The Department of Health, Bureau of Health Services Financing proposes to amend the provisions governing the licensing standards for home and community-based services (HCBS) providers in order to clarify the requirements for contract services to ensure that HCBS providers utilize contractors and/or subcontractors in compliance with all state and federal requirements.

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:

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have no impact on family functioning, stability or autonomy as described in R.S. 49:972.

Poverty Impact Statement

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

Provider Impact Statement

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

Public Comments

Interested persons may submit written comments to Cecile Castello, Health Standards Section, P.O. Box 3767, Baton Rouge, LA 70821 or by email to MedicaidPolicy@la.gov. Ms. Castello is responsible for responding to inquiries regarding this proposed Rule. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Public Hearing

A public hearing on this proposed Rule is scheduled for Thursday, June 28, 2018 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing.

Rebekah E. Gee MD, MPH
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES
RULE TITLE: Home and Community-Based Services Providers—Licensing Standards

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

It is anticipated that the implementation of this proposed rule will have no programmatic fiscal impact to the state other than the cost of promulgation for FY 17-18. It is anticipated that $324 (SGF) will be expended in FY 17-18 for the state's administrative expense for the promulgation of this proposed rule and the final rule.

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

It is anticipated that the implementation of this proposed rule will not affect federal revenue collections since the licensing fees, in the same amounts, will continue to be collected.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This proposed Rule is being promulgated to amend the provisions governing the licensing standards for home and community-based services (HCBS) providers in order to clarify the requirements for contract services to ensure that HCBS providers utilize contractors and/or subcontractors in compliance with all state and federal laws, rules, and/or regulations, including those enforced by the United States Department of Labor. It is anticipated that the implementation of this proposed rule will have no economic costs, but may be beneficial to HCBS providers in FY 17-18, FY 18-19 and FY 19-20 by providing clear and concise licensing standards.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This rule has no known effect on competition and employment.

Cecile Castello
Health Standards Section Director
1805#042

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

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

The Department of Health, Bureau of Health Services Financing proposes to amend the provisions governing the reimbursement methodology for intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) in order to: 1) clarify the provisions governing cost reports to align the direct care floor requirements for pervasive plus supplemental payments and complex care add-on payments with current practices; 2) require the annual renewal of the complex care add-on rate and submission of the associated documentation; and 3) eliminate the qualifying loss review requirement.

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.

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have no impact on family functioning, stability or autonomy as described in R.S. 49:972.

Poverty Impact Statement

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

Provider Impact Statement

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

Public Comments

Interested persons may submit written comments to Jen Steele, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Steele is responsible for responding to inquiries regarding this proposed Rule. The

deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Public Hearing

A public hearing on this proposed Rule is scheduled for Thursday, June 28, 2018 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing.

Rebekah E. Gee MD, MPH
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES
RULE TITLE: Intermediate Care Facilities for Persons with Intellectual Disabilities
Cost Reports and Complex Care Reimbursement

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

It is anticipated that implementation of this proposed rule will have no programmatic fiscal impact to the state other than the cost of promulgation for FY 17-18. It is anticipated that $1,188 ($594 SGF and $594 FED) will be expended in FY 17-18 for the state's administrative expense for promulgation of this proposed rule and the final rule.

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

It is anticipated that the implementation of this proposed rule will have no effect on revenue collections other than the federal share of the promulgation costs for FY 17-18. It is anticipated that $594 will be collected in FY 17-18 for the federal share of the expense for promulgation of this proposed rule and the final rule.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This proposed Rule amends the provisions governing the reimbursement methodology for intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) in order to: 1) clarify the provisions governing ICF/IID cost reports to align the direct care floor requirements for pervasive plus supplemental payments and complex care add-on payments with current practices, 2) require the annual renewal of the complex care add-on rate and submission of the associated documentation, and 3) eliminate the qualifying loss review requirement. There is no anticipated cost to providers since the proposed rule does not change the current reimbursement methodology; nor is there an anticipated fiscal impact to the Medicaid Program since the proposed rule is only being promulgated to ensure that the Rule provisions align with current operational practices and does not change the current budgeted amounts for ICF/IID services. This proposed rule may be beneficial to ICFs/IID in FY 17-18, FY 18-19 and FY 19-20 by aligning the reimbursement provisions with current practices and removing qualifying loss review requirements which are not currently in use.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This rule has no known effect on competition and employment.

Jen Steele
Medicaid Director
1805#043

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Public Safety and Corrections
Gaming Control Board

Internal Control; Slots (LAC 42:III.2723)

The Department of Public Safety and Corrections, Gaming Control Board, in accordance with R.S. 27:15 and 24 and with the Administrative Procedure Act, R.S. 49:950 et seq., hereby gives notice that it intends to amend LAC 42:III.2723, Internal Controls; Slots. The proposed amendment increases the minimum payout jackpot threshold triggering the licensee or casino operator having to perform certain duties such as verifying seals and photographing the internal functions of the slot machines.

Title 42
LOUISIANA GAMING
Part III. Gaming Control Board
Chapter 27. Accounting Regulations
§2723. Internal Controls; Slots

A. - D.1.i. …

j. verification and witness by an additional permitted gaming employee if the jackpot is less than $1,200. This signature is not required if the jackpot is paid in accordance with §2723.C.9. If the jackpot is $1,200 or greater, the additional permitted gaming employee shall be an employee from a department independent of the department performing the payout.

D.2. - E.4. …

F. If the jackpot is $10,000 or more, in addition to Subsections D and E of this Section, a surveillance photograph shall be taken of the winner and the payout form shall be signed by a slot supervisor or casino shift manager. The requirements of this Subsection shall be met prior to the device being returned to operation.

G. If the jackpot is greater than $50,000, in addition to Subsections D, E, and F of this Section, the slot attendant shall notify a slot technician who shall verify that division seals protecting the program storage media are intact. If the division seals are broken, the program storage media shall be tested to ensure compliance with these regulations. A photograph of the division seal covering the program storage media shall be taken or the test shall be completed before the jackpot is paid. The photograph may be in digital form and shall be timestamped. The photograph, or a copy of it, shall be attached to the jackpot payout form. Digital versions of the photograph shall be maintained for the same duration as the printed photograph. Surveillance shall record the process of certifying the division seals, any required testing, and the payment to the patron. The requirements of this Subsection shall be complied with prior to the device being returned to operation.

H. If the jackpot is $500,000 or more, in addition to Subsections D, E, F, and G of this Section, the licensee or casino operator shall immediately call for a division agent. Surveillance shall constantly monitor the electronic gaming device until payment of the jackpot has been completed or until otherwise directed by a division agent. With the exception of surveillance monitoring the game and the processing of the jackpot slip, W-2G, and DCFS jackpot intercept search, no action shall be taken until a division