermediate Care Facilities for Persons with Intellectual Disabilities

Chapter 329. Reimbursement Methodology

Subchapter A. Non-State Facilities

§32901. Cost Reports

A. – B.2. ...

C. Direct Care Floor

1. – 4. ...

5. Upon completion of desk reviews or audits, facilities will be notified by the bureau of any changes in amounts due based on audit or desk review adjustments.

a. Direct care floor recoupment as a result of a facility not meeting the required direct care per diem floor is considered effective 30 days from the issuance of the original notice of determination. Should an informal reconsideration be requested, the recoupment will be considered effective 30 days from the issuance of the results of an informal hearing. The filing of a timely and adequate notice of an administrative appeal does not suspend or delay the imposition of a recoupment(s).

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 31:1592 (July 2005), repromulgated LR 31:2252 (September 2005), amended LR 33:461 (March 2007), amended by the Department of Health, Bureau of Health Services Financing, LR 44:1446 (August 2018), LR 46:28 (January 2020), LR 47:

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.

Dr. Courtney N. Phillips

Secretary

RULE

Department of Health
Bureau of Health Services Financing
and
Office for Citizens with Developmental Disabilities

Targeted Case Management
(LAC 50:XV.Chapters 101-117)

The Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities have amended LAC 50:XV.Chapters 101-113 and 117, and repealed Chapter 115 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. This Subpart 7 governs the provision of case management services to targeted population groups and certain home and community based services waiver groups. The primary objective of case management is the attainment of the personal outcomes identified in the recipient’s comprehensive plan of care. All case management agencies shall be required to

incorporate personal outcome measures in the development of comprehensive plans of care and to implement procedures for self-evaluation of the agency. All case management agencies shall comply with the policies contained in this Subpart 7. Case management is defined as services provided to individuals to assist them in gaining access to the full range of needed services including:

1. – 4. ...

B. The department utilizes a broker model of case management in which recipients are referred to other agencies for the specific services they need. These services are determined by individualized planning with the recipient's family or legal guardian and other persons/professionals deemed appropriate. Services are provided in accordance with a written comprehensive plan of care which includes measurable person-centered outcomes.

C. Recipient Freedom of Choice. Recipients have the right to select the provider of their case management services from among those available agencies enrolled to participate in the program. If the recipient fails to respond the department shall automatically assign them to an available provider. Recipients who are auto-assigned may change once, after 30 days but before 45 days of auto assignment, to an available provider.

D. Recipients shall be linked to a case management agency for a six-month period before they can transfer to another agency unless there is good cause for the transfer. Approval of good cause shall be made by the LDH case management administrator. Good cause is determined to exist under the following circumstances:

1. the recipient moves to another LDH region; or

2. ...

E. Recipients who are age 25 and under and require ventilator assisted care may receive their case management services through the Children’s Hospital Ventilator Assisted Care Program.

F. Monitoring. The Department of Health and the Department of Health and Human Services have the authority to monitor and audit all case management agencies in order to determine continued compliance with the rules, policies, and procedures governing case management services.

G. 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 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:

Chapter 103. Core Elements

§10301. Services

A. – A.1. ...

2. Case Management Assessment. Assessment is the process of gathering and integrating formal and informal information regarding a recipient's goals, strengths, and needs to assist in the development of a person centered comprehensive plan of care. The purpose of the assessment is to assess support needs of the recipient for the provision of supports. The assessment shall be performed in the recipient’s home or another location that the recipient’s family or legal guardian chooses.

3. Comprehensive Plan of Care Development. The comprehensive plan of care (CPOC) is a written plan based upon assessment data (which may be multidisciplinary), observations and other sources of information which reflect the recipient's needs, capacities and priorities. The CPOC attempts to identify

the supports required and the resources available to meet these needs.

a. The CPOC shall be developed through a collaborative process involving the recipient, family or legal guardian, case manager, other support systems, appropriate professionals, and service providers. It shall be developed in the presence of the recipient; therefore, it cannot be completed prior to a meeting with the recipient. The recipient, family or legal guardian, case manager, support system and appropriate professional personnel shall be directly involved and agree to assume specific functions and responsibilities.

b. The CPOC shall be completed and submitted for approval within 60 calendar days of the referral for case management services for initial CPOCs.

