REIMBURSEMENT

Reimbursement for Adult Day Health Care (ADHC) Waiver services shall be a prospective flat rate for each approved unit of service provided to the recipient. Support coordination agencies and ADHC providers must utilize the Health Insurance Portability and Accountability Act (HIPAA) compliant billing procedure code and modifier, when applicable. (See to Appendix C of this manual chapter for information about procedure codes, units of service and current reimbursement rate).

The claim submission date cannot precede the date the service was rendered.

Support Coordination

Support coordination is reimbursed at an established monthly rate (see to Appendix C – Billing Codes). A unit of service is one month. The data contractor issues a monthly authorization to the support coordination agency. After the support coordination requirements are met and documented in the case management database, the authorization is released to the support coordination agency. For each quarter in the recipient's plan of care (POC) year, if the support coordination agency does not meet all of the requirements for documentation in the case management database, the prior authorization (PA) for the last month of that quarter will not be released until all requirements are met and the "Request for Payment/Override Form" has been completed and submitted to the office of Aging and Adult Services (OAAS) Regional Office for approval.

Transition Intensive Support Coordination (TISC)

TISC is reimbursed at an established monthly rate (see to Appendix C – Billing Codes), for a maximum of six months from the POC approval date prior to the date of transition. A service unit is one month. Payment will not be authorized until the data contractor receives an approved POC indicating that the individual was/is a nursing facility resident during the time period in which prior authorization is requested.

Transition Services

Transition services are reimbursed only for the exact amount of expenditures indicated on final approval and supporting documentation. Only one authorization for transition services is issued. The authorization period is the effective date of the POC or revision request through the POC end date. After the approved purchases are made, the POC (provisional, initial or revision) that includes the transition services, the receipts for the purchases and the "Transition Services Form (TSF)" are sent to the data contractor. (See Appendix B for a copy of this form.)

The support coordination agency is then notified of the release of the authorization and can bill the Medicaid fiscal intermediary for these expenses. If the support coordination agency did not initially pay for the pre-approved transition expenses, the support coordination agency shall reimburse the actual purchaser within ten calendar days of receipt of reimbursement.

The OAAS Regional Office, or its designee, shall maintain documentation, including each individual's TSF with original receipts and copies of canceled checks, as record of payment to the purchaser(s). This documentation is for accounting and monitoring purposes.

Billing for transition services must be completed within 60 calendar days after the individual's actual move date in order for the reimbursement to be paid.

NOTE: If the individual is not approved for ADHC Waiver services and/or does not transition, but transition service items were purchased, the OAAS Regional Office must notify the OAAS State Office to allow for possible reimbursement.

If it is determined that additional items are needed after the TSF was approved, and there are remaining transition funds in the individual's budget, the support coordinator must submit another TSF within 90 calendar days after the individual's actual move date. The same procedure outlined above shall be followed for any additional needs.

NOTE: If it is determined that the individual has additional needs that were not identified within the above established timelines, the OAAS Regional Office must notify OAAS State Office to review for exception.

ADHC Services

ADHC providers are reimbursed at a per quarter-hour-rate for services provided under a Prospective Payment System (PPS) that recognizes and reflects the cost of direct care services provided.

The ADHC provider receives notification of PA upon POC approval and can then bill the Medicaid fiscal intermediary for services provided.

The use of the Electronic Visit Verification (EVV) system is mandatory for ADHC services. The EVV system requires use of the Louisiana Services Reporting System (LaSRS®) or another EVV system approved by the Bureau of Health Services Financing (BHSF) and OAAS. The system is to be used to electronically "check in" and "check out" waiver participants when they arrive and when they leave the ADHC center. While there may be some circumstances that require manual edits, these should only be occasional.

The transportation component of ADHC is exempt from this mandatory EVV requirement. However, using the EVV system to electronically record when recipients get on/off the ADHC transportation vehicle may be beneficial to the ADHC provider in preventing overlaps with in-home services and for cost reporting.

In the event of an overlap, the provider that uses the EVV system (i.e. data has not been manually added or edited) will receive payment.

