REIMBURSEMENT

Reimbursement for Adult Day Health Care (ADHC) Waiver services vary based on the type of service being provided. Support coordination agencies and providers must utilize the Health Insurance Portability and Accountability Act (HIPAA) compliant billing procedure code and modifier, when applicable. (See Appendix C for information about procedure codes, units of service and current reimbursement rates).

Reimbursement for ADHC Waiver services will not be provided for any services delivered prior to the approval of the Plan of Care (POC) and the issuance of Prior Authorization (PA) for those services.
The ADHC Waiver is the payer of last resort as mandated by federal regulation 42 CFR §433.139. If a provider does not fully utilize all available third-party payment sources, the enrolled agency or provider may face the recoupment of funds that Medicaid has previously disbursed. Third-party sources encompass a range of options, including but not limited to private health insurance, casualty insurance, workers' compensation, estates, trusts, tort proceeds, and Medicare.
The claim submission date cannot precede the date the service was rendered.

For details regarding the submission of claims, refer to Appendix E.

Support Coordination

Support coordination is reimbursed at an established monthly rate. (See Appendix C – Billing Codes). The data contractor issues a monthly authorization to the support coordination agency. After the support coordination requirements are met and documented in the data contactor's database, the authorization is released to the support coordination agency. For each quarter in the beneficiary's plan of care (POC) year, if the support coordination agency does not meet all of the requirements for documentation in the data contactor's 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

Transition Intensive Support Coordination (TISC) is reimbursed at an established monthly rate (see to Appendix C – Billing Codes), for a maximum of six (6) months (not to exceed 180 calendar days) from the POC approval date for the months that the beneficiary was residing in the nursing facility. 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 the PA is requested.

Transition Services

Transition services are reimbursed only for the exact amount of expenditures indicated on final approval and supporting documentation. Only one (1) 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 the link to 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 (10) calendar days of receipt of reimbursement.

The OAAS Regional Office, or its designee, shall maintain documentation, including each beneficiary'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 beneficiary'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 beneficiary's budget, the support coordinator must submit another TSF within 90 calendar days after the beneficiary's actual move date. The same procedure outlined above shall be followed for any additional needs.

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

Adult Day Health Care Health Status Monitoring

Reimbursement for Adult Day Health Care Health Status Monitoring (ADHC HSM) must not exceed the set per diem rate. The release of PAs for this service is contingent on post authorization that occurs through the Electronic Visit Verification (EVV) system. The use of EVV is mandatory for ADHC HSM services. The EVV system requires use of the data contractor's database or another EVV system approved by the Bureau of Health Services Financing (BHSF) and OAAS. The system must be used to electronically record the start time and end time of this contact when

the ADHC provider is contacting ADHC Waiver beneficiaries via telephone for this service. Although there may be circumstances that require manual edits, these should only be occasional.

Adult Day Health Care 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.

Release of PA for ADHC services is contingent on post authorization. Post authorization occurs through the Electronic Visit Verification (EVV) system. The use of EVV is mandatory for ADHC services. The EVV system requires use of the data contactor's database or another EVV system approved by BHSF and OAAS. The system is to be used to electronically "check in" and "check out" waiver beneficiaries 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 services is exempt from this mandatory EVV requirement. However, using the EVV system to electronically record when beneficiaries 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 purposes.

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

ADHC Provider Cost Reporting

ADHC providers must submit annual cost reports that detail all reasonable and allowable expenses in an acceptable format. Refer to the Louisiana Administrative Code (LAC) Title 50: Part XXI. Home and Community-Based Services Waivers Subpart 1. Chapter 7. Subchapter B. Adult Day Health Care Providers for the details for the cost reporting requirements for ADHC providers – Link to this rule can be found in Appendix B.

The annual cost reports are the basis for determining reimbursement rates. ADHC providers are required to keep copies of all reports and statistical data for a minimum of six years after submission to BHSF or its designated representative. 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 ADHC centers shall be subject to a comprehensive, annual on-site audit.
All ADHC providers' cost reports must be filed:

1. Based on a fiscal year from July 1st through June 30th; and

2. On or before the last day of September following the close of the cost reporting period.

NOTE: If the cost report due date falls on a Saturday, Sunday or an official state or federal holiday, the due date will be the following business day.

If the LDH Audit contractor does not receive cost reports and all related forms by September 30th, a penalty may be assessed. A penalty of 5 percent of the total weekly payment will be enforced for each week of non-compliance until the completed cost report is submitted. The penalty may be increased an additional 5 percent each month until the completed report is submitted to the LDH Audit contractor. **The penalty is non-refundable and is not subject to an administrative appeal.**

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

ADHC providers can also reference the contact information in Appendix A to obtain information on cost reporting training and templates.