4. Case Management Linkage. Linkage is assignment of the case management agency (CMA) to an individual. The CMA is responsible for the arranging of services agreed upon with the recipient and identified in the CPOC. Upon the request of the recipient or responsible party, attempts shall be made to meet service needs with informal resources as much as possible.

5. Case Management Follow-Up/Monitoring. Follow-up/monitoring is the mechanism used by the case manager to assure the appropriateness of the CPOC. Through follow-up/monitoring activity, the case manager not only determines the

effectiveness of the CPOC in meeting the recipient's needs, but identifies when changes in the recipient's status necessitate a revision in the CPOC. The purpose of follow-up/monitoring contacts is to determine:

a. if supports are being delivered as planned;

b. if supports are effective and adequate to meet the recipient’s needs; and

c. whether the recipient is satisfied with the supports.

6. Case Management Reassessment. Reassessment is the process by which the baseline assessment is reviewed and information is gathered for evaluating and revising the overall CPOC. At least every quarter, a complete review of the CPOC shall be performed to assure that the goals and services are appropriate to the recipient's needs as identified in the assessment/reassessment process. A reassessment is also required when a major change occurs in the status of the recipient and/or his family or legal guardian.

7. Case Management Transition/Closure

a. Provided that the recipient has satisfied the requirements of linkage under §10301.A.4, discharge from a case management agency shall occur when the recipient:

i. – iv. ...

b. The closure process shall ease the transition to other services or care systems. The agency shall not retaliate in any way against the recipient for terminating services or transferring to another agency for case management services.

B. In addition to the provision of the core elements, a minimum of one home visit per quarter is required for all recipients of optional targeted and waiver case management services with the exception of individuals participating in either the Children's Choice Waiver or the Supports Waiver. The Children's Choice Waiver requires an in-home visit within six to nine months of the start of a plan of care. Additionally, an in-home visit is required for the annual planning meeting. For Supports Waiver, the in-home visit is required once a year. The remaining quarterly visit may occur at the vocational agency's location. The agency shall ensure that more frequent home visits are performed if indicated in the recipient's CPOC. The purpose of the home visit, if it is determined necessary, is to:

1. – 3. ...

C. The case management agency shall monitor service providers quarterly through telephone monitoring, on-site observation of service visits and review of the service providers' records. The agency shall also ensure that the

service provider and recipient are given a copy of the recipient’s most current CPOC and any subsequent updates.

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 LR 30:1036 (May 2004),amended by the Department of Health, Bureau of Health Services Financing, and the Office for Citizens with Developmental Disabilities, LR 47:

Chapter 105. Provider Participation

§10501. Participation Requirements

A. In order to participate as a case management services provider in the Medicaid Program, an agency shall comply with:

1. ...

2. provider enrollment;

3. ...

4. the specific terms of individual performance agreements.

B. The participation of case management agencies providing service to targeted and waiver populations shall be

limited contingent on the approval of a 1915(b)(4) waiver by the Centers for Medicare and Medicaid Service (CMS).

C. The following are enrollment requirements applicable to all case management agencies, regardless of the targeted or waiver group served. Failure to comply with these requirements may result in sanctions and/or recoupment and disenrollment. The agency shall:

1. demonstrate direct experience in successfully serving the target population and shall have demonstrated knowledge of available community services and methods for accessing them including:

a. the maintenance of a current file containing community resources available to the target population and established linkages with those resources;

b. demonstrating knowledge of the eligibility requirements and application procedures for federal, state, and local government assistance programs which are applicable to the target population served;

c. the employ of sufficient number of case manager and supervisory staff to comply with the staff coverage, staffing qualifications and maximum caseload size requirements described in §§10503, Provider Responsibilities and 10701, Reimbursement.

