RULE

Department of Health
Bureau of Health Services Financing

Home and Community-Based Services Providers
Licensing Standards
(LAC 48:I.5043)

The Department of Health, Bureau of Health Services Financing has amended LAC 48:I.5043 as authorized by R.S. 36:254 and R.S. 40:2120.2. 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 48

PUBLIC HEALTH–GENERAL
Part I. General Administration
Subpart 3. Licensing and Certification

Chapter 50. Home and Community-Based Services Providers Licensing Standards

Subchapter D. Service Delivery

§5043. Contract Services

A. – D. ...

E. Any HCBS provider that employs contractors, including independent contractors, shall ensure that such utilization complies with all state and federal laws, rules and/or regulations, including those enforced by the United States Department of Labor.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:77 (January 2012), amended LR 41:2638 (December 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:2511 (December 2017), LR 44:

Rebekah E. Gee MD, MPH

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Intermediate Care Facilities for Persons with Intellectual Disabilities
Cost Reports and Complex Care Reimbursement
(LAC 50:VII.Chapter 329)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:VII.Chapter 329 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 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. Intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) are required to file annual cost reports to the bureau in accordance with the following instructions.

1. Each ICF/IID is required to report all reasonable and allowable costs on a regular facility cost report, including any supplemental schedules designated by the bureau.

A.2. – B.2. ...

C. Direct Care Floor

1. ...

2. For providers receiving pervasive plus supplements in accordance with §32903.H or other client specific adjustments to the rate in accordance with §32903.I, the facility wide direct care floor is established at 94 percent of the per diem direct care payment and at 100 percent of any rate supplements or add-on payments received by the provider, including the pervasive plus supplement, the complex care add-on payment and other client specific adjustments to the rate. The direct care floor will be applied to the cost reporting year in which the facility receives a pervasive plus supplement and/or a client specific rate adjustment. In no case, however, shall a facility receiving a pervasive plus supplement and/or client specific rate adjustment have total facility payments reduced to less than 104 percent of the total facility cost as a result of imposition of the direct care floor.

3. For providers receiving complex care add-on payment in accordance with §32915, but not receiving pervasive plus supplements in accordance with §32903.H or other client

specific adjustments to the rate in accordance with §32903.I, the facility wide direct care floor is established at 85 percent of the per diem direct care payment and at 100 percent of the complex care add-on payment. The direct care floor will be applied to the cost reporting year in which the facility receives a complex care add-on payment. In no case shall a facility receiving a complex care add-on payment have total facility payments reduced to less than 104 percent of the total facility cost as a result of imposition of the direct care floor.

4. For facilities for which the direct care floor applies, if the direct care cost the facility incurred on a per diem basis is less than the appropriate facility direct care floor, the facility shall remit to the bureau the difference between these two amounts times the number of facility Medicaid days paid during the cost reporting period. This remittance shall be payable to the bureau upon submission of the cost report.

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.

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:

§**32915. Complex Care Reimbursements**

A. Effective for dates of service on or after October 1, 2014, non-state intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) may receive an add-on payment to the per diem rate for providing complex care to Medicaid recipients who require such services. The add-on rate adjustment shall be a flat fee amount and may consist of payment for any one of the following components:

1. – 7. ...

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

C. The complex support need screening tool shall be completed and submitted to the department annually from the date

of initial approval of each add-on payment. This annual submittal shall be accompanied by all medical documentation indicated by the screening tool form and any additional documentation requested by the department.

1. – 2.a.iii. Repealed.

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

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

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

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

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

ii. complex medical needs/medically fragile; or

iii. complex behavioral/mental health needs.

3. Repealed.

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

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

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

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

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

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

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

3. – 3.e. Repealed.

G. Qualification for a complex care add-on payment may be reviewed and re-determined by the department annually from the date of initial approval of each add-on payment. This review

shall be performed in the same manner and using the same standard as the initial qualifying review under this section.

H. The department may require compliance with all applicable laws, rules, and regulations as a condition of an ICF/IID's qualification for the complex care add-on rate and may evaluate such compliance in its initial and annual qualifying reviews.

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

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

2. Fiscal analysis and reporting will be required annually.

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

a. hospital admissions and diagnosis/reasons for admission;

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

c. major injuries;

d. falls; and

e. behavioral incidents.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 42:276 (February 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 44:

Subchapter B. Qualifying Loss Review (Private Facilities)

§32949. Basis for Administrative Review

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 24:66 (January 1998), repromulgated LR 31:2255 (September 2005), repealed by the Department of Health, Bureau of Health Services Financing, LR 44:

§32951. Request for Administrative Review

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 24:66 (January 1998), repromulgated LR

31:2255 (September 2005), repealed by the Department of Health, Bureau of Health Services Financing, LR 44:

§32953. Basis for Rate Adjustment

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 24:66 (January 1998), repromulgated LR 31:2256 (September 2005), repealed by the Department of Health, Bureau of Health Services Financing, LR 44:

§32955. Awarding Relief

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 24:66 (January 1998), repromulgated LR 31:2256 (September 2005), repealed by the Department of Health, Bureau of Health Services Financing, LR 44:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services

(CMS), if it is determined that submission to CMS for review and approval is required.

Rebekah E. Gee MD, MPH

Secretary