Span Date Billing

Specific services may be billed as span-dated. Each line on the claim form must represent billing for a single date of service for those services that cannot be span-dated. The following table identifies which ADHC Waiver services can or cannot be span-dated:

Services that CANNOT be Span-Dated	Services that CAN be Span-Dated
Adult Day Health Care	Support Coordination
Transition Services	Transition Intensive Support Coordination

Details about when claims can be filed for individual ADHC Waiver services can be found in Section 9.4 – Service Access and Authorization of this manual chapter.

ADHC Provider Cost Reporting

ADHC providers are required to file acceptable annual cost reports of all reasonable and allowable costs.

NOTE: The Louisiana Administrative Code (LAC) (Title 50) lists all allowable and non-allowable costs and all criteria for an acceptable cost report for ADHC providers.

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 six years following the date reports are submitted to the BHSF or its designee. A chart of accounts and an accounting system on accrual basis, or converted to the accrual basis at year's end, are required in the cost report preparation process. BHSF or its designee will perform desk reviews or audits of the cost

reports. A representative number of the centers shall be subject to a full-scope, annual on-site audit. All ADHC cost reports must be filed based on a fiscal year from July 1 through June 30 and filed on or before the last day of September following the close of the cost reporting period.

NOTE: Should the due date fall on a Saturday, Sunday, or an official state or federal holiday, the due date will be the following business day.

All ADHC centers must use the cost reporting forms and instructions developed by BHSF or its designee. Hospital-based and other provider based ADHCs which use Medicare forms for step down in completing their ADHC Medicaid cost reports must submit copies of the applicable Medicare cost report forms.

The Louisiana Administrative Code, Title 50 Subpart 3, Chapter 29 provides detailed information on cost and annual reporting for adult day health care centers. Providers may also reference the contact information in Appendix A to obtain information on cost report training and templates.

ADHC Provider Audits

All Medicaid ADHC providers are subject to financial and compliance audits, as well as audits by state or federal regulators or their designees. Audit selection is at the discretion of the Louisiana Department of Health (LDH). In the event of an audit, the ADHC Waiver provider is responsible for full cooperation as outlined in the LAC, Title 50, Subpart 3, Chapter 29.

If a center has repeat findings and adjustments in audit results, the LDH may:

- Withhold vendor payments until the center submits documentation that the non-compliance has been resolved;
- Exclude the provider's cost from the database used for rate setting purposes; and
- Impose civil monetary penalties until the center submits documentation that confirms the non-compliance has been resolved.

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

Vendor payments may also be withheld under the following conditions:

- A center fails to submit corrective action plans in response to financial and

compliance audit findings within 15 calendar days after receiving the notification letter from the auditor; or

- A center fails to respond satisfactorily to the request for information within 15 calendar days after receiving the notification letter.

The ADHC provider must cooperate with the audit process by:

- Promptly providing all documents needed for review;
- Providing adequate space for uninterrupted review of records;
- Making persons responsible for center records and cost report preparation available during the audit;
- Arranging for all pertinent personnel to attend the closing conference;
- Insuring that complete information is maintained in recipient's records; and
- Developing a plan of correction for areas of non-compliance with state and federal regulations immediately after the exit conference time limit of 30 calendar days.

ADHC Rate Determination

The methodology for calculating each individual component of the overall ADHC rate is a product of the median cost multiplied by an index factor as approved by administrative Rule detailed in the LAC for ADHC providers - Provider Reimbursement. The resultant calculations provide reasonable and adequate reimbursement required to cover the costs of economic and efficient ADHC services. The base rate is calculated using the most recent audit or desk review cost for all ADHC providers filing acceptable full year cost reports and includes the following components:

- Direct care;
- Care related costs;
- Administrative and operating costs;
- Property/capital costs; and

- Transportation costs.

Because of the wide variation in transportation cost, which is influenced by the rural or urban location of the ADHC center and the number of recipients using the ADHC's transportation services versus other means of transportation (e.g. transportation provided by family, etc.), the transportation component of ADHC reimbursement is calculated and paid individually to each ADHC center.

Exclusions from the ADHC Rate Determination Database

The following ADHC providers will be excluded from the database used to calculate the rates:

- Providers with disclaimed audits; and
- Providers with cost reports other than a 12-month period.