2. demonstrate administrative capacity and financial resources to provide all core elements of case management services and ensure effective service delivery in accordance with LDH licensing and programmatic requirements;

3. submit a yearly audit of case management costs only and have no outstanding or unresolved audit disclaimer(s) with LDH;

4. assure that all agency staff is employed in accordance with Internal Revenue Service (IRS) and Department of Labor regulations. The subcontracting of individual case managers and/or supervisors is prohibited. However, those agencies who have Medicaid contracts/performance agreements for case management services may subcontract with another licensed case management agency for case manager and/or supervisory staff if prior approval has been obtained from the department;

5. assure that all new staff satisfactorily completes an orientation and training program in the first 90 days of employment. All case managers shall attend all training mandated by the department. Each case manager and supervisor shall satisfactorily complete case management related training annually to meet the minimum training requirements;

6. submit to the local governing entity (LGE) an agency quality assurance plan (QAP) for approval within 90 days of enrollment. Six months following approval of the QAP and

annually thereafter, the agency shall submit an agency self-evaluation in accordance with departmental guidelines;

7. document and maintain recipient records in accordance with federal and state regulations governing confidentiality and licensing requirements;

8. assure the recipient's right to elect to receive or terminate case management services (except for recipients in any OCDD waiver). Assure that each recipient is offered freedom of choice in the selection of an available case management agency (per agency policy);

9. assure that the agency and case managers shall not provide case management and Medicaid reimbursed direct services to the same recipient(s) unless by an affiliate agency with a separate board of directors;

10. with the recipient’s permission, agree to maintain regular contact, share relevant information and coordinate medical services with the recipient’s qualified licensed physician or other licensed health care practitioner who is acting within the scope of practice of his/her respective licensing board(s) and/or certification(s);

11. demonstrate the capacity to participate in the department’s electronic data gathering system(s). All requirements for data submittal shall be followed and

participation is required for all enrolled case management agencies. The software is the property of the department;

12. complete management reports; and

13. assure that all current and potential employees, contractors and other agents and affiliates have not been excluded from participation in any federal health care program by checking the Department of Health and Human Services' Office of Inspector General website and the LDH Adverse Actions website upon hire and monthly thereafter. Potential employees must also have a satisfactory response to a criminal background check as required by the EarlySteps program.

D. – D.12. 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 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 23:732 (June 1997) repealed and promulgated LR 25:1251 (July 1999), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 29:38 (January 2003), repromulgated for inclusion in LAC, LR 30:1037 (May 2004), amended by the Department of Health and Hospitals, Office of the Secretary,

Office of Citizens with Developmental Disabilities, LR 32:1608 (September 2006), amended LR 34:663 (April 2008), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:

§10503. Provider Responsibilities

A. In order to be reimbursed by the Medicaid Program, an enrolled provider of targeted or waiver case management service shall comply with all of the requirements listed in this §10503.

B. Case management agencies shall maintain sufficient staff to serve recipients within the mandated caseload size of 35 with a supervisor to staff ratio of no more than eight case managers per supervisor. Agencies have the option to submit a written request to OCDD if they would like to exceed the 35 recipient maximum caseload per case manager on a time-limited basis. All exceptions to the maximum caseload size or full-time employment of staff requirements shall be prior authorized by the OCDD State Office Waiver Director/designee. All case managers shall be employed by the agency at least 40 hours per week and work at least 50 percent of the time during normal business hours (8 a.m. to 5 p.m., Monday through Friday). Case management supervisors shall be full-time employees and shall be continuously available to case managers. The agency shall have a written policy to ensure service coverage for all recipients

during the normal absences of case managers and supervisors or prior to the filling of vacated staff positions.