ADHC Provider Audits

All Medicaid ADHC providers are subject to financial and compliance audits, in addition to audits by state or federal regulators or their designees. Audit selection is at the discretion of the LDH. In the event of an audit, the ADHC Waiver provider is responsible for full cooperation as outlined in the following rules:

1. Louisiana Administrative Code (LAC) Title 50; Part XXI. Home and Community-Based Services Waivers; Subpart 1.; Chapter 7.; Subchapter B. Adult Day Health Care Providers; and

2. LAC, Title 50; Part XXI. Home and Community-Based Services Waiver; Subpart 3, Chapter 29. Reimbursement.

If an ADHC provider has repeat findings and adjustments in audit results, LDH may take the following actions:

1. Withhold vendor 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 confirms the non-compliance has been resolved.

If the auditors determine that a center's financial and/or census records are not auditable, the vendor payments may be withheld until the center submits records that can be audited. The provider shall be responsible for costs incurred by the auditors if additional services or procedures are performed to complete the audit.

Vendor payments may also be withheld under the following conditions:

1. ADHC center fails to submit corrective action plans in response to financial and compliance audit findings within 15 calendar days after receiving the the auditor's notification letter; or

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

The ADHC provider must 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 available the individuals responsible for center records and cost report preparation during the audit;

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

5. Ensuring that complete information is maintained in beneficiary's records; and

6. Developing a corrective action plan 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 services rate is a product of the median cost multiplied by an index factor as approved and identified in the LAC Title 50; Part XXI. Home and Community-Based Services Waivers; Subpart 1; Chapter 7; Subchapter B. Adult Day Health Care Providers.

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:

1. Direct care;
2. Care related costs;
3. Administrative and operating costs;
4. Property/capital costs; and
5. Transportation costs.

Due to the wide variation in transportation cost, which is influenced by the rural or urban location of the ADHC center and the number of beneficiaries using the ADHC center's transportation services compared to alternative options (such as family-provided transport), the reimbursement for the transportation component 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 ADHC services rates:

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

Home Delivered Meals

Reimbursement for meals must not exceed the set rate. The provider uses the PA to bill for services after the meals have been delivered.

Providers may span date bill for up to a two weeks' supply of meals.

Activity and Sensor Monitoring

Reimbursement for Activity and Sensor Monitoring (ASM) services includes a one-time installation fee that covers the cost of installation and removal and equipment. Additionally, a

monthly maintenance fee includes a face-to-face visit by a qualified professional should the collected data warrant a visit.

Billing for ASM services involves an installation fee and a monthly maintenance fee. Only one claim for each month is allowed. Claims may be span-dated at the discretion of the provider. Partial months shall not be billed.

If a beneficiary moves to a different location or changes providers, it is permissible to seek reimbursement for a second installation fee.

Personal Emergency Response System

Reimbursement for the Personal Emergency Response System (PERS) is based on a set installation fee and a monthly maintenance fee. The PERS provider may bill for services after they are delivered.

Billing for PERS services involves an installation fee and a monthly maintenance fee. Only one claim for each month is allowed. Claims may be span-dated at the discretion of the provider. Partial months shall not be billed.

If a beneficiary moves to a different location or changes providers, they are eligible for reimbursement for a second installation fee.

Assistive Technology

Assistive Technology (AT) services are reimbursed as noted below:

1. **For the device**: only the exact amount of expenditures indicated on the final approval and supporting documentation (receipts); and

2. **For the procurement/set-up visit**: a one-time lifetime maximum payment.

Only one authorization for AT services is issued. The authorization period is the effective date of the POC or POC Revision request through the POC end date.

After the approved device purchases are made and the in-person set-up visit completed, the POC/POC Revision, the receipt(s) for the purchases and the "Assistive Technology Form" (See Appendix B for the link to this form) must be submitted to the data contractor. Upon receiving complete and accurate information, the data contractor will issue and release the prior authorization (PA) to the support coordination agency. The support coordination agency is then notified of the release of the authorization and can bill the Medicaid fiscal intermediary for these expenses. OAAS, or its designee, shall maintain documentation, including each beneficiary's AT

service form with original receipts, as record of payment to the support coordination agency. This documentation is for accounting and monitoring purposes. Billing for AT services must be completed within 60 calendar days after the set-up visit in order for the reimbursement to be paid.

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
1. Adult Day Health Care 2. Transition Services 3. Adult Day Health Care Health Status Monitoring (ADHC HSM) 4. Activity and Sensor Monitoring, Installation 5. Personal Emergency Response System, Installation 6. Assistive Technology	1. Support Coordination 2. Transition Intensive Support Coordination 3. Home Delivered Meals 4. Activity and Sensor Monitoring, Monthly Service 5. Personal Emergency Response System Monthly Service

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