C. The agency shall maintain a toll-free telephone number to ensure that recipients have access to case management services 24 hours a day, seven days a week. Recipients shall be able to reach an actual person in case of an emergency, not a recording.

D. ...

1. Each case management agency shall have a written job description and consultation plan that describes how the nurse consultant shall participate in the comprehensive plan of care (CPOC) development for medically complex individuals and others as indicated by the high risk indicators.

2. ...

3. The nurse consultant shall be available to the case management agency at least four hours per week.

E. Records. All agency records shall be maintained in an accessible, standardized order and format at the LDH enrolled office site. The agency shall have sufficient space, facilities, and supplies to ensure effective record keeping.

1. Administrative and recipient records shall be maintained in a manner to ensure confidentiality and security against loss, tampering, destruction, or unauthorized use.

2. The case management agency shall retain its records for the longer of the following time frames:

a. six years from the date of the last payment; or

b. until the records are audited and all audit questions are answered.

3. Agency records shall be available for review by the appropriate state and federal personnel at all reasonable times.

F. – F.3. 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 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 23:732 (June 1997) repealed and promulgated LR 25:1251 (July 1999), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 29:38 (January 2003), repromulgated for inclusion in LAC, LR 30:1038 (May 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:

§10505. Staff Education and Experience

A. Each Medicaid-enrolled agency shall ensure that all staff providing case management services meet the qualifications required in this §10701 prior to assuming any full caseload responsibilities.

B. Case managers hired or promoted on or after the effective date of this rule revision shall meet the following criteria for education and experience qualifications:

1. a bachelor’s degree or master’s degree in social work from a program accredited by the Council on Social Work Education; or

2. a currently licensed registered nurse (RN); or

3. a bachelor’s or master’s degree in a human service related field which includes psychology education, counseling, social services, sociology, philosophy, family and consumer sciences, criminal justice, rehabilitation services, child development, substance abuse, gerontology, and vocational rehabilitation; or

a. Repealed.

4. a bachelor’s degree in liberal arts or general studies with a concentration of at least 16 hours in one of the fields listed in accordance with §10505.B.3.

C. Case management supervisors hired or promoted on or after the effective date of this rule revision, shall meet the following criteria for education and experience:

1. a bachelor’s or master’s degree in social work from a program accredited by the Council on Social Work Education and two years of paid post degree experience in providing support coordination services; or

2. a currently licensed registered nurse with at least two years of paid nursing experience; or

3. a bachelor’s or master’s degree in a human service related field which includes psychology, education, counseling, social services, sociology, philosophy, family and consumer sciences, criminal justice, rehabilitation services, child development, substance abuse, gerontology, and vocational rehabilitation and two years of paid post degree experience in providing support coordination services; or

4. a bachelor’s degree in liberal arts or general studies with a concentration of at least 16 hours in one of the fields listed in §10505.C.3 and two years of paid post degree experience in providing support coordination services.

a. Repealed.

D. Nurse Consultant. The nurse consultant shall meet the following educational qualifications:

1. – 2. ...

E. – E.2.e. 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 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 23:732 (June 1997) repealed and promulgated LR 25:1251 (July 1999), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 29:38 (January 2003), repromulgated for inclusion in LAC, LR 30:1038 (May 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 32:1608 (September 2006), amended LR 34:663 (April 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1700, 1701 (September 2014), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:

§10507. Staff Training

A. Training for case managers and supervisors shall be provided or arranged for by the case management agency. Agencies shall send the appropriate staff to all training mandated by LDH.

B. Training for New Staff. A minimum of 16 hours of orientation shall be provided to all staff, volunteers, and students within one week of employment. A minimum of eight hours

of the orientation training shall address the target population including, but not limited to, specific service needs, available resources and other topics. In addition to the required 16 hours of orientation, all new employees who have no documentation of previous training shall receive a minimum of 16 hours of training during the first 90 calendar days of employment related to the target population and the skills and techniques needed to provide case management to that population.

C. Annual Training. Case managers and supervisors shall satisfactorily complete a minimum of 20 hours of case management-related training annually which may include updates on subjects covered in orientation and initial training. The 16 hours of orientation training required for new employees are not included in the annual training requirement of at least 20 hours.

D. Documentation. All training required in Subsections B and C above shall be evidenced by written documentation and provided to the department upon request.

E. – E.3. ...

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 23:732 (June 1997), repealed and promulgated (LR 25:1251 (July 1999), amended LR 26:2796 (December 2000), LR 26:2797 (December 2000), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 29:39 (January 2003), repromulgated LR 30:1039 (May 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:

Chapter 107. Reimbursement

§10701. Reimbursement

A. Reimbursement for case management services for the Infant and Toddler Program (EarlySteps):

1. ...

2. All services shall be prior authorized.

B. – B.2. ...

C. Effective for dates of service on or after July 1, 2012, the reimbursement rate for case management services provided to the following targeted populations shall be reduced by 1.5 percent of the rates on file as of June 30, 2012:

1. participants in the Early and Periodic Screening, Diagnosis, and Treatment Program; and

2. individuals with developmental disabilities who participate in the New Opportunities Waiver.

D. Effective for dates of service on or after July 1, 2014, case management services provided to participants in the New Opportunities Waiver shall be reimbursed at a flat rate for each approved unit of service.

1. The standard unit of service is equivalent to one month and covers both service provision and administrative (overhead) costs.

a. Service provision includes the core elements in:

i. §10301 of this Chapter;

ii. the case management manual; and

iii. performance agreements.

2. All services shall be prior authorized.

E. Effective for dates of service on or after April 1, 2018, case management services provided to participants in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program shall be reimbursed at a flat rate for each approved unit of service. The standard of service is equivalent to one month.

E.1. – L. 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 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:

§10703. Cost Reports

A. Case management agencies shall provide annual cost reports based on the state fiscal year, July 1 through June 30. Completed reports are due within 90 calendar days after the end of each state fiscal year or by September 28 of each calendar year.

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 35:73 (January 2009), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:

Chapter 109. Infants and Toddlers

§10901. Introduction

A. This Chapter authorizes federal financial participation in the funding of optional targeted case management service for title XIX eligible infants and toddlers who are ages birth through 2 inclusive (0-36 months) who have a developmental delay or established medical condition associated with developmental delay according to the definition contained in part C of the Individuals with Disabilities Education Act, Sec.635(a)(1) [20 USC 1435 (a)(1)] and as further defined in Title 34 of the *Code of Federal Regulations*, Part 303, Section 21 (infant or toddler with a disability).

B. – B.4. ...

C. Definitions

***

Individualized Family Service Plan (IFSP)—a written plan that is developed jointly by the family and service providers which identifies the necessary services to enhance the development of the child as well as the family’s capacity to meet the needs of their child. The IFSP shall be based on the multidisciplinary evaluation and assessment of the child and the family’s identification of their strengths and needs. The initial IFSP shall be developed within 45 days following the referral to the regional system point of entry office with

periodic reviews conducted at least every six months and an annual evaluation to review and revise the IFSP as appropriate.

Multidisciplinary Evaluation (MDE)—the involvement of two or more disciplines or professions in the provision of integrated and coordinated diagnostic procedures to determine a child's eligibility for early intervention services. The evaluation shall include all major developmental areas including cognitive development, physical development including:

a. ...

b. hearing and communication development;

c. social-emotional development;

d. – f. ...

Parent—the term parent/legal guardian when used throughout this Subpart specifically in reference to parents or legal guardians of infants and toddlers aged birth through 2 inclusive (0-36 months) and having a developmental delay or an established medical condition associated with developmental delay refers to the definition of parent according to the Individuals with Disabilities Act, Part C and its accompanying regulations for Early Intervention Programs for Infants and Toddlers with Disabilities and therefore means the following:

a. a biological or adoptive parent of a child;

b. a foster parent, unless State law, regulations, or contractual obligations with a State or local entity prohibit a foster parent from acting as a parent;

c. a guardian generally authorized to act as the child's parent or authorized to make early intervention, educational, health, or developmental decisions for the child (but not the State if the child is a ward of the State);

d. an individual acting in the place of a biological or adoptive parent (including grandparent, stepparent, or other relative) with whom the child lives, or an individual who is legally responsible for the child's welfare; or

e. a surrogate parent who has been appointed in accordance with 34 CFR 303.422 or with the Individuals with Disabilities Education Act, Sec. 639(a)(5) [20 USC 1439(a)(5)].

NOTE: When more than one party is qualified under the definition contained in this Subsection to act as the parent, the biological or adoptive parent must be presumed to be the parent for purposes of Part C of the Individuals with Disabilities Education Act, when attempting to act as the parent under this definition, unless the biological or adoptive does not have legal authority to make educational or early intervention services decisions for the child. If a judicial decree or order identifies a specific person or persons under this subsection to act as the parent of a

child to make educational or early intervention service decisions on behalf of the child, then the person or persons must be determined to be the parent for purposes of Part C of the Individuals with Disabilities Education Act, except that if an early intervention services (EIS) provider or a public agency provides any services to a child or any family member of that child, that EIS provider or public agency may not act as a parent for that child.

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 18:849 (August 1992), amended LR 20:18 (January 1994), repromulgated for inclusion in LAC, LR 30:1040 (May 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:

§10903. Staff Qualifications

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 18:849 (August 1992), amended LR 20:18 (January 1994), repromulgated for inclusion in LAC, LR 30:1040

(May 2004), repealed by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:

§10905. Staff Training

A. The provider shall ensure that Medicaid-funded family service coordination services for eligible beneficiaries are provided by qualified individuals who meet the following training requirements:

1. satisfactory completion of at least 16 hours of orientation prior to performing any family service coordination tasks and an additional 24 hours of related training during the first 90 days of employment. The 16 hours of orientation cover the following subjects:

Agency Specific Training—Eight Hours	
1 hour	Child identification abuse reporting law, emergency and safety procedures
3 hours	Facility personnel policy
4 hours	Orientation to agency policy, including billing and documentation
EarlySteps Specific Training—Eight Hours	
1 hour	Components of the EarlySteps system
1 1/2 hours	Orientation to family needs and participation
2 hours	Interagency agreement/focus and team building
1 hour	Early intervention services (definition and resources)
1 hour	Child search and family service coordinator roles and responsibilities
1 1/2 hours	Multidisciplinary evaluation (MDE) and individualized Family service plan (IFSP) overview.

2. The 24 hours of training to be completed within the first 90 days shall cover the following advanced subjects:

a. state structure for EarlySteps, child search and early intervention service programs;

b. – j. ...

B. In-service training specific to EarlySteps is to be arranged and coordinated by the regional infant and toddler coordinator and specific training content shall be approved by a subcommittee of the state Interagency Coordinating Council, including members from at least the Medicaid agency and the Department of Education. Advanced training in specific subjects (i.e., multidisciplinary evaluations and individualized family service plans) shall be completed by the new family service coordinator prior to assuming those duties.

C. The provider shall ensure that each family service coordinator has completed the required orientation and advanced training during the first 90 days of employment and at least 20 hours of approved in-service education in family service coordination and related areas annually.

D. The provider shall ensure that family service coordinators are supervised by qualified individuals who meet the following licensure, education, experience, training, and other requirements:

1. satisfactorily completion of at least the 20 hours of family service coordination and related orientation required of family service coordinators during the first 90 days

of employment before assuming supervision of any family service coordination;

2. supervisors shall also complete 20 hours of in-service training each year on such subjects as:

a. – c. ...

E. The provider shall sign a notarized letter of assurance that the requirements of Louisiana Medicaid are met.

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 18:849 (August 1992), amended LR 19:648 (May 1993), LR 20:18 (January 1994), repromulgated for inclusion in LAC, LR 30:1040 (May 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:

Chapter 113. Early and Periodic Screening, Diagnosis and Treatment

§11301. Introduction

A. This Early and Periodic Screening, Diagnosis and Treatment (EPSDT) targeted population shall consist of recipients who are between the ages of 0 and 21 years old, on the Request for Services Registry, and meet the specified eligibility criteria. The point of entry for targeted EPSDT case

management services shall be the state Medicaid data contractor for EPSDT case management services. However, for those recipients under 3 years of age, case management services shall continue to be provided through EarlySteps, for eligible children.

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 26:2797 (December 2000), repromulgated for inclusion in LAC, LR 30:1042 (May 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:

§11303. Recipient Qualifications

A. In order to be eligible to receive case management services, the EPSDT recipient shall be between the age of 0 and 21 and meet one of the following criteria:

1. placement on the Request for Services Registry and determined to be eligible for OCDD services through the statement of approval process; or

2. for those who do not meet eligibility, or who are not undergoing eligibility determination, may still receive case management services if they meet the definition of a person with special needs.

a. *Special Needs*—a documented, established medical condition, as determined by a licensed physician or other qualified licensed health care practitioner in accordance with §10501.C.10, that has a high probability of resulting in a developmental delay or that gives rise to a need for multiple medical, social, educational, and other services. In the case of a hearing impairment, the determination of special needs must be made by a licensed audiologist or physician or other qualified licensed health care practitioner in accordance with §10501.C.10.

3. Documentation that substantiates that the EPSDT recipient meets the definition of special needs for case management services includes, but is not limited to:

a. ...

b. receipt of regular services from one or more physicians or other qualified licensed health care practitioner in accordance with §10501.C.10; or

c. ...

d. a report by the recipient’s physician or other qualified licensed health care practitioner in accordance with §10501.C.10 of multiple health or family issues that impact the recipient’s ongoing care; or

e. a determination of developmental delay based upon:

i. ...

ii. the Brigance Screens;

iii. – v. ...

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 26:2797 (December 2000) repromulgated for inclusion in LAC, LR 30:1042 (May 2004), amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:

Chapter 115. Foster Care and Family Support Worker Services

§11501. Introduction

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, Bureau of Health Services Financing, LR 41:1723 (September 2015), repealed by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:

§11503. Covered Services

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, Bureau of Health Services Financing, LR 41:1723 (September 2015), repealed by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:

§11505. Reimbursement

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, Bureau of Health Services Financing, LR 41:1724 (September 2015), repealed by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:

Chapter 117. Individuals with Intellectual Disabilities

§11701. Introduction

A. The targeted population for case management services shall consist of individuals with intellectual disabilities who are participants in the New Opportunities Waiver.

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 16:312 (April 1990), amended LR 23:732

(June 1997), repealed and promulgated LR 25:1251 (July 1999), repromulgated for inclusion in LAC, LR 30:1043 (May 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 32:1608 (September 2006), amended LR 34:664 (April 2008, amended by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 47:

§11703. Electronic Visit Verification

A. An electronic visit verification (EVV) system shall be used for verifying in-home or face-to-face visit requirements for case management services.

1. Case management providers identified by the department shall use the (EVV) system designated by the department;

2. Reimbursement for services may be withheld or denied if a provider:

a. fails to use the EVV system; or

b. uses the system not in compliance with Medicaid’s policies and procedures for EVV.

3. Requirements for proper use of the EVV system are outlined in the respective program’s guidelines.

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 and the Office for Citizens with Developmental Disabilities, LR 47:

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.

Dr. Courtney N. Phillips

Secretary